Ministry of Health

REPUBLIC OF KENYA

National Standards for Improving the Quality of Care for Children Including Small and Sick Newborns

National Standards for Improving the Quality of Care for Children Including Small and Sick Newborns in Health Facilities

NOVEMBER 2023

Contents

Acronyms and abbreviations

ICD	International Classification of Diseases
NICE	National Institute for Health and Care Excellence
UNICEF	United Nations Children's Emergency Fund
KDHS	Kenya Demographic Health Survey
WHO	World Health Organization
SSNB	Small and Sick Newborn
HIV	Human immunodeficiency Virus
KQMH	Kenya Quality Model for Health
QoC	Quality of Care
USAID	United States Agency for International Development
MCGL	MOMENTUM Country & Global Leadership
BPP	Basic paediatric Protocols
ETAT	Emergency Triage Assessment and Treatment plus Admission care
ICD	International Classification of Diseases for Mortality and Morbidity Statistics
IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Neonatal and Childhood Illness
IV	Intravenous
ORS	Oral Rehydration Salts
PSBI	Possible Serious Bacterial Infections
TB	Tuberculosis

Foreword

Kenya has achieved significant reduction in mortality among children aged below 5 years but child deaths remain unacceptably high. The Kenya Demographic Health Survey (KDHS 2022) shows that under-five mortality rate has decreased from 52 to 41 deaths per 1,000 live births, and infant mortality rate from 39 to 32 deaths per 1,000 live births. The neonatal mortality has decreased at a slower rate and currently stands at 21 from 22 deaths per 1,000 live births. According to the same report, neonatal deaths account for 66 percent of infant mortality and 51 percent of under-five mortality. Birth asphyxia, neonatal sepsis, pneumonia, diarrhea, malaria, and malnutrition are the top causes of death among children under the age of five. The majority of these deaths can be prevented by implementing well-known, high-impact evidence-based interventions. The SDG targets to reduce neonatal mortality rate to 12 deaths per 1,000 live births and under 5 mortality rate to 25 deaths per 1,000 live births by 2030. In response to this, the Ministry of Health has implemented several initiatives aimed at improving the quality of care provided to children including small and sick newborns (SSNBs) in health facilities across the country. One of these initiatives is the development of the Kenya National Standards for Improving the Quality of Care for Children including the Small and Sick Newborns. These have been adapted from the WHO Standards for improving the Quality of Care for Small and Sick Newborns in Health Facilities and the WHO Standards for Improving the Quality of Care for children and Young Adolescents in Health Facilities.

The standards are built on the WHO framework for improving the quality of paediatric care and the quality of care for small and sick newborns, which has eight domains that target to achieve the desired individual and facility outcomes. The eight domains define eight categories of Standards. Kenya added a ninth standard that covers community newborn and child health care services. In addition to the standards of care, core indicators to track quality of care for children including small and sick newborns in health facilities have been developed. The indicators will be incorporated into the Kenya Quality Model for Health (KQMH). A health facility quality of care assessment tool, which will be used to operationalize the standards, has also been developed.

It is envisioned that all individuals and institutions providing services to children including small and sick newborns will use these standards to improve the quality of care offered to all children including sick and small newborns to ultimately reduce neonatal und under five mortalities in Kenya.

The standards will also provide a resource for policy-makers, healthcare professionals, health service planners, programme managers, regulators, professional bodies, and technical partners involved in care, to help plan, deliver, and ensure the quality of health services among the children

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Acknowledgement

The Ministry of Health gratefully acknowledges the contribution of MOH Officers and implementing partners who supported the development of this document. We acknowledge Dr. Janette Karimi, Head Division of Newborn and Child Health, Dr. Caroline Mwangi, Dr. Richard Muthoka, Allan Govoga, Elsa Odira, Benard Wambu, Dr. Deborah Okumu, and Alex Mutua from the Division of Newborn and Child Health for their input towards development and finalization of this document.

We also thank the Division of Health Standards and Quality Assurance, Division of Family Wellness and Nutrition, Division of Health Informatics, Division of Reproductive Maternal Health and National Vaccines and Immunization Programme for their participation and contribution.

Our sincere gratitude goes to all County Directors of Health from the nine counties (Machakos, Kajiado, Turkana, Nakuru, Homabay, Kisumu, Narok, Kitui and Nyeri) where the WHO core pediatric Quality of Care indicators mapping and pretesting of the QoC health facility assessment tool was done. We appreciate their support and cooperation without which the entire exercise could not have been successfully completed.

Special thanks goes to the partners including WHO, UNICEF, USAID, MCGL, CHAI, and the Global fund for financial and technical support. We appreciate Dr. Makeba Shiroya, Dr. Desta Teshome, Dr Assumpta Muriithi, Dr Moise Muzigaba and Dr Josephine Agyeman (WHO), Judith Raburu and Dr. Laura Oyiengo (UNICEF), Dr. Cornellia Akinyi and Dr. Linda Misiko (USAID), Dr. Paul Odila, Dr. Abraham Afeworki and Teresa Akun (MCGL), Betty Wariari of Clinton Health Access Initiative (CHAI), .

Lastly, we acknowledge the HENIKE Consultants led by Dr. Crispin Ndedda and assisted by Dr. Annah Wamae, Dr. Emelda Manguro and Dr. Ruth Mutua for providing technical guidance in the development process. I sincerely thank all who participated in the development of this document.

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Definition of Terms

Caregiver	Parent, family member or any other person responsible for the care of a child.
Child	A person under the age of 18 years.(In this guideline, a child is considered to be less than 10 years)
Developmental supportive care	A broad category of interventions designed to minimize the stress of a neonatal intensive care unit. These strategies include control of external stimuli (vestibular, auditory, visual, tactile), clustering of nursery care activities and minimal handling, intentional positioning (nesting, prone position, swaddling) and protection of sleep.
Emergency care area	A designated room or unit in a facility where immediate care and resuscitation are provided for severe or sudden illness, trauma or injury.
Family	In this document, "family" is broadly construed to comprise relatives by blood, adoption or marriage and members of the same household.
Family-centred care	An approach to health care that is respectful of and responsive to individual families' needs and values.
Guideline	Rule or instruction on the best way of doing something.
Health care provider	A trained individual with knowledge and skills to provide preventive, curative, promotional or rehabilitative health care in a systematic way to people, families and communities. They include doctors, nurses, midwives, pharmacists and paramedical staff.
Infant	A child < 1 year of age.
Kangaroo mother care	Immediate, continuous, prolonged skin-to-skin contact between a mother or surrogate and her preterm/low birth weight baby.
Newborn	Infant < 1 month of age (neonate).
Preterm	A baby born above 28 gestational weeks and less than 37 complete gestational weeks
Protocol	A set of rules/procedures to be followed when giving medical treatment.
Quality measure	Criterion for assessing, measuring and monitoring the quality of care as specified in a quality statement.
Quality statement	A concise statement of what is required to ensure measurable quality of care.
Sick newborn	Newborn with any medical or surgical condition.
Small newborn	Newborn weighing < 2500 g at birth (includes preterm and low-birthweight newborns).
Standard	A general statement of what is expected to be provided to ensure high quality care for newborns.
Standard operating procedure	Established or prescribed method to be followed routinely in the performance of designated operations or in designated situations.
Young infant	Infant < 2 months of age.
Training	In this document, training refers to a full course or refresher sessions such as on job training, continuous medical education (CME), mentorship and supportive supervision.

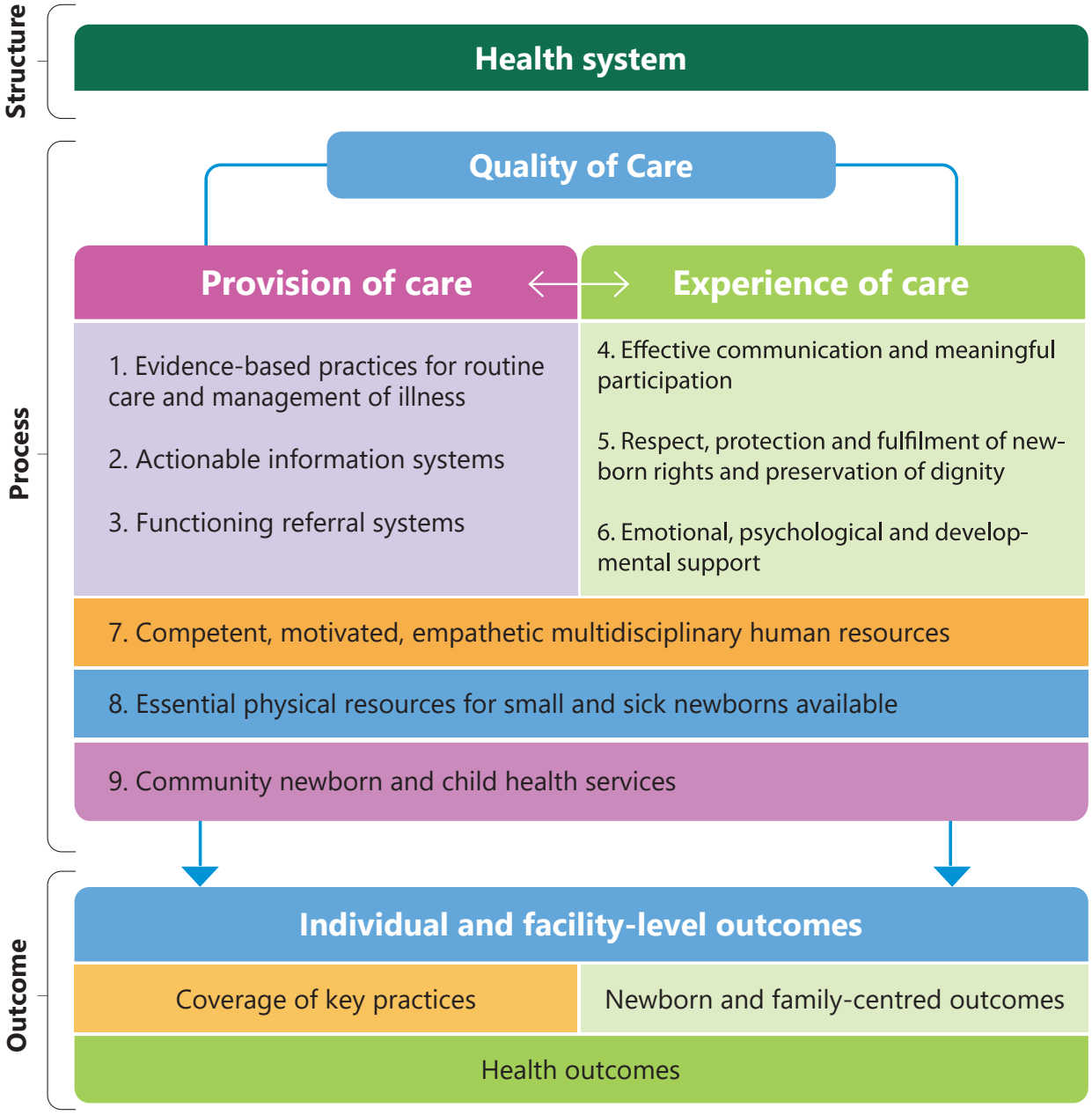
1.0 Background

1.1 Introduction

Kenya has committed to all global strategies for ending preventable newborn and child deaths. Despite significant improvement in child health indicators, Kenya still faces challenges in newborn and child health that impede the achievement of the sustainable development goals (SDGs). The Kenya Demographic Health Survey (KDHS 2022) shows that under-five mortality rate has decreased from 52 to 41 deaths per 1,000 live births, and infant mortality rate from 39 to 32 deaths per 1,000 live births. The neonatal mortality has decreased at a slower rate and currently stands at 21 from 22 deaths per 1,000 live births. According to the same report, neonatal deaths account for 66 percent of infant mortality and 51 percent of under 5 mortality. Birth asphyxia, neonatal sepsis, pneumonia, diarrhea, malaria, and malnutrition are the top causes of death among children under the age of five. The majority of these deaths can be prevented by implementing well-known, high-impact evidence-based interventions.

Improving the quality of care for children including the small and sick newborns is a major step that the Ministry of Health (MOH) has undertaken in order to reduce preventable newborn and child deaths. The MOH has adapted the WHO standards for improving the quality of care for small and sick newborns and children in health facilities to guide the quality of care in Kenya in the context of universal health coverage in the country.

These standards are built on the WHO framework for improving the quality of paediatric care and the quality of care for Small and Sick newborns (SSNB), which has eight domains that target to achieve the desired individual and facility outcomes. The eight domains define eight categories of Standards. Kenya added a ninth standard that covers Community Health Services. ***Figure 1*** illustrates the WHO quality of care framework.


Structure
Health system
Process
Quality of Care
Provision of care
Experience of care
1. Evidence-based practices for routine care and management of illness
2. Actionable information systems
3. Functioning referral systems
4. Effective communication and meaningful participation
5. Respect, protection and fulfilment of newborn rights and preservation of dignity
6. Emotional, psychological and developmental support
7. Competent, motivated, empathetic multidisciplinary human resources
8. Essential physical resources for small and sick newborns available
9. Community newborn and child health services
Outcome
Individual and facility-level outcomes
Coverage of key practices
Newborn and family-centred outcomes
Health outcomes

Methodology or process of adaptation of the standards

The objective of this process was for Kenya to adapt and adopt the WHO "Standards for improving the quality of care for children and young adolescents (2018)" and the WHO "Standards for improving the Quality of Care) for small and sick newborns in health facilities (2020)". National guidelines and other existing standards in Kenya such as Baby Friendly Hospital Initiative (BFHI) quality standards, Maternal and Newborn Health (MNH) standards were considered to ensure that the content in the adapted quality of care standards were aligning to the same where applicable. This guideline however, does not include the standards for improving the quality of care for the young adolescents owing to the fact that the policies and strategies for the same were still under development.

A multidisciplinary team (consisting of MOH representatives from the relevant divisions and stakeholders) was involved throughout the process. A consultant led the process and the development of the standards was accomplished through the steps outlined below;

Step 1: Assembling and reviewing of existing related policy and strategic documents, national guidelines, training materials, standard operating protocols, and monitoring & evaluation tools.

Step 2: A series of material development workshops to:

- Prioritize quality statements based on set parameters and merge the standards for improving the Quality of Care for SSNBs and the standards for improving the Quality of Care for Children into one document.
- Develop SSNB and child indicators (Indicator catalogue and CORE indicators) using a deductive approach that involved a series of prioritization of quality measures based on set parameters.
- Develop a Health facility Quality of Care Assessment tool for children including SSNBs.

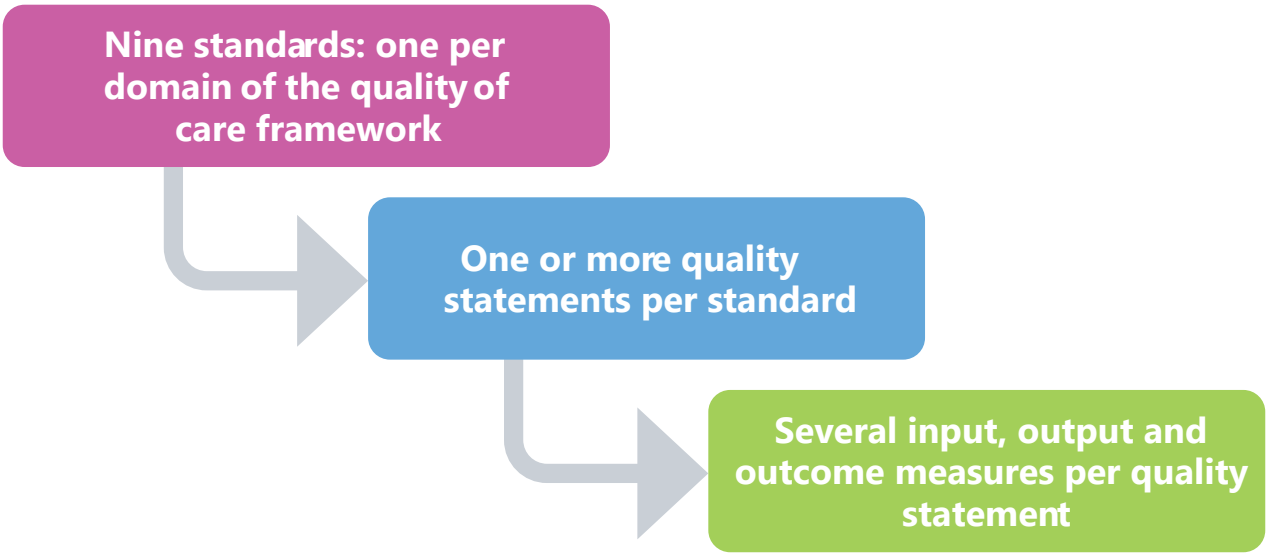
Step 3: Pretesting of draft health facility assessment tool (HFA-Tool) and using feedback from the pretest to improve the tool.

Step 4: Validation of QoC Standards for children including the SSNB and the HFA tool

Step 5: Validation of the core indicators for children including the SSNB, which was also informed by the mapping of the 25 WHO global paediatric quality of care indicators done in Kenya.

Structure of the standards

The Kenya National Standards for Improving the Quality of Care for Children including Small and Sick Newborns in Health Facilities has nine standards, which include the eight WHO standards and one additional standard on community newborn and child health care services.
The structure is as below:



1.1 Purpose and Application of the Standards

These standards are applicable to all facilities that care for children including SSNBs and are in line with the National guidelines. They address priority areas that will contribute significantly towards reducing morbidity and mortality in children including SSNBs. These standards outline the best practices and support measurement of performance against these practices in order to identify areas of improvement. Planners, managers and health care providers can use them to;

- Guide organization, planning and delivery of quality services to children including SSNBs.
- Identify gaps and the inputs that are required to bridge the gaps.
- Tracking quality improvement and monitoring performance in care or service delivery.
- Providing a bench mark for national Health Facility Assessments, Surveys, accreditation and performance rewards.

1.3 Summary of Standards

The quality-of-care standards are as follows;

Evidence-Based Practices for Routine Care and Management of Complications

Standard 1: Every child including the small and sick newborn receives evidence-based routine care and management of illnesses and complications according to MOH guidelines.

Actionable information systems

Standard 2: The health information system enables collection, analysis and use of data to ensure early, appropriate action to improve the care of every child including small and sick newborn.

Functioning referral systems

Standard 3: Every child including the small and sick newborns with condition(s) that cannot be treated effectively with the available resources receives appropriate, timely referral, through integrated newborn service pathways with continuity of care, including during transport according to the national referral guidelines

Effective communication and meaningful participation

Standard 4: Communication with children and their families is effective, with meaningful participation, and responds to their needs and preferences and parental involvement is encouraged and supported throughout the care pathway.

Respect, protection and fulfillment of rights of children including small and sick newborns and preservation of dignity

Standard 5: Every child's including newborn's rights are respected, protected and fulfilled, without discrimination, with preservation of dignity at all times and in all settings during care, transport and follow-up.

Emotional, psychosocial and developmental support

Standard 6: All children including the small and sick newborns are provided with family-centered developmental supportive care and follow-up, and their families receive emotional and psychosocial support that is sensitive to their needs and strengthens their capability.

Competent, motivated, empathetic multi-disciplinary human resources

Standard 7: For every child including small and sick newborn, competent, motivated, empathetic multidisciplinary staff are consistently available to provide routine care, manage childhood illnesses and complications and provide developmental and psychological support throughout the care pathway.

Essential physical resources for children including small and sick newborns

Standard 8: The health facility has an appropriate, child-friendly physical environment, with adequate water, sanitation, waste management, energy supply, medicines, medical supplies, and equipment for routine care and management of newborn and childhood illnesses and complications.

Community Newborn and Child Health Care Services

Standard 9: The health facility has functional linked community health units providing newborn and child health care services at the community level.

2.0 QUALITY OF CARE STANDARDS

2.1 Evidence-Based Practices for Routine Care and Management of Complications

Standard 1:

Every child including small and sick newborn receives evidence-based routine care and management according to MOH guidelines.

The aim of this standard is to ensure that all children including small and sick newborns who present to health facilities receive evidence-based care and that the care is provided in their best interests. It includes routine care, appropriate assessment with early identification of emergency signs (general danger signs) and appropriate management of common conditions. Although many conditions require attention, these standards apply only to those prioritized conditions associated with high morbidity and mortality in children including small and sick newborns.

Quality Statement 1.1: All newborns receive routine care immediately after birth

Rationale

Essential newborn care immediately after birth facilitates adaptation of the newborn to the new environment, meets the newborn's immediate needs and avoids preventable complications such as hypothermia and hypoglycemia. It entails thorough drying immediately after birth and placement in skin-to skin contact with the mother, delayed clamping of the umbilical cord until 1–3 minutes after birth and initiation of breastfeeding within 1hour of birth.

Quality Measures

Input

1. The health facility has up-to-date MOH Essential newborn care guidelines.
2. The health facility has supplies of clean towels for immediate drying of newborns, available in sufficient quantities (at least 2 per delivery pack).
3. Health care providers who care for newborns receive in-service training or regular refresher sessions in essential newborn care and breastfeeding support at least once every 12 months.
4. Health care providers who care for newborns receive at least quarterly drills or simulation exercises and supportive supervision in essential newborn care and breastfeeding support.
5. The health facility has local arrangements and mechanisms to maintain a draught free environment with a documented room temperature of 25-28 °C in the delivery room.

Process/Outputs

1. The proportion of stable newborns who received all four elements of essential newborn care: immediate and thorough drying, immediate skin-to-skin contact, delayed cord clamping, and initiation of breastfeeding within the first hour

Outcome (s)

1. The proportion of all newborns who had a normal body temperature (36.5–37.5 °C) at the first complete examination

Quality Statement 1.2 All newborns who are not breathing spontaneously receive appropriate stimulation and resuscitation with a bag-and-mask within 1 min of birth, according to MOH guidelines.

Rationale

Perinatal asphyxia is one of the leading causes of neonatal deaths within the first week of life. It is also responsible for long-term neurological impairment and disability and can be prevented by correct effective resuscitation of newborns who are not spontaneously breathing after birth.

Quality Measures

Inputs

1. The health facility has all the basic equipment and supplies required for neonatal resuscitation in the delivery room and in all the areas where newborns are cared for (See Annex 1).
2. The health facility has written up-to-date clinical protocols for managing newborns who are not breathing spontaneously according to MOH guidelines (e.g. Basic Paediatric Protocol/ETAT +, Comprehensive Newborn Care Protocols).
3. Health care staff in the childbirth and neonatal areas receive in-service training and regular refresher sessions in basic newborn resuscitation at least once every 12 months.
4. Health care staff in the childbirth and neonatal areas receive quarterly drills or simulation exercises and supportive supervision in basic newborn resuscitation.

Processes/Outputs

1. The proportion of all newborns who were not breathing spontaneously after additional stimulation at the health facility who were resuscitated with a bag-and-mask

Outcome

1. The proportion of all newborns in the health facility who were not breathing spontaneously at birth but were breathing spontaneously 5 min after resuscitation.

Quality Statement 1.3: All newborns at risk are correctly identified, as soon as possible after birth or on presentation to the health facility, and receive additional care

Quality Measures

Rationale

Small and sick newborns may require additional care and liaison with the maternal health care providers prior to delivery facilitates risk assessment for potentially sick newborns so that a team-based response to care may be initiated early leading to better outcomes. Newborns at risk of common complications should be closely monitored so that danger signs are recognized early and they are promptly managed. Common complications include hypothermia, hypoglycemia, respiratory distress syndrome (RDS), inability to breastfeed and apnoea of prematurity. Recurrent apnoea in preterm newborns can lead to hypoxia and bradycardia. Preterm newborns below 34 weeks gestation are at an increased risk of developing apnoea of prematurity and should be monitored closely. Caffeine citrate is used for prophylaxis and treatment of apnoea of prematurity in these newborns.

Respiratory distress syndrome (RDS) occurs predominantly in premature newborns and is a consequence of surfactant deficiency. Preterm newborns delivered at 28-30 weeks are at risk of RDS and prophylactic continuous

positive airway pressure (CPAP) should be initiated as soon as possible after birth. Surfactant therapy can also be considered as per the national guidelines.

Kangaroo Mother Care (KMC) has been shown to have several benefits for preterm and low birth weight newborns (<2500g) and should be initiated as soon as possible after birth for these newborns.

Inputs

1. The health facility has written up-to-date guidelines, protocols and standard operating procedures for identification and immediate care or referral of newborns at risk in the labour ward and all areas where newborns present for care that are consistent with MOH guidelines.
2. The health facility has written up-to-date guidelines, protocols and standard operating procedures for assessing, managing and preventing apnoea of prematurity in newborns.
3. The health facility has supplies and materials to provide optimal thermal care, including KMC, for small and sick newborns.
4. The health facility has a dedicated space, with infrastructure, supplies and materials, to provide optimal feeding to small and sick newborns and support for breastfeeding or alternative feeding.
5. Health care providers who care for small and sick newborns are trained on (KMC).

Process/Outputs

1. Proportion of all newborns born in or presenting to the health facility after birth who are weighed.
2. Proportion of SSNB who receive optimal feeding and support for breastfeeding or alternative feeding.
3. Proportion of preterm and low birth weight newborns who receive immediate KMC (within 30 minutes after delivery).

Outcome

1. Proportion of all newborns in the health facility who died within the first 7 days of life. (Early neonatal deaths)

Quality Statement 1.4: All children including small and sick newborns are assessed for respiratory compromise and are managed according to MOH guidelines.

Rationale

Children including SSNBs may deteriorate quickly from respiratory compromise. They therefore require prompt, accurate assessment for respiratory compromise. The pulse oximeter, which is non-invasive, determines the presence of hypoxia and guides the administration of oxygen therapy. Supplemental oxygen therapy should be provided safely through appropriate equipment and should be monitored using a pulse oximeter to prevent hyperoxia.

Small and sick newborns not responding to the conventional oxygen therapy can receive additional respiratory support through CPAP, according to MOH guidelines.

Inputs

1. The health facility has written up-to-date protocols for oxygen administration and management consistent with MOH guidelines. (Basic Paediatric Protocol and Comprehensive Newborn Care Protocol)
2. The health facility has an adequate supply of functional pulse oximeters (with neonatal and paediatric probes) in all the areas where children including SSNBs are cared for.
3. The health facility has a reliable functional oxygen supply at all times and appropriate equipment for management of children including SSNBs who require oxygen therapy.

4. The health facility has written, up-to-date guidelines, protocols and standard operating procedures for intubation, ventilation and other methods of ventilation, including non-invasive ventilation, in newborns.
5. The health facility has appropriate laboratory and diagnostic tests available for investigating children including small and sick newborns with respiratory conditions (See Annex 1).
6. The health care providers who care for children receive training and regular refresher sessions on oxygen administration and management at least once in the last 12 months.

Processes/outputs

1. Proportion of HCW trained on oxygen administration and management
2. Proportion of all children including small and sick newborns who had SPO2 checked using a pulse oximeter and recorded
3. Proportion of Small and sick newborns with RDS who were eligible for CPAP and were initiated on it
4. Proportion of all children including small and sick newborns with SPO2 below 90% who were correctly assessed and managed on oxygen as per MOH guidelines

Outcome

1. Proportion of newborns with RDS in the facility who died.

Quality Statement 1.5: All children, including small and sick newborns, are promptly triaged and receive appropriate care upon presentation to a health facility.

Rationale

In health facilities in which outpatient department is often crowded, it is important to have a triage system, which allows rapid identification of seriously ill children. Sick children, especially SSNBs deteriorate rapidly. The triage system allows rapid identification, assessment and provision of appropriate care for those with life-threatening medical and surgical problems. The flow of patients must not be a barrier to accessing urgent care and administrative or payment procedures must be delayed until the child has been started on medical care. All children must be quickly inspected to identify obvious signs of life threatening or serious illness that may be missed in long queues.

Quality Measures

Inputs

1. The health facility has written up-to-date clinical protocols and SOPs for emergency triage, assessment and management of common pediatrics emergencies consistent with MOH guidelines. (BPP and Comprehensive Newborn Care Protocols)
2. The health facility has essential equipment and supplies for assessing and managing pediatrics emergencies (See Annex 1).
3. The health facility has a 24-h triage system for every sick child to ensure a rapid visual inspection within a few minutes, without any delay
4. The health facility has a designated emergency area with age-appropriate pediatric equipment, commodities and supplies for emergency resuscitation and initial treatment of children including SSNBs (See Annex 1).
5. The health care providers conduct paediatric emergency care drills at least once every 6 months.
6. The health facility maintains an up-to-date 24-h staff duty roster, with a functioning contact mechanism for getting additional support.

Processes/Outputs

1. Proportion of all sick children who were triaged on arrival to the health facility.
2. Proportion of children less than 5 years who were correctly triaged according to MOH guidelines (BPP or IMNCI chart booklet)
3. Proportion of all children triaged as emergency who received emergency or pre-referral treatment within 15 minutes.
4. Proportion of all health care providers who triage children in a health facility who received training or refresher courses on triage (IMNCI/ETAT+) during the past 12 months.

Outcomes

1. Proportion of children who died within 24 h of admission disaggregated by age.

Quality Statement 1.6: All children including small and sick newborns are assessed and managed for medical and surgical conditions according to MOH guidelines

Rationale

Preterm birth complications, birth asphyxia and neonatal sepsis are the major causes of morbidity and mortality in newborns in Kenya. Preterm/low-birth-weight newborns are at risk of developing jaundice, RDS, intraventricular haemorrhage, retinopathy of prematurity and other complications. Birth asphyxia can lead to death or life long disability and complications like convulsive disorders. Newborns are also at a higher risk of infections due to their immature immune systems and can easily get infections in utero, during delivery or after delivery. Small and sick newborns can deteriorate and die very quickly if their condition is not rapidly identified and managed appropriately. Prompt management also decrease the chances of complications including disability. During inpatient care, small and sick newborns should be monitored as per MOH guidelines.

Pneumonia, diarrhea, malaria and malnutrition remain major causes of death in children under five years despite being preventable and treatable. Fever is also a common reason for seeking care and may be a presenting symptom of life-threatening infections such as malaria, pneumonia, meningitis, septicemia or urinary tract infection. A differential diagnosis of fever should be considered and appropriate investigations undertaken. The facility must have access to basic laboratory and diagnostic tests to exclude causes of serious febrile illness suggested by the disease epidemiology.

All children with symptoms of common childhood illnesses should therefore be correctly assessed, classified, managed appropriately and monitored according to the Ministry of Health (MOH) guidelines.

The most common congenital abnormalities are cleft lip and palate, congenital heart anomalies and neural tube defects. Majority of these conditions can be managed appropriately if identified early.

Quality Measures

Inputs

1. The health facility has up-to-date, evidence-based clinical protocols for identifying and managing children with medical and surgical conditions consistent with MOH guidelines.
2. Defined and established procedures for clinical assessment and reassessment/monitoring of the patients are available.
3. The health facility has adequate equipment, commodities and supplies for management of medical and surgical conditions.

4. The health care providers who care for children receive regular training on common medical & surgical conditions for children and newborns every 12 months.

Processes/outputs

1. Proportion of all children with medical and surgical conditions correctly assessed, classified, investigated and managed according to MOH guidelines

Outcomes

1. Case fatality less than 10 percent for SSNB and childhood illnesses

Quality Statement 1.7: For all children, including small and sick newborns, implement standard precautions to prevent healthcare-associated infections, including additional measures during outbreaks and Pandemics.

Rationale

Health care-associated infections are the most common adverse events in health care delivery. All children including SSNBs are at risk of developing hospital-acquired infections that increase the risk of death, the cost of care and duration of hospital stay. The main causes include non-adherence to standard infection control procedures, insufficient equipment and supplies, prolonged incorrect use of invasive devices, high-risk procedures, poor infrastructure, overcrowding and underlying immune-suppression. The most effective way of preventing health care-associated infection is implementation of standard infection prevention and control precautions.

Input

1. The health facility has written infection prevention and control (IPC) guidelines, protocols and standard operating procedures.
2. The health facility has plans for infection prevention and control preparedness and response for public health emergencies.
3. The health facility has a functioning improved water source and hand-washing stations with running water and soap or alcohol-based hand rub in all wards and consulting rooms.
4. The health facility has appropriate disinfectants and sterilizing facilities for medical equipment (See Annex 1).
5. The health facility has a system to ensure safe handling, collection, storage (puncture resistant) and final disposal of infectious waste.
6. Child health service providers receive training in standard infection prevention and control at least once every 12 months.

Processes/Outputs

1. Proportion of health care providers, who care for children including newborns, trained in infection prevention and control practices at least once in the last 12 months.
2. Proportion of health care providers observed conducting procedures who practice hand hygiene according to MOH standards

Outcomes

1. Proportion of admitted newborns and children who had nosocomial/hospital acquired infections

Quality Statement 1.8: All newborns receive routine postnatal care as per MOH guidelines

Rationale

Routine postnatal care allows prevention, early detection and management of complications in the newborns. It ensures that all newborns receive a complete physical assessment including weight measurement, skin-to-skin contact with the mother, eye prophylaxis, and umbilical cord care. Bathing is delayed for 24h, temperature is monitored, and vitamin K and vaccines are given as per the MOH guidelines. Weighing a newborn after delivery improves decision-making for newborn care. The newborn's weight also facilitates calculation of doses of medications and intravenous fluids. Monitoring newborns during routine postnatal care allows identification of complications that require management.

Quality Measures

Inputs

1. The health facility has written up-to-date protocols and guidelines for post-natal care services.
2. The health facility has adequate post-natal care supplies, equipment and reporting tools at all times
3. The health facility has at least one designated health care provider trained on post-natal care (PNC)

Processes/Outputs

1. Proportion of all newborns in postnatal wards for whom, there is documented information on the newborn body temperature, respiratory rate, feeding behaviour and the absence or presence of danger signs.
2. Proportion of all newborns in the health facility who received a full clinical examination before discharge.
3. Proportion of all newborns in postnatal wards and newborn unit of the health facility who received vitamin K, Chlorhexidine for cord care and Tetracycline eye ointment (TEO).
4. Proportion of all healthy mothers in postnatal wards who received breastfeeding counselling and support from a skilled health care provider.
5. Proportion of mothers who were offered counselling on importance of postnatal checkup within 48 hours, 2 weeks and 6 weeks.

Quality Statement 1.9: All children, including small and sick newborns, are assessed for immunization, vitamin A and deworming status and vaccinated as per National Schedule.

Rationale

Immunization prevents illness, disability and death from common infectious diseases. The National program on immunization has a targeted approach and defined schedules for vaccination against common vaccine-preventable diseases for children including the SSNBs. Small and sick newborns are at increased risk of mortality and morbidity from vaccine-preventable diseases and should be vaccinated before discharge, if they have no contraindications.
The immunization, vitamin A supplementation and deworming status of all children attending the health facility should be checked routinely and they should receive their age specific vaccinations, vitamin A supplementation and deworming medicines.

Quality measures

Inputs

1. The health facility has written, up-to-date protocols and guidelines for providing routine child immunization services, Vitamin A supplementation and deworming, including for LBW and preterm newborns, that are consistent with MOH guidelines
2. The health facility has a functioning vaccine cold-chain system with sufficient storage capacity.

3. The health facility has all EPI vaccine antigens, Vitamin A capsules and deworming medicines
4. The health facility provides immunization services, vitamin A supplementation and deworming as per MOH policy.
5. The health facility has a system for detecting whether a child has missed a vaccination, Vitamin A supplementation and deworming and offers "catch-up" services according to relevant MOH guidelines

Processes/Outputs

1. Proportion of days on which the refrigerator temperature, monitored twice daily, was within the range 2–8 °C in the past month.
2. Proportion of all children under 5 years of age who attended the health facility and received vaccination, vitamin A supplementation and deworming in the past 6 months as per MOH guidelines.
3. Proportion of all children seen in the health facility who were fully immunized at 1 year of age.

Quality Statement 1.10: All children including small and sick newborns are optimally fed, assessed for growth monitoring & nutrition status according to MOH guidelines.

Rationale

Adequate feeding is essential for growth and development. Poor feeding during infancy and particularly during illness can have lifelong consequences. Young infants, particularly those with a low birth weight (< 2500 g), are at much greater risk for illness and death if careful attention is not paid to feeding and appropriate care. Exclusive breastfeeding for the first 6 months gives children including newborns the best immune support, nutrition and enhanced growth and development. Breastfeeding also protects mothers against breast and ovarian cancer, improves birth spacing and protects them against type 2 diabetes. Mothers of SSNBs may need special support to initiate and maintain lactation when the newborn is unable to feed at the breast. If maternal breast milk is not available or is contraindicated, safe donated human milk is an acceptable alternative. Caregivers should also be counselled on timely introduction of appropriate complementary foods after the first 6 months of life and continued breastfeeding up to 24 months or beyond.

Quality Measures

Inputs

1. The health facility has up-to-date nutrition guidelines, protocols and SOPs
2. The health facility is baby friendly accredited and supports breastfeeding according to MOH guidelines
3. The health care providers receive training or regular refresher sessions on counselling on breastfeeding and optimal feeding for children including small and sick newborn at least once every 12 months

Process/Output

1. Proportion of all stable newborns who are initiated on breastfeeding or expressed breast milk within 1 hour after birth
2. Proportion of all newborn infants in the health facility whose caregivers have been taught on proper positioning and attachment at the time of discharge
3. Proportion of children < 6 months in the health facility, who are exclusively breastfeeding.
4. Proportion of children aged 6–23 months in the health facility receiving appropriate complementary foods according to MOH guidelines.
5. Proportion of caregivers in the health facility who have been counselled on breastfeeding and complementary feeding.

Quality Statement 1.11: All children including small and sick newborns who cannot breastfeed or be fed with expressed breast milk receive appropriate alternative feeding and are assessed for growth monitoring & nutritional support according to MOH guidelines

Quality Measures

Inputs

1. The health facility has a written, up-to-date protocols for alternative feeding for children including small and sick newborns, according to MOH guidelines
2. The health facility has the necessary supplies and materials to support alternative feeding (feeding cups, infant formula according to MOH guidelines, nasogastric tubes, infusion pumps/ syringe drivers and IV fluids)
3. The health care providers receive training and regular refresher sessions in counselling on appropriate alternative feeding for children including small and sick newborn with breast feeding challenges at least once every 12 months

Processes/Outputs

1. Proportion of children including small and sick newborn in the health facility who require alternative feeding who receive appropriate alternative feeding according to MOH guidelines
2. Proportion of caregivers in the health facility who have received counselling on appropriate alternative feeding of the children in their care

Outcome

1. Proportion of small and sick newborns who receive assisted feeding for whom a correctly prescribed feed volume appropriate for their weight and gestation age is documented.

Quality statement 1.12: All children, including newborns, are discharged from the health facility when home care is safe, caregivers are competent in delivering home care and a comprehensive management plan is in place.

Rationale

Children including SSNBs may require additional follow-up post discharge to assess recovery, feeding, weight gain and to monitor neurodevelopmental progress. Some may require follow-up appointments with relevant medical specialists and allied health professionals. Children, including SSNBs, should only be discharged from the health facility when home care is safe and caregivers have been counselled on home care including when to return immediately. A comprehensive follow up plan should also be in place.

Quality Measures

Inputs

1. The health facility has written, up-to-date guidelines, protocols, standard operating procedures on comprehensive discharge management plans
2. The health care providers counsel caregivers on danger signs to look out for and when to return.
3. The health facility has staff with appropriate competence to deliver coordinated multidisciplinary follow-up and linked appropriately.

Processes/Outputs

1. Proportion of children including SSNBs in the health facility whose caregivers reported having been sensitized on their discharge plans
2. Proportion of discharged children including SSNBs whose caregiver has a copy of a duly filled discharge summary.
3. Proportion of children including SSNBs whose return for scheduled follow-up according to discharge plan.

Actionable Health Information Systems

Standard 2:

The health information system enables collection, analysis and use of data to ensure early, appropriate action to improve the care of every child including small and sick newborns

The aim of this standard is to ensure that all vital information on patients is recorded, registered accurately and used to make appropriate decisions to maximize patient safety and the quality of care, to support professional best practice and to comply with the health information management system. A mechanism should be in place for collecting information from children and their families about their experience of the care provided. Standardized registers, patient clinical care records and clinical audit forms should be in place, with a standardized system to ensure the confidentiality of all these patient records. The facility should have a mechanism for allowing families to access their information and to provide feedback on their experience of care in the facility. The data should be appropriately de-identified, disaggregated, analyzed and the results used to report, provide feedback, monitor and improve performance at all levels of the health care system, including the performance of health care providers.

Quality statement 2.1: Every child including small and sick newborns has a complete, accurate, standardized, up-to-date medical record, which is accessible throughout their care, on discharge and on follow-up.

Rationale

Use of data for decision-making is an important aspect of quality improvement at all levels of the health system. A standardized complete, accurate medical recording is important for documenting care, clinical follow-up, accurate hand-over, early detection of complications and health outcomes. Documentation also provides information to identify areas of improvement. Standardized registers, medical recording forms or an electronic system for documenting the process of care are critical for ensuring appropriate patient care, early detection of complications, accurate hand-over and patient safety.

Quality Measures

Inputs

1. The health facility has standardized, age-appropriate individual MOH patient records (outpatient card/form or a complete inpatient record).
2. The health facility has a system for creating unique identifiers for new patients and locating preexisting unique identifiers for returning patients.
3. The health facility has an established confidential, safe, accessible, and easy retrieval storage system for patients' medical records.
4. The health facility has standardized up to date MOH data collection forms, registers, tally sheets and summary tools in place at all times to record all care processes and outcomes.

5. The health facility has a registration system for outpatients, admissions, discharges and referrals
6. The health facility has a registration system for births and deaths that is linked to the national vital statistics registration system.
7. The health facility has a standardized system for classifying clinical conditions, diseases and health outcomes, including births and deaths, linked to the Kenya Health Information System (KHIS) and aligned to current International Classification of Diseases (ICD).
8. The health care providers receive training or refresher sessions at least once every 12 months on the use of standardized medical records, including birth and death registration, KHIS and classification of conditions and diseases in accordance with the current ICD.

Processes/Outputs

1. Proportion of children including SSNBs who have standardized individual medical record which are complete and accurately filled
2. Proportion of health care providers trained at least once in the last 12 months on the use of standardized medical records, KHIS and ICD.
3. Proportion of children including SSNBs whose data entry into MOH registers is complete and accurate.
4. Proportion of births and deaths occurring in the health facility that were notified.
5. Proportion of all children including SSNBs currently in the health facility who have a unique patient identifier and an individual medical record.

Quality statement 2.2: Every health facility has a functional mechanism for collecting, analyzing and using data on children including the small and sick newborns as part of monitoring performance, quality improvement and providing feedback on services provided.

Rationale

Data management involves collection, validation, analysis and use of data collected from medical records to provide information that can be used to improve case management and health outcomes, feedback to health providers and for decision-making and planning.

Patient satisfaction reflects the experience and perception of the quality of the care received. The views of children and/or their caregivers can improve the services provided and ensure that they meet children's needs. Children's and caregivers' perceptions of their desired health outcome, access to and choice of health care and their relationships with health care providers constitute useful information on the quality of care provided.

Quality Measures

Inputs

1. The health facility has standard operating procedures and protocols for data management to make timely reports and visual charts
2. The health care providers and managers in the health facility meet regularly (at least once a month) to carry out a clinical audit to review patient care and outcomes for decision-making
3. The health facility has a functioning system for collecting information and responding to perceptions of the caregivers on services provided, as per MOH guidelines.

Processes/Outputs

1. Proportion of all perinatal deaths and neonatal deaths that occurred in the health facility in the last three months that were reviewed with standard MOH auditing tools.

2. Proportion of all child deaths that occurred in the health facility in the last three months that were reviewed with standard auditing tools.
3. Proportion of monthly reports from the health facility received by the next highest level of administration in the last 3 months.
4. Proportion of caregivers of children who are aware of the mechanism for patient feedback (e.g. suggestion box, compliment & complaint registers and child's help line number) in the health facility.
5. Proportion of all short-term recommendations following death reviews done past 3 months that have been fully implemented.

Functional Referral Systems

Standard 3:

Every child including small and sick newborns with conditions that cannot be treated effectively with the available resources receives appropriate, timely referral, with continuity of care including during transport, according to national referral guidelines.

The aim of this standard is to ensure appropriate, timely referral of all children who require further care that cannot be provided at the referring health facility. Health facilities within a geographic area should be part of a referral network within the area with predefined types of services available at each facility. The resources and capacity of each health facility in the network, including mechanisms for communication among facilities (e.g. telephone, radio) and transport services that operate 24 h a day, 7 days a week. Health care professionals trained in paediatric life support are available to escort critically ill children within or between health facilities. Complete referral and counter-referral notes are available, and feedback on the condition of the child is sought periodically to improve care in both the referring and referral health facility.

Quality statement 3.1: Every child including the small and sick newborn who requires referral receives appropriate pre-referral care, and the decision to refer is made immediately.

Rationale

Although most cases of childhood illness including newborn conditions are managed at primary health facilities, severely ill children including newborn and those who require further or specialized care may have to be referred to another facility. It is vital to recognize cases that require referral rapidly in order to ensure that every patient receives timely, appropriate care and to avoid unnecessary complications.

Quality Measures

Inputs

1. The health facility has written, up-to-date guidelines, protocols and standard operating procedures for pre-referral management of all children including SSNBs who require referral
2. Referrals to and from the health facility are recorded appropriately in the registers
3. The health facility has at least one health care provider on duty at all times who is trained in any one of the: IMNCI, ETAT+ & essential newborn care and competent in emergency triage, assessment and treatment or basic newborn life support.
4. The health facility is equipped with age-appropriate medicines and other supplies, as per Kenya Essential

Medicines List (KEML) and Kenya Essential Medical Supplies List (KEMSL), for stabilization and pre-referral treatment of children including small and/or sick newborns who require referral as per MOH guidelines.

5. The health care provider communicates clearly with family members about the reasons for referral and about where the child will be referred.
6. The facility has a functional mechanism for follow up / feedback for referrals
7. The health facility refers children including small and sick newborns within 30 minutes after stabilization and pre referral treatment.
8. Every newborn who requires referral is referred in the skin-to-skin whenever possible.

Processes/Outputs

1. Proportion of referred children including SSNBs who were given appropriate pre-referral treatment.
2. Proportion of caregivers of referred children including SSNBs who report having received appropriate information about the reason for referral and where they will be referred to for further care.
3. Proportion of SSNBs referred while in the skin-to-skin position.

Outcome (s)

1. Proportion of children seen at the health facility within the past 3 months who fulfilled the facility's criteria for referral and who were actually referred to a referral facility
2. Number of children who died as a result of delayed referral.
3. Proportion of newborns referred from the health facility who are normothermic (36.5- 37.50C) at arrival.

Quality statement 3.2: Every child including small and sick newborn who requires referral receives seamless, coordinated care by a qualified health care provider using functional and equipped ambulances.

Rationale

A pre-established plan for referral expedites the process, prevents unnecessary delay and results in timely management of patients. Appropriate information exchange and feedback within and between health facilities improves patient care, increases the motivation of health care workers and helps learning from experience. Evidence has shown that specialized paediatric teams accompanying referred sick children between facilities is associated with better outcomes and safety.

Quality Measures

Inputs

1. The health facility has referral SOPs to ensure that children including SSNBs who require referral are referred to an appropriate level of care without delay (within 30 min of stabilization/pre referral care)
2. The health facility has access to a network with well-equipped ambulances for emergency transport to referral facilities.
3. A qualified health care provider accompanies every child including the SSNB during transport to the referral facility.

Processes/Outputs

1. Proportion of children including small and sick newborns in a health facility who had timely referral (within 30 minutes of stabilization or pre referral treatment)
2. Proportion of referred children including the SSNBs who were accompanied by a health care provider to a receiving facility.
3. Proportion of children including small and sick newborns who were referred with appropriate emergency transport.

Quality statement 3.3: For every newborn and child referred or counter-referred, there is appropriate information exchange and feedback given to relevant health care providers.

Rationale

Efficient communication channels among health facilities in a referral network are vital for appropriate information exchange and feedback. Good communication improves patient care, increases the motivation of health care providers, facilitates learning from experience and improves patient outcomes.

Quality Measures

Inputs

1. The health facility has a standardized MOH referral form for documenting relevant demographic, contacts and clinical information (summary of medical history, clinical findings, investigations, diagnosis and treatment given) and the reason for referral.
2. The health facility has reliable methods of communication (mobile phone, landline or radio call) that are functional at all times for facilitating referrals.
3. The health facility has communication arrangements and a feedback system with the referral facilities in the network.

Processes/Outputs

1. Proportion of children including SSNBs referred by a health facility for whom referral feedback information was provided by the receiving facility
2. Proportion of referred children including SSNBs who had an appropriate referral note/form

Effective Communication and Meaningful Participation

Standard 4:

Communication with children and their families is effective, with meaningful participation, and responds to their needs and preferences.

Children should receive care that is family- centered, integrated and coordinated. This care should also meet their particular needs and the needs of their families. Caregivers often help to determine the presence and severity of symptoms therefore; communication must be suitable for children as well as for accompanying family members. Effective communication and meaningful participation are every child's right and are essential components of the experience of care received. Communication and participation should be tailored to the evolving capacity of children. Effective communication between health care providers and children and their caregivers will reduce unnecessary anxiety and stress and make the hospital stay a positive experience.

Quality statement 4.1: Caregivers and/or children are effectively informed about the child's illness and care so that they understand and cope with the condition and the necessary treatment.

Rationale

Children and their caregivers may find the hospital experience stressful. Feelings of helplessness and fear may reduce the caregivers' confidence in caring for their children including SSNBs during hospital admission and upon discharge. Communication between children and/or their families and health care providers is a critical component

of safe care and the foundation of child and family-centered care. Effective communication helps children and/or their caregivers feel more involved in their care, avoids unnecessary anxiety, misunderstanding and wrong expectations. It also gives them a better understanding of their illness, including the management, which promotes trust, cooperation and an overall positive experience.

Quality Measures

Inputs

1. The health facility has a written policy and provisions to ensure that all staff are identifiable, with name badges, and that they always introduce themselves to children and their caregivers and use the name of the child or caregivers when communicating with them.
2. The health facility policy provides that children and their families be entitled to receive appropriate information about the child's care and other relevant aspects during their stay in the facility.
3. The health facility makes available child-friendly, age-appropriate health information materials that are accessible, in the language(s) relevant to the population and in appropriate formats (e.g. audiovisual or visual material, diagrams, and illustrations) to facilitate understanding by children and caregivers.
4. Health care providers receive training and regular mentoring or refresher training at least every 12 months in effective communication skills including psychological counselling.

Processes/Outputs

1. Proportion of health care providers who care for children including the SSNBs in the health facility wearing identification badges.
2. Proportion of health care providers who received training in communication and counselling in the last 12 months.
3. Proportion of health care providers in the health facility who demonstrate good communication skills: asking and listening to children and caregivers, enabling them to ask questions, explaining with examples to ensure understanding and verifying their understanding.
4. Proportion of all children admitted to the health facility or their caregivers who know their primary health care provider by name.

Outcomes

1. Proportion of children and their caregivers who consider that they were given the information they required in a timely, respectful manner.
2. Proportion of interviewed children and/or caregivers seen in the outpatient department of the health facility who can correctly state their diagnosis (condition they are being managed for)
3. Proportion of interviewed children and/or caregivers discharged from inpatient department who can correctly state home care messages and can describe correctly how to take or give the discharge treatment at home and follow up.

Quality Statement 4.2: All children including the small and sick newborns and their caregivers experience coordinated care, with clear, accurate information exchange among relevant health care workers.

Rationale

Several health and allied health professionals may be involved in the care of children including SSNBs. Any gap in communication may result in a serious breakdown in the continuity of care and could lead to inappropriate treatment and unintended harm to the patient. Coordinated care and accurate hand-over of information among health care providers is essential to maintain continuity in patient care and to avoid unnecessary delays in treatment.

Quality Measures

Inputs

1. The health facility has a written, up-to-date, structured, standard form to facilitate written hand-over of patients among caring teams at shift changes.
2. The health facility has a functional communication system for exchanging information among relevant service providers that reaches all critical staff 24hrs a day, 7 days a week.
3. Staff who care for children including SSNBs receive orientation or refresher sessions in clinical hand-over procedures and communication at least once every 12 months.

Processes/Outputs

1. Proportion of clinical records that demonstrate that all correspondence about investigations and clinical interventions received were reviewed by health care staff, signed and acted upon in a timely manner
2. Proportion of children including SSNBs admitted to the health facility for whom there is an up-to-date, appropriately completed monitoring chart that indicates that all vital signs were monitored according to MOH guidelines.

Outcomes

1. Proportion of caregivers who express satisfaction with the continuity of care received from different health care providers.

Quality Statement 4.3: All children and their caregivers are enabled to participate actively in the child's care through family-centered approach, in decision-making, in exercising the right to informed consent and in making choices according to their evolving capacity

Rationale

Evidence indicates that family and cultural considerations, including family-centered care, culturally effective care, family education and provision of care close to the family's home are important in the care of children including SSNBs. Children and/or their caregivers have the right to participate in making decisions that affect their health in a manner consistent with their age and evolving capacity. It is important to understand children's developmental stages, their psychological needs and the wider needs of family members. As children and their caregivers become more involved, their knowledge improves, their anxiety lessens, and they are more satisfied

Quality Measures

Inputs

1. The health facility has up-to-date protocols, guidelines and job aids for providing information to children and their caregivers about their care, the purpose, importance, benefits, risks and possible costs of proposed investigations, referrals or management
2. The health facility has an up-to-date patients' right's charter that states the policies for child- and family-centered care, guidance on confidentiality and the practice and culture of family presence during clinical examinations, procedures and treatment of children.
3. The health facility has appropriate forms for written consent for procedures where caregivers sign. Verbal consent is documented on the patient's records.
4. All staff who care for children including SSNBs receive orientation or training in patient-centered care, medico-legal and ethical principles at least once every 12 months.

Processes/Outputs

1. Proportion of children or their caregivers who were informed about their right to express their views and participate in making decisions about their care.
2. Proportion of caregivers in the health facility who were offered the option and were present with their child during medical procedures.

Outcomes

1. Proportion of children and/or their caregivers who considered that the health care providers considered their views or sought their opinion when making decisions about their care.
2. Proportion of caregivers of children who underwent a procedure, who gave their informed, documented consent for procedures.

Quality Statement 4.4: All caregivers receive appropriate counselling and health education on recommended evidence-based childcare practices

Rationale

The health facility provides an invaluable platform for health education and counselling of caregivers and other influencers. Health facilities are encouraged to carry out group sessions aimed at providing health education on a wide spectrum of topics for health promotion and counselling. Caregivers have an opportunity for cross learning and seeking clarifications on any topic.

Quality Measures

Inputs

1. The health facility has strategically displayed information education communication (IEC) materials about common childhood illnesses and others for distribution to children and caregivers.
2. The health facility ensures that every child below 5 years has a Mother and Child Health (MCH) Handbook that the caregivers keep and health providers use to document relevant information.
3. The health facility holds regular Mother and Child Health clinics (MCH) (e.g. well child and immunization clinics, health talk sessions, counselling services), which are used as opportunities for health promotion and preventive care.
4. Facility has a written schedule of health education topics in the child welfare clinics, which is followed.

Processes/Outputs

1. Proportion of caregivers and/or children who report having attended at least a health education session at the health facility in the previous or current visit.

Respect, Protection and Fulfilment of the Right of Children Including Small and Sick Newborns and preservation of dignity

Standard 5:

Rights of children including the newborns are respected, protected and fulfilled, without discrimination, with preservation of dignity at all times and in all settings during care, transport and follow-up.

The standard complements and reinforces the rights of children embedded in all the other standards. Health care providers should treat children with respect and sensitivity and ensure their dignity, give them the care they need without discrimination, respect their privacy and confidentiality, provide age- and culturally appropriate food and nutrition and protect them from any form of violence while in care, including physical, sexual and verbal abuse, neglect, detainment or extortion.

The identification and management of vulnerable children requires special skills and liaison. All staff who care for children should be vigilant in detecting harmful caregiver– child interactions. The patients' rights charter should clearly spell out children's right to health the patients' rights charter in a format that children and/or caregivers can easily understand. The rights to health include equal access to health care including immunization, nutritious food, sanitation and clean water.

Quality Statement 5.1 All children including newborns are protected from any violation of their human rights, physical or mental violence, injury, abuse, neglect or any other form of maltreatment

Rationale

The Convention on the Rights of the Child ensures that their health is a human right and provides a holistic legal and normative framework for national laws, policies, strategies and programmes for reducing mortality and improving services. The Kenya Children's Act, 2022 stipulates that children including newborns are recognized not as mere recipients of care but as human beings with fundamental rights. These rights include; the right to life, survival, health and development, the right to a legal identity from birth, the right to be protected from harm, violence and neglect and the right to a caring, loving and nurturing environment. Children including newborns are often not seen as individuals with the right to access care. Stigmatization and discrimination have been reported against children including newborns, and denial of care has been threatened for those born at home. Lack of consent for care was also reported, with unauthorized care, referrals, and detainment for non-payment of health facility bills. "Child protection" entails safeguarding children including newborns from maltreatment and any action that increases their exposure to risks or potential harm. Child's rights are often violated in places of trust such as in families, communities and health facilities.

Quality Measures

Inputs

1. The health facility has clear mechanisms, policies, procedures and up-to-date national protocols that comply and are consistent with the Children's Act, 2022.
2. The health facility has protocols, job aids or checklists that provide guidance for health care providers on detecting, documenting, reporting and caring for child victims of maltreatment (Children's act 2022)
3. The health facility has a system for registration and follow up of children who have been or are victims of any kind of suspected maltreatment.

4. The health facility has clear mechanisms and protocols for sharing appropriate information and concerns with relevant agencies.
5. The health facility has link to an effective multidisciplinary team from all relevant government and non-government agencies to investigate, care for and provide the necessary support to children with suspected maltreatment.
6. The health care providers receive training in identifying, assessing, communicating with, providing care and support for child victims of any form of maltreatment and on child protection procedures at least once in 12 months

Processes/Outputs

1. Number of cases of suspected child maltreatment identified in the health facility in the last 12 months.
2. Proportion of health care providers who care for children including newborns who are trained in child protection, care and support.

Outcome(s)

1. Proportion of children including newborns identified as victims of maltreatment who received protection, psychosocial support and appropriate referral.

Quality statement 5.2: All children including newborns have access to safe, adequate nutrition that is appropriate for both their age and their health condition during their care in a facility.

Rationale

Adequate nutrition is crucial for the survival, growth and development of children including SSNBs. It also plays an important role in their recovery from illness. Children including SSNBs need sufficient feeds to meet their nutritional and growth requirements. Children and newborns are particularly vulnerable to under nutrition because of their rapid physical and cognitive development; they have smaller energy stores and use energy at a higher rate.

Quality Measures

Inputs

1. The health facility has a food and nutrition policy and guidelines to meet children and newborn's nutritional needs, including special needs, consistent with dietary requirements
2. The health facility has an up-to-date, written policy on breastfeeding that adheres to the Breast-milk Substitutes (Regulation and Control) Act, 2012 and is routinely communicated to all health care providers.
3. The health facility has appropriate alternative feeding methods to meet needs of the children including SSNBs.
4. The health facility has an adequately equipped, designated kitchen (area or room) with facilities for food preparation and safe storage.
5. The health facility has a nutrition specialist or dedicated health care provider responsible for preparing children's menus.
6. The health facility provides regular, safe, nutritious, appetizing, high-quality meals of sufficient variety to meet the needs of paediatric patients.

Processes/Outputs

1. Proportion of health care providers who received training on child health nutrition, including counselling on breastfeeding, at least once in the last 12 months.

2. Proportion of breastfeeding mothers who report that a health care provider demonstrated how to express breast milk or gave them written information about expressing breast milk.
3. Proportion of children and their caregivers in the health facility who are satisfied with the facility meal service in terms of variety, quantity, quality and number of servings per day.

Outcome (s)

1. Proportion of children admitted to the health facility who were given food appropriate to their dietary requirements.

Quality Statement 5.3: All children, including small and sick newborns, undergo screening for signs of maltreatment, neglect, violence, and are safeguarded from harmful practices during care.

Rationale

Early case recognition and continuous care of child victims of maltreatment are critical to ensure safety and reduce re-occurrences that may have physical and psychological consequences. Maltreatment of children including newborns comprises all types of physical and emotional ill treatment, abuse and neglect, including sexual abuse. Children including newborns who have experienced physical abuse may present with unintentional injuries or suspicious fractures, and those who have been sexually abused may present with injuries around the genitalia, inappropriate sexual behaviour, unexplained pregnancy or sexually transmitted infection.

Despite the growing use of evidence-based practices and patient safety, harmful practices by health care providers still persist. Common harmful practices include unnecessary procedures, treatment or admissions, prolonged hospital stays, keeping newborns away from their mothers and allowing advertising and promotion of breast-milk substitutes and bottle-feeding. Children including newborns' experiences with caregivers can have a significant, lasting impact. Children including newborns feel pain and discomfort and can experience emotional distress, particularly when separated from their families in the first hours of life. Good early care, including attachment and breastfeeding, has a lasting positive impact on the health and well-being of newborns throughout their lives.

Health care providers who care for children should be able to recognize the warning signs of maltreatment, identify children and families who may require assistance and take appropriate, timely action.

Quality Measures

Inputs

1. The health facility has a comprehensive written protocol for identifying, assessing and managing children with any suspected harmful practices.
2. The health care providers receive training and refresher sessions on screening, preventing, protecting and managing children with evidence maltreatment.
3. The health facility has supplies and materials to provide optimal, coordinated care to children who have experienced harmful practices.

Processes/Outputs

1. Proportion of all children attended to at health facilities suspected to experience harmful practices managed according to national guidelines

Educational, Emotional & Psychological and Developmental Support

Standard 6:

All children including newborns receive developmental supportive care and follow-up, and their families receive emotional and psychosocial support that is sensitive to their needs and strengthens their capability

Emotional and psychosocial support are essential components of care, including during diagnosis, treatment and supportive care.. Children may feel threatened or stressed by visiting a health facility or being hospitalized, because of the unfamiliarity of the facility and of medical procedures and poor understanding of the reasons for hospitalization. Frightening or distressing experiences can have a profound, lasting effect on a child's attitude to health services and can have lasting effects on their psychological development. They can result in anger, uncertainty, anxiety and feelings of helplessness. The physical environment must therefore promote psychosocial well-being by providing opportunities for activities such as play, recreation and education. Continuing support from parents, family and friends who feel comfortable both physically and emotionally in the setting is also crucial. Play and recreational activities are vital elements of the normal growth and development of children and are widely used to alleviate the stress experienced by paediatric patients and their families during hospitalization.

Quality statement 6.1: All children including newborns are allowed to be with their caregivers, and the role of caregivers is recognized and supported at all times during care, including rooming-in during the child's hospitalization

Rationale

Caregivers should stay with their children including newborns during examination, procedures, treatment and in the inpatient setting where applicable. Non-separation contributes to reduced infection, better bonding, promotion of breastfeeding and safety. Rooming-in promotes breastfeeding, bonding and empowerment of caregivers.

The environment of a health facility may be traumatic as children are vulnerable to unfamiliarity. Accompaniment by caregivers provides comfort and helps to reduce anxiety, which can be beneficial for the child's health. Caregivers can often aid health care providers in reassuring the children during procedures and they can help the health care providers to understand a child's condition better.

Quality Measures

Inputs

1. The health facility has written up-to-date, policies, guidelines, protocols and standards operating procedures to promote rooming in of children including newborns and their caregivers.
2. The health facility has a rooming-in policy so that parents or caregivers can stay with their children and provides accommodation close to the child's bed and meals for the care giver

Processes/Outputs

1. Proportion of caregivers who were given the opportunity to room-in with their children.
2. Proportion of children in the health facility who stayed with their caregivers throughout their treatment.
3. Proportion of children admitted to the health facility whose caregivers were provided with food during the time their children were admitted.

Quality statement 6.2: All children and their caregivers receive emotional and psychosocial support that is sensitive to their needs, with opportunities for play and learning that stimulate and strengthen their capability.

Rationale

Emotional support for caregivers of children including SSNBs is particularly important because of the combination of a highly stressful medical environment and their need to assume responsibility for their newborn in the future. Emotional, psychosocial and developmental support also provides an environment for the survival and thriving of the children including newborns. Family-centered care delivered appropriately can bridge this gap, with graduated parental responsibility, initially under supervision, and developing partnerships with caregivers and empowering them to become more independent. Play and learning have important roles in children's development and add value to therapeutic care during hospitalization. The educational needs of children are closely related to the therapeutic process. Teamwork between medical and educational staff is important for the well-being of children. Play and recreation help to reduce children's anxiety and stress. It helps them to cope with their management, pain and outcomes of procedures.

Quality Measures

Inputs

1. The health facility has a written, up-to-date policy to protect children's right to play and learn while at the health facility.
2. The health facility has a system for meeting the educational and learning needs of admitted school-aged children.
3. The health facility has dedicated spaces for age-appropriate play, which are accessible to all children, including those with a disability.
4. The health care providers are trained in using various forms of play, including sensory stimulation for young infants.

Processes/Outputs

1. Proportion of children who accessed and used the play area during their stay in the health facility.
2. Proportion of children who cannot leave their room who had access to some form of play provided by the health facility or a play therapist.
3. Proportion of children who received play therapy during their most recent medical procedure or treatment.
4. Proportion of school-aged children who accessed and used the facility's educational programme during their hospitalization.

Quality statement 6.3: All children including small and sick newborns are assessed routinely for pain or symptoms of distress and receive appropriate management according to MOH guidelines

Rationale

Pain and other symptoms of distress are unpleasant to children as well as their caregivers. They delay recovery, lead to physical or social limitations and add to the trauma of illness or injury. Pain due to illness and invasive medical procedures affects children and their families and may result in distress or other problems, such as depression and anxiety.

Quality Measures

Inputs

1. The health facility has up-to-date guidelines and protocols for the assessment, recognition, prevention and management of pain in all children SSNBs that are consistent with MOH guidelines.
2. The health facility has standardized age-appropriate pain score card/tape.
3. The health facility uses individual plans for pain management or non-pharmacological strategies to reduce pain and relieve distressing symptoms, with the active involvement of children.
4. The health facility has facilities to provide psychological and spiritual support to children who require palliative care and their families.
5. The health care providers receive training in assessing, preventing and controlling children's pain at least once every 12 months.
6. The health facility has protocols and procedures in place to support the safe storage and use of pain-control medicines and conducts regular audits of pain management.
7. The health facility has adequate supplies and storage system for pharmaceuticals according to levels of care.

Process/output

1. Proportion of healthcare providers in the facility who are aware of the facility's protocols and standard operating procedures for pain management
2. Proportion of health care providers who have received training in children's pain management and palliative care within the last 12 months
3. Proportion of children's clinical records reviewed that include an assessment or a pain score card/tape
4. Proportion of children seen in the health facility in the last 6 months who required and received palliative care or were referred to an appropriate center
5. Proportion of children who received adequate analgesia after surgery or a painful medical procedure

Outcome

1. Proportion of caregivers who reported that their child's pain or symptoms of distress were alleviated by the action of health care providers.

Quality statement 6.4: All children including newborns receive appropriate developmental supportive care, and their families are recognized as partners in care by coordinated multidisciplinary developmental follow-up

Rationale

Nurturing care starts before birth, keeps the child safe, healthy, well nourished, ensures that their needs are met and they can interact with their caregivers and others. Children are a vulnerable group who benefit more from nurturing care and are at risk of developmental difficulties without it.

Developmental follow-up with coordinated multidisciplinary teams consisting of allied health workers who provide physiotherapy, speech and occupational therapy and screening for vision and hearing abnormalities, improve the outcomes of children including SSNBs. Developmental review, with assessments of various parameters and monitoring of general health, growth and development after discharge at follow-up visits is beneficial.

Quality Measures

Inputs

1. The health facility has written, up-to-date guidelines, posters, protocols, standard operating procedures and mechanisms to ensure that health care providers and caregivers provide developmental assessment and supportive care for children e.g. MCH Handbook
2. The health care providers are trained on developmental surveillance and nurturing care practice at least once in the last 12 months.
3. The health facility has a mechanism for regular collection of information on caregiver and provider experiences of developmental supportive care.
4. The health facility has health care providers with appropriate competence to deliver coordinated multidisciplinary developmental follow-up.

Processes/Outputs

1. Proportion of children in the health facility who were assessed, received appropriate developmental supportive care and documentation was done.
2. Proportion of children in the health facility whose caregivers reported having been sensitized on their child's developmental milestones.
3. Proportion of children who return for scheduled follow-up and developmental milestones assessment was done.

Outcome

1. Proportion of children identified to have developmental challenges who were linked to appropriate developmental support.

Competent, Motivated, Empathetic Multi-Disciplinary Human Resources

Standard 7:

For every child including the small and sick newborn, competent, motivated, empathetic, multidisciplinary staff are consistently available to provide routine care, manage childhood illnesses and complications and provide developmental and psychological support throughout the care pathway.

Good leadership and management of a health facility is necessary to ensure support and continuous quality improvement. The facility should have mechanisms for recruitment, deployment, regular orientation, mentoring and competence- and skills-building for staff. The facility should have an open culture and systems for reflective review, non-punitive enquiry to ensure learning and positive practice development. Health care providers caring for children including SSNBs should be trained to recognize and meet their physical, psychosocial, developmental, communication and cultural needs. Staff must be available 24 h a day (or during all the working hours of the service) in sufficient numbers and with the appropriate skills for the expected workload. They should be fully aware of children's rights and other relevant national legal entitlements, regulatory and policy frameworks, clinical guidelines and protocols that meet the needs of children for health care, including their protection. The health facility should ensure that these resources are up to date and are accessible to the health care providers.

Quality statement 7.1: All children including small and sick newborns have access to adequate multidisciplinary health workforce at all times according to MOH Human Resources for Health Norms and Standards for health sector.

Rationale

The availability of health care providers around the clock is essential for optimal routine and emergency care of children, including SSNBs, as well as timely management of complications. Children including SSNBs should have access to health care workers with paediatric clinical experience and expertise. They should also have access to other specialists and allied health care providers depending on their problems and need. Children or their families in distress should also have access to social workers and counsellors. Critically ill children including newborns require higher staff to patient ratios than other patients.

Quality Measures

Inputs

1. The health facility has a written, up-to-date staffing policy that defines the staffing criteria and standards, lists the numbers, types and competence (job description) of each staff member and is reviewed regularly (monthly/quarterly) according to the workload and MOH guidelines.
2. The health facility has standard procedures and plans for recruitment, deployment within departments and retention of all staff.
3. The health facility has SOPs or administrative directive for retaining health care providers who have been trained on paediatric and newborn courses (e.g. IMNCI, ETAT+ or Newborn ETAT+ are retained in departments offering newborn and child health services for at least 12 months).
4. The health facility has SOPs or administrative directive that ensures minimal rotation of paediatric and neonatal nurses.
5. The health facility has a duty roster displayed in all areas with the names of staff on duty, the times of their shifts and their specific roles and responsibilities.
6. The health facility has adequate multidisciplinary health care providers offering newborn and child health services who are available at all times, according to staff projection

Processes/Outputs

1. Proportion of health care providers with paediatric and child health training who have been retained in their respective departments over the last 12 months.

Quality Statement 7.2: Health care providers and support staff have the appropriate skills and knowledge to fulfil the health, psychological, developmental, communication and cultural needs of children including the small and sick newborns.

Rationale

Qualification, training and orientation of staff improve their performance of their roles and responsibilities. Health care providers caring for Children including SSNBs should be trained to meet their physical, psychosocial, developmental, communication and cultural needs.

Quality Measures

Inputs

1. The health facility has staff with skills that meet the psychosocial, developmental, communication and cultural needs of children at all times or has access to the same.

2. The health facility has a program for continuous professional (e.g. CME), attitude and skills development for health care providers and support staff who care for children including SSNBs.

Processes/Outputs

1. Proportion of health care providers who have been oriented on their functions, roles and responsibilities in the facility or unit to which they are assigned.
2. Proportion of health care providers who care for children including SSNBs who received continuous professional development (in-service training including refresher sessions) on care of children including newborns within the past 12 months
3. Proportion of staff who interacted with professional mentors to ensure clinical competence and improve performance in the past 3 months.

Quality Statement 7.3: Every health facility has managerial leadership that collectively develops, implements and monitors appropriate policies and legal entitlements that foster an environment for continuous quality improvement for newborn and child health.

Rationale

Good managerial and clinical leadership improve performance by showing direction and creating a workplace culture that is conducive to continuous quality improvement. Excellent care for SSNBs requires strong managerial leadership and advocacy.

Quality Measures

Inputs

1. The health facility has Guidelines and/or protocols and/or SOPs for periodically appraising all staff.
2. The health facility has a mechanism for recognizing good performance.
3. The health facility provides an enabling, supportive environment for professional staff development, with regular supervision and mentoring.
4. The health facility has a written, up-to-date leadership structure, with defined roles and responsibilities, standard governing policies and protocols and lines for reporting and accountability.
5. The health facility has a written, up-to-date plan for ensuring health care providers safety to minimize occupational hazards.
6. The health facility has a system of regular meetings between administrators and health providers to exchange feedback and staff satisfaction.
7. The health facility has a team or at least one person designated to champion or lead initiatives for improving the quality of care in the facility.
8. The health facility has a costed, budgeted plan and established mechanisms to support identified activities for quality improvement.

Processes/Outputs

1. Proportion of staff at the health facility who received a written job description on deployment to the facility.
2. Evidence that the health facility has a mechanism in place for soliciting feedback from staff on issues that might affect or improve staff performance.
3. Number of internal support supervision sessions conducted within the departments offering newborn and child health services at the health facility to improve clinical competence and performance in the past 12 months.
4. Proportion of staff offering newborn and child health services at the health facility who had a performance

assessment conducted and given feedback, at least once in the past 12 months.

5. Evidence that the health facility regularly tracks and monitors performance to improve the quality of care from up-to-date dashboards or performance charts.
6. The health facility holds at least two meetings a year with stakeholders (e.g. the community, service users, partners) to review the community scorecard to gauge the facility's performance, identify problems and make recommendations for joint actions to improve quality.

Outcome (s)

1. Proportion of health care providers and support staff in the health facility who are satisfied with their workload and their roles and responsibilities in the facility or the unit to which they are assigned
2. Proportion of all staff at the health facility who could identify and report on at least one activity for improving clinical quality in which they were personally involved in the past 6 months
3. Proportion of health care providers and support staff who care for children at the health facility whose preceding performance appraisal was satisfactory.
4. Proportion of planned quality improvement projects completed in the past 6 months.

Essential Physical Resources for children including Small and Sick Newborns Available

Standard 8:

The health facility has an appropriate, child-friendly physical environment, with adequate water, sanitation, waste management, energy supply, medicines, medical supplies, and equipment for routine care and management of childhood illnesses and complications

Children, including SSNBs, are different from adults and require distinct, tailored services. Care should be provided in buildings that are easily accessible, safe, secure and suitable for children and with a family-friendly environment. Every health facility should have child and newborn friendly basic infrastructure and amenities, including water, sanitation, hygiene, electricity and waste disposal, a stock of essential medicines, supplies and equipment, including for play and learning. The health facility should have outpatient, emergency and inpatient care areas dedicated for children and newborns, separate from areas for adults, which are appropriately furnished. There should be dedicated areas with adequate facilities for caregivers to sleep, wash, or stay with their children. The health facility should have appropriately equipped child- and newborn friendly facilities, including an appropriately furnished play and learning area. The environment should be clean, comfortable and logically organized and furnished to maintain continuity of care and minimize a detrimental impact on the experience of the child or the family of health care.

Quality Statement 8.1: Children including Small and sick newborns are cared for in a well-maintained, safe, secure physical environment, including adequate and uninterrupted energy supply, designed to promote family centered care and other health care needs.

Rationale

Children including SSNBs are different from adults and require distinct tailored services. Care should be provided in buildings that are easily accessible, safe, secure, well-ventilated and suitable for children and with a family friendly environment.

Quality Measures

Inputs

1. The health facility is designed to provide seamless access to child friendly dedicated areas for the care of children including SSNBs, which are separate from adult areas.
2. The health facility has appropriate space and facilities for kangaroo mother care, family-centered care and rooming-in for mothers or caregivers with their newborns 24 h a day.
3. The health facility has a room or a screened-off area in the outpatient department and in wards that ensures privacy for consultation and examination of children including SSNBs.
4. The health facility is adequately maintained, safe, clean, appropriately lit, well-ventilated for children including newborns and their families.
5. The health facility has a power source that can meet all the demands of the facility and associated infrastructure for electricity at all times, with a back-up power source.
6. The health facility has sufficient safety measures, including safe windows and doors, emergency exit doors, operational fire extinguishers for each area and floor, a clearly designed plan of evacuation in case of emergency.
7. The health facility conducts fire drills at least once every 12 months
8. The health facility has appropriate space and amenities for the expression and safe storage of breast milk and privacy for mothers to breastfeed.
9. The heath facility has a plant and machinery preventive maintenance plan supported by an adequate budget, maintained by appropriately trained staff and regulated by a competent authority.
10. The heath facility has a fuel management plan and a local buffer stock, supported by an adequate budget for all the fuel needs as required at all times.
11. The health facility has adequate budget and staff for rehabilitation, improvement and continuous operation and maintenance of the facility infrastructure.

Processes/Outputs

1. Number of power failures from main supply lasting > 2 h during the previous month.

Quality statement 8.2: Water, sanitation, hand hygiene and waste disposal facilities are easily accessible, appropriate, functional, reliable, safe and sufficient to ensure strict infection prevention and control and meet the needs of newborns, children, caregivers and staff

Rationale

A safe, clean, hygienic environment with continuous supplies of clean water, sanitation and safe waste disposal is critical in the provision of high-quality care and infection prevention and control. These should be availed in every health facility and together with a budget and protocols for the operation and maintenance of safe water and sanitation services.

Quality Measures

Inputs

1. The health facility has written, up-to-date guidelines, protocols, standard operating procedures and awareness-raising materials (e.g., posters) on cleaning, disinfection, hand hygiene, maintenance of water, sanitation and hygiene facilities and safe waste management.
2. The health facility has a functioning source of safe water on the premises that is adequate to meet all demands (according to MOH standards), for drinking, personal hygiene, medical interventions, cleaning, laundry and cooking for use by staff and all children and newborns and their care givers.

3. The health facility has leak-proof, covered, color coded pedal-waste bins and impermeable sharps containers in every treatment area to ensure segregation of waste into various categories
4. The health facility has at least one functional hand hygiene station at the entrances to all units and in all rooms where children including SSNBs are assessed and/or treated.
5. The health facility has at least one functional hand hygiene station per 10 beds for children and 6-8 beds for the newborns, , in all wards, at least one of which is accessible to children (i.e. lower or with a stool to reach taps).
6. The health facility has adequate laundry facilities, including running water, detergent and space for drying.
7. The health facility has an environmental health management risk plan, with an adequate budget, for managing and improving water, sanitation, hygiene and waste management services, including infection prevention and control.

Processes/Outputs

1. Number of functional hand hygiene stations per bed capacity.
2. Number of days in the past 3 months when handwashing soap and running water from a safe and approved source was not available on the premises.
3. Proportion of health care providers and support staff who received training in sanitation, hand hygiene and infection prevention and control in the past 12 months.

Outcome (s)

1. Proportion of children and their families at the health facility who are satisfied with the water, sanitation and waste management services.
2. Proportion of all health care staff at the health facility who are satisfied with the water, sanitation and waste management services.

Quality Statement 8.3: Newborn and Child-friendly, environment which is appropriately designed, furnished and decorated to meet their developmental, learning, recreation and play needs.

Rationale

Children including SSNBs receive optimal care when the environment is specifically designed to meet their size and their learning, recreational and development needs. Safe, age and size appropriate sanitation facilities (e.g. toilets, bedpans and sinks) bedding (cots, high and low beds, bed rails, mattresses, bed linen), play, entertainment and education equipment should be available for all age groups.

Quality Measures

Inputs

1. The health facility areas dedicated for children (outpatients and inpatients) are furnished, decorated appropriately for the children's age, and meet their educational and play needs.
2. The health facility has sanitation facilities (e.g. pans, toilets, latrines) on the premises for infants and children that are adapted for their use (with, e.g. smaller seats or latrines, child-sized bedpans), segregated by sex for older children, appropriately lit and accessible to people with limited mobility.
3. The health facility has culturally acceptable and age-appropriate toys, games, books and facilities for play and entertainment of children in the wards and in play and recreational areas.

Processes/Outputs

1. Proportion of all children and their families who attended the health facility who were satisfied with the availability of child-friendly amenities for education and play.

Quality Statement 8.4: Adequate stocks of age-appropriate health products and technologies and equipment are available for the routine care and management of acute and chronic conditions.

Rationale

Adequate child-friendly essential medicines and other medical supplies are critical for the provision of optimal care to children including SSNBs. Children including SSNBs need special different care hence age-appropriate formulations of medicines, equipment, laboratory and diagnostic supplies for efficiency, efficacy and safety. Use of adult dosage formulations may result in inaccurate dosing for children or difficulty in administration, which may lead to medical errors such as under- or overdosing.

Quality measures

Inputs

1. The health facility has written, up-to-date guidelines, protocols or standard operating procedures for the selection, quantification, procurement and maintenance of newborn and child equipment by level of care according to MOH guidelines.
2. The health facility has a functional, age appropriate, essential diagnostic and therapeutic equipment and supplies for routine care and management of complications in children including SSNBs at all times.
3. The health facility has a safe, uninterrupted source of medical gases (oxygen and air) with delivery equipment and supplies.
4. The health facility has a diagnostic service available 24 h a day, 7 days per week for performing urgent tests as per MOH guidelines.
5. The health facility has written, up-to-date guidelines, protocols or SOPs for safe handling and supply chain management of health products and technologies.
6. The facility has a system for the storage and distribution of all vaccines and their diluents in a cold-chain system maintained at the MOH-recommended temperature range at all times.
7. The health facility has an updated inventory of medical equipment, with documentation of breakage or malfunction and dates of repair or replacement.
8. The health facility has supplies essential medicines available at all times for the management of children including SSNBs as per MOH guidelines.
9. The heath facility has a medical equipment preventive maintenance plan supported by an adequate budget, maintained by appropriately trained staff and regulated by a competent authority.
10. The health facility has an on-site pharmacy managed by a competent health care provider, pharmacists or pharmaceutical technologist according to MOH guidelines.

Processes/Outputs

1. Number of days in the last 3 months during which one or more essential tracer medicines, medical supplies and diagnostic reagents and supplies as listed in MOH647 of newborn and child healthcare services were out of stock as per KEML and KEMSL.
2. Number of days in the last 3 months during which an oxygen source and delivery systems were out of stock for delivery of newborn and child healthcare services.

3. Number of days in the last 3 months during which one or more essential age-appropriate equipment of newborn and child healthcare services were not available
4. Number of days in the past 3 months when there was a stock out of blood and blood products

Outcomes

1. Proportion child and newborn deaths audited in the last quarter in which the child and newborn did not receive appropriate care because of lack of essential medicines or supplies.

Community Newborn and Child Health Care Services

Standard 9:

Every child including the small and sick newborn has access to community newborn and child health care services

The community newborn and child health care services are anchored in the Kenya Community Health Policy (2020 – 2030) which aims to streamline the implementation of community health services in Kenya. The goal of the Policy is to empower individuals, families and communities to attain the highest possible standard of health. The community newborn and child health services include; Integrated Community Case Management (iCCM), Community Maternal and Newborn Care (CMNC), Community Management of Acute Malnutrition (CMAM) and Nurturing Care for Early Childhood Development. These comprise the equity-focused interventions aiming to improve access to quality essential health care for children including newborns.

The standard model employs Community Health Promoters (CHPs) to provide maternal, newborn, child and nutrition health care services at the community level.

Quality Statement 9.1: Regular health education, sensitization sessions, community mobilization and advocacy on Newborn and child Health are conducted at the community level by community health workforce

Rationale.

Community involvement leads to awareness, increased demand for health rights and quality services from the link health facilities. It also demands accountability for the efficiency and effectiveness of health services. The community members should be empowered with the necessary information and education, which will enable them to actively participate and make informed decisions regarding newborn and child health.

Quality Measures

Inputs

1. Community health workforce sensitize the community on newborn and child health and nutrition interventions through various delivery platforms.
2. The link facility in conjunction with the Community health committee (CHC) and other relevant stakeholders advocates for acceptability of newborn and child health interventions within the community.
3. The link facility in conjunction with the Community health committee advocates for resources to support newborn and child health services from stakeholders.
4. The community are empowered to demand quality newborn and child health services.

Processes/Outputs

1. Proportion of Community Health units that hold at least one dialogue meeting that include newborn and child health care topics every 3 months.
2. Proportion of advocacy meetings held by CHCs with different stakeholders on discussing the CHPs mandate on newborn and child health interventions
3. Proportion of resource mobilization meetings held by CHCs with different stakeholders on newborn and child health interventions
4. Proportion of proposals on newborn and child health that were funded.

Outcome (s)

1. Proportion of households reached with newborn and child health high impact intervention messages
2. Proportion of children with acute illnesses whose caregivers sought medical care within 24 hours of onset of the illness.

Quality Statement 9.2: Well trained, equipped and supervised community health promoters providing quality community maternal and newborn care, nurturing care, community management of acute malnutrition and integrated community case management according to MOH guidelines

Rationale for quality statement 9.2 and quality statement 9.3

Community health has been recognized as an effective way of improving health status of a population by increasing access to quality health care services. Community Health Promoters make home visits, deliver key health messages and perform necessary interventions such as treating common ailments as per the Integrated Community Case Management (iCCM) guidelines and Community Management of Acute Malnutrition or referral of the complicated cases to the link facilities. They also participate in community maternal and newborn care that ensures access to antenatal services and postnatal services allowing breastfeeding support, early recognition of danger signs and referral to the link facility. They play a key role in providing key messages to caregivers that promote nurturing care.

Quality Measures

Inputs

1. CHPs have up to date guidelines, protocols and flip charts on child health that are consistent with MOH guidelines
2. CHPs are trained and given regular refresher sessions on current newborn and child health (CMNC, ICCM, CMAM and nurturing care for ECD) modules as per MOH guidelines once every 12 months
3. Trained CHPs are followed up 4 weeks after training and accredited according to ICCM guidelines.
4. CHPs who are trained on newborn and child health technical modules are supervised on a monthly basis

Processes/Outputs

1. Proportion of community health promoters who have been trained on any community newborn and child health interventions at least once in the last 6 months
2. Proportion of CHPs who were followed up and accredited after training as per MOH guidelines.
3. Proportion of CHPs who have the necessary CHP kits as per MOH guidelines.

Quality Statement 9.3: There are functional linkages, communication channels, interactions and collaborations between the community health unit and the link health facility as per MOH guidelines.

Quality Measures

Inputs

1. The health facility has a Community Health Assistant(s)
2. The community and the link health facility are part of a referral network in the same geographical area with agreed arrangements under the current primary health care guidelines
3. The community health units have established mechanisms to provide complete referrals to the link health facility.
4. The community health promoters have reliable methods for communication (mobile phones, landline or radio call) that are functional at all times for facilitating referrals

Processes/Outputs

1. The facility has an up-to-date chalk board (MOH 516) for the past month
2. The number of children including newborns referred to the health facility who were confirmed to have gone to the health facility during referral follow up.
3. The proportion of all children referred by CHP for whom written counter referral feedback information was provided by the receiving facility

Quality Statement 9.4: Every school age child in the community has access to school health services

Rationale

School health services are an important aspect of community health. The aim of the school health services is to promote, protect and maintain the health of school age children hence reducing morbidity and mortality among them.

Quality Measures

Inputs

1. The health facility has up to date guidelines, policies and SOPs for school health services as per Kenya School Health Policy.
2. The health facility has a schedule for school health activities
3. The health facility has a focal person for school health services
4. The health facility has adequate supplies and tools to deliver the school health services.

Processes/Outputs:

1. Proportion of schools linked to the health facility who have active school health programme (deworming, medical screening and assessing water quality and safety).

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ANNEX 1:

HEALTH FACILITY QoC ASSESSMENT TOOL – (HFA-TOOL)

HEALTH FACILITY QUALITY OF CARE ASSESSMENT TOOL FOR CHILDREN INCLUDING THE SMALL AND SICK NEWBORNS

Health Facility profile

Health Facility Name:	
Health Facility Level (insert ✓ where appropriate)	☐ Level 2 ☐ Level 3 ☐ Level 4 ☐ Level 5 ☐ Level 6
Health Facility ownership (insert ✓ where appropriate)	☐ GOK ☐ FBO ☐ PRIVATE
Health Facility MFL code	
County	
Sub County	
Facility in-charge's name	
Facility contact/in-charge's telephone number	
Date of assessment	

Names and contacts of the assessors (fill in table below)

Name	Designation	Telephone number

MODULE ONE:

General Information

This first section of the tool looks at the general hospital information on the basic infrastructure, layout of the facility and hospital support systems including overall staffing. The areas that are assessed in this section are:

- Lay out
- Infrastructure
- Infection prevention and control
- Staffing
- Training
- Health information systems and medical records
- Health facility statistics
- Essential drugs
- Laboratory and blood products
- Guidelines and auditing
- Referral

1. Layout

Source: Information will be collected through health facility walkthrough, observation, and interviews with facility leadership.

Instructions: Collect information on numbers and time where applicable. Several questions have space for you to describe your answer in more detail.

Score Yes = 5 No = 1. Indicate N/A for Not Applicable

	Y	N	N/A
OUTPATIENT			
Are sick children including the small and sick newborns seen separately from adults in the outpatient area?			
Does the health facility have a designated emergency area?			
Is there a functional Oral Rehydration Therapy (ORT) corner? (verify by checking presence of the space, supplies and register)			
Is a service charter displayed in the outpatient department			
Is a patient's rights charter displayed in the outpatient department			
Is the facility open 24 hours a day? (Applicable to level 3 to 6)			
NEWBORN UNIT/WARD (level 4 to 6)			
Does the health facility have a newborn unit for admitting newborns?			
If yes to above, how many beds (cots and incubators)? ..... beds			
Does the health facility have a separate room or ward for admitting newborn "Infectious" cases (i.e. isolation ward)?			
If yes to above, how many beds? ..... beds			
Does the health facility have a newborn ICU? (level 5 and 6)			
PAEDIATRIC WARD (level 4 to 6)			
Does the health facility have a separate ward for admitting paediatric patients?			
If yes, how many beds? ..... beds			
Does the health facility have a separate room or ward for admitting paediatric "Infectious" cases (i.e. isolation ward)?			
If yes, how many beds? ..... beds			
Is there a separate room/section of the ward/ward for admitting paediatric surgical cases?			
Does the health facility have a paediatric intensive care unit? (level 5 and 6)			

Summary layout	**Score (1-5)**	**Comments**
Outpatient		
Newborn unit		
Paediatric ward		

Summary score [Average of all the Yes + No scores] - layout					
(to be circled)	5	4	3	2	1

Please indicate the quality of layout by marking one of the 5 numbers; 5 indicates excellent layout practices are being used at all times. 4 to 1 indicating levels of necessary improvement (4= Sufficient layout practices are being used with small need for improvement, 3 -some layout practices are being used with moderate need for Improvement, 2= very few layout practices are being used, there is significant need for improvement 1= No layout practices are being used urgent need for improvement/life threatening practices)

2. Infrastructure

Source: Information will be collected through health facility walkthrough (MCH/OPD, paediatric ward and newborn unit where applicable) observation, and interviews with health facility leadership. Score each statement.

Standards or criteria	**Score 1-5**	**Comments**
Does the facility have uninterrupted power supply?		
Is there a functional back-up power supply in the case of a power interruption (i.e. diesel generator, solar)?		
Is there a safe source of water to meet all the demands of the facility? (Piped water, borehole or rain water)		
Does the health facility have appropriately lit baths and toilets for children and their caregivers on the premises?		
Are the baths and toilets adapted for use by young children?		
Are the baths and toilets adapted for use by children/ caregivers with disability?		
Are the baths and toilets segregated by sex for older children and their caregivers?		
Are there functional hand washing stations, complete with running water and liquid soap, within 5M of the toilets?		
Are there handwashing stations adapted for use by young children? (low sinks or stools to step on)		
Are there safety measures including external barriers, functional fire extinguishers, fire assembly point, safe windows and doors with exit signage in all areas where children including small and sick newborns are cared for?		
Is there a functional fridge available for drugs, reagents and vaccines?		
Is there an incinerator or arrangements for medical waste disposal e.g. medical waste company collecting the waste		
Is there a play area with age-appropriate play items for the stable children?		
Are there child friendly wall paintings or pictures in all the areas where children are cared for?		

Is there a grievance redress system (hotline or compliments and complaints book) through which patients can communicate with the hospital or functional Suggestion boxes with the following features; • Lockable • Reviewed by a committee on quarterly basis • With writing papers and pens		

Summary score [Average of all scores] - Infrastructure					
(to be circled)	5	4	3	2	1

Please indicate the quality of infrastructure by marking one of the 5 numbers; 5 indicates excellent infrastructure practices are being used at all times. 4 to 1 indicating levels of necessary improvement (4= sufficient infrastructure practices are being used with small need for improvement, 3 = some infrastructure practices are being used, moderate need for Improvement, 2= very few infrastructure practices are being used -significant need for improvement, 1= No infrastructure practices are being used urgent need for improvement/life threatening practices)

3. Infection prevention and control in the outpatient department, neonatal unit and paediatric wards

Source: Information will be collected through health facility walkthrough (MCH/OPD, paediatric ward and newborn unit where applicable) observation, and interviews with health facility leadership. Score each statement

Standards and criteria	**Outpatient Department** **Score 1-5**	**Neonatal unit** **Score 1-5 (Level 4 to 6)**	**Paediatric ward** **Score 1-5 Level 4 to 6**	**Comments**
Hand hygiene and gloves				
Functional hand washing stations equipped with running water and liquid soap and/or alcohol-based hand rub at the entrance and in all the rooms; (Verify availability of a functional station per 10 beds in the paediatric ward and 1 station per 6-8 cots/incubators in the newborn unit.)				
Job aids on hand washing technique and How to hand rub are displayed above or near the sinks and the alcohol based for-mulation dispensers respectively.				

HCWs' adherence to recommended hand hygiene practices. Observe the 5 moments of hand washing outlined below: 1. Before touching a patient 2. Before a procedure 3. After a procedure or body fluid exposure 4. After touching a patient 5. After touching a patient's surrounding. If there is no procedure ask for a hand washing audit				
Gloves are used when anticipating contact with potentially infectious waste and the same pair of gloves are not used for the care of more than one patient.				
Sterile gloves are used for sterile procedures				
Infection control				
Protocols and/or SOPs (consistent with National guidelines) on infection control are available				
Availability of the following sterilizing facilities and disinfectants for medical equipment and surfaces: • Autoclave and/or chemical disinfectants e.g. glutaraldehyde (cidex) • Chorine solution and/or enzymatic solutions. • 70% alcohol solution				
Regular surveillance for infections (swabbing the equipment and surfaces to isolate any organisms)				
Routine cleaning/disinfection of premises is performed regularly				
Availability and correct use of the following for safe handling, collection, storage and final disposal of infectious waste • Colour coded bins with the appropriate bin liners (verify availability of at least yellow, red and black bins) • Puncture resistant sharps containers				
Mechanisms to minimize overcrowding verify that the paediatric ward has 1 child per bed/the newborn unit has 1 newborn per cot/incubator and the distance between cots or beds is 1m				
Routine policy of changing dress, footwear and wearing of caps by staff observed	N/A			
There is an infection control policy for visitors in the hospital, that may require restriction of access to some patients				

4. Summary score for infection prevention and control

Summary infection prevention and control	Outpatient (Score 1-5)	Neonatal unit (Score 1-5)	Paediatric Ward (Score 1-5)	Comments
Appropriate hand hygiene and use of gloves				
Practices for infection control				

Summary score [Average of outpatient, newborn unit and paediatric ward mean scores] - Infection control					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates excellent infections control practices are being used at all times in all wards. 4 to 1 indicating levels of necessary improvement (4= sufficient infection prevention practices are being used with small need for improvement, 3= some infection prevention practices are being used, moderate need for improvement, 2= very few infection prevention practices are being used, significant need for improvement 1= No infections control practices are being used urgent need for improvement/life threatening)

5. Staffing

Source; Data for section 4.1 and 4.2 through interviews with the health facility leadership.

6. Staffing management

Standard or criteria	MOV	Score 1- 5	Comments
The health facility has a written, up-to-date staff projection plan.	Check for presence of staff projection plan		
The health facility ensures minimal rotation of paediatric and neonatal nurses	Presence of a written directive		
The health facility ensures that the health care providers with paediatric and child health training are retained in their respective departments for at least 12 months.			
The health facility has skilled child health care providers available at all times	Duty Roster		
The health facility has a clear structure and communication channels to reach staff on duty at all times.	Verify availability of communication structure		

7. Facility staffing level

Cadre	Level 2		Level 3		Level 4		Level 5		Level 6		%
	Norm	At hand	Norm	At hand	Norm	At hand	Norm	At hand	Norm	At hand	
Neonatologists	N/A		N/A		1		2		10		
Paediatricians	N/A		N/A		2		4		20		

Medical Officers	N/A		2		16		50		100		
Clinical Officers paediatrics	N/A		1		2		6				
Clinical Officers	1		6		30		44				
Midwives	1		3								
Neonatal nurses	N/A		N/A				20				
Paediatric nurses	N/A		N/A		10		20				
Registered nurses	1		2		40		100				
Enrolled Nurses	2		3		6		10				
Nutritionists	1		N/A		2		36				
physiotherapists	N/A		N/A		9		17				
Occupational therapists	N/A		N/A		10		12				
Pharmacists											
Pharmaceutical Technologists											
Lab-Technologists											
Social Workers											

Ministry of Health, Kenya. (2014). Human Resources For Health Norms and Standards Guidelines For The Health Sector. Nairobi, Kenya.

8. Newborn unit staffing

Source: To be collected at the newborn unit or by interviewing the newborn unit in charge

	Average number on day shift	Average number on night shift	Average numberon weekend shifts
Paediatricians and/or neonatologists			
Medical Officers			
Neonatal nurses			
Paediatric Nurses			
Nurses			
Auxiliary staff			
Others (please specify)			

9. Paediatric ward Staffing

Source: To be collected at the paediatric ward or by interviewing the paediatric ward in charge

	Average number on day shift	Average number on night shift	Average number on weekend shifts
Paediatricians			
Medical Officers			
Clinical Officers, paediatrics			
Clinical officers			
Paediatric nurses			
Nurses			
Auxiliary staff			
Others (please specify)			

10. Staff training

Source: Information will be collected from the training database, CME register and Mentorship register. Score each statement.

Standards and criteria	Score 1-5	comments
At least 60% of the health care providers who care for children , including the small and sick newborns, in the inpatient departments and emergency department have been trained on newborn ETAT or ETAT plus		
At least 60% of the health care providers who care for children including the small and sick newborn in the outpatient department have been trained on IMNCI or ETAT plus		
At least 60% of the midwives who conduct deliveries have been trained on essential newborn care or EmONC		
Health care providers in the neonatal unit received refresher sessions (CMEs/Mentorships) on these three common neonatal conditions (newborn resuscitation, neonatal sepsis, prematurity)at least once in 12 months		
Health care providers who care for children receive refresher sessions (CMEs/Mentorships) on these common childhood conditions (pneumonia, diarrhea, severe acute malnutrition and malaria) at least once in 12 months.		
The health care providers who care for children including the small and sick newborns receive training or refresher sessions on infection prevention and control at least once in 12 months		
Health care providers received training on data management at least once in 12 months		
Health care providers received training/refresher courses in nurturing care at least once in the last 12 months		

11. Summary score for staffing

Summary score for staffing	Score 1-5	Comments
Staffing management		
Staff training		

Summary score [Average of all the scores] - staffing					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates excellent staffing practices are being used at all times. 4 to 1 indicating levels of necessary improvement (4= sufficient staffing practices are being used small need for improvement, 3= some staffing practices are being used, moderate need for improvement, 2= Very few staffing practices are being used significant need for improvement 1= No infections control practices are being used urgent need for improvement/life threatening practices).

12. Health information system and medical records

Source: Collect the information early during the visit from the records department, chief nursing officer, or hospital administration.

13. Health information system for children including small and sick newborns

Standards and criteria	**Score 1-5**	**Comments**
Existence and quality of a standardized computer or paper-based information system on patient flow (admissions, outpatients, etc.)		
Existence of an up to date standardized electronic or paper-based Health Information System on important medical indicators. Verify availability of the Kenya Health Information System (KHIS) or all of the following up to date MOH (Ministry of Health) summary tools and registers; MOH 711A (Integrated tool for RH, HIV, Malaria, TB and Child Nutrition) MOH 717(Monthly workload report) MOH 705A (under 5 daily morbidity register) MOH 705B (over 5 daily morbidity register) MOH 713 (Integrated Management of Acute Malnutrition Program) MOH 373(newborn register) MOH 333(maternity register) MOH 301(in patient register)		
The health facility has a registration system for births and deaths that is linked to the national vital registration system at all times		
Periodical review and evaluation of statistics and indicators by the relevant professional teams (verify using data review meeting minutes)		

15. Medical records for children including small and sick newborns

Source: Sample 5 patient files.

Standards and criteria	Score 1-5	Comments
The health facility has a standardized electronic or physical outpatient card		
The health facility has electronic or physical complete neonatal admission files (with standardized newborn admission record form, continuation forms, nursing cardex, newborn monitoring chart, treatment sheet and a discharge summary)		
Complete electronic or physical paediatric admission files (with standardized paediatric admission record form, continuation forms, nursing cardex, monitoring chart, treatment sheet and a discharge summary)		
Are records dated, clear and legible?		
Are all admissions and discharge diagnoses clearly written in the notes?		
Are all drugs and treatments clearly identifiable?		
Is information from previous admissions available to staff providing care to children including small and sick newborns through a retrieval system for patient's records?		

16. Summary score Health information system and medical records

Summary score for health information system and medical records	Score 1-5	Comments
Health Information systems		
Medical records		

Summary score [Average of all the sub-section mean scores] - Health information system and medical records					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates efficient and quality health record management, 4 to 1 indicating levels of necessary improvement (4=just a few shortcomings in health record management small need for improvement, 3=moderate need for improvement, 2=significant shortcomings, significant need for improvement 1=non-existent health records).

17. Health facility statistics

Source: This information should ideally be collected 2 weeks before the visit and be available for reference during the visit. If it has not been collected before, collect the information early during the visit from the records department, chief nursing officer, or hospital administration.

18. Neonatal statistics

Source: KHIS or Revised MOH 711 (2019 Version)

Please use the figures for the previous last 3 months. If data are available for a different period, please specify.

Year: ..... Any other period .....

Number of deliveries	
Number of live births	
Number of low-birth-weight babies (below 2500g)	
Number of low-birth-weight newborn babies (1500 g-2500g) *	
Number of very low birth weight newborn babies (1000-1499 g) *	
Number of extremely low birth weight babies (<1000g)*	
Number of preterm babies	
Number of deliveries: 32-37 completed weeks*	
Number of deliveries: < 32 weeks*	
Number of babies with APGAR score <6 at 5 min	
Number of babies with Apgar score <3 at 5 minutes	
Number of still births (¼Macerated still births+¼ Fresh still births)	
Number of perinatal deaths in the hospital (number of stillbirths plus early neonatal deaths within the first seven days)	
Number of neonatal deaths due to neonatal sepsis	
Number of neonatal deaths due to perinatal asphyxia	
Number of neonatal deaths due to prematurity	
Number of neonatal deaths (0-28 days) (also available in MOH 717)	
Number of babies applied chlorhexidine for cord care	

**The neonatal statistics in italics are not captured in KHIS or the summary tool MOH 711.Ministry of Health to consider revising MOH 711 and MOH 333 (Maternity Register) to capture the data.*

19. Paediatric statistics (level 4 to 6)

Source: KHIS (aggregate and tracker) or MOH 717 (Monthly workload report for hospitals) if KHIS is not available. Severe acute malnutrition data to be collected from KHIS or MOH 713(Integrated Management of acute malnutrition).

Please use the figures for the previous year. If data are available for a different period, please specify.

Year ..... Any other period .....

Facility under 5 catchment population for the period under review	
Number of children under-5 hospitalized in the facility	
Number of under-5 child deaths in the facility	
Under-5 mortality rate in facility (under 5 deaths during the period being reviewed/facility under 5 catchment population for the period under review×1000)	
Number of child deaths reviewed in the health facility	
Number of hospitalized children with pneumonia	
Number of child deaths caused by pneumonia in facility	
Number of children hospitalized with diarrhoea	
Number of child deaths caused by diarrhoeal disease in facility	
Number of children admitted in facility with severe malnutrition	
Number of child deaths caused by severe malnutrition in facility	

20. Patient load, deaths and fatality rates

Source: KHIS (aggregate and tracker) if not available MOH 711 summary tool, MOH 705 A, MOH 705 B, MOH 301

Indicate the total number of outpatient visits and admissions over the last year for children including the small and sick newborns (indicate year; if any other period of time, e.g. Q1, Q2, Q3, is used, indicate the exact period). Include all medical diagnosis but exclude patients dead on arrival.

Year: .....

SSNB/Paediatric	Outpatient visits	Inpatients/ admissions	Number of deaths	Age-specific fatality rate
0-<7 days				
7-28 days				
29 days -<5 years*				
5-10 years*				
<5years				
>5years				

**Data in italics is not captured in KHIS and summary tools that lump the > 5 years with adults. MOH to consider revising the registers, summary tool and KHIS to capture 5-10 years. MOH to also develop a standardized paediatric mortality register/summary tool since the only source of mortality data apart from manual tallying from the registers is KHIS tracker which is not available at all times in all facilities*

21. Reasons for hospital visits and admissions, deaths and case fatality rates

From the hospital records, list the five most important medical reasons for neonates and for children.

NEONATAL Most frequent diagnosis	Outpatient visits	Admissions	Deaths	Case fatality rate
1.				
2.				

3.				
4.				
5.				
PAEDIATRIC Most frequent diagnosis	**Outpatient visits**	**Hospital admissions**	**Deaths**	**Case fatality rate**
1.				
2.				
3.				
4.				
5.				

22. Essential Medicines and supplies

Source: Collect the information early during the visit to the pharmacy or store, nutrition department or store and Maternal and Child Health (MCH) department

Instructions: Availability of drugs varies considerably in different levels of service delivery. Check for the presence of medicines. Enquire with staff whether the medicines have been available for the last 3 months with no stock outs. Check expiry dates. Note whether medicine with the earliest expiry date are used first (in the front-row).

23. Basic essential medicines for prevention/managing common neonatal and childhood conditions as per level of care

Standard or criteria	**Pharmacy/ store (Score1-5)**	**N/A**	**Comments**
First and second line injectable antibiotics			
Level 2 to 6			
Crystalline penicillin			
Gentamicin			
Ceftriaxone			
Level 4 to 6			

Ceftazidime or cefotaxime			
Antimalarial medicines			
Level 2 to 6			
Artesunate			
Artemether Lumefantrine			
Level 3 to 6			
Dihydro Artemisine Piperaquin (DHPPQ)			
Emergency medicines and fluids			
Level 2 to 6			
10% dextrose			
50% dextrose			
Normal saline			
Ringers lactate			
Adrenaline 1mg/1 ml			
Diazepam injection			
Phenobarbitone injection			
Salbutamol nebulizer solution			
Salbutamol metered dose inhaler			
Level 4 to 6			
Calcium gluconate			
Potassium chloride			
Drugs for respiratory conditions in newborns			
Caffeine citrate (level 4 to 6)			
Surfactant solution for intratracheal instillation (level 5 and 6)			
Other basic essential drugs (level 2 to 6)			
Amoxicillin DT			
Cotrimoxazole (tabs/suspension)			
ORS and zinc co pack			
Iron supplements			
Albendazole (200mg and 400mg)			

Vitamin A (100, 000 units and 200,000 units)			
Vitamin K			
Tetracycline eye ointment			
Chlorhexidine digluconate 7.1%			
Nutrition feeds for managing severe acute malnutrition	**Nutrition department/ stores**	**N/A**	**Comment**
Level 2 to 6			
Ready to use therapeutic food (RUTF)			
Level 4 to 6			
Therapeutic diet feed (F100)			
Therapeutic diet feed (F75)			
Rehydration solution for malnutrition (ReSo-MaL)			
Vaccines (level 2 to 6)	**MCH department**	**Comment**	
All the vaccines in the latest National Routine Immunization Schedule (see annex)			

Ministry of Health, Kenya. (2019). Kenya Essential Medicines list.

24. Management of essential medicines including vaccines

Standard or criteria	Score 1-5	Comments
Does the health facility have policies and SOPs on management of medicines?		
Does the health facility have a mechanism for tracking expired medicines?		
Are expired medicines documented?		
Are expired medicines kept separately in a secure location?		
Is cold chain maintained for vaccines? Verify availability of all of the following: A functional fridge, cool boxes with ice packs and a temperature log.		

25. Summary Score- Essential Medicines including vaccines availability and management

Summary score for health information system and medical records	Score 1-5	Comments
Essential medicines and supplies availability		
Management of essential medicines		

Summary score (average of availability of essential medicines and management of essential medicines) - Essential Medicines					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates all essential drugs are available, not expired and all the medicine management practices are in place. 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 3= moderate need for improvement, 2= significant need for improvement1=urgent or chronic shortages of drugs/chronic lapses in the quality leading to potentially life-threatening situation to both patient and staff)

26. Laboratory

Source: Collect the information during the visit to the laboratory and/or from the chief laboratory technician.

27. Laboratory tests

Try to see as many essential laboratory investigations being carried out as possible. If available, indicate average time to get results. Emergency tests like blood glucose should be available immediately. Score 1 to 5 depending on functionality and time for results (as per the facility laboratory service charter). Insert N/A where the equipment is not applicable to the health facility.

Lab test	Available Score 1-5	Time to get results Score 1-5	N/A	Comments
Level 2 to 6				
Blood glucose				
Haemoglobin level				
Blood slide for malaria parasite(Level 2 to 6)				
Level 4 to 6				
Blood grouping and cross matching				
Bilirubin				
Rhesus antibodies				
Full blood count				
CSF, microscopy, bio-chemistry and culture)				
Blood culture				
Level 5 and 6				
Blood gas analysis				

28. Blood and blood products

Standards and criteria	Yes	No	N/A	Comments
Is the facility able to transfuse?				
Are the essential blood and blood products below available when needed?				
• Packed red cells				
• Whole blood				

29. Summary – Laboratory and blood products

Summary score for laboratory and blood products	Score 1-5	Comments
Laboratory tests (average of availability and time to get results)		
Blood and blood products		

Summary score - Laboratory and blood products					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates all lab tests are available and are results are available within the expected time as per the laboratory service charter. 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 3= moderate need for improvement, 2= significant need for improvement1=urgent or chronic unavailability of tests and results leading to potentially life-threatening situations)

30. Guidelines and auditing

Guidelines

Standards and criteria	Score 1-5	N/A	Comments
Up to date guidelines/protocols on essential newborn care are available			
Up to date guidelines/protocols on management of common conditions for children including small and sick newborns are available as; • Wall charts, or job aids • KMC guidelines • IMNCI chart booklet 2018 • MCH hand book 2020 • Pocket instructions (comprehensive newborn protocol, November 2022 or basic paediatric protocol, November 2022) (level 4 to 6)			
Up to date Hospital essential drugs list is available			
Up to date Infection prevention and control guidelines and or SOPs are available			
Baby Friendly Hospital Initiative (BFHI) and Mother infant and Young Child nutrition guidelines			

Periodical staff meetings are held to discuss and revise standard operating procedures and job aids (level 5 and 6)			

31. Auditing

Standards and criteria	Score 1 -5	Comments
All perinatal deaths are audited (verify using MPDSR forms)		
Audits are conducted to review cases of paediatric deaths and complications at least once a month (verify using audit minutes)		
Clinical audits teams are multidisciplinary involving all the cadres involved in care of children including small and sick newborns		
The audits take into account monitoring, hospital flow and quality of care as well as more clinical aspects		
Recommendations from audits are discussed and implemented		

32. Summary – Guidelines and auditing

Summary score for laboratory and blood products	Score 1-5	Comments
Guidelines		
Auditing		

Summary score (Average of sub-section means) - Guidelines and auditing					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates excellent guidelines, protocols and information are available for staff; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

33. Referral Care

Standards and Criteria	Score 1-5	Comments
The health facility has written, up-to-date pre-referral guidelines, protocols and standard operating procedures		
The health facility has a standardized referral form to document relevant demographic and clinical information		
The facility communicates the referral to the referral unit		
The health facility refers children including small and sick newborns within 30 minutes of stabilization or pre referral treatment		

Referrals to and from the health facility are recorded appropriately in the registers		
The health care provider communicates clearly with family members about the condition of their child/ newborn and about why and where the child will be referred for further care		
Small and sick newborns are referred maintaining the warm chain using skin-to skin contact		
The facility has a functional mechanism for follow up / feedback mechanism for referrals		

Summary score (Average of all the scores) - Referral care					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates that all the referral practices are being carried out; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 3= moderate need for improvement, 2= significant need for improvement 1=urgent need for improvement/life threatening practices)

34. Summary score: Module 1

Instructions; Circle the average score for each subsection. Calculate an average of all the subsection score to get the overall mean score for module 1 and circle module 1 mean score

Summary scores						
1	Layout	5	4	3	2	1
2.	Infrastructure	5	4	3	2	1
3	Infection Prevention and Control	5	4	3	2	1
4	Staffing	5	4	3	2	1
5	Health information System and Medical Records	5	4	3	2	1
6	Health Facility statistics	5	4	3	2	1
7	Essential medicines including vaccines	5	4	3	2	1
8	Laboratory and blood products	5	4	3	2	1
9	Guidelines and auditing	5	4	3	2	1
10.	Referral	5	4	3	2	1
Module One	MEAN SCORE	5	4	3	2	1

MODULE TWO:

OUTPATIENT CASE MANAGEMENT

2.1 Paediatric emergency care

Source: Visit the paediatric emergency areas i.e., paediatric outpatient, maternal child health clinic area, or any other area where children from home including small and sick newborns present for care.

Instructions: Observe or interview staff where emergencies would present. Find out who sees the emergency cases; how emergency/senior staff is called and where and how emergency conditions are handled.

Layout and structure of emergency care

Standards and criteria	Score 1-5	NA	Comments
A space designated for emergency care with necessary equipment (pulse oximeter, thermometer, scale, etc.)			
A wall chart or job aid for identifying, assessment and classification of children's conditions by the severity is located in the emergency care area.			
A skilled provider trained in the management of complications (ETAT+/ IMNCI) is assigned 24/7 (i.e. for every shift)			
A system is in place to prioritize severely ill patients (triage)			
Emergency assessment is done immediately and not hindered by registration procedures, payment, etc. before lifesaving action takes place			

Summary- paediatric emergency care

Summary score (Average of All the scores) -paediatric emergency care					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care i.e. well-staffed emergency department with experienced and trained staff available on hand at all hours to help manage emergency cases, 4 to 1 indicates levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

2.2 Outpatient case management of small and sick newborns (less than 2 months)

Source: This information should be collected by observing case management at the outpatient section/ MOH 204 A or looking at the patient records and health worker interview

Please note: *Case management should be according to IMNCI, basic paediatric protocol and other MOH guidelines*

Standards and criteria	Score 1-5	Comments
Outpatient Management of the SSNB		
All SSNB checked for PSBI and local bacterial infection		
All SSNB checked for Jaundice		
All SSNB assessed for diarrhoea		
All SSNB assessed for suspected HIV infection		
All SSNB assessed for feeding problem or low weight		
All SSNB assessed for immunization status		
All SSNB correctly classified for the presenting illness		
SSNB with non-severe classifications managed according to IMNCI guidelines		
SSNB with severe classifications given pre-referral treatment and appropriately referred		

Comments

Summary score (Average of all the mean sub-section scores above) - Case management and sick newborn care					
(to be circled)	5	4	3	2	1

2.3 Case management of common paediatric diseases – children 2 months upto 5 years

Source: This information should be collected by observing case management at the outpatient section/ or checking the MOH 204A or looking at the patient records. In addition, for each main symptom, select at least 5 outpatient records and 5 inpatient files for review.

Please note: Case management is done according to updated IMNCI, basic paediatric protocols and other MOH guidelines

Cough/difficult breathing-Review 5 outpatient records

Standards and Criteria	Score 1-5	Comments
Assessment of pneumonia		
Health workers correctly assess, classify or diagnose pneumonia according to MOH guidelines		
Oxygen saturation is assessed using a pulse oximeter		
Administration of antibiotics		
Antibiotics are correctly prescribed based on the classification of pneumonia as per MOH guidelines		
Children diagnosed with pneumonia are given first doses of all treatments in the outpatient		

Summary - Cough/difficult breathing

Score

Summary score -Cough and difficult breathing					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Diarrhoea - Review 5 outpatient records

Standards and Criteria	**Score 1-5**	**Comments**
Patients with diarrhea are assessed for dehydration and correctly classified according to MOH guidelines.		
The correct rehydration plan for children without Severe acute malnutrition is chosen based on the severity of dehydration (Plan A, Plan B, Plan C as per IMNCI guidelines)		
ORS and Zinc supplementation is given for cases of diarrhoea with no or some dehydration		
Children diagnosed with diarrhoea with severe dehydration correctly initiated on treatment as per IMNCI guidelines or referred urgently		
Antibiotics are not given to children with only watery diarrhea and without any other condition requiring antibiotic treatment.		
Feeding (breast milk and/or other food as appropriate) is continued and encouraged during illness		

Summary score

- Management of Diarrhoea					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good practice complying to standard of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement)

Fever - Review 5 outpatient records

Standards and Criteria	**Score 1-5**	**Comments**
Differential diagnosis and investigations		
Patients with fever are assessed and correctly classified according to MOH guidelines.		

All children presenting with fever in high-risk malaria areas or with history of travel to those areas are tested for malaria		
All children in low-risk malaria areas are tested for malaria after ruling out other causes of fever		
Children presenting with fever that have severe classifications are given pre-referral treatment and referred appropriately		
Children with non-severe malaria are given appropriate anti-malaria treatment according to MoH guidelines		
Children presenting with fever with non-severe classifications are given first doses of appropriate treatment in the health facility		

Summary score on management of fever

-Fever					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Acute Malnutrition (Select at least 5 cases in OTP clinic and review what is documented)

Standards and Criteria	**Score 1-5**	**Comments**
Assessment of nutritional status		
Nutritional status for all children less than 5 years seen at the facility is assessed using MUAC for those >6 months of age or WHZ scores recorded		
Clinical examination for signs and complications of severe malnutrition is done		
Malnutrition is correctly classified/triaged		
Health facility offers Out Patient Therapeutic programme services of cases of Severe Acute Malnutrition (SAM) without complications		
Broad spectrum antibiotics are administered to all severely acute malnourished patients on admission to OTP as per the MOH guidelines.		

Summary Score- Management of Malnutrition

Summary score - Malnutrition					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good practice complying to standard of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement)

2.3 Childhood Immunization, Vitamin A Supplementation and Deworming and Mother and child handbook

Standards and Criteria	Score 1-5	Comments
Childhood Immunization		
All sick children are assessed for immunization status All sick children due for immunization are given according to the MoH immunization schedules		
Vitamin A Supplementation and Deworming		
All sick children are assessed for Vitamin A supplementation and deworming status		
All sick children due for Vitamin supplementation and deworming are given according to the MoH Vitamin A supplementation and deworming schedules		
Mother and Child Health Handbook		
All children have individual patient records (Mother and Child handbook)-check at least 5 children		
All preventive and promotive services offered to children including small and sick newborns are documented in the Mother and Child handbook		

Summary Score- Management of Malnutrition

Summary score (to be circled)					
Childhood Immunization	5	4	3	2	1
Vitamin A and deworming	5	4	3	2	1
Mother and Child Handbook	5	4	3	2	1

Overall Summary score					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good practice complying to standard of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement)

2.4 HIV/AIDS

Standards and criteria	Score 1-5	Comments
Counselling, diagnosis and management of paediatric HIV/AIDS		
All pregnant and breastfeeding women are tested for HIV status		
All sick children are checked for suspected HIV using the MOH guidelines		
All HIV exposed newborns are started on prophylaxis and referred for follow up.		
All positive cases are started on treatment and linked to care.		

Summary - Counselling and diagnosis of paediatric HIV/AIDS					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

ADDITIONAL INFORMATION WILL BE OBTAINED THROUGH CAREGIVER EXIT INTERVIEWS AND HEALTH WORKER INTERVIEWS

MODULE THREE:

CARE OF THE NEWBORN

Source: Observation during the visit to the delivery room and post-natal area. If there is no ongoing delivery interview staff (provide a scenario)

3.1 Routine Newborn care

Standards and criteria	Score 1-5	Comments
Essential Newborn Care		
The delivery room is warm and draught free with a documented temperature 25^{0}C- 28 (Verify using room temperature thermometer)		
Baby is placed in skin-to-skin contact with the mother (if no need for resuscitation or no maternal problems)		
The newborn baby is thoroughly dried and assessed immediately after birth		
Cord clamping is delayed for 1-3 min (if no need for resuscitation)		
Breastfeeding is initiated as soon as possible after birth, within 1 hour, and newborn is not routinely separated from the mother		
Routine prophylaxis		
Eye prophylaxis with tetracycline eye ointment is given immediately after delivery		
Cord care with 7.1% chlorhexidine digluconate gel is done		
Vitamin K prophylaxis is given		
Immunizations (oral polio and BCG) are administered to the stable newborns by the time they are being discharged according to MOH guidelines		
Discharge/Follow up		
Gestational age, weight, length and head circumference at birth and weight at discharge are recorded in the discharge summary		
Mothers are counselled on exclusive breastfeeding, danger signs, cord care and postnatal visits (establish through exit interviews)		

Summary - Routine Newborn Care (Average of each sub-section mean)

Summary Routine Newborn Care	Score 1-5	Comments
Essential newborn care		
Routine prophylaxis		
Discharge/follow up		

Summary Score Routine newborn care (Average of the sub-section means above)					
(to be circled)	5	4	3	2	1

Please indicate the quality of routine care by marking one of the 5 numbers. 5 indicates excellent routine care quality 4 to 1 indicating levels of necessary improvement (4=sufficient routine neonatal care, small need for improvement; 3= some of the routine care practices are being carried out, moderate need for improvement; 2= few routine practices are being carried out, significant need for improvement; 1=none of the routine practices; urgent need for improvement/life threatening practices).

3.2 Newborn Resuscitation

Source: Observation during the visit, and interviews with staff (give a scenario if no delivery, see annex)

Standards and Criteria	**Score 1-5**	**Comments**
At every delivery there is skilled health care provider available to provide stimulation and resuscitation with bag and mask within 1 minute if needed		
At least two dry towels per delivery pack for drying the baby		
The health facility has a designated resuscitation area that is warm and has the following functional resuscitation equipment; • Resuscitaire or resuscitation table. • Warmer. Resuscitation tray with an updated check-list of the following; • Penguin sucker and/or functional suction device with appropriate sizes of suction catheters. • Self-inflating bags (250- 300 ml). • Neonatal masks sizes (0 and 1). • Pulse oximeter with a neonatal probe • Stethoscope • IV cannula set (G 26, G24)		
Post resuscitation care is provided appropriately once adequate ventilation and circulation has been established. • Newborn is returned to mother for skin-to-skin contact or transferred to the newborn unit if there is need. • Family centred care (mother/family is appraised on the newborns condition)		

Summary - Newborn Resuscitation

Summary score (Average of all scores) - Newborn Resuscitation					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates adequately staffed, clean and well-equipped nursery facilities; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=indicates significant deficiencies in one or more of the wards)

3.3 Newborn Unit/Ward (Level 4 and 6)

Source: Observation during the visit to the neonatal unit where small and sick neonates are admitted.

Newborn Unit Layout

Standards and criteria	Score 1-5	Comments
There is a functional heat source in the newborn unit to maintain room temperature at 25^{0}C		
Thermometer is available for monitoring room temperature		
The seriously ill small and sick newborns are cared for close to the nursing station where they receive closer attention		
Mothers are NOT routinely separated from babies, and can room-in together where applicable		
There is a resuscitation area complete with the neonatal equipment listed above		
There is a room or an enclosed area that is equipped for mothers to express breast-milk		
There are provisions for mothers/caregivers to perform KMC to eligible newborns		

Summary Score for Newborn Unit

Summary score Newborn Unit (Average of all the scores)					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates adequately staffed, clean and well-equipped nursery facilities; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=indicates significant deficiencies in one or more of the Ward

3.4 Functional Newborn Equipment and Supplies (as per the level of care)

Equipment	Score 1-5	N/A	Comments
Glucometer (level 2 to 6)			
Functional supply of oxygen with its accessories (any one of piped oxygen, oxygen cylinder or concentrator)- level 2 to 6			
Newborn size oxygen delivery services- nasal prongs and non-rebreather masks (level 2 to 6)			
Pulse oximeters (level 2 to 6)			
Level 4 to 6			
Incubators			
Radiant warmers			
cots			
Phototherapy units with light meters and all the normograms			
CPAP machines			
Continuous vital signs monitoring devices			

Nasogastric tubes (size 4or 5, 6 and 8) for feeding and litmus paper			
Calibrated cups for feeding			
Infusion pumps /syringe drivers			
Level 6			
Ventilators			
portable X-ray			
Ultra sound			

Summary Score for Neonatal Equipment and Supplies

Summary score equipment and supplies (Score 1 -5 based on the approximate proportion of equipment & Supplies that are available for the level of health facility)					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates all essential equipment and supplies are available and functional (4=small need for improvement, 1=urgent or chronic shortages of drugs/ chronic lapses in the quality of equipment leading to potentially life-threatening situation to both patient and health care providers

3.5 Case Management of the Small and Sick Newborn

Note: Small and sick newborns might be admitted in different areas, the maternity/postnatal ward or newborn unit Information should be primarily by case observation. Review at least 5 files of small and sick newborns as deemed necessary)

Monitoring and Treatment for Sick Newborns

Standards and criteria	**Score 1-5**	**Comments**
A standard newborn monitoring chart with provision for recording details of clinical progress, vital signs, growth, treatment and supportive care provided is used		
Weight is recorded at least daily		
Special feeding needs are included in the plan/record		
Oxygen need is prescribed (flow-rate, appropriate device and target saturation)		
Oxygen is routinely assessed using a pulse oximeter and supplementation is done according to MOH guidelines		
Antibiotics and IV fluids are prescribed according to age and weight		
All patients are reassessed daily during working days by a doctor/clinician		
Sick neonates or new admissions are also reviewed by a medical officer on weekends and holidays		

Specific Feeding Needs

Standards and criteria	Score 1-5	Comments
Mothers' milk is given to small and sick newborns as the priority feed		
Babies unable to breastfeed are given expressed breast milk by cup or naso-gastric tubes and intake is monitored		
Babies who are not able to feed enterally are given maintenance fluids or parenteral feeds (as per age, weight and level of care)		
LBW babies < 36weeks gestation or <2000g receive routinely recommended vitamins and minerals as per MOH guidelines		
In LBW babies <2500g that are being nursed, heat loss is minimized by kangaroo-care and a cap on the head		

Follow up

Standards and criteria	Score 1-5	Comments
Follow up is arranged for stable newborns before discharge		
All mothers/caretakers of admitted neonates receive a discharge note explaining their condition and providing information for the staff at the follow up facility		

Summary - Case Management of the Sick Newborn (Average of each sub-section scores)

Summary	Score 1-5	Comments
Monitoring and treatment for sick newborns		
Specific feeding needs		
Follow up		

Score

Summary score (Average of all the mean sub-section scores above) - Case management and sick newborn care					
(to be circled)	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practice

Summary scores – Module Three: Newborn Care

Summary scores		5	4	3	2	1
1	Routine care for the newborns	5	4	3	2	1
2.	Newborn resuscitation	5	4	3	2	1
3	Newborn ward	5	4	3	2	1
4	Equipment and supplies	5	4	3	2	1

5	Case management of the sick newborn (including monitoring and follow up)	5	4	3	2	1
Module two	MEAN/AVERAGE SCORE	5	4	3	2	1

Comments on the summary scores/ total score:

MODULE FOUR:

PAEDIATRIC INPATIENT QUALITY OF CARE

Source: This information should be collected by checking for equipment and supplies; and through sampling of files or observing the treatment and care of children presenting with common childhood conditions and emergencies. Also giving case scenarios where there are no cases at the time of assessment.

3 Pediatric wards (Level 4 – Level 6)

Source: Observation during the visit to the ward and interviews with staff and persons accompanying the patients.

4 Attention to the most seriously ill patients

Score Yes = 5 No = 1

Standards and criteria	Yes	No	N/A	comments
Is there an emergency management area in the paediatric wards?				
Are the most seriously ill cared for in an area close to the nursing station?				

Summary-Attention to the most seriously sick

Summary score (Average of all the scores) Attention to the most seriously ill patients					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of care by marking one of the 5 numbers; 5 indicates adequately staffed, and well-equipped paediatric ward; 4 to 1 indicates levels of necessary improvement (4 small need for improvement, 1=indicates significant deficiencies in one or more of the wards)

5 Equipment and Supplies

Is the following equipment available in the emergency area, or on the ward/other child caring areas? Ask the person in charge of the area/ward for the items to be shown to you, and check that they are safe, hygienic, and in good working order. Check that the size is adequate for use in infants and children

6 Essential equipment and supplies

(scoring is based on both availability, status and functionality-scale 1-5)

Standards and criteria	Emergency area (Score 1-5)	Ward/other child careering areas (Score 1-5)	Comments
Functional, clean and safe to use pen torch	N/A		
Functional, clean and safe to use otoscope	N/A		
Functional, clean and safe to use weighing scales for children			

MUAC tapes			
Functional clean and safe to use length and height board (lying/ standing according to age)			
Functional Stethoscopes			
Functional clinical thermometers			
Functional Glucometer			
Functional pulse oximeter			
Functional heat source			
Functional oxygen source (Oxygen cylinder or piped)			
Portable oxygen cylinders			
Oxygen concentrators	N/A		
Functional flow meters for oxygen			
Functional, clean, and safe-to-use equipment for the administration of oxygen			
Functional, clean and safe to use self-inflating bags for resuscitation (300 and 500mls)			
Clean and safe to use IV-giving sets with 150mm chambers for paediatric use			
Clean and safe to use Butterflies and/or cannulas of paediatric size (23,24,26)			
Functional, clean and safe to use NG-tubes, paediatric size			
Clean and safe to use IV-giving sets with 150mm chambers for paediatric use			
Clean and safe to use Butterflies and/or cannulas of paediatric size(, 23,24,26)			
Functional, clean and safe to use NG-tubes, paediatric size			
Functional clean and safe to use suction equipment with different sizes (6, 8, 10) of suction catheters			
Functional, clean, and safe to use nebulizers for the administration of salbutamol			
Functional, clean, and safe to use newborn and paediatric inhaler spacers (or equivalent) with masks for the administration of metered doses (spray) of salbutamol			

7 Summary- Equipment and supplies by area assessed

Summary	Score 1-5	Comments
Emergency Area (Mean score-rounded up to the lower value)		

Ward/other child careering areas (Mean score-rounded up to the lower value)		

3.2 Summary- Equipment and supplies

Summary score (Average of All the scores) -Equipment and supplies					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates an adequate amount and quality of all essential equipment and supplies, 4 to 1 indicates levels of necessary improvement (4=small need for improvement, 1=indicates chronic shortages of essential equipment and supplies or recurrent lapses in the quality leading to potentially dangerous and life-threatening situations to both patients and staff)

8 Supportive care for admitted children (L4-L6)

9 Nutritional needs

Standards and criteria	**Score 1-5**	**NA**	**Comments**
Nutritional needs of all patients are met, according to age and ability to feed			
Breastfed infants continue to receive breast milk from mother			
Appropriate complementary feeding is offered			
Children too sick to feed are fed by nasogastric tube and /or maintenance fluids according to MOH guide-lines.			

Summary score (Average of All the scores) -Nutritional Needs					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

10 Blood and blood products transfusion

Standards and criteria	**Score 1-5**	**NA**	**Comments**
Blood and blood products are only given when indicated			
Only screened, grouped and cross-matched blood and blood products are used			
The flow rate and transfusion reactions are monitored using a blood and blood products transfusion chart			

11 Summary- Supportive care for admitted children

Summary	**Score 1-5**	**Comments**
Nutritional needs (Mean score-rounded up to the lower value)		

Blood and blood products transfusion (Mean score-rounded up to the lower value)		

Summary score (Average of sub-section means) - Supportive care					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

12 Case management of common paediatric diseases

Source: This information should be collected by observing the treatment/ or sampling of at least 5 files of children with the relevant conditions

Please note: Case management is done according to basic paediatric protocols and other MOH guidelines

13 5.1 Cough/difficult breathing

Standards and Criteria	**Score 1-5**	**Comments**
Health workers correctly assess, classify or diagnose pneumonia according to MOH guidelines		
Antibiotics are correctly prescribed based on the classification of pneumonia as per MOH guidelines		
Oxygen is prescribed/administered to children with severe pneumonia (signs of hypoxemia or saturations <90%) as per MOH guidelines (Amount, concentration, method of delivery)		
Oxygen saturation is monitored using a pulse oximeter		
Administration of bronchodilators		
Bronchodilators are administered by spacer or nebulizer to children diagnosed with a wheeze		

5.1.1 Summary - Cough/difficult breathing

Summary	**Score 1-5**	**Comments**
1. Assessment of pneumonia		
2. Administration of antibiotics		
3. Administration of oxygen therapy (Mean score-rounded up to the lower value)		
4. administration of bronchodilators		

Score

Summary score -Cough and difficult breathing					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

14 Diarrhoea

Standards and Criteria	Score 1-5	Comments
Patients with diarrhea are assessed for dehydration and correctly classified according to MOH guidelines.		
The correct rehydration plan for children without Severe acute malnutrition is chosen based on the severity of dehydration (Plan A, Plan B, Plan C)		
Zinc is given		
Antibiotics are NOT given to children with watery diarrhea and without any other condition requiring antibiotic treatment.		
Feeding (breast milk and/or other food) is continued and encouraged		

Summary score

- Management of Diarrhoea					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good practice complying to standard of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement)

15 Fever

Standards and Criteria	Score 1-5	Comments
Differential diagnosis and investigations		
Children with fever have a differential diagnosis for possible and likely conditions considered		
Appropriate assessment and investigations are undertaken for all children presenting with fever, with appropriate consideration of potential differential diagnoses		
Diagnosis and management of meningitis		
Lumbar puncture is performed without delay (within 30 minutes) when meningitis is suspected		
Antibiotic treatment is initiated without delay when meningitis is suspected		
Diagnosis and management of severe/complicated malaria		
Malaria is classified and treated as per MOH guidelines		

Summary – Management components of Fever

Summary Fever	Score 1-5	Comments
1. Differential diagnosis and investigations (Mean score-rounded up to the lower value)		
2. Diagnosis and management of meningitis) Mean score-rounded up to the lower value)		
3. Diagnosis and management of severe / complicated malaria		

Summary score on management of fever

Fever					
(to be circled) Mean score-rounded up to the lower value	**5**	**4**	**3**	**2**	**1**

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

16 Malnutrition

Standards and Criteria	Score 1-5	Comments
Assessment of nutritional status		
Nutritional status for all children less than 5 years seen at the facility is assessed using MUAC >6 months or WHZ scores and recorded		
Clinical examination for signs and complications of severe malnutrition is done		
Differential diagnoses for malnutrition considered and ruled out, if needed		
Management of severe acute malnutrition		
Broad spectrum antibiotics are administered to all severely acute malnourished patients at admission as per the MOH guidelines.		
Admitted children with severe acute malnutrition are kept in a warm room free of draught		
Children with severe acute malnutrition who are admitted are managed according to the 10 steps of malnutrition as per the MOH guidelines Look for at least the 1st 7 of the following (1. Prevent and treat hypoglycaemia 2. Prevent and treat hypothermia 3. Prevent and treat dehydration 4. Correct electrolyte imbalance 5. Presumptive treatment for infections 6. Correct micronutrient deficiencies 7. Start cautious feeding 8. Monitor catch-up growth 9. Sensory stimulation 10. Prepare for follow-up)		

Summary - Malnutrition

Summary	Score 1-5	Comments
1. Assessment of nutritional status (Mean score-rounded up to the lower value)		
2. Management of SAM as per the 10 steps in the MOH guidelines (Mean score-rounded up to the lower value)		

Summary Score- Management of Malnutrition

Summary score - Malnutrition					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good practice complying to standard of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement).

17 HIV/AIDS

Standards and criteria	Score 1-5	Comments
Counselling and diagnosis of paediatric HIV/AIDS		
All HIV exposed neonates and infants are given prophylaxis to prevent mother to child transmission and are followed up as per MOH guidelines.		
All paediatric admissions are offered HIV counselling and testing according to MOH guidelines.		
All positive cases are started on treatment and linked to care.		

Summary - Counselling and diagnosis of paediatric HIV/AIDS					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care, 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

6. Monitoring and follow-up (L4 – L6)

6.1 Monitoring of admitted Child's progress

Standards and criteria	Score 1-5	NA	Comments
Weight is monitored at least on alternate days for all admitted children			
At the time of admission, a monitoring plan for the child's condition is made according to the severity of the patient's condition			
A standard monitoring chart is used with the following information: patient details, vital signs, clinical signs depending on condition, treatments given, feeding and outcome			

6.2 Monitoring by nurses

Standards and criteria	Score 1-5	NA	Comments
Vital signs are monitored and recorded at least 4- hourly for the first 24 hours of admission or as prescribed for critically ill patients			
Dosages and time are recorded in the treatment sheet for every patient receiving medications and IV fluids given by the nurse			
Additional special monitoring is performed and recorded appropriately when needed to follow the progress of particular conditions			
Nurses use the results of patient monitoring to alert the clinicians of problems or changing patient status warranting their attention			

6.3 Reassessment by doctors/clinicians (Check Patient Files)

Standards and criteria	Score 1-5	NA	Comments
Seriously ill patients are assessed by a doctor/clinician upon admission and reviewed at least twice daily until improved			
All patients are reassessed daily during working days by a doctor/clinician			
Sick patients or new admissions are also reviewed by a doctor/clinician on weekends and holidays			

6.4 Follow up

Standards and criteria	Score 1-5	NA	Comments
Follow up is arranged before discharge with linkage to the appropriate follow up services			
All mothers/caretakers receive a discharge summary explaining their condition and providing information for the staff at the follow up facility			

6.5 Summary - Monitoring and follow up

Summary	Score 1-5	Comments
1. Monitoring of admitted child's progress (Mean score-rounded up to the lower value)		
2. Monitoring by nurses (Mean score-rounded up to the lower value)		
3. Reassessment by doctors/clinicians (Mean score-rounded up to the lower value)		
4. Follow-up (Mean score-rounded up to the lower value		

Score

Summary score - Monitoring and follow up					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates good quality of care and excellent monitoring and follow/up procedures of all patients occurs; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practices)

Overall summary scores – module three

Summary scores		**Score 1-5**	**Comments**
1.	Paediatric emergency care		
2.	Paediatric wards		
3.	Equipment and supplies		
4.	Supportive care		
5.	Case management		
6.	Monitoring and follow up		

Score

Summary score -Module three paediatric care					
(to be circled) Mean score of all subsections-rounded up to the lower value	5	4	3	2	1

MODULE 5:

COMMUNITY NEWBORN AND CHILD HEALTH SERVICES

Data Source: Community case management data should be harvested from the MOH 521-treatment and commodity tracking register; Referral information can be obtained from MoH 100. The CHA will be particularly useful as an informant for this module.

1 Community newborn and child health services (Convert proportions to values 1 -5)

Standards and criteria	Score 1-5	Comments
The health facility is linked to at least one community health units as per MOH guidelines		
The health facility has a Community Health Assistant (CHA) or Community Health Officer (CHO)		
The number of Community Health Promoters (CHP) who reported post-natal home visits in the last quarter (Out of 10 per CHU)		
The Community Health Promoters refer children to the health facility for various services (verify using filed MOH 100)		
At least 50% of community health promoters trained on ICCM. (Number of CHVs Trained on ICCM/Number of CHPs *100)		
The proportion of community health promoters trained on community maternal newborn care as per County targets (Number of CHVs Trained on CMNC/Number of CHPs *100)		
The proportion of CHPs trained on ICCM who have been given kits (Number of CHPs given kits/Number of CHPs trained on ICCM *100		
The proportion of CHPs trained on nurturing care as per county targets.		
A record showing replenishment of CHP kits (ORS/zinc co pack, mRDT kit, AL, paracetamol, albendazole, Amoxicillin DT, Zinc and MUAC tape) is available. (Check the MOH 521-treatment and commodity tracking register)		
Presence of an updated complete community health unit chalkboard at the health facility (MCH/OPD)		
Presence of a functional Community Health Committee (verify using minutes filed by the CHA)		

Summary score for community child Health Services

Summary score **Community child healthcare**					
(to be circled) Mean score-rounded up to the lower value	5	4	3	2	1

Please indicate the quality of support by marking one of the 5 numbers; 5 indicates excellent guidelines, protocols and information are available for staff; 4 to 1 indicating levels of necessary improvement (4=small need for improvement, 1=urgent need for improvement/life threatening practice**.**

ANNEX 2:

KENYA CHILD AND NEWBORN CORE INDICATORS

Indicator Name	Objective Of The Indicator	Indicator Classification	SERVICE LEVEL	NUMERATOR	DENOMINATOR	INDICATOR APPLICATION LEVEL	DATA SOURCE	SUMMARY TOOL	PROPOSED MEASUREMENT METHODS	FREQUENCY	GLOBAL
Proportion of level 4,5 and 6 health facilities with a level 2 newborn unit	Establishing Newborn units	Input	Newborn unit	Number of level-4, 5 and 6 health facilities with a level 2 newborn unit	Total number of level 4, 5 and 6 health facilities assessed	Sub county, County, National	Health facility Assessment/ survey	N/A	Review of health facility database	Annual	Global Adopted from ENAP coverage target
Number of newborns admitted for care for any cause	Caseload	Process	All Wards	N/A	N/A	Facility, Sub-county, County, National	Inpatient Neonatal Register (MOH 373)	KHIS, MOH 717 and MOH 711	Review of KHIS	Monthly	
Percentage of newborn units with stockout of safe oxygen delivery systems in the last 3 months	To promote availability of safe oxygen delivery systems at all times	Input	Inpatient/ Outpatient	Number of newborn units reporting stockout of safe oxygen delivery in the last 3 months.	Total number of newborn units assessed	Sub county, County, National	Supervisory Reports/ Health facility assessments	N/A	observation during supervisory visits or HFA	Quarterly for supervisory visits and annually for HFA	
Percentage of newborn units reporting stockout of three essential tracer medicines in correct formulations in a specified period	Availability of essential medicines	Input	Inpatient	Number of health facilities with newborn units reporting stockout of three essential tracer medicines in correct formulations: 1. first-line injectable antibiotics, 2. phenobarbital 3. caffeine citrate	Total number of health facilities with newborn units assessed	Sub county, County, National	Supervisory Reports	N/A	Observation during supervisory visits	Quarterly	Global WHO-SSNB Core Indicators

Percentage of newborn units reporting lack of any one of the specified newborn care bundle equipment and supplies in the last 3 months	Availability of essential supplies and equipment	Input	Inpatient	Number of newborn units reporting lack of any one of the following functional essential newborn care bundle equipment (radiant warmer, suction machine, pulse oximeter, oxygen concentrator, CPAP, phototherapy units, glucometer plus strips) during the last 3 months	Total number of health facilities with newborn units assessed during the reporting period	Sub county, County, National	Supervisory Reports	N/A	Observation during supervisory visit	Quarterly	Global WHO-SSNB Core Indicators
Proportion of newborns who received chlorhexidine digluconate 7.1% for cord care at birth	To reduce neonatal and infant morbidity and mortality	output	Inpatient	Number of newborns who received chlorhexidine digluconate 7.1% for cord care at birth	Total number of live births during the reporting period	Facility, Sub-county, County, National	MOH 333	KHIS/ MOH 711	Review of KHIS/MOH 711	monthly	Global
Proportion of newborns born in a health facility who are breastfed within 1 hour after birth	To reduce to prevent hypoglycaemia, hypothermia and breastfeeding problems,	Process	Inpatient	Number of newborns in a facility who are breastfed within 1 hour after birth	Total number of live births in the health facility during the reporting period	Facility	Maternity Register MOH 333	KHIS, MOH 711	Review of KHIS/MOH 711	Monthly	

Proportion of low-birth weight babies (<2500g) delivered at the health facility	To track trends low birth weight babies and plan for manage-ment	Output	Inpatient	Number of low birth-weight babies delivered in the health facility	Total number of live births in the health facility during the reporting period	facility	Maternity register (MOH 333)	KHIS/ MOH 711	Review of KHIS/MOH 711	Monthly	
Percentage of in-fants weighing 2000 g or less initiated on KMC	To reduce neonatal and infant mortality by pro-moting newborns growth and develop-ment	Process/ output	Inpatient	Number of in-fants weighing 2000g or less initiated on KMC	Total number of infants weighing 2000 g in the health facility during the reporting period	Facility, Sub county, County, National	Inpatient newborn register (MOH 373)	KHIS/ MOH 711	Review of KHIS/MOH 711	monthly	Global
Percentage of newborns with birth weight less than 1300g who were initiated on prophy-lactic CPAP	To reduce neonatal and infant morbidity and mor-tality	Process/ output	Inpatient	Number of new-borns with birth weight < 1300g who were initi-ated on CPAP	Total number of newborns with birth weight less than1300g during the period in review	Facility, Sub-county, County, National	Supervisory Reports/ Health facil-ity assess-ments	N/A	Review of pa-tient records	Quarterly	Global
Facility neonatal death rate per 1000 live births	To achieve maximum neonatal survival and health status for the new-born	Outcome	Inpatient	Number of neonatal deaths reported in the Health Facilities	Total live births	Facility, Sub county, County, National	MOH 711, MOH 717	KHIS, MOH 711 and MOH 717	Review of KHIS	monthly	Global
proportion of neo-natal deaths due to Sepsis	To improve prevention and man-agement of neonatal sepsis	Outcome	Inpatient	Number of neo-natal deaths due to Sepsis	Total number of neonatal deaths during the reporting period	Facility, Sub county, County, National	Newborn inpatient register, MOH 373	MOH 711	Review of KHIS	monthly	Global

Proportion of neonatal deaths due to prematurity	To improve prevention and management of prematurity	Outcome	Inpatient	Number of babies born before 37weeks of gestation who die before discharge	Total live births in a specified period	Facility, Sub county, County, National	Newborn register (MOH 373)	KHIS, MOH 711	Review of MOH reports/ facility, sub county, county, national records	monthly	Global
Proportion of neonatal deaths due to asphyxia	To improve management of asphyxia	Outcome	Inpatient	Number of neonatal deaths due to asphyxia	Total number of neonatal with asphyxia during the reporting period	Facility, Sub county, County, National	Maternity register, MOH 333	MOH 711	Review of KHIS/ MOH 711	monthly	Global
Percentage of neonatal deaths audited	To determine factors contributing to Neonatal deaths	Output	Inpatient/ Outpatient	Number of newborn deaths audited	Total number of newborn deaths during the reporting period	Facility, Sub county, County, National	Neonatal Death review form	KHIS Tracker	Review of Needed reports/ facility, sub county, county, national records	Monthly	
Percentage of child deaths audited	To determine factors contributing to Neonatal deaths	Output	Inpatient/ Outpatient	Number of child death audited	Total number of child deaths during the reporting period	Facility, Sub county, County, National	Paediatric Death Review Form	KHIS Tracker	Review of Needed reports/ facility, sub county, county, national records	Monthly	
Number of newborns babies born with birth deformities	To identify various types newborns deformities	Output	inpatient	Number of newborns babies born with birth deformities	Total live-births during the reporting period	facility, Sub county, County, National	MOH 333	KHIS/ MOH 711	Review of KHIS/MOH 711	monthly	Global
Proportion of health care providers who care for children including SSNBs trained on newborn ETAT+, ETAT+ or IMNCI as per level of care.	To impart knowledge and skills to service providers	Output	Inpatient/ Outpatient	Number of health care providers who care for children trained on newborn ETAT+, ETAT+ or IMNCI	Total number health care providers who ca managing children	Facility, Sub county, County, National	Training database; CME registers	N/A	Review of database	Anually	

Proportion of health facilities with stock outs of essential medicines for children in the past 3 months	To minimize stockout of essential medicines	Input	Inpatient/ Outpatient/ pharmacy and stores	Number of health facilities with stock outs of any of the following essential medicines (crystalline penicillin, gentamicin, amoxicillin DT, ORS/ zinc co pack, anti-malarials in endemic areas*).	Total number of facilities assessed	Sub county, County, National	Superiviso-ry visits/ HFA	Super-visory and HFA reports	Observation	Quarterly	Global
Proportion of children less than 5 years who died due to pneumonia.	To improve prevention and management of pneumonia	Outcome	Inpatient	Number of children less than 5 years with pneumonia who died	Total number of children less than 5 years who died	facility	MOH 301	MOH 717	review of KHIs	Monthly	National
Proportion of children less than 5 years who died due to diarrhoea.	To improve prevention and management of diarrhoea	Outcome	Inpatient	Number of children less than 5 years with diarrhoea who died	Total number of children less than 5 years who died	facility	MOH 301	MOH 717	Review of KHIS	Monthly	National
Proportion of children less than 5 years who died due to malaria.	To improve prevention and management of Malaria	Outcome	Inpatient	Number of children less than 5 years with malaria who died	Total number of children less than 5 years who died	facility	MOH 301	MOH 717	Review of KHIS	Monthly	National
Proportion of children less than 5 years who died due to SAM.	To improve prevention and management of SAM	Outcome	Inpatient	Number of children less than 5 years with SAM who died	Total number of children less than 5 years who died	facility	HFA	N/A	HFA	Annually	National

Percentage of health facilities with a designated play area or room with play facilities for admitted children	To enhance development and enable children to cope with treatment	Input	Inpatient	Number of health facilities with a designated play area or room with play facilities for admitted children	Number of health facilities assessed	Facility	HFA	N/A	Periodic health facility survey	Annual	Global
Proportion of newborns with an admission temperature 36.5-37.5 °C on admission to the newborn unit from other hospital ward or referral	Maintenance of warm chain	Output	Inpatient/ NBU	Number of newborns who arrive on the newborn unit with an admission temperature 36.5- 37.5^{0}C	Total number of newborns assessed	Health Facility	Supervisory reports	N/A	Review of NAR during supervisory visits	Quarterly	Global SSNB
Proportion of facilities with functional age-appropriate equipment and supplies for resuscitation of children including newborns	To improve survival of children including newborns	Input	Inpatient/ outpatient	Number of facilities with the age-appropriate equipment and supplies for resuscitation of children including newborns	Total number of facilities assessed	Sub County, County, National	supervisory reports	N/A	Supervisory visits	Quarterly	
Proportion of mother-baby pairs (<2 months post-delivery) who report having had postnatal home visits by CHP within the first 2 days post discharge	Prompt identification & referral of complications, care challenges and health promotion	Output	Outpatient	Number of mother-baby pairs who report having had postnatal home visits by CHP within the first 2 days post discharge	Total number of mother-baby pairs who were interviewed	Facility	Supervisory reports	N/A	Exit Interviews during supervisory visits	quarterly	New
Proportion of all children < 5 years with delayed milestones	Monitoring development to identify and address delays early for better outcomes	Output	Outpatient/ Inpatient	Number of children < 5 years with delayed milestones.	Total number of children < 5 years attended to in the health facility during the period in review	Facility	CWC register (MOH 511)	MOH 711	Review of KHIS	Monthly	

Proportion of children under 5 years with pneumonia treated with amoxicillin DT	To reduce morbidity and mortality from pneumonia	output	outpatient	Number of children under 5 with pneumonia (non-severe) who were treated with Amoxil DT	Total number of children with pneumonia (non-severe)	Health facility	MOH 204A	KHIS/ MOH 705 A	Review of KHIS	Monthly	
Proportion of children under 5 years with diarrhea treated with ORS and zinc (community and facility)	To reduce morbidity and mortality from diarrhoea	Output	Outpatient	Number of children under 5 years diarrhea treated with ORS/Zinc co pack	Total number of children < 5 years with diarrhea who visited health facility during the reporting period	Health Facility	204A	KHIS/ MOH 711, MOH 515 for the community	Review of KHIS	Monthly	Global National
Proportion of Children with Severe Pneumonia. treated with Oxygen	To reduce morbidity and mortality from pneumonia	Process / Output	Outpatient/Inpatient	Number of children under 5 years with severe pneumonia who were put on oxygen therapy	Total number of children under 5 years with an admission diagnosis of severe pneumonia during the reporting period	Health Facility	Supervisory report	N/A	Review of ward registers or patient medical records during supervisory visit	quarterly	Global
Proportion of Children with Cough or difficulty in breathing confirmed to have Pneumonia	To reduce morbidity and mortality due to pneumonia	Process / Output	Outpatient	Number of children under 5 years presenting with cough or difficult breathing confirmed to have pneumonia	Total number of children under 5 years with cough or diffcult breathing treated during the reporting period	Health Facility	Supervisory report	N/A	Review of ward registers or patient medical records during supervisory visit	quarterly	Global

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