for a Strategy to KMC Implementation in France

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FRANCE

65, 5 millions/habitants(2013)

- 30 y:Pregnancy average age
- Fertility rate: 2,01 (2012)
- 810 500 births (2012)
- 5,4 % of preterm infants

Family friendly policy

- Free access to family planning
- Legal abortion till 12 weeks GA and medical abortion till term
- “ Protection Maternelle et Infantile “ free ante and post natal care ,delivery, infant and child care till 6 years.

French's specificities of Perinatal care

There are 3 levels of delivery care:

- 1st level: normal pregnancy, singleton fetus
  - **pediatrician but not neonatal ward**
- 2nd level : medium risk
  - **Neonatal ward or NICU**
  - **Moderate prematurity over 34 weeks**
- 3rd level: high risk
  - NICU and neonatal ward
  - Maternal or fetal pathological condition
  - Gestation age less 33 weeks
  - Multiple pregnancy (twin, triple)
    - **most severe preterm infants are born in a 3 rd level maternity using in-utero transfer**
- According to the law KMC should be implemented only in neonatal ward or NICU

"Protection Maternelle et Infantile"

- Since 1945,(after second world war) France is implementing for all families a **free** friendly policy for pregnant women and children, to decrease the mortality
- 1970: important role in reduction of the perinatal mortality and the screening of psycho, sensitive and motor invalidities
- *For parents :*
  - Reproductive care including family planning
  - Ante natal care
  - Post partum care
- *For children*
  - Free routine care until 6 years including immunisations

France : Prematurity and Small infants

More and more preterm infants in France as well as in other developed countries:

- **USA (Goldenberg 2008)**
  - 9,5% in 1981
  - 12,7% in 2008
- **Europe (Goldenberg 2008)**
  - 5 to 9% in 2008
- **France (AUDIPOG and DRESS)**
  - 5.9% in 1995
  - 7% in 2003
  - 8,4% in 2009

Estimation for year 2009

Total : of Preterm + Small infants ≈ 100 000

50 000 preterm infants

including **8 000 infants < 33 weeks GA**

Mainly it is the number of children born less than 28 week GA which is increasing

Early Neonatal Mortality/Causes

- **2, 3 per 1000 life births** (Peristat 2010)

Causes :

- Congenital malformations (including refused proposal of therapeutic abortions for diagnosed lethal malformations)
- Infection (EUN)
- Prematurity

WHO' Recommendations for Infants < 2500 g

- Infant and mother should stay together as much as their health allow it
- All newborn and especially small infant should be carefully dry after birth and place in skin to skin contact to prevent hypothermia
- Early breastfeeding should be initiate within 2 hours after birth (direct feeding or expressed milk)
- KMC should be implemented for all preterm and small babies as a standard care in addition to other perinatal technologies

Steps of Implementation in France

- Since 1978 active involvement of the French Society of Neonatology
- Several examples of “grass root implementation ” KMC early 1980
  - Dissemination of scienftific results through professional press
- Repeated sensitization sessions during pediatric’ professional meetings
- Media involvement
  - TV dissemination
  - Parents magazines
  - Professional press
- 1992 Creation of the French KMC association to :
  - Bring interest together
  - Dissemination to midwifes, pediatric nurses,pediatricians
  - Networking with Parent Association of Preterm infants
  - Networking with other countries and with the Kangaroo Foundation (Bogota)

KMC Implementation Pathways(1)

KMC could be implemented in 3 ways, each has implications for education and training

1. **The grassroots pathway : Some interested and conviced individual institutions or individuals, initiate some form of KMC, either the NICU , in the high-care unit or even in maternity wards**
   - **Professional teams are extensively trained in "centers of excellence" (e.g. Kangaroo Foundation in Colombia)**
     - **It is a comprehensive "in- service training" including theoretical as well as administrative issues**
   - **Some individuals learned solely reading or using videotapes**

- **Then in-service trainings are organized in the department to implement KMC**

Challenge: this pathway is extremely person dependent++

KMC Implementation Pathways (2)

2. The policy pathway : Education and training are planned at a national or regional level and systematic efforts are made to bring KMC training to health workers from all or to selected facilities

Ideally KMC should be included in pre /in service and post graduate education but often only for post graduate professionels(Colombia, Sweden ??)

3. The academic pathway : The teaching hospital becomes a center for education and training , which is accessed by individual institutions and health authorities

KMC should be included in pre /in service and post graduate education e.g CHR Valenciennes France (as champion)

All 3 pathways are reinforced by a multidisciplinary approach

Implementation 2014

Piece and parcel and very much person dependant !

- KMC is seen as a “ non really scientific ” methodology
  - Fear of increasing neonatal mortality
  - Fear of change
- Some NICU departments implement intermittent skin to skin but not exclusive breastfeeding
- Parents are not allowed to be the first care givers for their infants, often they cannot come in the ward 24h/24
- The academic society and main neonatologists are not really convinced of the benefits of KMC and still resistant

Challenges

- Implementation is strictly person dependant
- Academic society is not supporting KMC despite Evidence Based Medicine results
  - French medicine is not attracted by EBM!
- No economic issue : KMC is not for profit

Implementation strategy

1. Important sensitization meeting for decision leaders organized together with patient associations
   - French ministry of health
   - Regional health authorities
   - Hospital administrative leaders
   - Health insurances companies
   - Neonatologist leaders
   - Media
2. Curricula revision for medical student , nurses and midwifes to include KMC as a standard care for preterm and small infants
   - Crucial importance for maternity ‘ pediatricians++ and for midwifes++

Implementation strategy

3. Suggestion of the revision of national perinatal plan
4. Free continuous education on KMC for multidisciplinary teams or individuals
   - 2-day training theoretical and practical with a supportive follow up visit and feedback
5. Development of specific evaluation tools, then integration in the national Health Information System

Conclusion

- Until now the implementation is limited
- The previous strategy based on medical sensitization and information on KMC EBM was not really effective. The doctors fear to loose their power !!!
- The consensus of Istambul in October 2013 initiated by FBMG will surely help us.
- The new strategy will focus on:
  - Decision leaders information/sensitization
  - Curricula revision
  - Continuous training with supportive follow up visits

Thank you for your attention