Maternal and Child Survival Program

Kangaroo Mother Care
An Epitome of Quality "Loving" Care

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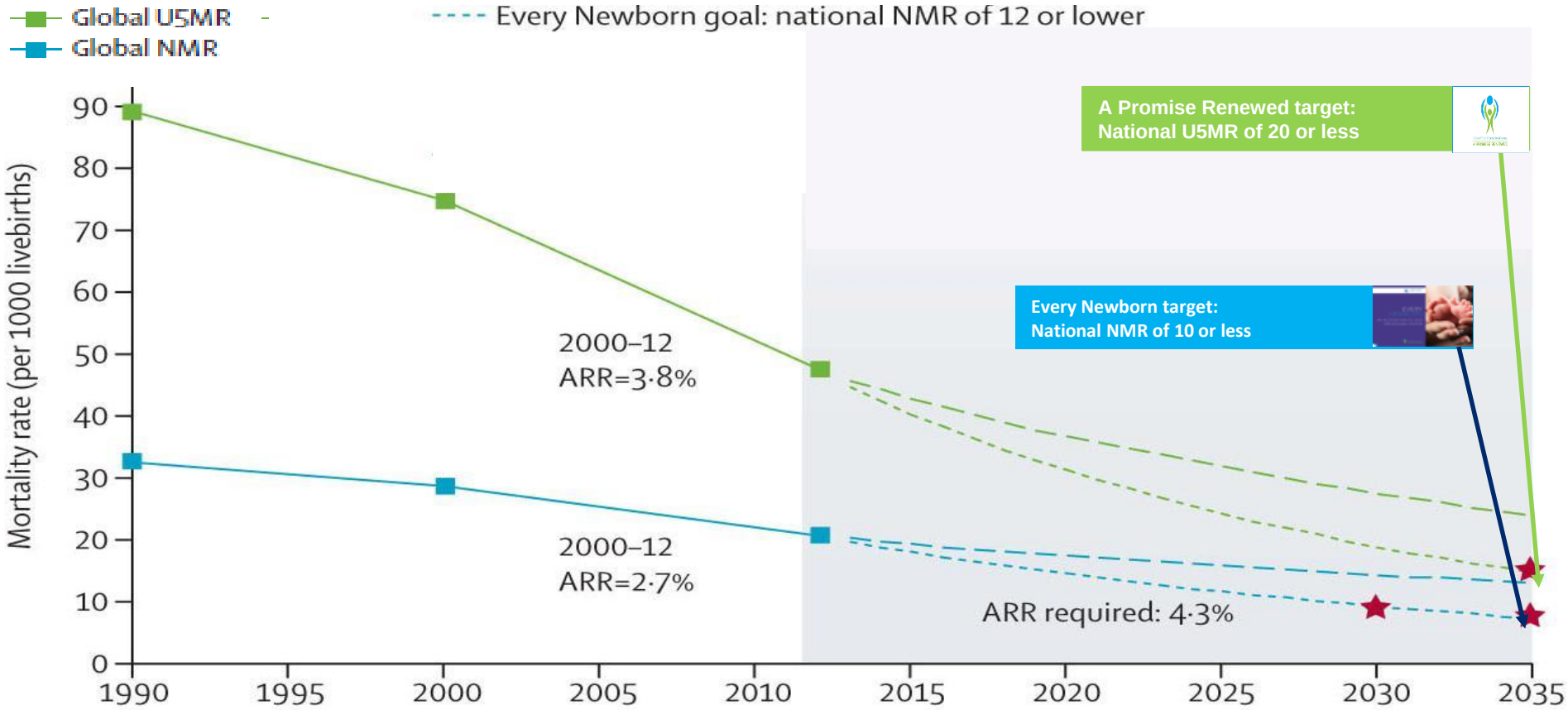
Maternal and Child Survival Program

Scheme of Presentation

- Every Newborn Action Plan, coverage and quality of care
- Kangaroo Mother Care and focus on Quality of Care
- Kangaroo Mother Care and quality "loving" care

Ending preventable child deaths

COMMITTING TO CHILD SURVIVAL
A PROMISE RENEWED

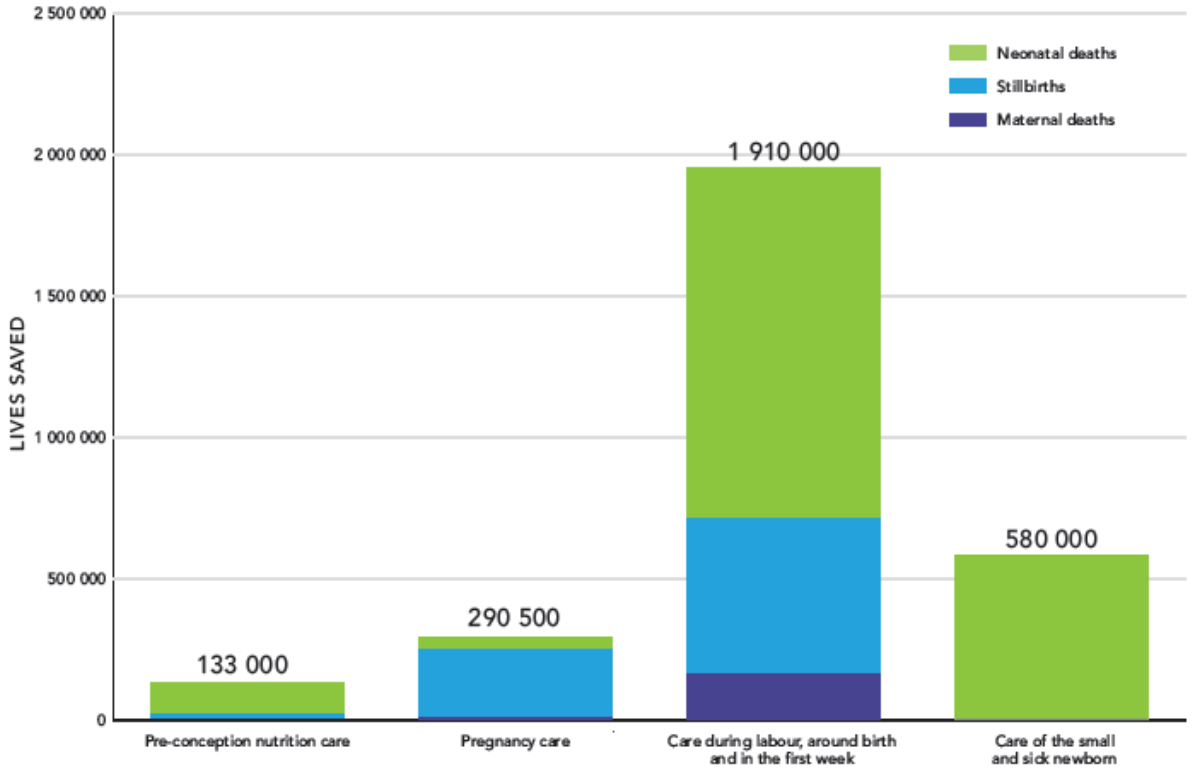


From 2.9 to 0.8 million neonatal deaths

About 34 countries will have to more than double their rates of progress

Lives that could be saved by 2035 with universal health coverage of care

Fig. 5 Lives that could be saved by 2025 with universal coverage of care



Source: The Lancet Every Newborn Series, Bhutta Z et al. *Lancet*, 2014 (*5*).

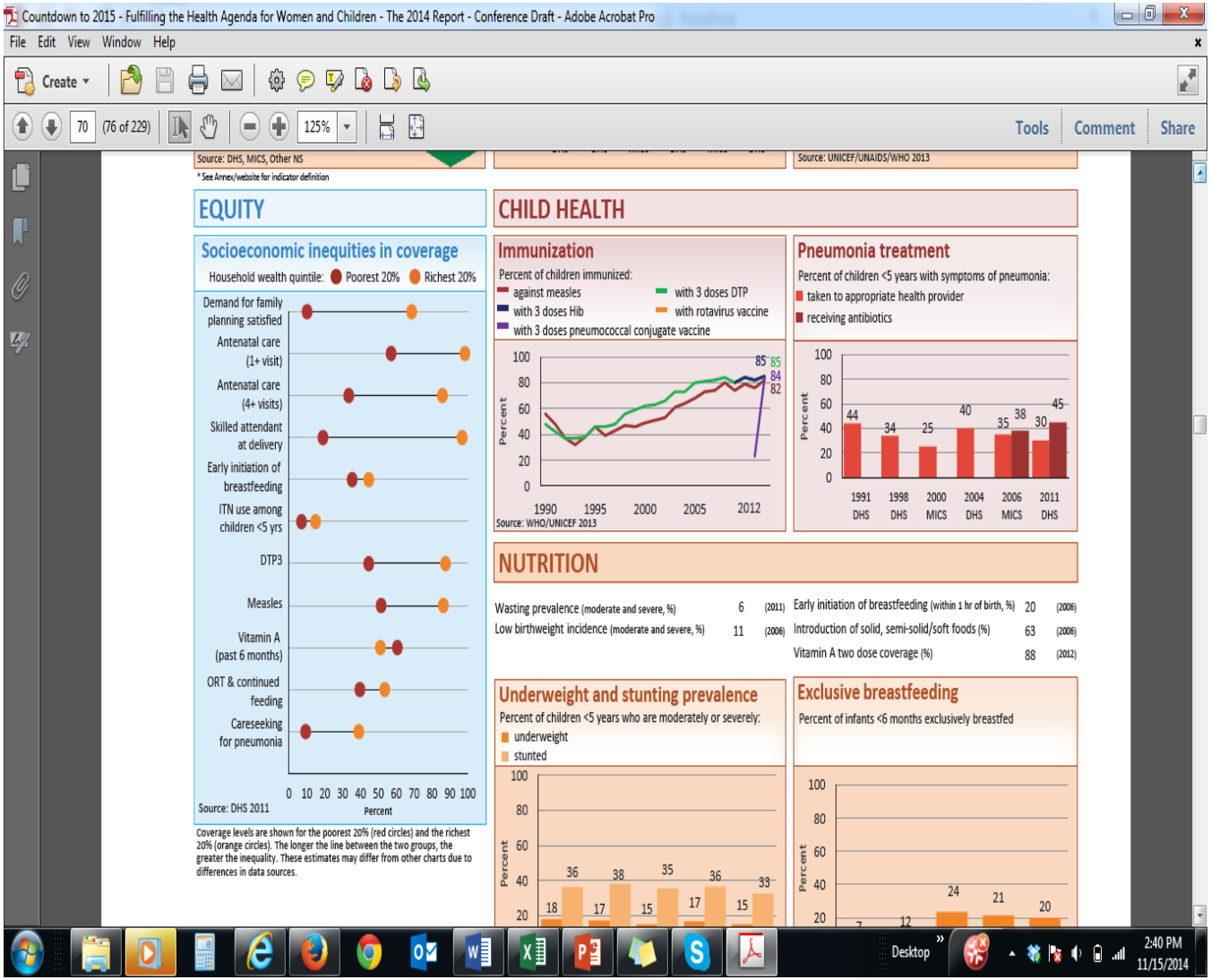
Source: The Lancet Every Newborn series, paper 3

Skilled Birth Attendance and mortality reduction

	SBA	NMR	SBR
Cambodia	**72%**	**18**	**18**
Malawi	**71%**	**24**	**24**

Source: Countdown 2014

Cambodia


Countdown to 2015 - Fulfilling the Health Agenda for Women and Children - The 2014 Report - Conference Draft - Adobe Acrobat Pro
File Edit View Window Help
Create
70 (76 of 229)
125%
Tools Comment Share
Source: DHS, MICS, Other NS
* See Annex/website for indicator definition
Source: UNICEF/UNAIDS/WHO 2013
EQUITY
Socioeconomic inequities in coverage
Household wealth quintile: Poorest 20% Richest 20%
Demand for family planning satisfied
Antenatal care (1+ visit)
Antenatal care (4+ visits)
Skilled attendant at delivery
Early initiation of breastfeeding
ITN use among children <5 yrs
DTP3
Measles
Vitamin A (past 6 months)
ORT & continued feeding
Careseeking for pneumonia
0 10 20 30 40 50 60 70 80 90 100
Percent
Source: DHS 2011
Coverage levels are shown for the poorest 20% (red circles) and the richest 20% (orange circles). The longer the line between the two groups, the greater the inequality. These estimates may differ from other charts due to differences in data sources.
CHILD HEALTH
Immunization
Percent of children immunized:
against measles
with 3 doses DTP
with 3 doses Hib
with rotavirus vaccine
with 3 doses pneumococcal conjugate vaccine
Percent
100 80 60 40 20 0
85 85 84 82
1990 1995 2000 2005 2012
Source: WHO/UNICEF 2013
Pneumonia treatment
Percent of children <5 years with symptoms of pneumonia:
taken to appropriate health provider
receiving antibiotics
Percent
100 80 60 40 20 0
44 34 25 40 35 38 30 45
1991 DHS 1998 DHS 2000 MICS 2004 DHS 2006 MICS 2011 DHS
NUTRITION
Wasting prevalence (moderate and severe, %) 6 (2011)
Low birthweight incidence (moderate and severe, %) 11 (2006)
Early initiation of breastfeeding (within 1 hr of birth, %) 20 (2006)
Introduction of solid, semi-solid/soft foods (%) 63 (2006)
Vitamin A two dose coverage (%) 88 (2012)
Underweight and stunting prevalence
Percent of children <5 years who are moderately or severely:
underweight
stunted
Percent
100 80 60 40 20
18 36 17 38 15 35 17 36 15 33
Exclusive breastfeeding
Percent of infants <6 months exclusively breastfed
Percent
100 80 60 40 20
7 12 24 21 20
Desktop
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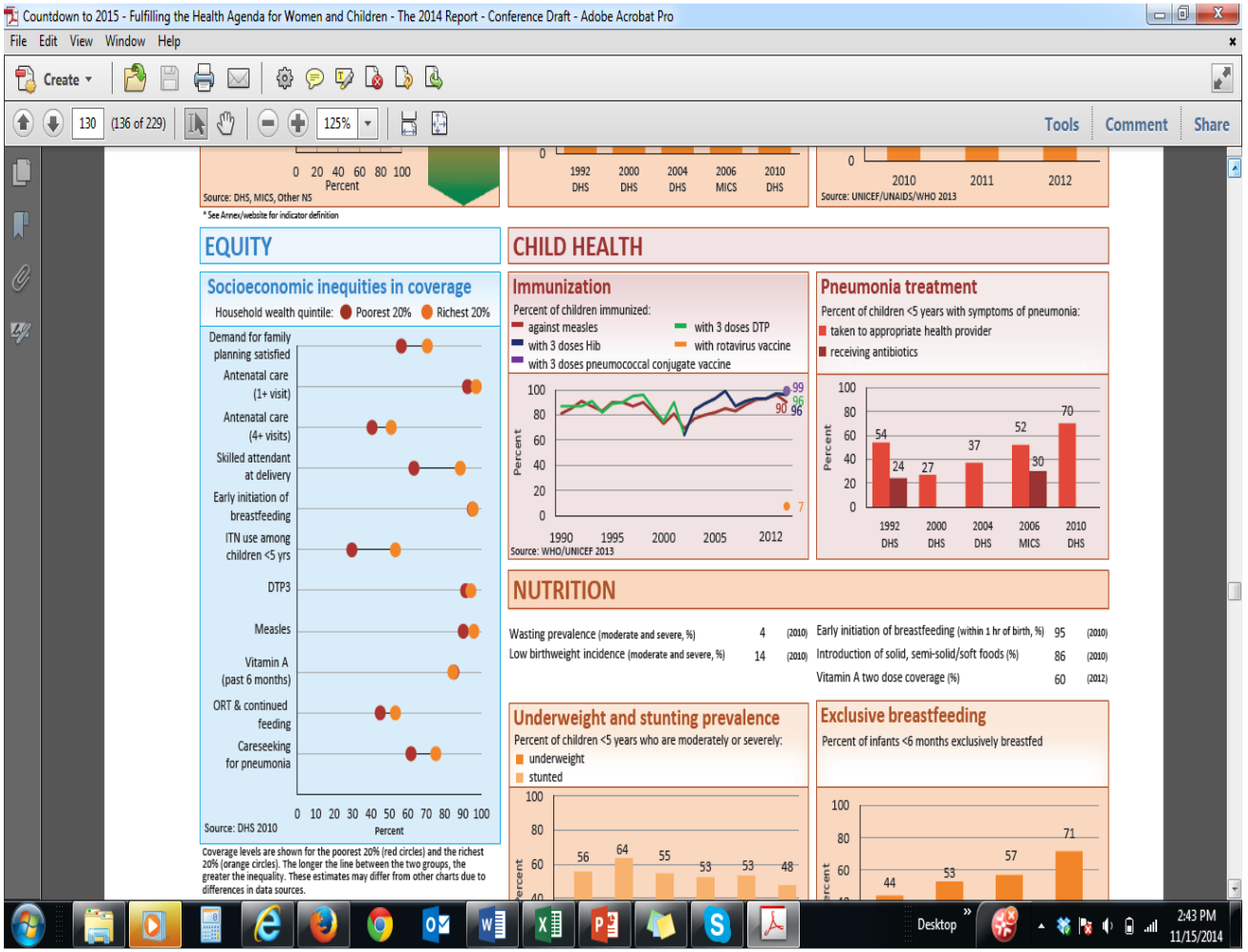
Malawi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130 (136 of 229)
125%
Tools Comment Share
0 20 40 60 80 100
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Source: DHS, MICS, Other NS
* See Annex/website for indicator definition
1992 DHS 2000 DHS 2004 DHS 2006 MICS 2010 DHS
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1992 DHS 2000 DHS 2004 DHS 2006 MICS 2010 DHS
NUTRITION
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Low birthweight incidence (moderate and severe, %) 14 (2010)
Early initiation of breastfeeding (within 1 hr of birth, %) 95 (2010)
Introduction of solid, semi-solid/soft foods (%) 86 (2010)
Vitamin A two dose coverage (%) 60 (2012)
Underweight and stunting prevalence
Percent of children <5 years who are moderately or severely:
underweight
stunted
56 64 55 53 53 48
Exclusive breastfeeding
Percent of infants <6 months exclusively breastfed
44 53 57 71
Desktop
2:43 PM
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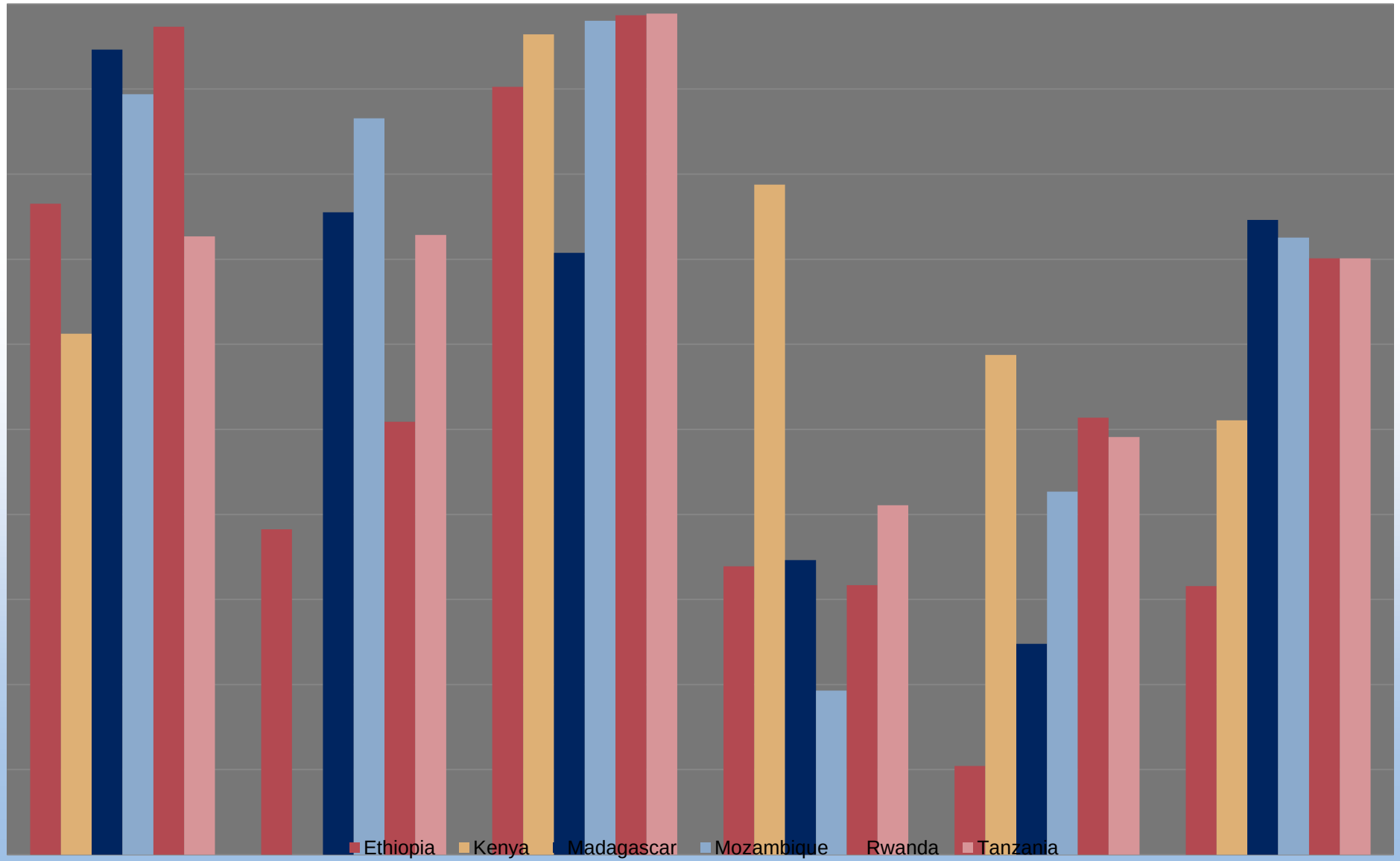
MCHIP Quality of Care Study

- Sub-Saharan African countries: Kenya, Madagascar, Mozambique, Rwanda, Tanzania
- 1016 health workers interviewed, 2377 babies observed
- Assessment on health facility readiness for provision of quality of care of essential newborn care services: thermal care, cord care, early initiation of breastfeeding, knowledge and skills of health workers, actual or simulated resuscitation

Observations of Immediate Newborn Care



Results of MCHIP Quality of Care Assessment

- Major deficiencies in the availability of essential newborn care supplies
- Low health worker knowledge and performance of key routine newborn care practices - particularly initiation of breastfeeding and skin-to-skin contact
- Quality of simulated resuscitation using a NeoNatalie model – over two third of providers errors with ventilation skills

Detailed Components of KMC
Mother-Baby Interface: "AS IS" against "IDEAL"

In delivery room:
Dry and stimulate, Check ABC's. If HR/RR stable*, babies <2500 g placed on mother's chest in immediate STS. Transfer to appropriate ward.

Midwives deliver baby and continue to work on the mother to deliver the placenta. No practitioner "assigned" to the baby. Once the mother is taken care of, the baby is wrapped and sent to the nursery, and babies often arrive hypothermic

Baby dressed in hat, socks, and diaper

Many babies do not have hats, although hats are available on the ward

Baby placed in continuous STSC for >20 hrs/day between breasts, neck midline, head in "sniff" position

Babies are not spending anywhere near 20 hours in KMC position

Exclusive breastfeeding on demand (q2-3 active feeding w/ cup/spoon if poor demand)

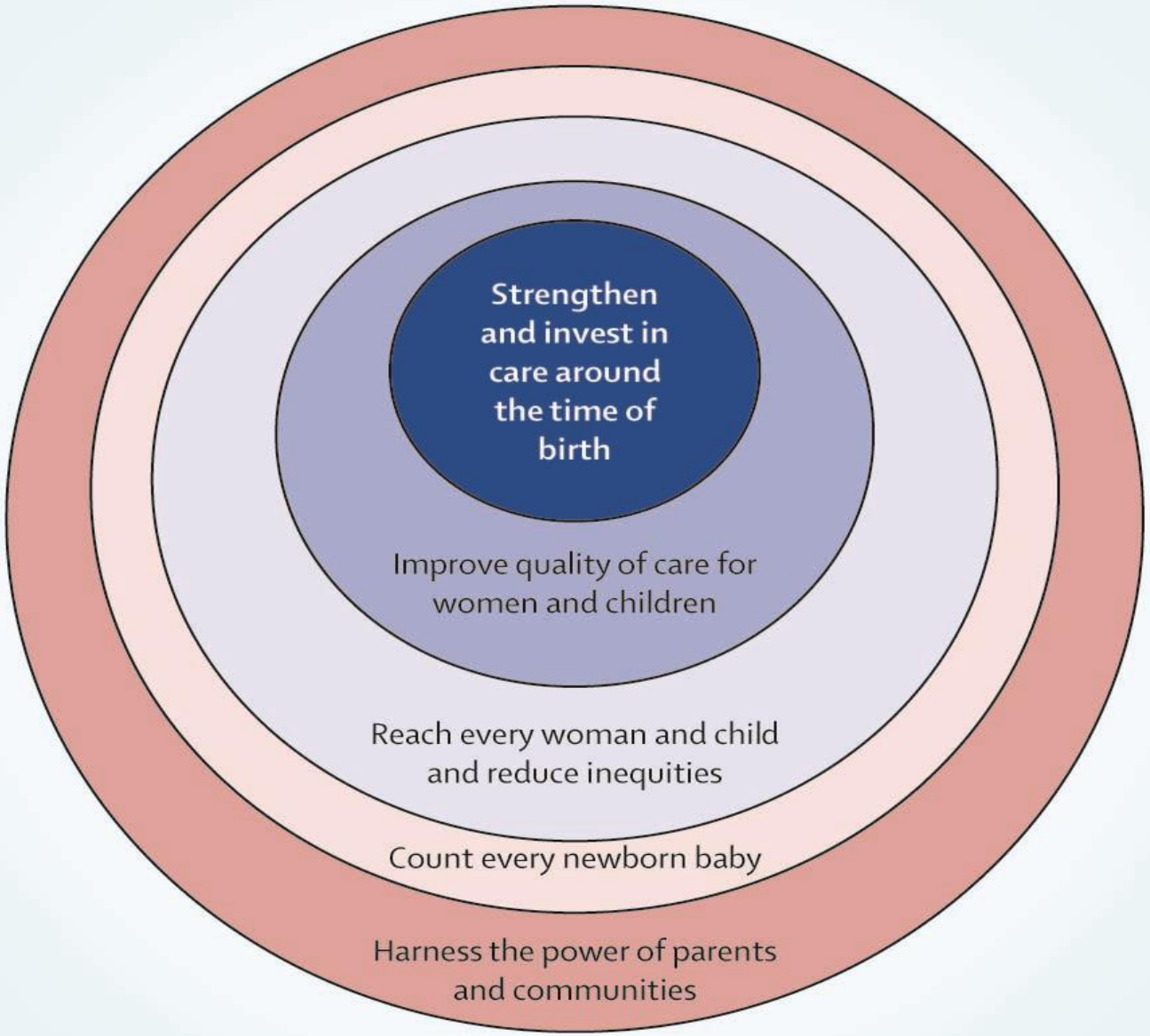
Because of high patient volume, feeding is the mother's responsibility and is not monitored.

Discharge criteria of 1500 g is well-known to mothers, and is followed. Many families leave against medical advice

Coverage yes, but quality of care?

Source: Lancet Every Newborn series, paper 3

Every Newborn's 5 Strategic Objectives



- Effective care at time around labour, childbirth, and the first days after birth has the highest effect on stillbirth, newborn, and maternal mortality
- Quality care along the continuum of care, delivered by skilled health-care workers with access to essential commodities, including family planning
- Universal coverage to expand access to and use of interventions for the most vulnerable and hardest to reach populations
- Data for action and to achieve equity, including birth and death registration, health service performance data, and mortality audits with response
- Parents, families, and communities that are empowered and engaged to demand quality care and not accept preventable newborn and maternal deaths

Principles: Country leadership, human rights, integration, equity, accountability, innovation

Every Mother, Every Newborn Quality Improvement Initiative

- Every Mother Every Newborn: **standards of quality care**
- Improve **facility-based care** for women and babies while strengthening the linkages with communities

Source: Lancet Every Newborn series, paper 5

Maternal and Child Survival Program

Kangaroo Mother Care Coverage and Quality Go Hand in Hand

Focus on Quality, Coverage will follow…..

What is quality Kangaroo Mother Care?

- The preterm or low birth weight baby is at the heart of the care
- Mother, the main care provider, she too is at the center of the care
- Quality KMC for baby - skin to skin, feeding, early discharge and follow up
- Quality care for mom – communication, respect, mental and physical support to provide KMC
- Every other quality improvement effort should be build around the care for baby and mom

What would be required to provide Quality Kangaroo Mother Care?

- **Inputs:**
  - Policies and systems to facilitate quality KMC
  - Standards, training, skills transfer, skills retention
  - Providers – who, which cadre / level, what roles
  - KMC room / space / furniture
- **Processes:**
  - Preparation for preterm birth, decision for admission, counseling, feeding, daily monitoring, discharge, follow up
  - Practice by mother, family
  - Mother, family and community engagement, information, communications, respect and ensuring satisfaction with care provided

Quality KMC room / space

- KMC room /space / furniture – usually the first input
- Yet, how many such space are languishing empty?

- Rooms / space: do they cater to needs of moms and families?
- Enabling policies? Visiting hours? Home food / food from outside? Hygiene measures etc.

Quality KMC by Health Service Providers

- Who should be trained to support mothers and families to practice KMC? Pediatricians / Nurses / Ward attendants? Task shifting…
- Skills retention and staff retention – institutionalization of care
- Champions within facilities – practice what they preach; set good example; mentor; everyone becomes a champion
- Motivation of health workers – intrinsic motivation; yet health providers perform at lower capacity than they are able
- Often strong disincentives to deliver quality care
- Low salaries, paid without regard to performance, overwork, lack of accountability and supervisory support, fear of negative clinical outcomes

Mom, Dad, Family, Neighbors…..and quality KMC

- KMC and influence of culture / social norms
- Communication – information, active communication, continuous communications, decision aids and in a language that is understood ("mayako angalo" in Nepal, "monkey care" in Ahmedabad, India)
- Community perceptions – active involvement, requires providers time, attention
- Satisfaction – caring and respectful behaviors of providers, shared decision making, comfort and support from providers
- Engage parents, families, community – because they care, they can change any existing culture or social norm

Professional bodies and their role in quality KMC

- Influential community – role model for providers, mothers, families
- Intellectual community requires evidence based reasoning
- Proof of impact – local evidence generation
- Professional bodies- ensure nurses, midwives, obstetricians, pediatricians are all together
- Distant, aloof and not willing to learn?
  - *Advocate, persevere and win over….*
  - *Convert each one into champions…*

Use every channel of programming – make KMC everyone's favorite intervention

- Open up the KMC platform / integrate?
- Platform for postnatal care for mothers
- Platform for postpartum family planning
- Platform for maternal nutrition
- Other non-health interventions? Child health, adolescent health, psychosocial, gender, livelihood

KMC Vertical versus KMC in ENC

- Should components of KMC become a norm of care for all babies?
- Should KMC be simplified?
- Prolonged skin to skin care for all babies?

Breastfeeding: the messages equally important for bigger babies too

- Follow up / postnatal care – applies to all babies

Metrics

- Measure and **USE** data: to track progress, to prove and to improve
- Limit the number of KMC indicators – integrate into ENC indicators?
- Formative studies: important for behavior change among mothers, families
- Formative studies: important for behavior change among providers

What could be the quality of care models for KMC?

- Client Oriented Provider Efficient Services (COPE); Fully Functional Service Delivery Point (FFSDP), Improvement Collaborative, Partner Defined Quality, Reaching Every District, Standards Based Management and Recognition….
- Standards, situation analysis, interventions and aim for quality improvement, tools, deliberate steps of implementation, monitoring, documentation etc.

- KEEP IT SIMPLE….AND TAKE ONE STEP AT A TIME
- MOVE WITH QUALITY, COVERAGE WILL FOLLOW CLOSELY

Kangaroo Mother Care
An Epitome of Quality "**Loving**" Care

For more information, please visit

www.mcsprogram.org

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