WHAT IS THE VISION FOR IMPROVING THE CARE OF SMALL AND SICK NEWBORNS FOR 2021 IN YOUR REGION?

ADVANCES, CHALLENGES AND WAY FORWARD “INDIA”

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INDIA
Our Mission:
• Mother’s chest is the best place for the care of the newborns
• Mother’s milk is the best food for the newborns
• Zero Separation of mother and her baby

Our Vision:
• KMC to be part of routine care for all the newborns, specially for the newborns with birth weight <2000g, at all levels of care
NEWBORN CARE - CHALLENGES IN INDIA

• India’s share of estimated annual global burden SRS 2016
  • The highest no. of births (> 25millions) – 20% (25,794,000)
  • The highest no. of neonatal deaths (> 0.6 million) – 27% (695,000)
  • The highest no. of LBWI (7.5 millions) – (20%)
  • The highest no. of preterm births – 25%
  • The highest no. of still births – 40%
  • The highest no. of maternal deaths – 25%
  • Wide disparities – Urban/Rural, Rich/Poor, Gender, Regional & other factors
STATUS OF INFANTS “BORN TOO SOON” AND “BORN TOO SMALL”

- 25% of Global burden of Pre term
- 40% of Global burden of LBWI including PT
- 28% of births in India (13% PT AGA 15% FT SFD/IUGR)
- 60% of LBWI in India - born at term SFD/ Intra uterine growth restriction “Born too small”
- 40% of LBWI in India - are preterm “Born too soon”
- Have the highest rates of morbidity and mortality (almost 80% of neonatal mortality)
  Direct PT deaths in a year- 367,600
- Preterm Survivors have the highest rates of neurological disabilities and developmental problems (Impaired PT survivors in a year - 80,700)
- Long term risks of stunting, disabilities and NCDs in LBWI
NEONATAL DEATHS IN INDIA

• Neonatal mortality – 56% of U5MR in India 2012
• Neonatal deaths in first week of life ----75%
• Neonatal deaths within first 24 hours-----37%

• Reduction in Neonatal mortality lags behind post neonatal mortality

Healthcare workforce for PT babies- 24.1 per 10, 000 population
( Doctor, nurses and midwives ) + SBAs in community
The Story of Large Numbers...

Highest Number of Neonatal Deaths in the World

- India – 696,000
- Pakistan – 245,000
- Nigeria – 240,000
- DR Congo – 94,000
- China – 93,000

Data Source – Levels and Trends in Child Mortality 2015 Report
Causes of Neonatal Mortality

- Birth asphyxia: 35%
- Sepsis: 15%
- Preterm: 15%
- Pneumonia: 16%
- Diarrhea: 9%
- Malformations: 2%
- Other: 3%

Total: 100%
EVERY NEWBORN ACTION PLAN TO ACCELERATE PROGRESS AND IMPROVE OUTCOMES 2014

* Strengthen and invest in care of Small and Sick Newborns (SSNB)
* Improve quality of maternal and newborn care
* Reach every woman and newborn to reduce inequities
* Harness the power of parents, families and communities
* Count and track every small and sick newborn
* Strengthened legal, regulatory and policy environment
* Consistent and robust research
* Commitment, collaboration, Sector Alignment
* Accurate and context specific data
INDIA NEWBORN ACTION PLAN INAP (2014)

• Goals:
  1 To end preventable neonatal deaths
  2 To achieve single digit NMR by 2030
  Single digit NMR individually in states by 2035
  Single digit SBR by 2030
  Single digit SBR individually in states by 2035
SIX INTERVENTION PACKAGES

Preconception & Antenatal Care

Care during labour & childbirth

Immediate newborn care

Care of healthy newborn

Care of small & sick newborn

Care beyond survival

Across family and community level, outreach/Sub Centre level & at the facility

Committed to single digit Neonatal mortality rate and stillbirth rate
Number of Deaths Averted by Stage of Intervention

- Preconception Nutrition: 43,500
- Antenatal Care: 45,500
- Care during labour and birth including complications: 4,56,000
- Immediate Newborn Care: 52,000
- Care of the healthy newborn: 54,500
- Care of the small & sick newborn: 1,870,000

- Newborn lives saved
- Maternal lives saved
- Stillbirths averted

India specific analyses based on EN Lancet Paper 3, 2014 by AIIMS, V.K Paul
POTENTIAL FOR NEONATAL LIFE SAVING

- Intrapartum care – about 40% fresh still births can be averted (A few very early neonatal deaths may have been included in this group)
- Care at the time of birth - about 40% neonatal deaths can be averted
- Care of small and sick newborns – about 30% deaths can be averted
TARGETS OF SUSTAINABLE DEVELOPMENTAL GOALS (SDG) 3

SDG 3: Ensure healthy lives and promote well being for all at all ages

By year 2030

- 3.1 Reduce global maternal mortality ratio to < 70 per 100,000 live births
- 3.2 End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce
  - Neonatal mortality to at least as low as 12 per 1000 live births
  - U5MR to at least as low as 25 per 1000 live births
- Achieve Universal Health Coverage
- Reduce no. of deaths from hazardous chemicals and air, water and soil pollution and contamination
- Increase health financing and recruitment, development, training and retention of health workforce in LMICs
WHO STANDARDS FOR CARE OF SSNB
(TO BE FOLLOWED DILIGENTLY EVEN IN COVID ERA)

• 1 Evidence based practices
• 2 Actionable information system
• 3 Functioning referral system
• 4 Effective communication and meaningful participation
• 5 Respect, protection and fulfilment of newborn rights and preservation of dignity
• 6 Emotional, psychosocial and developmental support
• 7 Competent, motivated, empathetic and multidisciplinary human resources
• 8 Essential physical resources for small and sick newborns
INDIA’S PROGRESS IN NEWBORN CARE PARAMETERS

• Considering the huge challenge of newborn care, considerable progress in India in recent years
• The NMR has reduced from 47.1 in 2001 to 23 per 1000 live births in 2019
• Several important programs including training have been introduced to take care of babies in facilities as well as at homes
• Institutional delivery rate has gone up considerably. (>70%)
OTHER PROGRAMS RELATED TO NEWBORN CARE IN INDIA

- Janani Suraksha Yojana JSY (cash incentives for institutional delivery)
- Janani and Shishu Suraksha Karyakram JSSK (Incentivised ante natal care and institutional delivery program)
- Navjaat Shishu Suraksha Karyakram NSSK (Essential newborn care)
- Pradhan Mantri Suraksha Matrutva Abhiyan PMSMA (PPP model of Mother’s check up)
- Em Obst – Emergency Obstetrics Care
- Co - Obst- Comprehensive Obstetric care
- National Family Welfare Program
- Mother’s Absolute Affection MAA program for promotion of breast feeding
- Comprehensive Lactation Management and Human Milk banking
- Nutrition programs
- Family participatory care (FPC) program and others
CURRENT STRUCTURE OF NEWBORN CARE IN INDIA

• **Public Sector:**
  • **Facility based:**
    • Tertiary care NICUs and SNCUs – Medical college units (> 542+64)
    • Special Newborn Care Units (SNCU) - At District and Sub District Hospitals (894)
    • Newborn Stabilization Units (NBSU) – At First Referral Units (FRU) and Community Health centres (CHC) (2579)
    • Newborn Care Corners (NBCC) – At every delivery point (> 40,000)

• **Community Based:**
  • Home Based Newborn Care by ASHA and AWW and ANMs (> 10 lakh home visits by CHWs)
CURRENT STRUCTURE OF NEWBORN CARE IN INDIA

- Private sector
- Facility based
- Tertiary Care NICUs and Special Newborn Care units - in Corporate hospitals
- Independent hospitals and smaller nursing homes
- Charitable hospitals, Private maternity homes
- Private consultants from Allopathy, Ayurveda, Homeopathy and other systems
- Community based
- Voluntary health care organizations in deprived communities
- Local practitioners, Quacks, Family members etc.
Facility Based Newborn Care Activities (FBNC) in Public Health Sector

- Neonatal Intensive Care Units and SNCUs - Government Medical Colleges
- Newborn care corners NBCC - At all delivery points
- Immediate care after birth including basic neonatal resuscitation
- Newborn Stabilization Units NBSU - at Community health centres (CHC and First referral units (FRUs))
- Essential newborn care ENBC, Basic neonatal resuscitation, care of a few neonatal problems like phototherapy, feeding problems, minor problems etc and stabilization and proper referral to higher centres of care
- Special Newborn Care Units SNCU - at district and subdistrict hospitals and a few medical colleges
- All other neonatal problems except advanced ventilation, surgeries etc.
Newborn Health

Essential newborn care
894 SNCUs, 2579 NBSUs & 18750 NBCCs
Home based newborn care
Visited ~ 10mn newborns every year,
Extended follow up for SNCU discharges

Mother Newborn Care units at high caseload SNCUs
to promote early childhood development
Checklists available for assessment under National Quality Assurance accreditation & certification

SNCU online reporting system
90% units reporting online using uniform recording system

Screening and management of children with 4Ds-RBSK program
822.6mn+ Children Screened

Promotion of breastfeeding/complementary feeding
MAA programme

Service Utilization
One million admissions with less than 10% average national mortality
Care at Birth for Small and Sick Newborn

- Care for Small and Sick - SNCUs
- Kangaroo Mother Care & guideline
- Early initiation of Breast Feeding
- NBCCs at delivery points
GOI guideline for conducting USGs at FRU level around 20 weeks

- Certification of Labour Rooms & Maternity OTs
- Focus on Quality Improvement & Respectful Maternity Care

*Labour Room Quality Improvement Initiative*

*Early Childhood Development - Journey of the First 1000 Days*
Going beyond ....for care of preterm

Family Participatory Care

FAMILY PARTICIPATORY CARE FOR IMPROVING NEWBORN HEALTH
OPERATIONAL GUIDELINES FOR PLANNING & IMPLEMENTATION
July 2017

District Early Intervention Clinic & Universal eye screening

Ministry of Health & Family Welfare
Government of India

Home based newborn care

HOME BASED NEWBORN CARE Operational Guidelines (Revised 2014)

Comprehensive lactation Management

National Guidelines on Lactation Management Centres in Public Health Facilities

JUNE 2017
KMC implementation: As per SNCU online data 2018

42% of all admissions receive KMC.

27% of SNCU admissions weigh less than 2000gm
43% of discharged cases weigh between 1.5kg to 2.499gm

30 states report online on KMC

Day 2 - 25% of admissions provide KMC
Day 7 - less than 10% continue KMC
Key achievements

- 82% districts now have SNCUs
- 200,000 new born lives saved during 2012-16
- 23% reduction in NMR in last five years
DIRECT SKIN TO SKIN CONTACT
CHEST TO CHEST CONTACT

YES OR NO?
IF YES, WHY AND HOW?
IF NO, WHY?
CURRENT RECOMMENDATIONS
(TILL FURTHER EVIDENCE IS GENERATED TO STOP THE PRACTICE)

Weighing the risks and benefits- as far as possible

• Continue breast feeding
• Immediate skin to skin contact soon after birth for all babies
• Zero Separation of mother and her baby
• Kangaroo Mother Care
• *** Taking all precautions for infection prevention including respiratory hygiene, hand hygiene and cleaning surface contacts by mother, mother companions from family and health care providers
Many achievements
but miles to go.......... Many Challenges to Surmount
ISSUES RELATED TO BIRTH WEIGHT RECORDING IN DEVELOPING COUNTRIES

In community settings, difficult to reach for the health worker-

The earliest weight recorded within first seven days is considered as birth weight for records.

The day on which it has been recorded, has to be mentioned

Issues for birth weight recording:

Health worker not present at the time of birth

Weighing scale not available, Defective scales

• Not very sensitive for small weight fluctuations

• No proper training or careless about recording and others

• Even Facility born babies do not have birth weight records some times.
A FEW OBSERVATIONS ON REGION WISE ESTIMATES FOR PREVALENCE OF LBW BIRTHS

• Western Europe - Minimum prevalence and Variations
• South Asia - Maximum prevalence - Wide variations - estimates not available/or partially available - Data may not be fully reliable
  Bangladesh, Nepal – high prevalence
• Pakistan - estimates not available
• India - Only partial estimates available and wide state to state variations and also inequities among rich-poor, rural-urban, tribal/urban slums etc.
• West and Central Africa - Many countries – estimates not available-prevalence of LBW is lesser than South Asian region
• USA and Japan - prevalence is more than Western Europe - but variations minimal
IMPLEMENTATION CHALLENGES OF FBNCS FOR THE CARE OF SSNB (SNCU, NBSU, NBCC AND TERTIARY CARE UNITS)

• Infrastructure: Appropriate locations and space (Proximity to LR, KMC wards/MNCU including privacy and other facilities for personal needs of mothers and helpers), Maintenance and repairs, water supply, electricity etc.

• Human Resource: Availability, Number, Capacity, Motivation, Retention

• Equipment supply and maintenance

• Follow up mechanisms very weak. Not properly organized

• Quality of data and reporting from SNCUs requires improvement

• Socio Cultural barriers for hospital stay for the required period and also for exclusive breast feeding, KMC etc.

• Inadequate communication and proper counselling

• No respect or dignity to patients
ISSUES RELATED TO PROGRAM MANAGEMENT

• State to state variations in policy implementation, monitoring, supervision and planning for the SNCU and other services
• Lack of coordination between NBCC, NBSU, SNCU and higher tertiary care centres
• NBSUs are not fully functional in many places.
• Quality Improvement needed in data collection and audit, regular review in HMIS
  (Definitions have to be standardized. Before sending the data to higher levels the local in charge doctors must verify the data and then send. The whole process is done very casually/mechanically at times in a few places)
• Quality of data and use reflects the quality of services provided and the functioning of the whole system)
• Training of all the staff must be ensured.
• Public private partnership programs must be handled properly
CHALLENGES IN PRIVATE SECTOR

• No accountability of clinical services
• Ongoing training programs /CMEs are limited. Latest information may not be available. Age old clinical practices continue, Some of the practices are not evidence based.
• Accreditation of unit not obligatory
• No regular liaison with public sector units
• All the helping staff may not have required training
• No data or information available regarding the volume and quality of services available
• Out of pocket expenses for the patient often very high.
A FEW IMPORTANT GAPS IN PATIENT CARE SERVICES

• Communication and counselling very much lacking
• Neonatal follow up services not properly organized
• No regionalization of newborn care and proper liaison with the higher service centres
• Neonatal transport. Emergency ambulance services are now available in most of the states. But facilities for sick baby/high risk baby transport are very meagre or not at all available, has a vast scope for improvement
• Many available services are under utilized due to multiple reasons including lack of information.
WAY FORWARD FOR 2021

• In Covid time, hard won gains will falter, if continued attention is not given including Breast feeding, KMC, Immunizations etc. for both baby and the mother

• IPC measures of mothers, family members and those of health care providers must be strictly followed in OPD, Indoor, during delivery and everywhere.

• All the identified gaps in terms of infrastructure and staff will have to be filled up in SNCU, NBSU, NBCC
“In developing countries like India, with very high neonatal mortality rates combined with weak public health systems and inadequate facilities, simple interventions like **Breast feeding promotion, Kangaroo Mother Care, Hand washing**, and others can save thousands of neonates from dying due to easily avoidable as well as treatable causes, provided at least 90% coverage is achieved.”

The Lancet Neonatal Survival Series 2005
POSTNATAL EFFECTIVE INTERVENTIONS
(THE LANCET NEONATAL SURVIVAL SERIES 2005)

• At 90% coverage, estimated potential to reduce neonatal mortality
• Neonatal resuscitation -- 6-42%
• Breast feeding------------------55-87%
• Prevention & management of Hypothermia--18-42%
• KMC (care of LBW in health facilities)
  Incidence of infections - 51% (7-75%)
• Community based pneumonia care - 27% (18-35%)
UPSCALING OF BREAST MILK FEEDING

• Breast feeding and KMC - very fundamental aspects of care of small and sick babies also.

• Usual advice and practices should continue. A few additional points for consideration.

• Team work including obstetrician, pediatrician, nurses, Midwives.

• All the concerned professional organizations should join together and work out a common minimum program of training and capacity building, public awareness and demand generation, vigilant monitoring, mentoring, quality data, training material in local languages and modified to suit the local culture and ethos without compromising on scientific content.

• In private practice the rates of BF and KMC are very low. Special attention is required.

• Sale of formulae and other items are being promoted without adequate justifications. That should be dissuaded.

• Feeding with expressed milk needs to be handled better.
KANGAROO MOTHER CARE
UPSCALING OF KMC

• Recognised as high in impact, but still very low in uptake and a lot of inequities and misconceptions.

• **Quality and coverage should improve**

• **Current coverage**— in SNCUs 42% (other data not available)

• **Definition not clear. Data likely to be in accurate.**

• Even to day ,most of the persons think it is only for preventing hypothermia. The comprehensive role with multiple benefits including neuro development is not appreciated. For many, it is still a poor man’s incubator.

• **Scope of KMC practice must be expanded**
IMPORTANT SCOPE FOR EXPANSION OF KMC IN INDIA

• Require priority attention and implementation

• Systematic guidelines to be disseminated for

• **Early skin to skin contact soon after birth** to be prolonged for at least one hour (early KMC)

• **Home based KMC** – Current data suggests facility based newborn care reaches only for about 50% of newborns including LBW and PT babies. Efforts made to reach others through home based newborn care

• **HBKMC needs to be included as a part of HBNC**

• **KMC during neonatal transport**

• Often life saving to many newborns in Resource Restricted Regions
TRAINING AND GUIDELINES FOR HBKMC

• **HBKMC should be given special attention** – much needed in India to cover almost 20 to 25% of LBWI who are left out currently due to several constraints.

• Our experience, research study and training programs have given very encouraging feedback

• **Evidence**: Our experience in Gujarat (since 2005) and study (2014-15) followed by studies by ICMR 2016 (Published in Indian Journal of Med. Research)

• Recent large published study in Haryana, India 2018-19 (The Lancet)

• HBKMC reduces mortality in newborns

• Govt of Maharashtra in 78 Tribal blocks 2019 Govt of Odisha – showing very encouraging results

• “Safe, feasible and acceptable to community-”

• Many benefits apart from prevention of hypothermia
SPECIAL EMPHASIS OF KMC PRACTICE

• All the babies get same benefits. But for each level of family groups, emphasis of priority may be different
• For resource poor low income families-
  • Can be even life saving intervention of newborns
• For middle income families-
  • Can be cost saving intervention of newborn care
• For higher income families –
  • Can be a brain saving intervention of newborn care
• Ref: Nathalie Charpak Kangaroo Foundation, Bogota, Colombia
HOME BASED KANGAROO MOTHER CARE (HBKMC)

• Required in following three groups in India

• Group I: Hosp. delivered – KMC started- Planned Early Discharge- continued KMC as HBKMC (Follow up element is very weak in India) (About 5 to 7%)

• Group II: Hosp. delivered – Random Early discharge- No KMC in hosp. HBKMC needed

• Currently this is the major group (almost 60 to 80%)

• (Day-1 – KMC initiated in 45% of admissions in SNCU

• Day 2- KMC continued only in 25% of admissions

• Day 3- KMC continued in less than 10% of cases (Mostly Random early discharge)

• Post natal care within 2 days in newborns 34% cases & Mothers- 37% cases
HBKMC IN INDIA

• Group III- Home delivered and had to be taken care only at home
• Many home deliveries still continue in tribal areas (6.8% population), Remote rural areas in RRR, and even Urban slums (34% of population)
• At times this may be the only available life saving intervention.
• Community Health Workers (CHWs) ASHA, AWW, ANM, others
• Can offer after proper training, guidelines and through regular frequent home visits as a part of HBNC
KMC DURING NEONATAL TRANSPORT IN INDIA

• Neonatal transport often life saving, more so in remote or difficult regions from where high risk newborn is being referred to higher centres for critical care.

• Type of care during transport and the distances – major determinants for the outcome

• Emergency ambulances and special ambulances with transport incubators and well organized transport care team for critical care of newborn - very few and almost not available in RRR.

• Transport of the baby in KMC offers many benefits apart from prevention of hypothermia (Reduces, apnea, regurgitation and stress of baby and mother, improves breast feeding and monitoring, prevents infection rate etc.)

• Transport in KP/KMC has to be systematically developed.

• Even where transport incubators are available, KMC appears much safer and useful. Multiple benefits apart from prevention of hypothermia
CAN YOU BELIEVE?

• Through HBKMC
• A newborn with birth weight of 600 grams has been saved and thriving well with the weight of 3800 grams after 72 days. Now 8 years old, normal development
• A set of twins with birth weight of 1200 and 1600 grams are thriving well.

(We brought several such babies to 9th International conference of KMC at Ahmedabad. And now in our list
• When no other alternatives are available, HBKMC is worth trying.
FURTHER SCOPE FOR KMC IN INDIA

• **For CS babies** where mother is not sick and help available

• A large number of babies covered. Systematic approach with the support of Obst, Anaesthetist, neonatal nurse and Birth companion

• **For sick babies** start intermittently and then continued

• Immediate KMC even in sick newborn (IKMC) and Mother in NICU (MNICU)

• **For promoting zero/non separation of mother and her baby**

• All possible opportunities - during investigations, therapeutic procedures and as pain relieving measure etc.

• Mother in SNCU – MNCU Already budget provided

• Mother in NICU (MNICU) mainly in tertiary care units and well developed SNCUs

• **EBM collection centres of Human milk banks** and others
OTHER ASPECTS OF ENBC

• Handwashing and infection prevention measures particularly important in COVID era

• Stopping harmful traditional practices with a lot of counselling and education
PHASES OF NEWBORN CARE

• Pre-conception and Ante natal care ***
• Care during labour and childbirth ***
• Immediate newborn care soon after birth ***
• Care of healthy newborn **
• Care of small and sick newborn **
• Care beyond newborn survival *

Obstetrician’s role:

*** crucial and essential
** often required
* desirable

• Leads newborn care
IMPORTANT ADDITIONAL RECOMMENDATIONS FOR DIFFERENT STAGES OF NEWBORN CARE

• **Pre conception and antenatal period** - Govt of Maharashtra introduced preconception care program modified to suit local needs from WHO recommendations
  - Deserves serious consideration for reducing pre term and LBW births
  - Includes improving nutrition, micronutrient supplementation
  - Treatment of anemia and deworming of women
  - Stopping use of tobacco, alcohol, drugs etc
  - Other measures such as increasing age of marriage, inter pregnancy interval, age of marriage and such measures
ANTENATAL CHECK UP

Do not forget counselling for mother’s readiness for early skin to skin contact of the baby soon after birth in all stable cases including term babies, and continue keeping the baby on mother’s chest for at least one hour and encourage early breast feeding as early as possible within one hour of birth

Explain about Several advantages:

I. Early physiological stability (Heart rate and respirations)
II. Early bonding and relieving stress for both mother and her baby
III. Stimulates early breast milk secretion and successful breast feeding
IV. Prevents hypothermia and even hypoglycemia in small babies
CARE OF THE NEWLY BORN BABY SOON AFTER BIRTH

• **Immediate skin to skin contact on** mother’s abdomen, thigh or chest even before cutting the cord if urgent resuscitation or life saving intervention not needed

• **Delayed cord cutting**, preferably physiological cord cutting after the cord pulsations stop

• **Quickly mop the baby dry** and shift to mother’s chest

• **Keep the baby on mother’s chest for at least one hour continuously.** Initiate breast feeding or EBM and other routines can continue

• Vit K can be given while the baby is on mothers chest. Identity tag also can be given there. Weight can be taken after one hour

• **Mother and baby transferred to post natal wards in KMC position**

• Even pre term babies benefit. **Do not separate the baby just for observation under warmer or incubator**

• **KMC can be started soon after birth to even mild to moderate sick babies**
CARE OF SMALL AND SICK BABIES

- Depending on weight and gestational age of the baby SNCU care/NICU care
- Immediate kangaroo care and feeding with breast milk either as direct feeding or as expressed milk as early as possible
- Close monitoring and supervision as per the guidelines of KMC and feeding of the LBWI
- Planned early discharge and regularly scheduled follow up should not be missed. This component is weak in India
- Routine follow up can be either at facility or during home visits of ASHA
- For ROP checking, Screening for hearing and neuro developmental assessment, facility visit is required
- KMC is the foundation for early child development and early multi-sensory stimulation for better neural development
ROLE OF PROFESSIONAL ORGANIZATIONS IN IMPROVING CARE OF SSNB

• All the concerned professional organizations (Paediatricians, neonatologists, Obstetricians, Nurses, Midwives, Community medicine, Breast feeding promotion, KMC Foundation and others) should join together and establish common minimum program of training and capacity building

• Public awareness and demand generation

• Vigilant monitoring

• Technical guidance and mentoring of SNCUs

• Help in generating quality data, QI exercises

• Help in producing training material in local languages and modified to suit the local culture without compromising on scientific content
SUMMARY OF WAY FORWARD FOR 2021
CARE OF SMALL AND SICK NEWBORNS

* Continue all the services and training programs with suitable modifications for COVID 19 precautions and if available vaccination of all the health care providers and family members
* Fill in the identified gaps in already continuing services in terms of infrastructure, manpower etc
* Special attention for increasing the quality and coverage of breast feeding and KMC at primary care level
SUMMARY

• **Improving the record and reporting of KMC** with proper definitions and regular review and actions. Improve the parameters of KMC in HMIS to capture the quality and coverage properly.

• **Include HBKMC as an important component in HBNC module** and introduce in community in a big scale. ASHA workers and other CHWs from resource restricted regions will have to be specially trained for the same (HBKMC in RRR - guidelines prepared by KMCF, India)

• **Introduce KMC transport** with systematic guidelines and training. This will also be on the agenda for the KMC foundation.
PLEA TO THE POLICY MAKERS AND FUNDING AGENCIES

• Increase the number of functional SNCUs to cover more regions
• In each district at least one functional tertiary care unit with life support system and one DEIC by 2021 and regionalization of perinatal care can be initiated.
• More funding to develop HBKMC program and KMC transport program
• More funds for community awareness programs, material and celebrations of International KMC awareness day, World Breast feeding week, International prematurity day and newborn care week
• Produce more training materials in local languages and culturally suitable
• Develop online training programs
• Increase use of digital technology and mobile apps for CHWs for HBKMC
• A few research projects including KMC in tertiary care units, KMC coverage in private practice and many others
NAMASTE

THANK YOU