Title: Kangaroo mother care in Viet Nam: an overview for implementation and scaling up

Author: MCH Dept., Ministry of Health, KMC team Viet Nam

# Background: neonatal mortality rate in Viet Nam is about 12 per 1000 live births, representing 60% of under-5 mortality. Two thirds of all newborn deaths occurs in the first three days of life from complications of prematurity/low birth weight (LBW), sepsis and asphyxia. It is estimated that LBW newborns accounted for 5.7%. Kangaroo mother care (KMC), a lifesaving intervention for LBW newborns, has been implemented in Viet Nam for more than 20 years. However, it has yet scaled up national wide. To understand the key challenges and establish recommended priority actions to accelerate KMC, an overview of the status of KMC implementation is needed.

Methodologies: we conducted an analysis of existing documents, routine reports and surveys, consultations with relevant national and provincial neonatal and KMC experts, and field visits to observe KMC implementation in selected hospitals.

Results: KMC was firstly introduced in Viet Nam in 1996-1997 starting with one national hospital followed with trainings for provincial hospitals without a formal enabling environment and legal framework for institutionalization and scaling up. It was until 2004 and 2009 when the WHO KMC guidelines Vietnamese version was published and standardized in the national guidelines for reproductive healthcare respectively. In 2014 the Minister of Ministry of Health approved the technical materials on “Guideline to implement Kangaroo Mother Care at all healthcare facility levels”. To date, out of 63 provincial hospitals, 58 facilities in 48 provinces and cities have been trained and introduced KMC. However, it has been implemented in only 24 hospitals and two national hospitals. In 2015, while national routine data reported that 5,050 out of 61,825 LBW newborns received KMC, the formal data from 7 provincial hospitals implementing KMC showed that 2,013 out of 9,153 LBW babies received KMC in 2015.

Inadequate awareness and support from hospital leaders has prevented timely and properly implementation of the decisions and regulations on KMC issued by MOH as well as sufficient allocation of staff and space for KMC in the hospital setting. There has been a lack of monitoring and supervision by MOH, resulting in irregular following up and report on KMC implementation including the challenges and solutions by hospitals. In addition, training and coaching methodologies for heath staff, training materials, and supportive supervision on KMC have been inadequate and inappropriate with different hospital settings in Viet Nam.

Though KMC has been included in the national maternal and child healthcare action plan 2016-2020, to accelerate the progress, it is necessary for Viet Nam to update the national guidelines and regulations including sufficient staffing and spacing for KMC, conduct KMC clinical training and coaching, carry out integrated supportive supervision on KMC and early essential newborn care, include KMC in the hospital performance assessment, and secure support of healthcare leaders through generating and dissemination of evidence and organization of national advocacy workshops on KMC implementation.

Conclusion: good progress has been made by Viet Nam in implementation of KMC however challenges remain. Key next steps to scale up national wide are provision of sufficient capacity building and supportive supervision, inclusion of KMC in the hospital quality and performance assessment, and securing active participation and support of the national and provincial health programme managers and hospital leaders.

Barriers

1. Lack of support from MOH through putting supportive policies and penalties to hospitals who do not implement KMC
2. Lack of medical universities involved
3. Lack of awareness and support from hospital leaders
4. Lack of policy, formal KMC guidelines in hospitals.
5. Staff moving: staff who had been trained in KMC moved to other working places.
6. Many health professionals consider KMC to be a method for very low resource setting, they just want to focus on high technology care for newborns, therefore they do not prioritise space, resources and staff for KMC.
7. Lack of family education and support therefore family are not willing to do KMC
8. Lack of monitoring and technical supervision from experts to hospitals who do not have strong KMC program.
9. Lack of management to run a proper KMC program from OBGYN to Neonatal care to follow up.
10. Lack of collection data base for KMC follow up.

Enablers

1. Updating policies to support KMC practices
2. Securing commitment from hospital directors and senior staff; allocating space, staff and equipment to support KMC;
3. Further implementing KMC clinical coaching and mentoring;
4. Improving hospital counselling and health education for mothers and families.
5. Carrying out integrated supportive supervision on KMC and early essential newborn care, include KMC in the hospital performance assessment
6. Building at least 3 KMC excellence centres in 3 regions of Viet Nam leading the scaling up.
7. Building a KMC network in neonatal staff
8. Creating good education materials for family
9. Building simple data base for KMC follow-up