

# Lessons learned in implementing kangaroo mother care in Latin American and Caribbean countries through a regional network



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- Kangaroo Mother Care (KMC) is an evidence-based technology that has been shown useful for ameliorating LBW effects on infant mortality and morbidity, nutrition and early development.
- Major components of KMC are Kangaroo Position (prolonged skin-to-skin contact) Kangaroo nutrition (breast milk based nutrition) and kangaroo discharge policies (early discharge in kangaroo position at home or in a KMC ward and strict follow up)

- One of the major contributors to the so-called 90-10 gap that brings apart affluent and less developed countries is the inadequate access to knowledge (knowledge transfer) and when accessible, the insufficient translation of that knowledge into action.
- A group of researchers and health care professionals decided to tackle this double challenge by creating a non governmental non for profit organization called the «Fundación Canguro» (Kangaroo Foundation) in 1994 in Bogotá, Colombia.

# KMC training: how to do it?

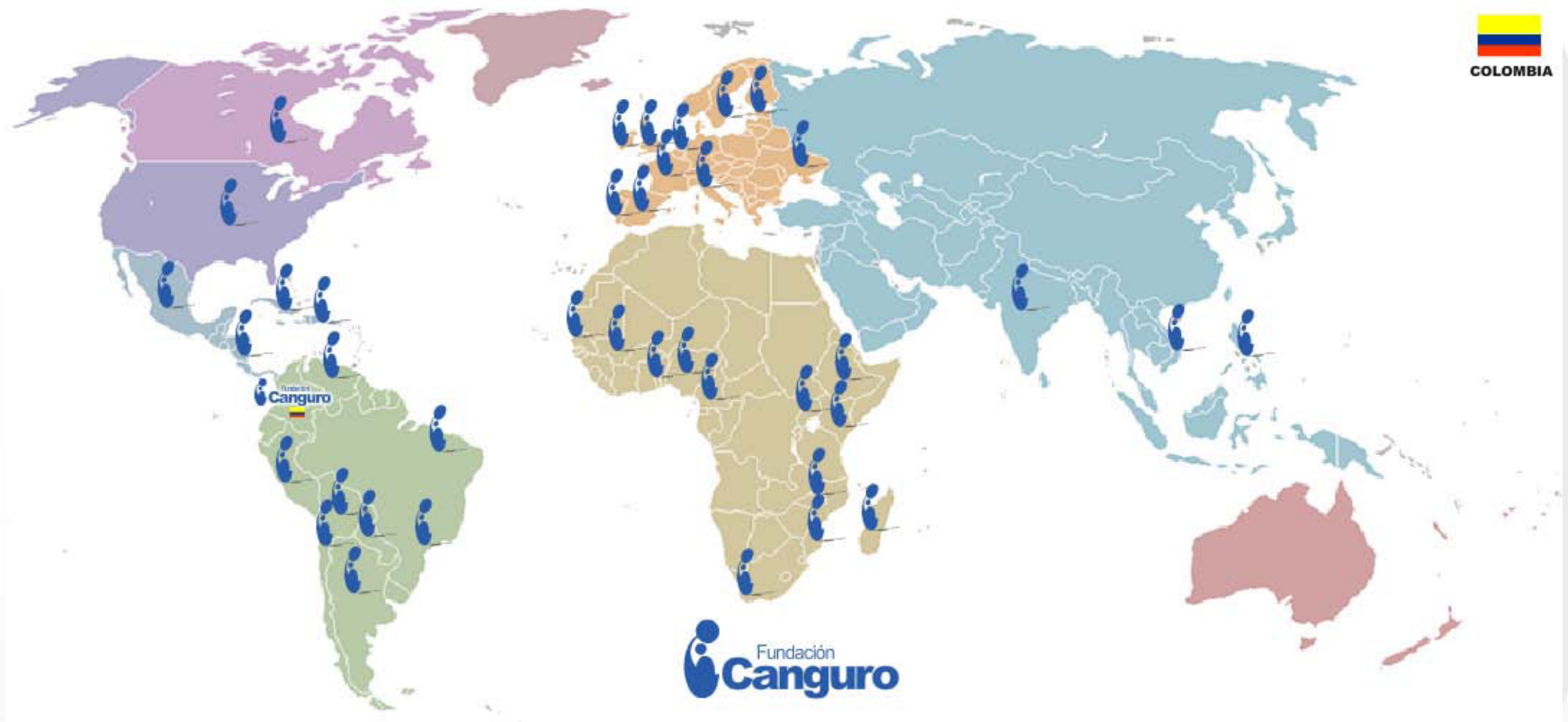
Traditionally, cooperation in health is organized and thought in a one way direction, from North to South countries. It often meets resistances because of:

- 1) Bad functioning of the project once the financial support is over, especially when the long term sustainability was not planned.
- 2) Difficulties in the maintenance of technological material.
- 3) Poor acceptance of new knowledge because scientific evidences are too often produced in the northern countries and not adapted to local circumstances.

- Currently South-to-South cooperation is in a dynamic expansion. Middle income countries have now technical competencies and excellence centers in a lot of forefront fields including health and are claiming for more participation in cooperation decisions.
- Knowledge transfer is usually better accepted because contents are more appropriate. Professionals from middle income countries have the experience of more depressed territories with low level of development in their own countries and very often have seen life in the same situation in past years.
- It allows a more egalitarian and respectful knowledge transfer, more direct and more adapted to local situation with more possibilities to be successful.

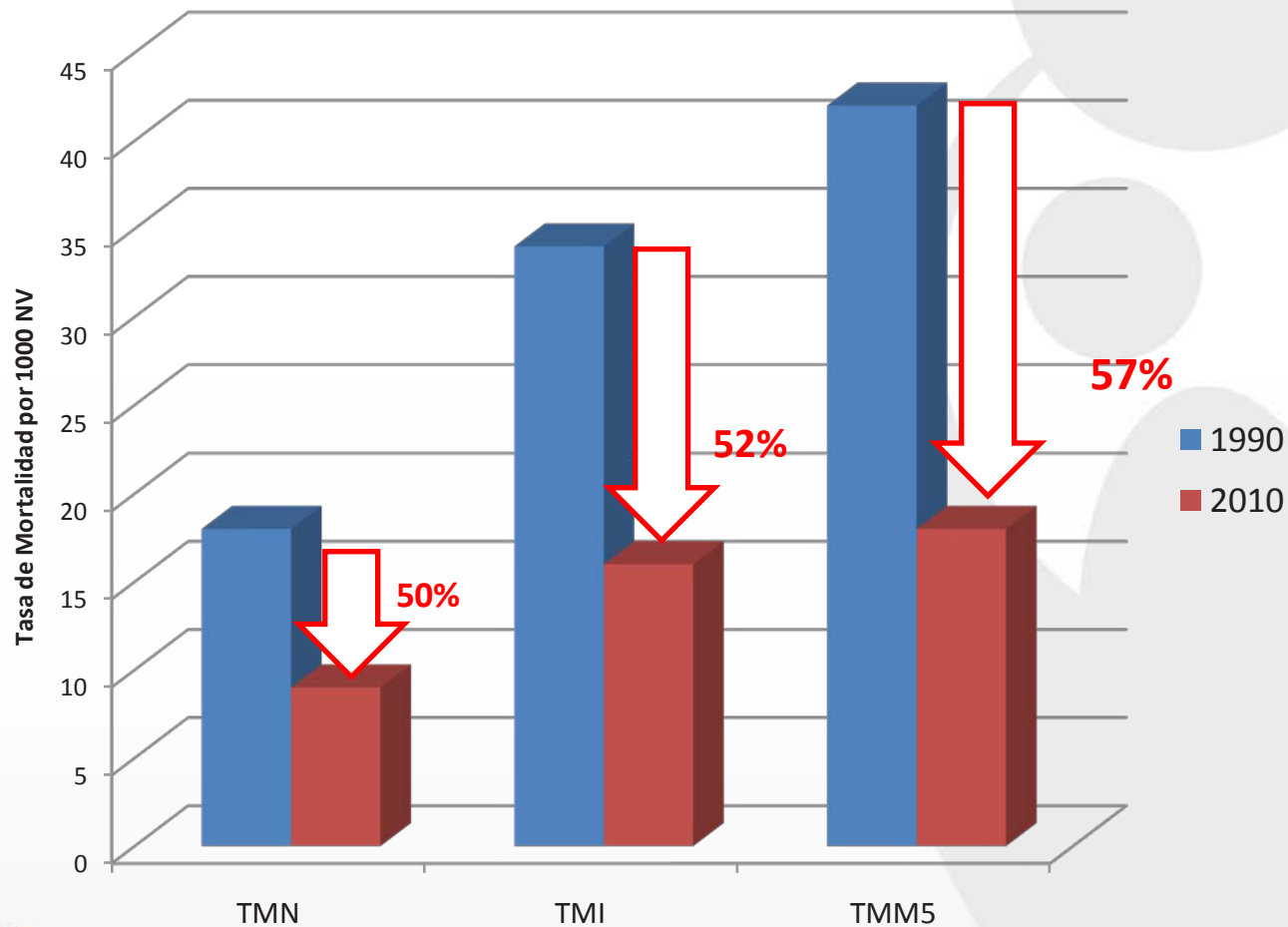
- Since 1994 more than 60 multidisciplinary health-care teams mainly from crowded cities' hospitals in more than 25 developing countries have been trained in Bogotá in our center with the financial support of various official and non official NGO and institutions. We want specially to thank USAIDS, Peg Marshall, Goldy Mazias and Jorge Herminda, who supported during these last 2 years the training of Salvador , Honduras, Guatemala, Nicaragua , Republica Dominicana and the French embassy of Haiti who supported KMC implementation in this country (2 and soon 3 KMCP) in collaboration with Unicef

More than 60 teams from 25 countries have been trained in Bogota, Colombia.



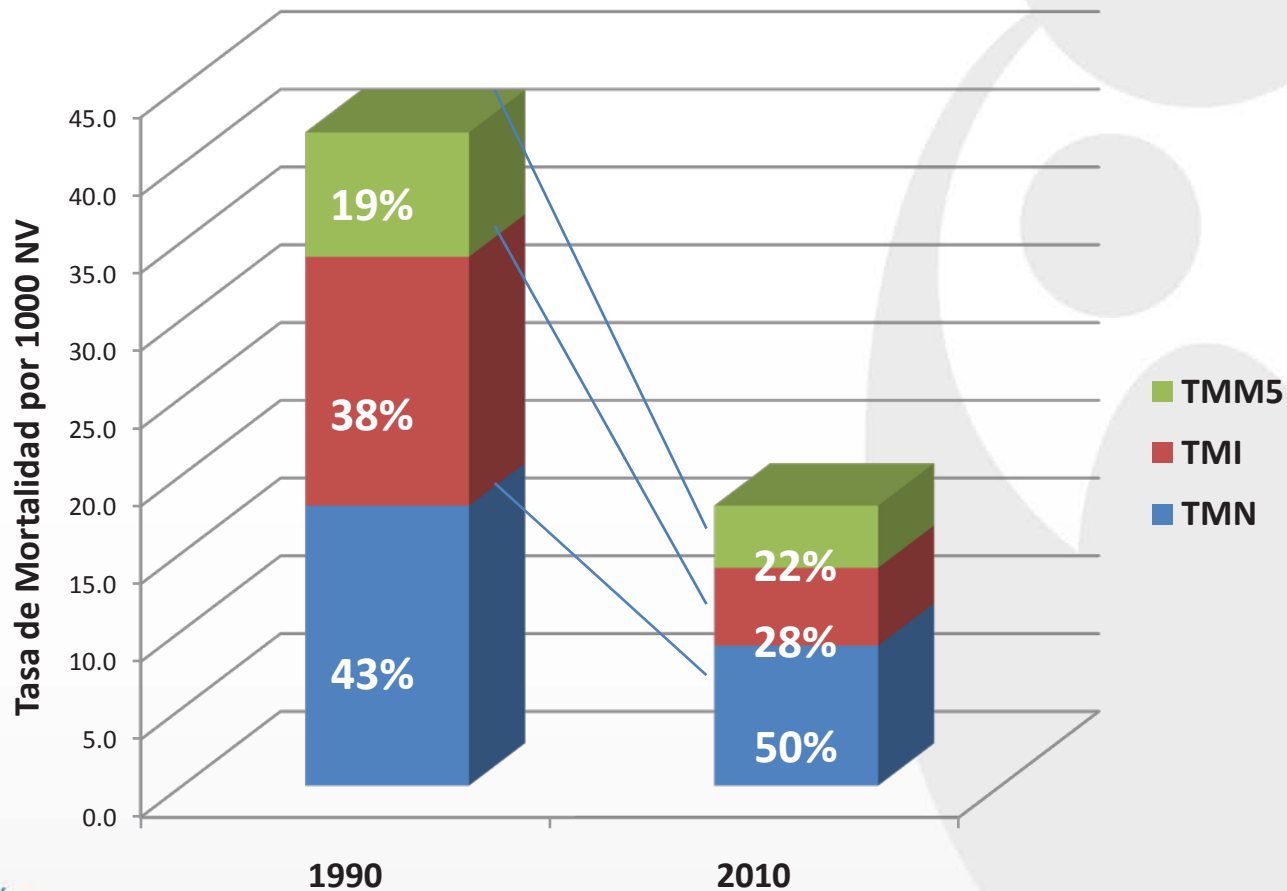


# Changes in Neonatal, Infant and less than 5 years mortality in Latin American countries 1990 - 2010

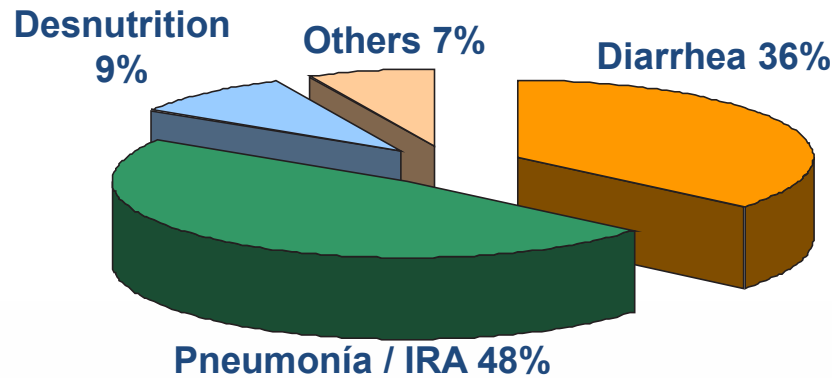




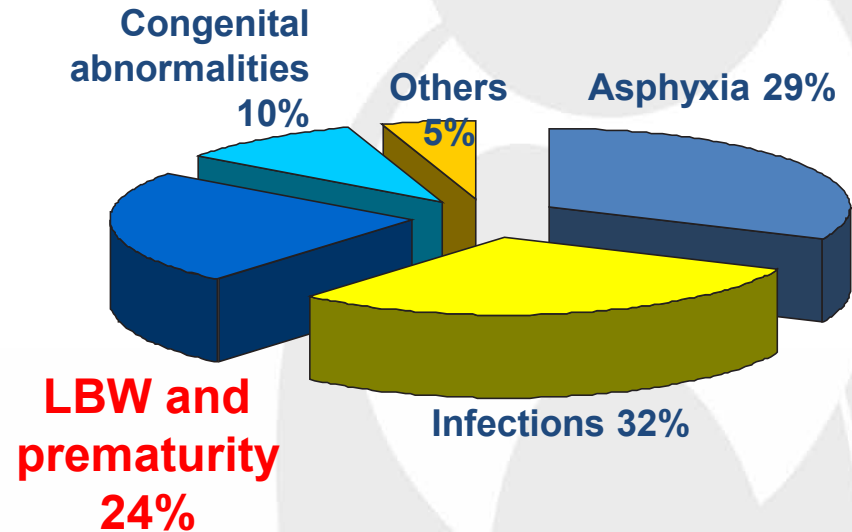
# Mortality of less than 5 years children according to the component in Latin American Countries 1990-2010



# Main diagnosis of Infant mortality in Latin American and Caribbean countries



Post-neonatal (29%)



Neonatal (71%)

Fuente: Estimaciones de FCH/CA con base de datos de HA-OPS, 2010

# The training model of the KF

- See one, do one, teach one



- The model of KMC diffusion we chose is “see one, do one, teach one”, meaning that in order to translate KMC to another geographical location we invite health care leaders to be trained in KMC in our center (see one), implement a KMC program in their home institutions (do one) and afterwards, train other centers in their region and help them implement it (teach one). The success of knowledge transfer in Central America and Caribbean countries has been high: nearly all teams trained in Bogotá implemented with success, despite specific needs and difficulties encountered by each program in each setting. Various KMC programs already began a national KMC training diffusion program in their countries (Republica Dominicana).

- Trained teams are also provided with the basic tools for translating knowledge into health care actions.
- A new multimedia KMC kit is now available on our home page, construction was supported by the Colombian health ministry and the World Food Program and english translation by MCHIP, JSI and the Kangaroo Foundation. We just received a grant for the French translation.
- We developp this multimedia KMC kit, free, easy to read, to support local diffusion and to empower the newly trained KMC center as an excellence center in their country

# Comments

Guidelines by themselves are not enough to develop a good quality program.

Our experience shows that training and exposure to successful practice “*hands-on training*” in reference KMC centers has been key to successful dissemination

# Major difficulties in the KMC diffusion

- Right choice of the team to be trained
- Adaptation of the 3 components of KMC to local circumstances, patient needs and level of care.
- Early discharge and ambulatory follow up clinic
- Insufficient access to Kangaroo network and scientific literature on KMC
- Insufficient local research and monitoring capability
- Costs: Direct cost of training kangaroo team, cost of KMC staff and physical structure
- Quick turnover of administrative and medical staff
- Sustainability
- Integration in the public health policies of the health ministry