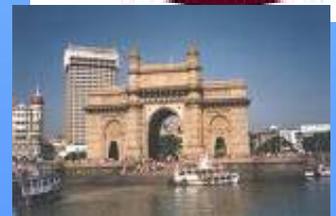
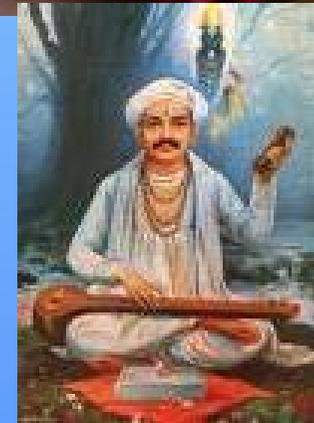
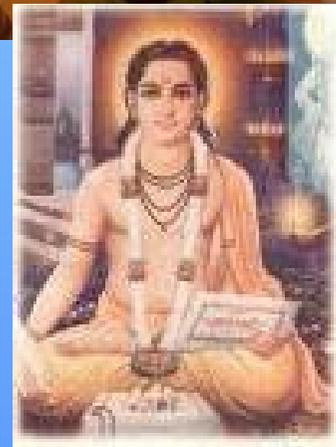
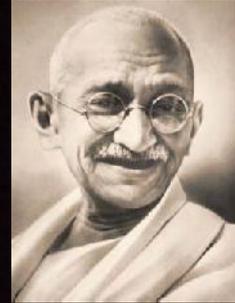
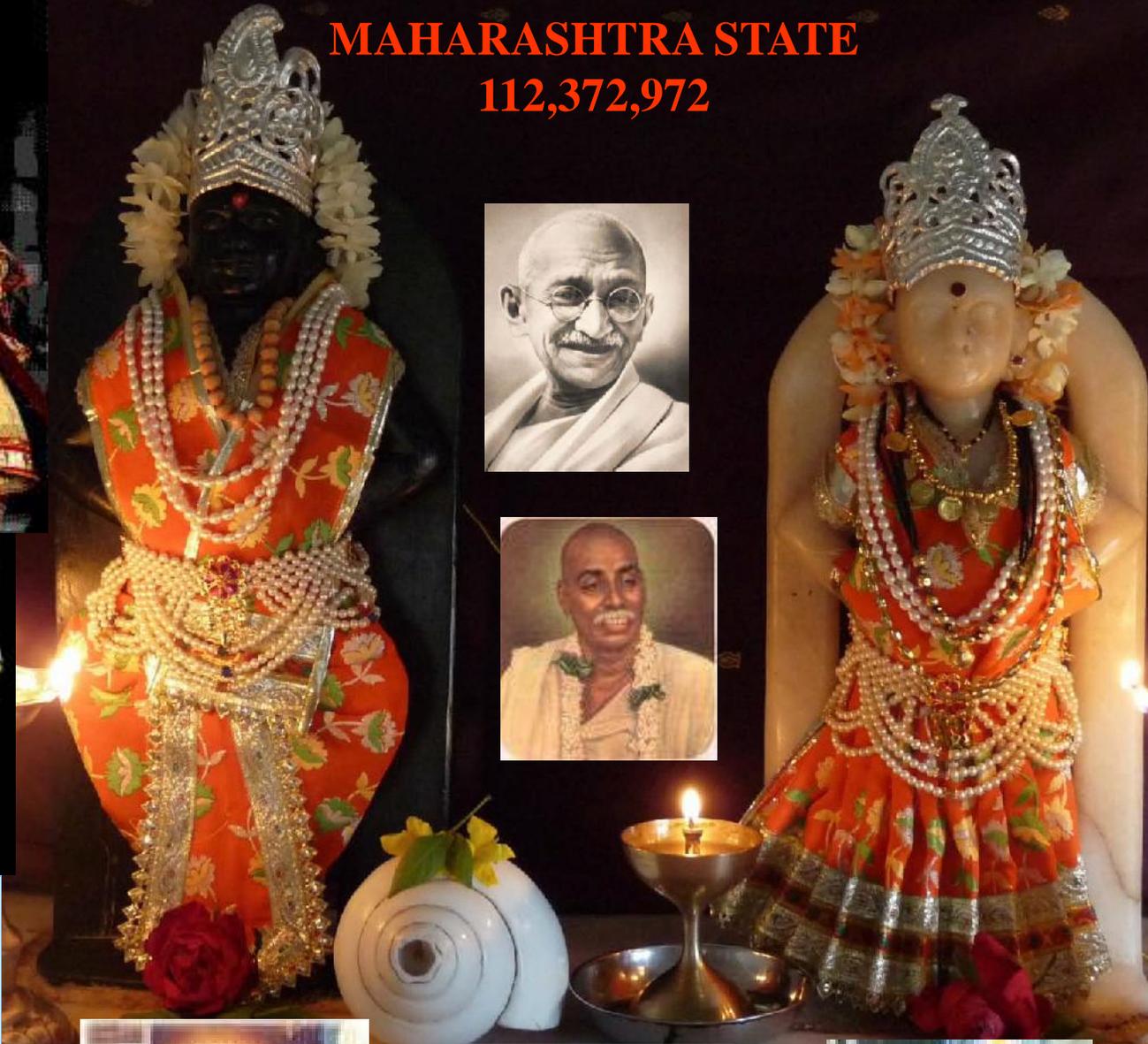


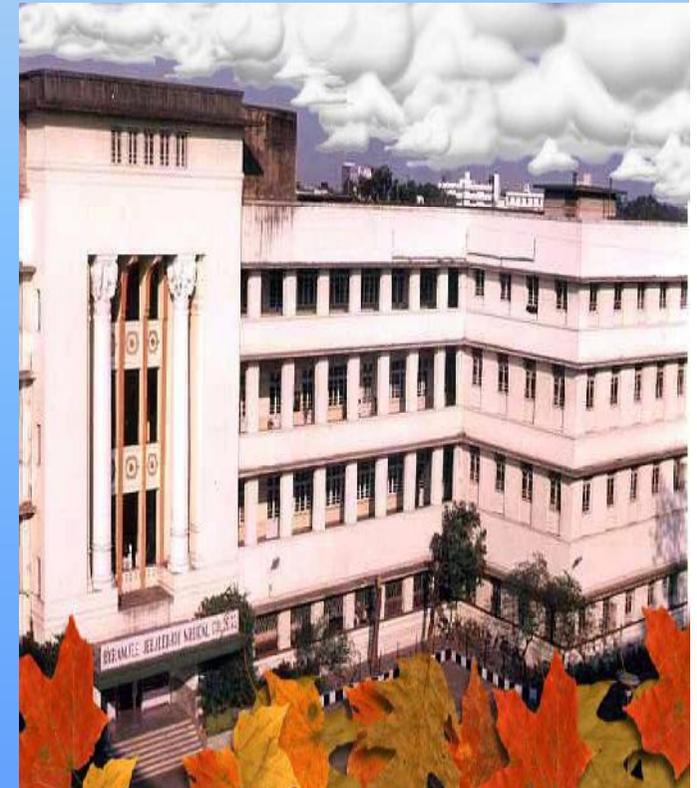
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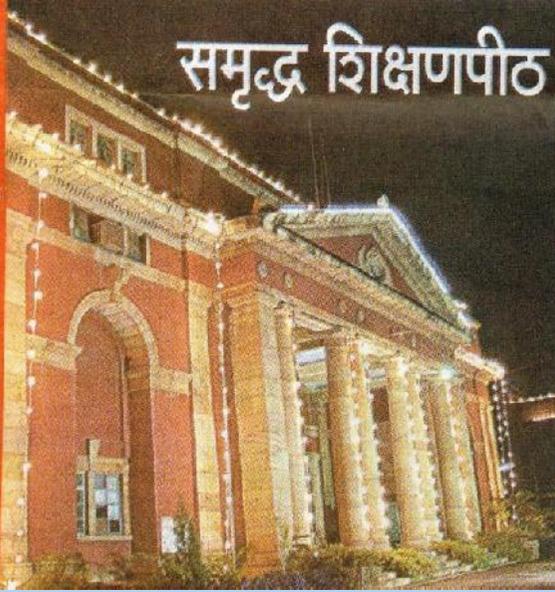
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OBSTACLES AND RECOMMENDATIONS FOR ADAPTATION OF ART AND SCIENCE OF KANGAROO MOTHER CARE PRACTICES AT RESOURCE LIMITED CENTER IN MAHARASHTRA.

DR.SANDHYA KHADSE
PROFESSOR AND HEAD
DEPARTMENT OF PAEDIATRICS
BJMC AND SASSOON GENERAL
HOSPITAL
PUNE





CREDENTIALS.....

- ***SIX GOLD MEDALS*** IN UNIVERSITY EXAMINATIONS.
- James Flett Endowment Award. (1995).
- Bibi Sunder Kaur IAP Fellowship. (1996)
- First Prize for Best Poster PEDICON (1997)
- Gold Medal for Best Paper presentation ASCODD 2001.
- Patented Pediatrician Award MahaPedicon 2003.
- FIAP Award – Outstanding Contribution in Paediatrics. (2005)
- Best paper Award at MAHAPEDICON 2006 Solapur.

CREDENTIALS.....CONTINUED.....

- ❖ Chief Officer Child Health Monitoring Committee, Maharashtra State.
- ❖ Delivered around 150 guest lectures in various National & International Conferences .
- ❖ 50 publications in various National & International journals .
- ❖ Visiting professor at John Hopkins School of medicine.
- ❖ Nutrition Expert & Board of study member at Footprints Academy Preschool daycare Center at Florida USA.
- ❖ Academy advisor to the U.S. Fulbright programme & resource person for United States India Educational Foundation. (USIEF)
- ❖ Executive Committee member of CANCL Group & IACP.
- ❖ Technical Expert for Human Milk Bank Project.

INTRODUCTION

- ❖ Low birth weight is a major public health incident in India.
- ❖ Of the estimated 10 million live births in India each year, 10% are Low Birth Weight (LBW).
- ❖ If we wish to reduce the Infant Mortality Rate (IMR), it is necessary to reduce the incidence of LBW and morbidity.
- ❖ Unfortunately, the problem of LBW is closely linked to the health status of women during her pregnancy and child birth.



30% to 40%

of infants, preterm infants constitute 20%.

The infant mortality rate is a measure of fetal mortality and neonatal mortality rate (NMR).

Due to the high mortality rate of babies is a major public health problem. Babies who are received in the neonatal intensive care unit (NICU) and

• *Kangaroo mother care is a special low cost comprehensive method of caring of LBW babies. It fosters their health and well being by promoting effective thermal control, breast feeding, infection prevention and bonding.*



- The two important components of KMC are
 - skin to skin Contact
 - exclusive breast feeding.
- The pre requisite of KMC is support to mother in hospital, at home and post discharge follow up.

❖ Apart from the benefit of the breast feeding, thermal control, early discharge, good weight gain, less morbidity are present.

❖ Mothers are less stressed, they report a stronger bonding with the baby, increased confidence and deep satisfaction.

❖ Father too feels more relaxed, comfortable and better bonding.

❖ The child internalizes and assimilates this and it becomes the corner stone for his overall growth





KMC



It is utmost important to educate the health care personnel involved with maternal and child care in the art and science of kangaroo mother care.



However to give this best start of life to LBW babies with a humane touch at the resource limited health care facility lot of difficulties are faced.



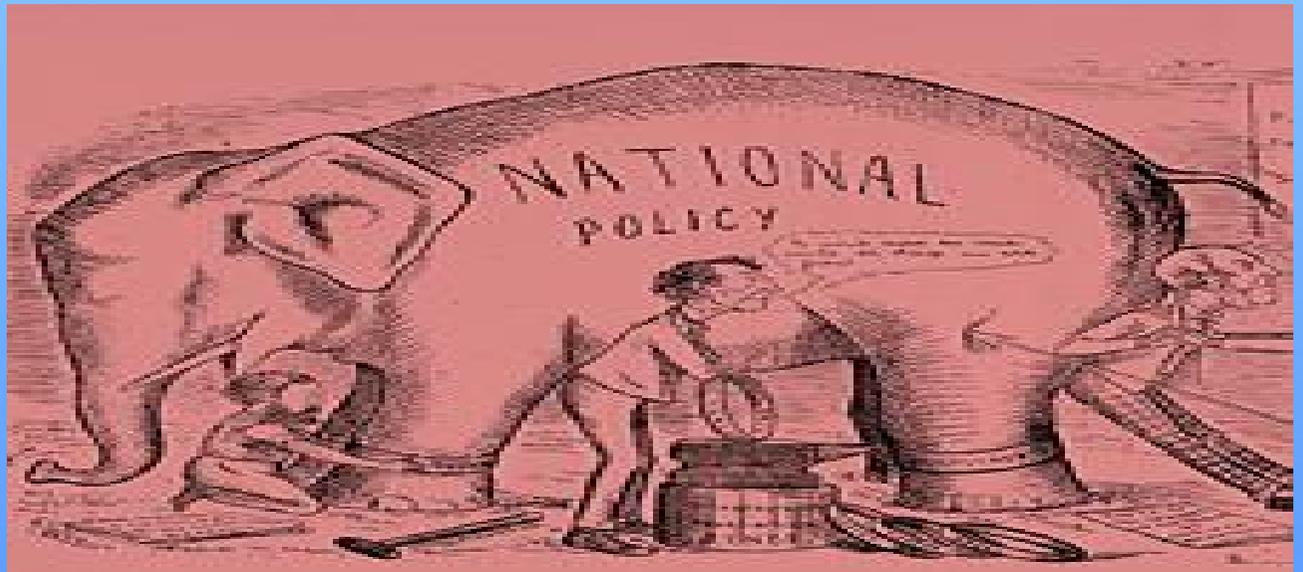
Even though a unanimous agreement has been reached on the need for global support for kangaroo Mother care- a strategy for child survival, by health experts, head of the state, nongovernmental organizations (NGOs) and WHO, still while adopting and practicing KMC by considerable number of institutions, several loop holes have been identified.

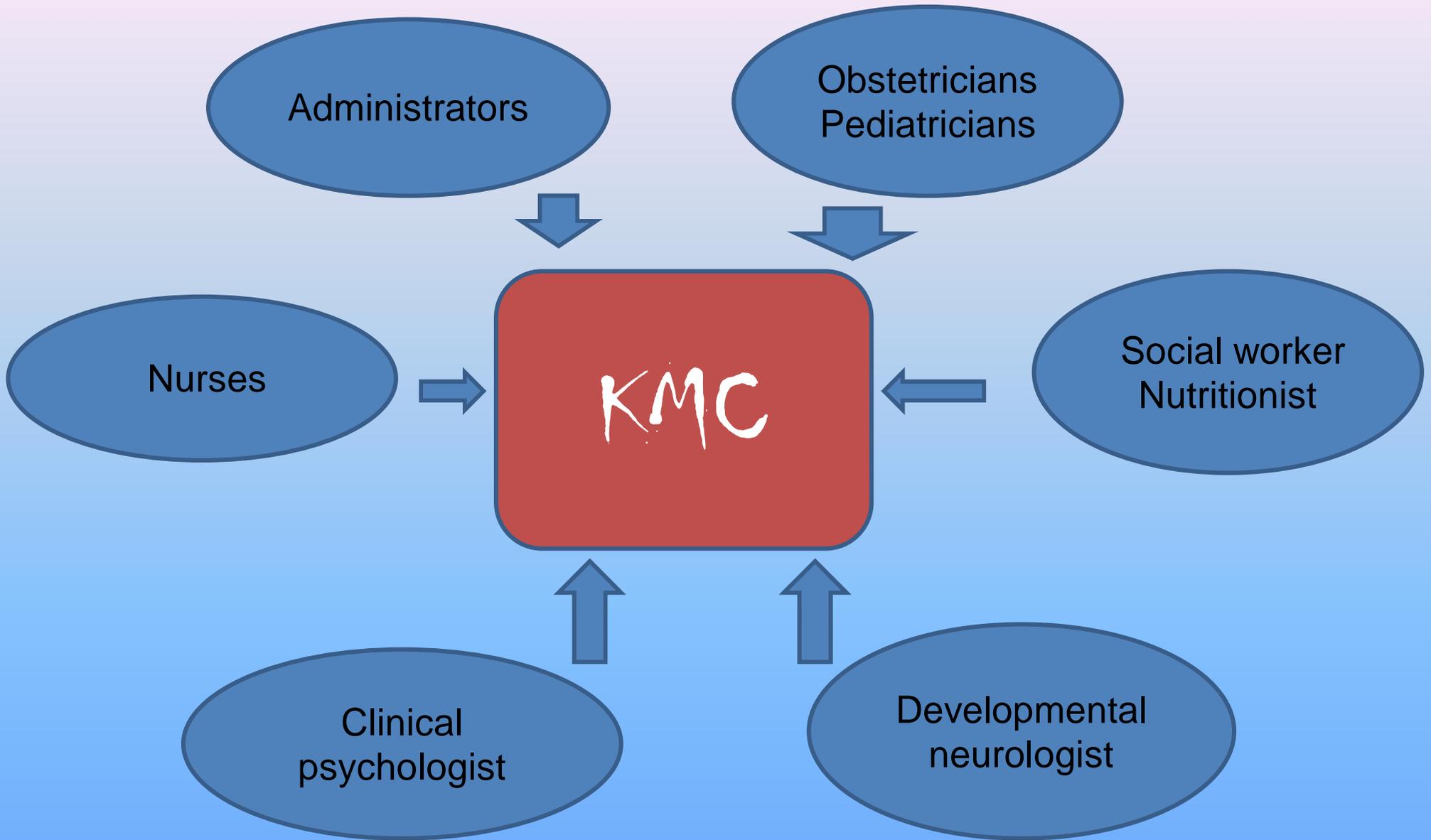


There is an urgent need to recognize the problem encountered and find out amicable solution in the best interest of mother and baby.

Policy matter:-

- ❖ No National policy available for KMC.
- ❖ Lack of plans.
- ❖ Lack of institutional/professional/academic support.
- ❖ Absolute lack of political will and administrative support.
- ❖ Lack of provision in the annual Program Implementation Plan (PIP) of NRHM and public health
- ❖ Lack of co-ordination between the ministry of public Health, medical education and research and ministry of women and child, regarding implementation





Lack of co-ordination

Training:-

- ❖ Lack of adequate training and continuous education for all cadres of health care professional.
- ❖ Lack of isolated and vertical program on training.
- ❖ No assistance by the health care system.
- ❖ No allocated funds and budgets for the training.



Extensive Training, motivation, commitment...



Monitoring:-

- ❖ Lack of standard for monitoring and evaluation of the results of KMC practices.
- ❖ Non availability of authenticated quality assured monitoring and supervision team.
- ❖ Lack of appointment of isolated and designated health care professional as a program manager to evaluate the KMC care practices.



Man power:-

❖ Lack of trained staff in NICU, PNC wards, Immunization and follow up clinics.

❖ Lack of Clinical psychologist, pediatric counselor, social worker, developmental interventionist in various government institutes.

❖ In spite of vacancy and provision as per MCI, still the post of clinical psychologist and social worker is vacant in most of the medical colleges.



Problems in implementation:-

- ❖ Poor access to information.
- ❖ Poor facilities, equipment, supplies and organizations.
- ❖ Lack of time, space and funds.
- ❖ Lack of trained staff as training for KMC till date is optional and not compulsory.
- ❖ Lack of provision for sleeping and resting during KMC for mothers in NICU.
- ❖ Non availability of culturally acceptable, privacy standard in the nursery and post neonatal care ward for practicing KMC.



- ❖ The lack of flexibility in the policy of NICU on restricted entry of male care givers and poor administrative will and support to change the policy.
- ❖ Lack of confidence amongst the staff to initiate KMC on oxygen dependent babies and babies on IV fluids.
- ❖ Lack of provision of the environment with a mother friendly ambience for successful implementation of KMC.



Communication:-

- ❖ Mother and families totally unaware of KMC.
- ❖ KMC practice is totally untouched and uncovered area in the antenatal clinic.
- ❖ Lack of time and patience amongst the staff to offer counselling, due to overcrowding in NICU.
- ❖ Poor follow up of the patient.



Cultural issues:-

- ❖ Misguided beliefs and attitude which are difficult to change.
- ❖ **Skepticism and ignorance**, resistance of the mother and family for maintenance of basic standard of hygiene and hand washing, daily bath, clean clothes and suitable dress code of KMC.
- ❖ Cultural resistance for removing bangles, rings, chains, threads etc.
- ❖ Maternal fear of suffocation, baby's fall and fear of not providing enough milk.
- ❖ Inability to understand the thermal synchrony of KMC and apnea and withdrawal from KMC on slight temperature fluctuation or respiratory problem.



RECOMMENDATIONS:



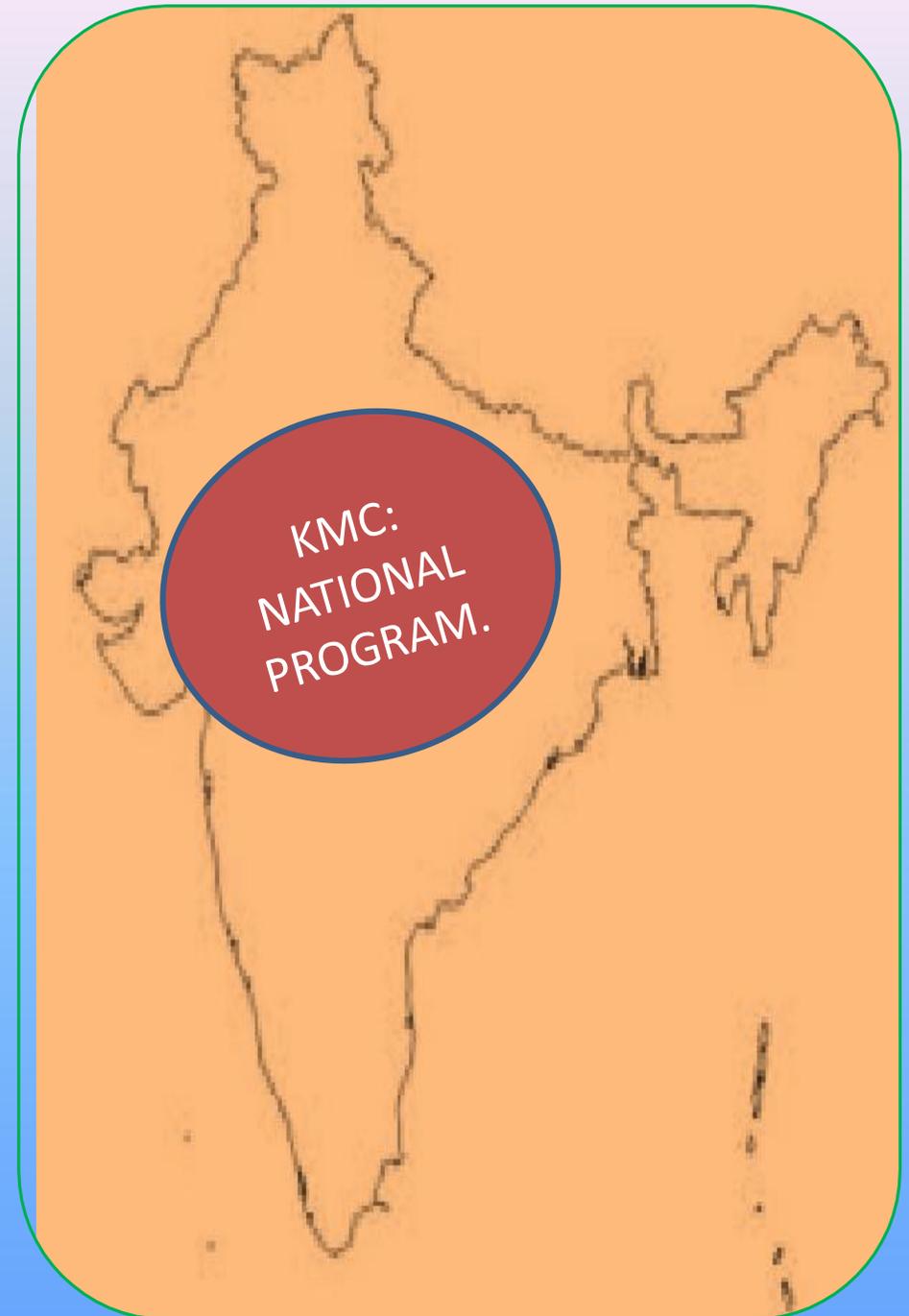
- ❖ A national policy to follow **ten steps** towards successful KMC.
- ❖ Compulsory **training and refresher course** in skills necessary to implement these policy programs on KMC for all basic health care providers.
- ❖ Compulsory rule for all the facilities providing maternal and child care facility to get accredited for KMC practices and display a certificate with periodical renewal like baby friendly hospital.
- ❖ **Strategic action plan** with quality assured monitoring tools for implementation of KMC in all health care facility.
- ❖ **Stringent policy of reward and punishment** with a note in annual confidential report of permanent government employees for adherence and non adherence to KMC practice.



❖ A **separate budget plan** for providing all necessary equipment and infrastructure for implementation of KMC, as it is one of the most effective baby mother friendly care.

❖ To **allocate a separate budgetary provision for periodical training and certification of health care providers** with lot of emphasis and stress on the quality of training.

❖ To make KMC **as National program for targeted intervention** to reduce the infant mortality rate and give it a top priority.



❖ To have a **separate cadre of support staff** exclusively and only for implementing nutrition and KMC care through national rural health mission with a provision of performance based incentive for successful implementation.

❖ To make KMC **a separate chapter in the curriculum** of undergraduates and post graduates in pediatrics, preventive & social medicine and in obstetrics and gynecology with special marks allocated in theory and practical examination.

❖ **Wide publicity** through media, brand ambassador for mass awareness campaign.

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ENCOURAGE PRACTISING KMC ALL
AROUND.....



THANK YOU

