recommendations regarding the acute management of sepsis and septic shock are the first step toward improved outcomes for this important group of critically ill patients. (Crit Care Med 2008; 36:296-327)

28) Palestinian experiences in IMCI strategy

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Introduction and background: The MOH has adopted the Integrated Management of Childhood Illness (IMCI) strategy since 2001 as a major strategy for improving child's health and nutrition in the occupied Palestinian Territories (oPT), with UNICEF as a major partner and funding agency in the process.

The IMCI strategy seeks to reduce the child mortality through a broad and cross-cutting approach with components as:

- improving the case management skills of the health workers;
- improving the health system; and
- Improving the family and community practices.

Initially the plan focuses on the first two components. Gradually, more attention is being to fully integrated child care addressing health, growth and development of all children, sick and healthy, in health care facilities and in the home. Emphasis is being placed on promoting good child care practices at home and in the community. A separate plan in respect to the community component is currently under development and should be parallel implemented. The IMCI National Plan of Action 2006-2008 is in line with the Program Policy Agreement 2006-2007, between MoH and UNICEF. The development of a national child health policy initiative that will embrace all elements related to child health and morbidity towards contributing to the reduction of child mortality will putted in consideration.

Implementation of IMCI involves three phases:

- the introductory phase to ensure that key persons in MoH and other health services providers understand IMCI strategy, to establish a management structure and to build national capacity;

- the early implementation phase to plan and prepare for IMCI implementation, including adaptation of the generic IMCI clinical guidelines, selection of a limited number of districts for initial implementation, and to build national and district capacity to implement IMCI activities;

- the expansion phase includes efforts to increase access and to broaden the range of IMCI interventions. Problems identified during the early implementation phase are addressed, priorities agreed, and strategies for expanding access while maintaining quality are developed.

Currently in OPT the expansion phase is being in process and a three-year National Plan for implementation is designed.

Recently WHO (EMRO) **announce** that IMCI is adopted by the Regional Office as the primary child health care strategy, offering a wide range of interventions under its overall umbrella and countries invited to see IMCI within this vision, and not as a vertical training programme, and to commit increased resources for it to achieve the child mortality-related Millennium Development Goal no. 4.

IMCI components under activation:

1- National child health policy initiative (NCHPI).
2- IMCI community component (CIMCI).
3- IMCI psychosocial component (generic in Palestine).
4- Breast feeding and supplementary feeding counsel for infants and young children component.
5- Adapting IMCI curriculum for pre-service training at medical and nursing colleges.

6- IMCI Follow up after training and ongoing supervising.
7- Scaling up the IMCI Training activities

29) Patient Education "Using Film to Reduce Unnecessary Pediatric Emergency Departments Visits"

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Presenter: Samer AbdelRazeq, *Sixth year medical student, Al-Quds University , Faculty of Medicine*

Unpublished literature review was done by IPEME "International Pediatric Emergency Program Elective" participants in Sick Kids Hospital, Toronto, Canada.

Needs analyses conducted in emergency departments (EDs) in Middle East and Canada

suggests that growing numbers of pediatric visits is a cross-border issue. Downstream effects of increased visits include prolonged waiting times, patient/parent dissatisfaction, physician dissatisfaction, and decreased quality of patient care. The needs analyses showed that fever, vomiting/diarrhea and respiratory complaints are the three most common reasons for pediatric EDvisits. Parents often have significant anxiety around these complaints; particularly fever (Betz and Grunfeld, 2006). While many visits are warranted, large volumes of non-urgent visits may affect the quality of care in emergency departments (Pines and Hollander, 2008) and increase the number of patients who leave without being seen by a physician (Fernandes *et. al.*, 1997). Addressing the three most common causes of pediatric visits may improve the situation in EDs in these countries.