

Brief Report

Progress in the Implementation of Kangaroo Mother Care in 10 Hospitals in Indonesia

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Summary

Kangaroo mother care (KMC) is an effective and safe method of caring for low-birthweight infants. This article describes the results of a health systems strengthening intervention in KMC involving 10 hospitals in Java, Indonesia. Implementation progress was measured with an instrument scoring hospitals out of 100. Hospital scores ranged from 28 to 85, with a mean score of 62.1. One hospital had not reached the level of 'evidence of practice'; five hospitals had reached the expected level of 'evidence of practice' and two hospitals already scored on the level of 'evidence of routine and integration'. The two training hospitals were on the border of 'evidence of sustainable practice'. The implementation of KMC is a long-term process that requires dedication and support for a number of years. Some items in the progress-monitoring tool could be used to set standards for KMC that hospitals must meet for accreditation purposes.

Key words: infant care, infant, premature, program evaluation, Indonesia, kangaroo mother care.

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Introduction

During the past two decades, kangaroo mother care (KMC) has become well accepted as an effective and safe method of caring for preterm and low-birthweight infants who would traditionally have received incubator and/or crib care [1–5]. The kangaroo method was introduced in Indonesia in the 1990s and has since gained recognition. Training in KMC is continuously done to assist hospitals wishing to implement the practice. Recently, the importance of KMC in low- and middle-income countries has been highlighted as a contributing factor to the achievement of the Millennium Development Goal4 [4, 6] that targets a reduction by two-thirds of under-five mortality rates between 1990 and 2015 [7].

In 2010, an intervention to scale up KMC to more hospitals was conducted in Java by the Indonesian Society for Perinatology (Perinasia). The aim was to

introduce KMC where it was not practiced and to strengthen the practices in those hospitals already implementing KMC. Ten hospitals participated, with two central hospitals serving as training centers for the remaining eight hospitals. In addition to the two teaching hospitals, two regional and four district hospitals, as well as one maternity and one mother and child hospital participated in the intervention. Ownership of hospitals varied and included two central hospitals under the Ministry of Health, three under provincial governments, four under district governments and one belonging to a foundation.

The intervention consisted of four phases covering a period of 5 months:

- (i) a baseline assessment that was meant to get a sense of the newborn care facilities available in each of the 10 participating hospitals;
- (ii) 5-day training workshops attended by four members of each hospital;
- (iii) two supervisory visits to each hospital by a team from Perinasia; and
- (iv) an end-line assessment that included a visit to each of the 10 hospitals.

This report summarizes some of the results regarding the progress with KMC implementation in the 10 participating hospitals at the end of the intervention.

Methods

A previously validated instrument developed and applied in South Africa [8–10] was adapted to measure progress with implementation. Data were collected under 18 headings (Table 1). Certain items in the instrument contributed to the progress score of a hospital. The scoring is based on a stages of change model with three phases of change or progress, each comprising two stages (Fig. 1) [8]. It starts with pre-implementation activities such as sensitization, training and the adoption of the KMC concept. The implementation phase includes the mobilization of resources and the first evidence of KMC practice. This is followed by the institutionalization of KMC as is demonstrated by integrated and routine practice of KMC and sustainable practice. Within ~6–8 months after an intervention, it is expected that health care facilities should at least be able to demonstrate evidence of KMC practice (Stage 4).

For each of the six stages, a score is allocated. The maximum score is 100. This is an adaptation of the score of 30 that appeared in the original model [8], with a slightly different weighting of the different stages to take the context of implementation into account. Table 2 gives an overview of the scoring per implementation stage, with a comparison in relation to the original scoring model.

TABLE 1
Information collected in the end-line assessment

1. Health care facility (basic information)
2. Neonatal and KMC (types of care and facilities available)
3. Skin-to-skin practices (types of KMC practiced— intermittent and continuous)
4. History of KMC implementation
5. Involvement of different role-players
6. Resources (for the implementation of KMC)
7. KMC space: continuous KMC (probing the ability to provide services for continuous KMC)
8. Neonatal unit or nursery: intermittent KMC (verification of current practice)
9. Feeding and weight monitoring
10. Records in use for KMC information
11. KMC education (health promotion for mothers and families)
12. Documents (analysis of available documentation pertaining to KMC, e.g. vision and mission statements, standard operating procedures, medical records)
13. Referrals, discharge and follow-up (probing for the existence of a sound system)
14. Staff orientation and training
15. Staff rotations
16. Strengths and challenges (qualitative observations)
17. General observations and impressions (qualitative observations)

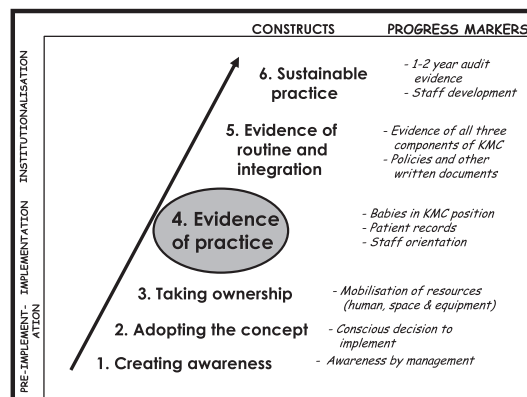


FIG. 1. Model for KMC progress monitoring.

Results and Discussion

The results of the progress monitoring are graphically depicted in Fig. 2. Hospital scores ranged from 28.0 to 84.5 out of a possible 100 points. The mean score was 62.1 and the median 61.9.

TABLE 2
Progress scoring

Stages and phases	Project scoring		Published scoring ^[8]	
	Points per stage	Cumulative points	Points (%) per stage	Cumulative points (%)
Pre-implementation phase				
Stage 1: Creating awareness	12	12	2 (7)	2 (7)
Stage 2: Adopting the concept	8	20	2 (7)	4 (13)
Implementation phase				
Stage 3: Taking ownership	25	45	6 (20)	10 (33)
Stage 4: Evidence of practice	20	65	7 (23)	17 (57)
Institutionalization phase				
Stage 5: Evidence of routine and integration	20	85	7 (23)	24 (80)
Stage 6: Sustainable practice	15	100	6 (20)	30 (100)
Total		100 points		30 points

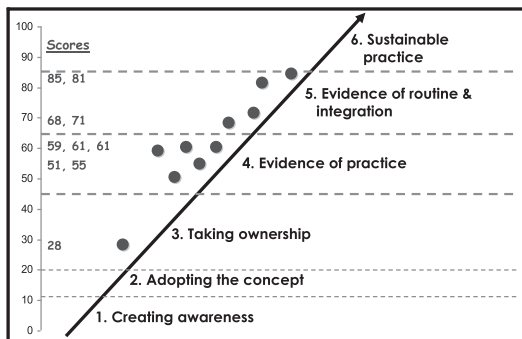


FIG. 2. KMC implementation progress in the ten hospitals.

One hospital had not reached the level of ‘evidence of practice’ and was still at the level of ‘taking ownership’ (Stage 3). It did not have a decree signed by the director, nor had it developed standard operating procedures for KMC. KMC data could only be provided for three infants in the first month of the project.

Five hospitals scored at the expected level of ‘evidence of practice’ (Stage 4). The maternity hospital and one district hospital exceeded the expectation by already scoring on the level of ‘evidence of routine and integration’ (Stage 5). One of these had been practicing intermittent KMC since 2007 and was now able to expand to include rooming-in facilities where continuous KMC could be practiced. The other hospital is reported to have a hospital director who is keenly interested in KMC and demonstrates exceptional leadership.

The two training hospitals in this project were on the upper end of the level ‘evidence of routine and integration’ (Stage 5) and the bottom level of

‘evidence of sustainable practice’ (Stage 6). They had been prepared and supported to serve as training centers for other hospitals since 2008, which explains why they had better implementation scores.

Institutional arrangements that could potentially facilitate or hamper KMC relate to the preparation for KMC implementation by formally deciding to introduce KMC and by getting a formal commitment from the hospital director, for example, by means of a decree or some form of written commitment. [9, 10] Some hospitals that had been implementing KMC for a while already had a decree in place by the time the intervention started.

Conclusion

The implementation of KMC is a long-term process that requires dedication and support for a number of years. Many aspects of KMC needing further strengthening were identified in the eight hospitals recruited to attend training at the two training centers. Before considering large-scale KMC implementation programs, it is important to first strengthen practices at the existing hospitals with KMC. Although hospital directors were generally supportive of KMC, it is very challenging where this support is absent. Building networks cutting across the working areas of health authorities, especially for postnatal care, has also been identified as a priority action area.

Repeating the progress-monitoring exercise every year or two until KMC is totally integrated into the neonatal care philosophy and practice may provide encouragement, motivation and the support needed to keep the momentum going. Some of the items in the progress-monitoring tool could also be used to set standards for KMC that hospitals must meet in order to get accreditation for their neonatal services.

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