

Rapid Health Facility Assessment on Service Availability and Delivery of Care to Premature and/or Low Birth Weight Babies

Background

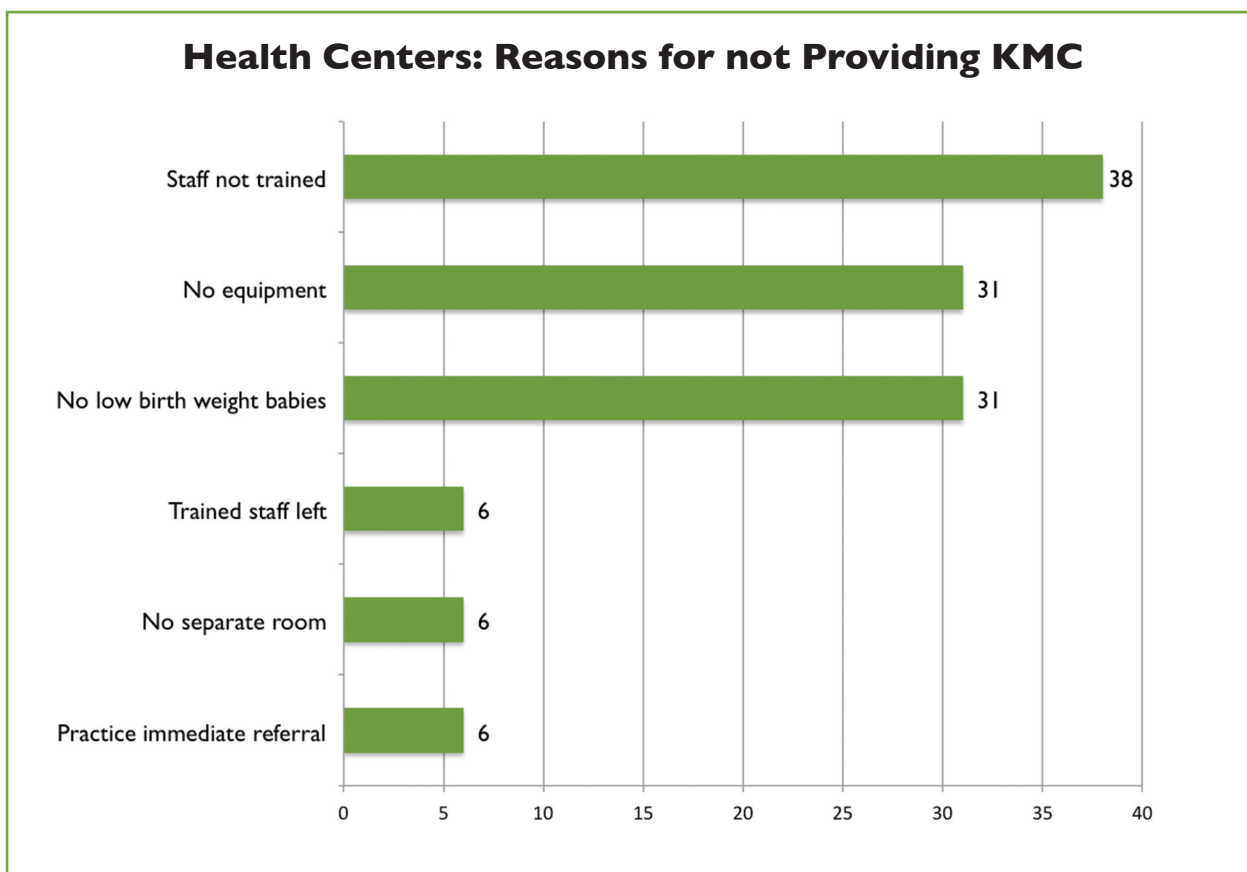
Prematurity-related death is a leading cause of under-5 mortality in Ethiopia, and is the unfinished agenda for maternal-child health as Ethiopia enters the era of the Sustainable Development Goals.¹ Kangaroo Mother Care (KMC) can reduce mortality among low birthweight and premature babies by up to 40% when implemented appropriately and as part of quality care for small newborns.² Recognizing this, the National Newborn Child Survival Strategy calls for a national scale-up of facility-based KMC services as part of a package of high-impact interventions for low birthweight babies. A rapid facility assessment

of KMC services, conducted by the Saving Newborn Lives Program at Save the Children, is summarized below, with recommendations to assist FMOH in their efforts to increase availability of quality KMC in health facilities.

Key Findings from Rapid Health Facility Assessment

The *objective of the assessment* was to determine facility readiness to provide KMC and other services for preterm/low birthweight (LBW) babies including availability of knowledgeable and skilled staff, supplies and space, and supervision.





All hospitals and 19 randomly selected health centers in three zones (East Shoa, Sidama, Gurage) were surveyed using qualitative and quantitative techniques. Key findings are summarized below.

Availability of data

- Data is necessary to track progress of service provision and quality of care. There is currently a lack of KMC data in Ethiopia. Admission to KMC service is included in the HMIS delivery register, but is not currently included on the reporting form, and registers are often not complete.

Identification of eligible newborns

- Timely and accurate identification of low birthweight newborns is required for initiation of KMC. Approximately 5% of total births in surveyed facilities were identified as LBW. This is far lower than expected, either due to failure to correctly weigh and identify small newborns, a genuine absence of cases, or both.

Main barriers to implementation

- The top 3 barriers to provision of KMC, as cited by providers, are: small volume of low birthweight newborns, no equipment, and untrained staff.

- Despite small number of low birthweight babies eligible for KMC, there is still a large unmet need for KMC, evidenced by the gap between eligible babies and documented number of cases of KMC: only 14% of eligible babies were enrolled in KMC service.



Abayanesu, 22, with her one-month-old newborn daughter in Black Lion Hospital, Addis Ababa, Ethiopia.

- Equipment and supplies for the care of low birthweight newborns are lacking particularly at the health center level. Most HCs had IV fluids, but no oxygen or nasogastric tubes. Approximately half of facilities had amenities in place to make families comfortable for an extended stay in KMC.
- Less than 20% of delivery attendants, who are primarily responsible for timely initiation of KMC, are trained in KMC. Knowledge about admission criteria in particular was a knowledge gap, despite inclusion of admission criteria in the Essential Newborn Care Training Manual.
- Barriers from the family perspective, as described by providers, are: mothers do not want other people to see their small baby, and holding the baby on the chest is not customary.

Supervision and follow-up

- Supervision for maternal-newborn care was available in all hospitals, but was lacking in health centers. Only 20% of attendants were trained in KMC, and the largest knowledge gaps were seen for admission criteria.

- Follow-up of KMC cases after hospital discharge is essential for ensuring survival. Although 78% of health centers report a follow-up system consisting of either phone, letter, or supervision mechanism, the rate and timeliness of follow-up completion is unknown.

Recommendations

Develop detailed national KMC guidelines.

These should include admission criteria (including definition of clinical stability), inpatient management, discharge criteria, follow up, home care, referral, and transport at all levels of the health system. Effective implementation is required for achieving expected impact, and should be standardized based on global guidance forthcoming from the World Health Organization (early-2016) that can be adapted in consultation by a consortium of pediatric and neonatal professionals in Ethiopia.

Formalize and standardize the referral

mechanism for babies discharged from KMC service. This should include a standard protocol for contacting the health facility and HEW with whom



the baby will follow-up and a standardized document used for tracking baby's growth, development, and clinical progress (i.e. health passport).

Include KMC in pre-service training for all health workers involved in delivery and care for preterm/LBW babies. This is especially important for midwives, as they are the primary cadre in a position to immediately initiate KMC. Capacity-building needs to also address health workers' misconception that separate space is a pre-requisite for KMC or that KMC is a last option when incubator is not available. Pre-service training is a longer pipeline to service delivery than in-service training, but is less dependent on donor support.

Ensure that admission to KMC is reported in HMIS. National progress on KMC implementation can only be assessed if KMC admissions are completely recorded in registers and reported through HMIS. Consider selecting a standard denominator to produce a meaningful KMC indicator, rather than reporting numbers of admitted patients.

Provide health education and anticipatory guidance for women at risk of preterm birth during antenatal care. Changing social norms and practices for care for small newborns will require a two-pronged approach: targeted health education for at-risk pregnancies, and wide social norm change for attitudes about babies born preterm. We recommend beginning with targeted ANC education, followed by leveraging HDA platform for social norm change.

Begin by concentrating on expanding provision of quality KMC services in Type A Health Centers, and strengthening KMC services in hospitals, with the ultimate goal of quality KMC in all hospitals and health centers. An accelerated phased approach, focusing first on hospitals and Type A health centers, will allow for adequate and simultaneous investment of resources to improve referral, transport, and follow-up systems, development of national KMC guidelines and measurement mechanisms, as described in the recommendations above.

Leverage resources from the global community. The KMC Acceleration Partnership is working with WHO to make available global guidance for implementation of KMC (anticipated available early 2016) and has disseminated a set of 10 core KMC indicators that can be incorporated into routine health systems. Limited technical assistance from the global KMC community will also be available in 2016 through Africa regional KMC meetings.

Notes

- 1 Victora CG, Requejo JH, Barros AJD, et al. *Countdown to 2015: A Decade of Tracking Progress for Maternal, Newborn, and Child Survival.*; 2015. doi:10.1016/S0140-6736(15)00519-X.
- 2 Conde-Agudelo A, Belizan JM, Diaz-Rossello J. Kangaroo mother care to reduce morbidity and mortality in low birthweight infants. *Cochrane Database Syst Rev.* 2011; 3:CD002771.

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