A situation analysis of Facility based KMC in a Zimbabwean province in preparation for program scale up

Presented by

F. Mutseyekwa, MD, MPH

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MCHIP Maternal and Child Health Integrated Program

Background

- Population 13,1mil
- No. of deliveries per year = 450,000 (*2012 Census report*)
- Skilled birth attendant rates = 80% (*MICS 2014*)
- Neonatal mortality rate for Zim = 29/1000 live births (*MICS 2014*)
- Prematurity is the commonest cause of newborn mortality in Zimbabwe =39% (*MPM study 2009*)
- About 11% of newborns are LBW and about 9% of newborn babies are preterm (*ZDHS 2010/2011*)
- MCHIP is supporting MOHCC plans to scale up KMC revitalisation in Manicaland province
- This situation analysis was conducted to assess KMC service delivery at 6 high volume secondary level health facilities in Manicaland province in preparation for KMC program scale up in 2015

Objectives of the situation analysis

- To document the caseload, coverage and KMC outcomes in 6 high volume hospitals in Manicaland province
- To establish the availability of KMC commodities and guidelines governing the implementation of KMC
- To investigate the environmental context in which KMC is being implemented (human resources, infrastructure, M & E, research agenda, communication strategies)
- To use data to raise awareness and for programming for accelerated KMC scale up in Manicaland Province

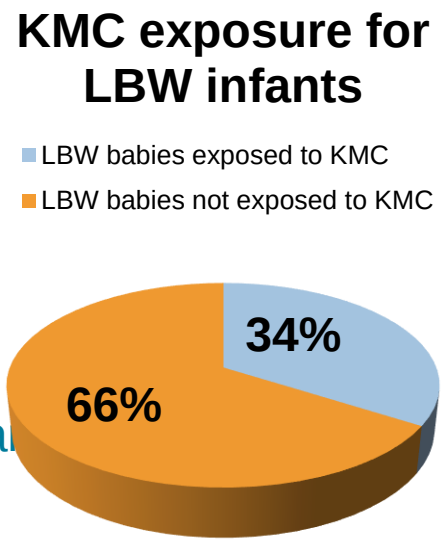
Methods

- Descriptive cross-sectional design
- Purposive sampling of 6 high volume secondary level health facilities
- Review of records from 1 June 2013 to 31 July 2014
- Interviewed
  - 6 Health managers (Sister in Charge Maternity ward)- as key informants
  - 20 health workers (at least 3 HCW per site) to assess knowledge, practice, perceptions and acceptability of KMC
- Assessed commodity availability and hospital's capacity to manage a functional KMC unit using a facility readiness checklist
- Quantitative data was captured and analyzed for frequencies and means using Excel worksheets while qualitative data was sorted and analyzed for content manually

Results

Program Coverage & Outcomes

- All 6 hospitals offering KMC services
- 900 LBW babies were delivered in the 6 facilities
- There was low KMC coverage
  - 66% of eligible infants were not exposed to KMC
- Admission criteria to KMC was Bwt ≤ 2000g
- Only 1 of 6 institutions had an out patient follow up progra in place
- 4/6 facilities had KMC guidelines and 5/6 managers reported awareness of the existence of the guidelines
- Incomplete mortality data especially for those not receiving KMC
- Mortality among infants admitted to KMC units was 9.8% (33 of 337)
- Poor documentation of KMC outcomes in registers and minimal analysis and use of data for decision making



Results

Facility readiness

- All 6 units reported shortages or non availability of essential commodities for KMC unit functionality such as linen, weighing scales, thermometers, heaters and suction machines.
- Shortage of space
- Reported high community acceptability of method
- No KMC research agenda or activities underway
- No communication strategy for community/stakeholders engagement or involvement

Results

Human Resources

- Staff overstretched due to staff shortages
- High acceptability of the KMC concept reported
- Knowledge test scores among HCWs involved in KMC duties on a daily basis ranged between 10-64%
- Nurse aides in some institutions demonstrating willingness and capacity to provide support for KMC mothers

Recommendations

1. Support training and orientation of HCWs in KMC best practices including admission and discharge criteria,
2. Strengthen post-discharge follow up
3. Strengthen supportive supervision
4. Support procurement of essential commodities for KMC
5. Address issues of space in order to improve client coverage
6. Support facilities to develop and implement KMC communication strategies to facilitate wider engagement of stakeholders including communities
7. Strengthen documentation, monitoring systems and promote implementation research