Scaling up an integrated maternal and newborn care package with KMC in a network of regional hospitals in Uganda - early implementation experiences

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Outline

- Background
- Study objectives
- Methodology
- Results

Background

- Global and national policies advocate for integrated maternal and newborn care
- The ENAP and the Ending Preventable Maternal Deaths Plans emphasize quality of care around the time of birth for the mother and baby
- Although KMC is effective, it focuses on the baby and ignores the mother
- Moreover sustainable models for rapid scale up of maternal and newborn integrated interventions are needed

Lessons from newborn implementation in Uganda

438 per 100,000 Maternal mortality ratio

57% Facility Deliveries

48% ANC Coverage (4 visits)

42% Births attended by skilled personnel

26% Contraceptive Prevalence Rate

42% Pregnant women with HIV receiving PMTCT

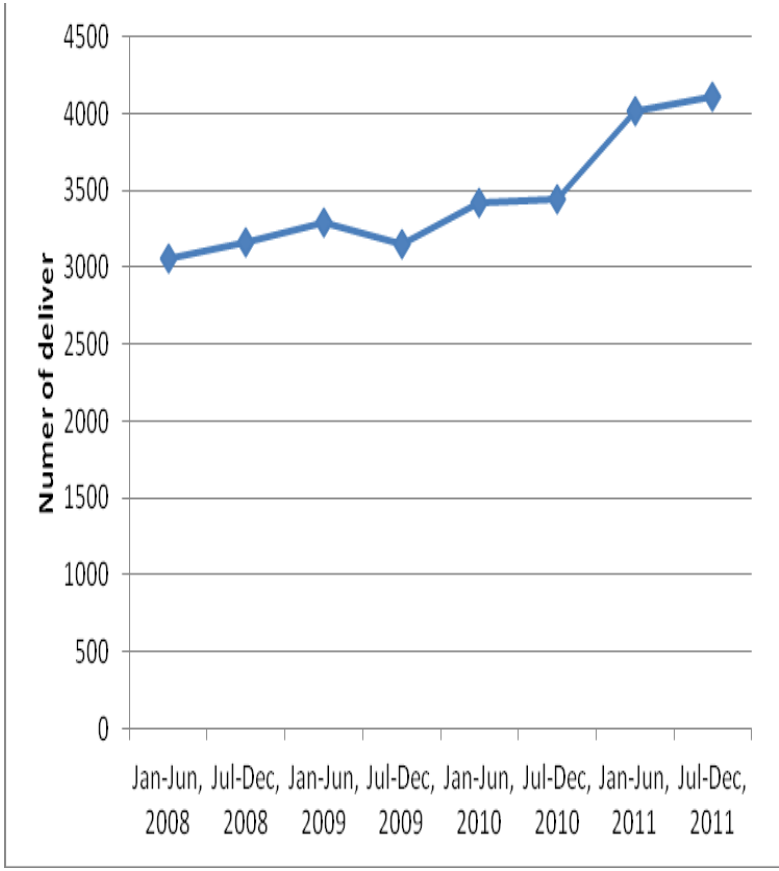
Sources: WHO World Health Statistics 2012; UNFPA State of the World Population Report 2012; Uganda Demographic and Health Survey 2011

A pilot project with the following package in one hospital showed success

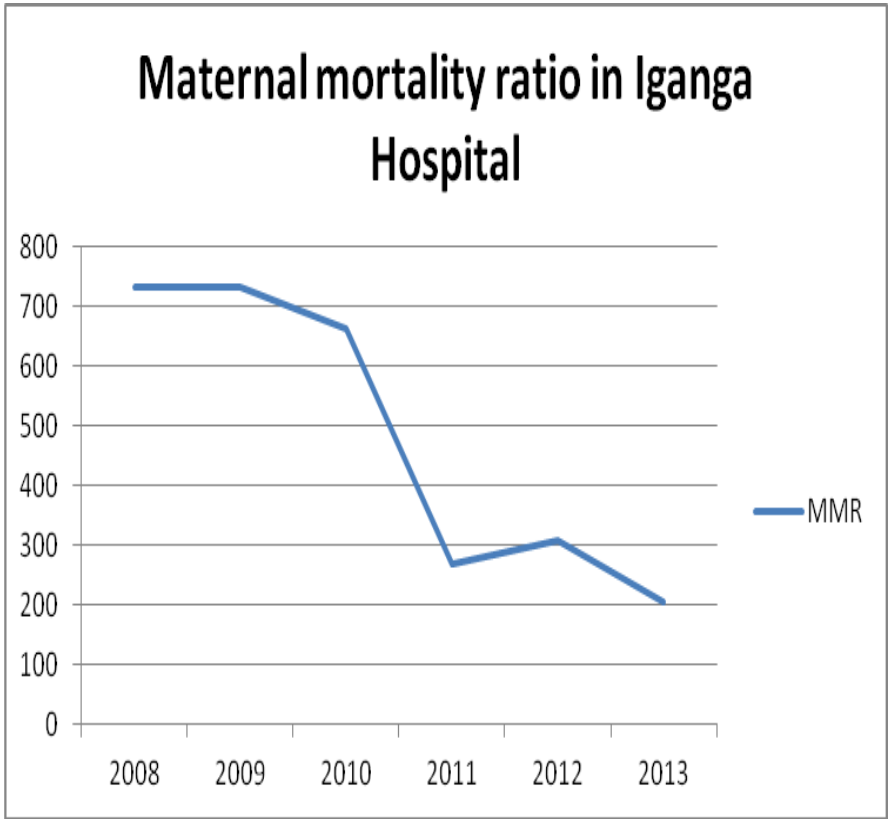
- Engaging leaders and champions
- Training of health workers in a six day hands integrated course focusing on:
  - Labour management
  - Immediate newborn care
  - Care for LBW babies
  - Care for sick newborn
  - Maternal and perinatal audit
- Once off equipment and drugs supplies
- Three monthly supervision and mentorship

Successful pilot (UNEST study)

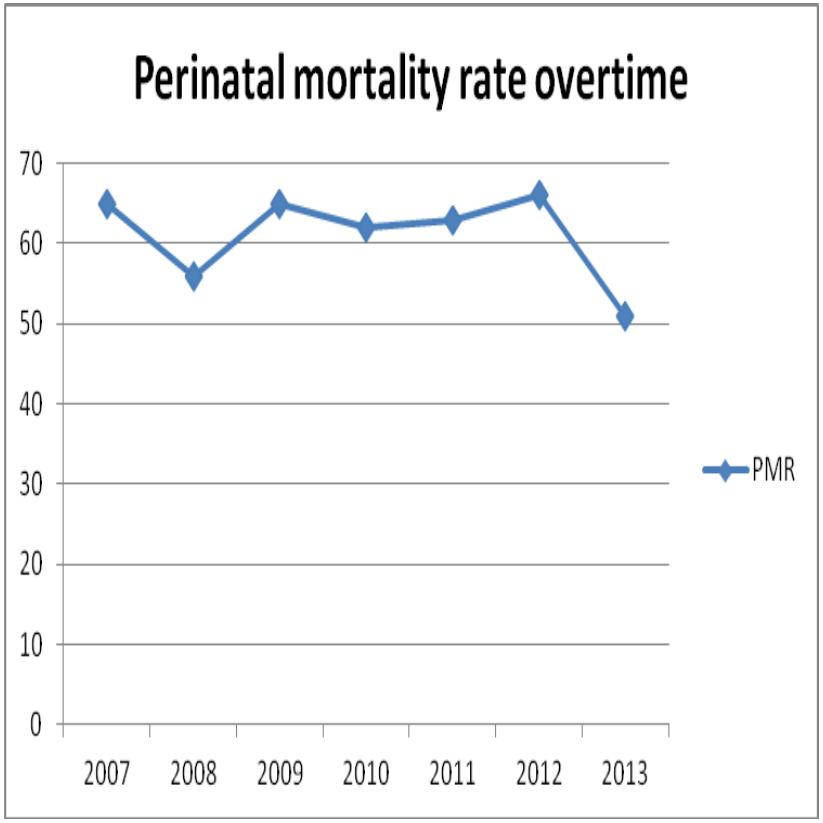
- Health facility delivery increased by 30% (from 2700 to 3435, larger than the increase in births in the districts)
- **547 preterm babies were admitted to Kangaroo Care, 85% were discharged alive**
- **249 sick newborn babies were admitted on the paediatric unit; with 75% survival rate**
- Bathing within 6 hrs decreased from 56% to 20% although almost all bathed within 24 hours
- Immediate initiation of breastfeeding increased from 52% to 80%



Successful pilot: Maternal and Perinatal mortality



In-hospital maternal deaths reduced during the study period and sustained decreases even beyond the study period



In-hospital perinatal mortality reduced from 65/1000 at baseline to 50/1000 live births in 2013

Qn: How to rapidly scale up a successful integrated MN pilot?

- A regional hospital network
- Leadership and champions
- Higher level hospital builds capacity of lower level hospitals
- Repeat successful fundamentals of the pilot:
  - Engaging leaders and champions
  - Integrated training and follow up
  - Once off equipment and drugs supplies
  - Three (initially 2) monthly supervision and mentorship from the regional hospital

Methodology

- Eastern Uganda east central region
- Six hospitals: 1 regional referral, 3 district, 2 private mission hospitals
- Retrospective baseline and quarterly ongoing M&E – quantitative and qualitative

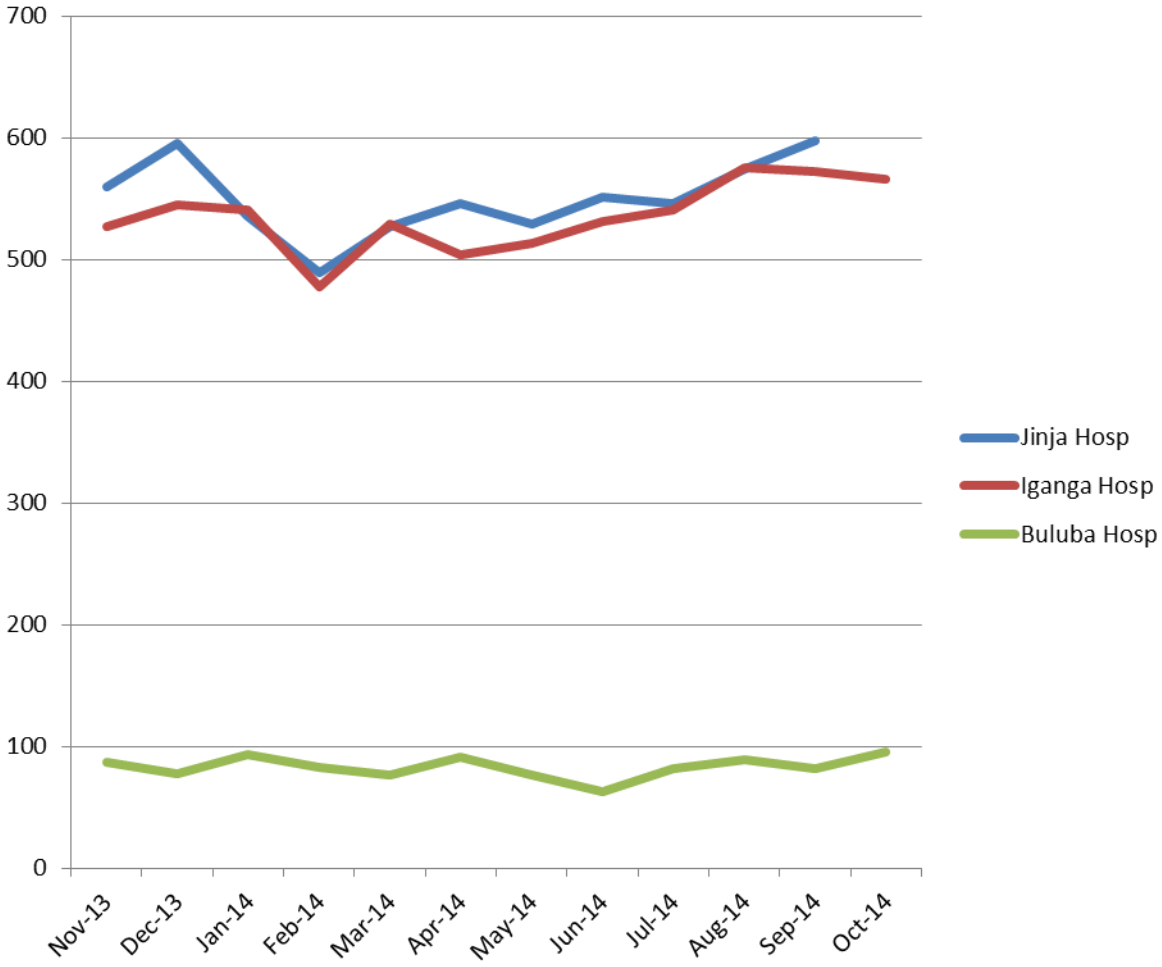
Methodology cont'd

- Training of Health workers in Maternal and Newborn care; Resuscitation, AMSTL, labour monitoring, Feeding etc

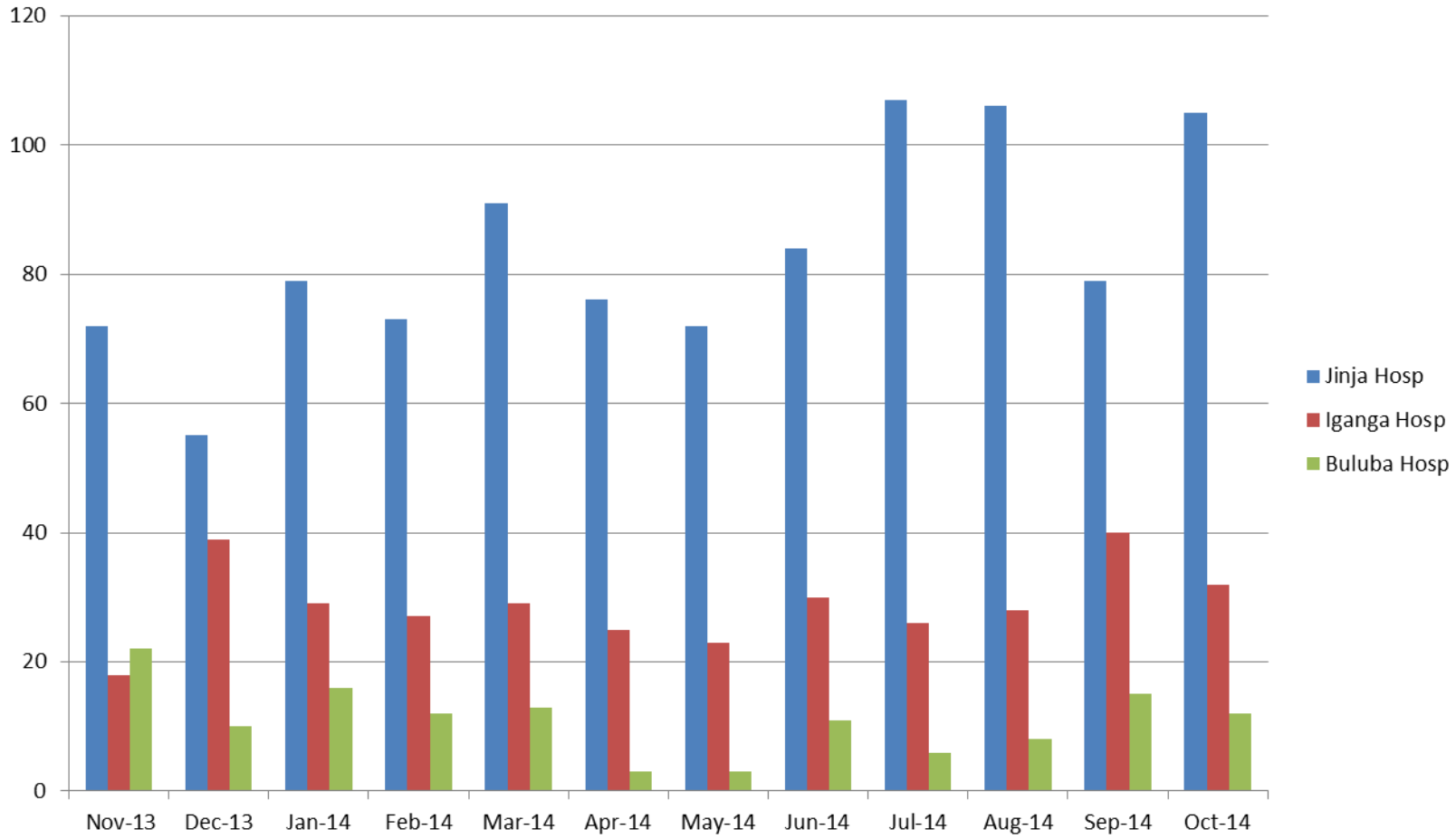
Methodology cont'd

Supply of Drugs and Equipments; Oxygen concentrators, Phototherapy machine, BP machines among other supplies

RESULTS: Ten months experience



Sick Newborn Admissions



What we found at baseline

- High maternal and neonatal mortality
- High c-section rates in mission hospitals
- Partograph not used
- KMC available only in 2/6 hospitals
- Infection control was a problem
  - *'We were not emphasizing KMC, we had incubators and mothers were sleeping there, their beds, luggage and everything was within the SCU, their visitors would come and they would eat from there and didn't observe infection prevention' (Maternity In-charge, district hospital)*

Experiences after integrated intervention

- Rapid scale-up of integrated package
- Referral hospital network operationalised
- Reduced pressure on regional hospital and improved pre-referral case management
- All hospitals have KMC and basic level neonatal units
- All hospitals now able to manage asphyxiated and sick newborns
- Reduced c/s rates
- Reported reduction in maternal and neonatal deaths
- Hospitals using PMDA to advance change: renovations, remodelling; improved MN drugs, equipment and supplies, infection control, follow up clinics
- Emergence of champions led by the leaders

Challenges

- MoH has no register for newborn care including KMC
- Few yet high turnover of staff and skills retention.
- Infrastructure – care units are small despite reorganization.
- Lack of essential drugs and equipment
- Emergence obstetric care been slowest to impact
- High inflow of visitors to patients who are a source of infection.
- 10% “run away” admissions

Conclusions

- An integrated maternal and newborn care with KMC is feasible and saves babies and mothers
- Using a regional level strategy leads to rapid scale up
- More research is needed to understand the phenomenon and outcomes of “runaway” babies in this setting

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Thanks for listening