

# From policy to implementation: strengthening kangaroo mother care through district clinical specialist teams in South Africa

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## Background

South Africa is one of the pioneer countries in the scale-up of kangaroo mother care (KMC). In 2000 a recommendation was made for the implementation of KMC.<sup>1</sup> The scale-up was facilitated by the existence of a perinatal audit system in the country.<sup>2</sup> Data from these audits showed an association between KMC and a significant reduction in neonatal deaths.<sup>3</sup>

Since 2000 smaller and larger outreach initiatives in various provinces have been undertaken to initiate KMC services, including stand-alone efforts or integrated into newborn care packages. In some of the provinces KMC is monitored as part of newborn outreaches and accreditation initiatives.

Since 2012 there has been a more systematic national and provincial drive for KMC implementation across the country. The primary healthcare reengineering<sup>4</sup> was a health system improvement initiative that included the formation of district clinical specialist teams (DCSTs) for each health district.<sup>5,6</sup> Their focus is specifically on establishing systems and conducting activities to enhance the neonatal care continuum and to reduce maternal and newborn deaths. KMC is considered a priority area for which provincial directives have been issued.

## District clinical specialist teams

Not facility based, but moving between health facilities in the district

**Composition** – senior personnel

- Obstetrician and midwife pair
- Paediatrician and paediatric nurse pair
- Family physician and primary health care nurse pair
- Anaesthetist

**Roles**

- Training
- Supportive supervision
- Clinical governance
- Facilitating care networks
- Strengthening referral systems

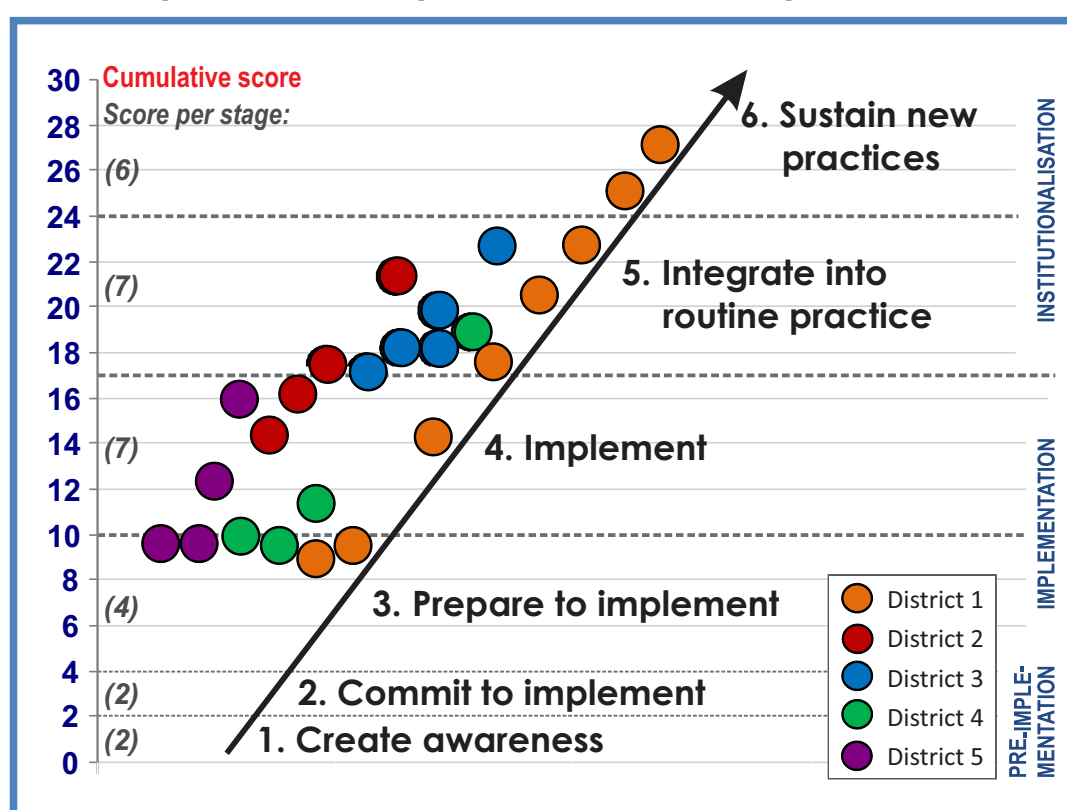
## Methods

- Surveys on KMC services: 5 districts, 2 provinces (2014-15)
- Two experienced external assessors plus members of local DCSTs
- Visits to all 26 hospitals:
  - 6 tertiary, 3 regional and 17 district hospitals
- Hospitals scored on KMC implementation with a standardised tool<sup>7</sup>
- Activities preceding surveys:
  - KMC-specific training
  - sick and small newborn care training
  - benchmark visits to KMC centres of excellence
  - individual engagements with specific hospitals



## Results

### KMC implementation performance of hospitals



The performance of the districts could be partly ascribed to the functionality of the DCST of a district. District 1, with a very strong DCST, was the district with the longest history of KMC implementation but also a district with new non-KMC hospitals added in its boundaries in the recent past. District 3, the other better performing district, has a strong paediatric component committed to KMC implementation. The DCST in District 2 was also a stable team, with some hospitals having a longer history of KMC implementation. The two poorer performing districts (4 and 5) had less coherent DCSTs not functioning to their full capacity. Outlier hospitals in these two districts are individual hospitals with a longer history of KMC implementation or of good governance.

## Conclusion

Providing supportive supervision by building supervisor skills and providing opportunities for hospitals to interact were beneficial for highlighting KMC implementation issues, but at the same time for integrating KMC into the total newborn care package.

## Lessons learned

- DCSTs and hospital staff – especially those without clinical experience in KMC – benefited from observing the modelling of supportive supervision during survey
- Opportunity for hospital staff to improve skills
- Change has to be enabled within existing structures and budgets
- DCSTs are
  - crucial for continuous supportive supervision
  - can influence and effect change
- KMC quality improvement projects can be used as entry point for improving care for low birth weight infants and neonates in general

### References

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