**KMC Workshop Italy 2016**

**Population Information¹·²**

Population: 55.6M (2016)

* Female: Male is 51% to 49%
* Youth: 36%
* Formal Housing: 79.2%
* Access to water: 83.5%

|  |  |  |
| --- | --- | --- |
| **Province** | **Population No. (Million)** | |
|  | 2011 | 2016 |
| Gauteng (GAU) | 12.3 | 13.4 |
| Kwazulu-Natal (KZN) | 10.3 | 11.1 |
| Eastern Cape (EC) | 6.6 | 7.0 |
| Western Cape (WC) | 5.8 | 6.3 |
| Limpopo (LIM) | 5.4 | 5.8 |
| Mpumalanga (MPU) | 4.03 | 4.3 |
| North West (NW) | 3.5 | 3.7 |
| Free State (FS) | 2.7 | 2.8 |
| Northern Cape (NC) | 1.1 | 1.2 |

**Total Births:**

Comparison of Births in the DHIS and PPIP (2012=2013)³

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | EC | FS | GAU | KZN | LIM | MPU | NW | NC | WC | SA |
| 500-999g | 1415 | 1344 | 3848 | 2739 | 1778 | 1437 | 1263 | 711 | 3207 | 17742 |
| 1000-1.499g | 2429 | 1912 | 5228 | 3547 | 2949 | 2451 | 1926 | 912 | 3779 | 25133 |
| 1.500-1.999g | 4381 | 3229 | 8801 | 5805 | 5449 | 4151 | 3218 | 1763 | 6912 | 43709 |
| 2.000-2.499g | 12637 | 7635 | 25460 | 16193 | 15818 | 12618 | 9931 | 4409 | 18453 | 123154 |
| 2.500g+ | 121509 | 75443 | 247319 | 176376 | 181835 | 135809 | 93009 | 30128 | 149198 | 1210626 |
| PPIP Total  DHIS Total | 142371  234841 | 89563  94139 | 290656  415840 | 204660  381262 | 207829  254249 | 156466  153206 | 109347  115828 | 37923  43093 | 181549  185821 | 1420364  1878279 |
| Difference | 92470 | 4576 | 125184 | 176602 | 46420 | -3260 | 6481 | 5170 | 4272 | 457915 |
| % missing from PPIP | 39.4 | 4.9 | 30.1 | 46.3 | 18.3 | -2.1 | 5.6 | 12.0 | 2.3 | 24.4 |

Percentage Low Birth Weight: 15%

**Health Facilities Available³**

Tertiary Hospitals: 22

Regional Hospitals: 42

District Hospitals: 188

**Percentage of LBW:** 15%

**Neonatal Deaths:** 34% Prematurity

**Access to a facility with Kangaroo Mother Care:**

There is no national survey on Kangaroo Mother Care (will keep on checking asking- might have more information later but highly unlikely) in South Africa. There is no documentation on what percentage of babies have access to KMC. We have 9 provinces in the country and there documented pockets of access to KMC in less than half of those provinces. Pockets of KMC practice occur mainly in Gauteng, Limpopo, Kwazulu Natal, Free State, Eastern and Western Cape. Government needs to have a very strong stance on supporting and funding KMC as well as assist in scaling it up throughout the country.

National Perinatal Mortality and Morbidity Committee (NaPeMMCo) has made recommendations as to what interventions are need to reduce mortality related to prematurity by 2020. Some of the recommendations are shown below and KMC is strongly suggested.

**High-impact interventions to reduce neonatal mortality suggested by NaPeMMCo⁵**

**RECOMMENDATIONS INTERVENTIONS**

**1**. Ensure that corticosteroids are given to every woman in preterm labour

2. Ensure antibiotics are given with preterm premature rupture of membranes

3. Ensure the appropriate hospitals are skilled in the used of nasal continuous positive airway pressure

4**. Ensure that all mothers of immature infants have easy access to Kangaroo Mother Care**

1. <http://www.statssa.gov.za/?page_id=964>
2. <http://cs2016.statssa.gov.za/>
3. <http://www.ppip.co.za/wp-content/uploads/Saving-Babies-2012-2013.pdf>
4. <http://www.who.int/maternal_child_adolescent/epidemiology/profiles/neonatal_child/zaf.pdf>
5. <http://www.statssa.gov.za/MDG/MDG_Goal4_report_2015_.pdf>

**Kangaroo Mother Care Enhancers and Barriers**

1. **Infant, Mother and those surrounding them**
2. **Mother Infant Dyad**

**Enhancers:**

1. Support for the mother is very crucial. Knowing more about the mother and all the psychosocial issues they have to face is very important. Having an interview with the mother within the first few days of admission into the KMC unit are important. That way you are able to individualise the needs of that mother. The mother is also comforted because they feel you care. Having done that, also make you more approachable and those mothers are able to come to you for advice. They also open up to tell you more than they would have otherwise.
2. Young Mothers (especially Teenage Mothers)

Teenage mothers have different kind of stressors and that needs to be taken into account. Some of them still need to be in school and they even need to be supported through this. The environment and clothes that young mothers use to practice KMC can be enhancers or barriers. I find that if they look funky in their clothes and feel that they are being heard, they are more encouraged to do KMC. They should be in those dreary hospital clothes where possible, not forgetting to practise hygienic methods.

In this group of mothers it is important to involve the rest of the family early, especially grandmothers. If you get a buy-in from the grandmother you have already won by far. Involving a grandmothers whether maternal or paternal helps even in mothers that are not so young.

1. Breastfeeding: supporting the mothers with breastfeeding is very, very important. We therefore people that have been trained in lactation management. Ideally it would be nice for every staff member to be trained in lactation management. What was really enhancing in our unit was that even that everybody, even, the cleaners and ward attendants would pick up if a mother is struggling with breast and they would alert the nursing staff.
2. The Kangaroo Mother Care Unit Team;

First of all you need a champion in the form of a nurse. Someone who feels passionate about it and a person who is willing to take it forward no matter what it takes. This person needs to have leadership skills

It is important that every person that works in the KMC Unit knows about the Kangaroo Care Method and how it can be applied. We found that if we teach or involve all the members of the team about it, irrespective of whether they are messengers or even cleaners in the ward, they tend to informally support the mothers and spread to their own families and communities.

Send the team conferences, workshops and all important meetings because they will help them take ownership of the programme.

1. Comfortable and friendly surroundings: try to make those surroundings during their stay in the unit as comfortable as much as you can. If you can afford comfortable furniture and other amenities do so.
2. Follow-up; following up those mothers with their infants gives even more confidence. They gain confidence in the team and be accessible to them after discharge or between visits. We always encouraged mothers who have had a good outcome to come and encourage the mothers who are still in the unit. They listen better and understand a person who have gone through the same journey.
3. **Family**
4. Involving the rest of the family early is very important. In cases where the mother does not have family, find ways to support her in that regard. There are two main family members that enhanced KMC practice both in the unit after discharge; the father of the infant and a grandmother. Those two individuals played a very crucial role.
5. Grandmother

This is where the success of our unit was. We engaged the grandmother in what we intended to do in the unit and after discharge and also listened and answered their questions where needed. We did not try to take their power away but we worked with them.

1. Father/Partner

Allowing fathers to carry their infants on their chest and do KMC during hospital visits even in a traditional African setting was very useful. It not enhanced the bond between the infant and the infant but it also increased the bond the mother and the father. It even reversed the negative decisions that some partners had decided like abandoning the mother and the infant.

In our unit we found that those fathers that practised KMC in the hospital were more likely to come to every follow-up visit and be actively involved in raising their child.

In regards to HIV positive mothers, it was easy to encourage and help them disclose to the partner at follow-up. There was less violence and more support in cases where there was discordance.

1. **Community**

Make the communities where the mothers come from understand and buy into KMC practice. It may be difficult if you are in a setting where they are referred from other areas but do certainly try to reach those communities somehow. Encourages those mothers to preach KMC to their communities when they get back.

Some of our mothers would even educate commuters that they are with, in a taxi, for instance. Be passionate about it as staff and practise it in the communities you live in as well.

1. **Transport**

It would be ideal if those mothers/families have access to transport to visit their loved once.

1. **Institution**
2. Having an appropriate facility in the institution that is used for KMC
3. Support from administrative staff in higher position, for a example a CEO (Chief Executive Officer). It was very useful for us when we had a CEO that believed in support KMC. He was involved in raising funds for the unit and exposing the unit to every potential donor. When he was transferred that fell apart because his successor did not necessarily have the same aspirations.
4. **Government**

Policies from government that endorses KMC and make it a standard of care for every health facility are paramount.

1. **Higher Education Curriculum**

Making KMC part of the curriculum in health sciences is essential.

**Barriers;**

1. **Mother**
2. **Fatigue**
3. **Illness**
4. **Age and/or multiparous mothers**

**I have already something about teenagers. The multiparous mothers on the other hand will tell you that they have raised many children already and they have nothing to learn from anybody.**

1. **Staff**

Staff that is not empowered to carry out all that is needed.

1. **Fear**

Fear that the infants might be hurt in process but this dissipates after more training and engagement

1. **Lack of support**

Lack of support from the senior executives in the institutions and government is a huge barrier. As soon as those that were passionate about KMC leave or retire, things fall apart or what worked well disintegrates.

1. **Lack of rooming-in facilities for mothers**

**What does it take to implement kangaroo mother care?**

**Part of feedback to plenary by Anne-Marie Bergh**

**Group discussion, SA KMC Conference, 18-20 November 2015, Cape St Francis, Eastern Cape, South Africa**

**Key messages for KMC implementation**

* **KMC awareness – health workers, management, patients, wider community**
* **Mandate for implementation – policies and buy-in**
* **Business plan and budget**
* **Minimal standards according to level of care**
* **Staffing norms**
* **Initial training of key staff**
* **Multidisciplinary team strengthens KMC practices**
* **Staff empowerment through continuous, in-service training**
* **Champions/drivers of KMC for sustainability**
* **Standardized practice**
* **Involving mothers’ significant others to prevent separation – parent preparation**
* **Communications skills for health workers → be less authoritarian with mothers**
* **Non-rotation of staff**
* **Continuous evaluation to improve quality of KMC**

Dear Mantoa

Thanks for the feedback. I hope it is okay if I make a few additional comments for consideration.

KMC is now a priority area of government and the district clinical specialist teams (DCSTs) are tasked with overseeing its implementation and strengthening in all public hospitals (since 2012), especially the paediatrician-paediatric nurse pairs. The “Newborn Care Charts” for the care of all newborns in district hospitals, CHCs and MOUs include guidelines for the management of the sick and small newborn in hospital (also KMC) and was the basis for the training of the DCSTs and other health workers in the provinces. The skin-to-skin component is also included in emergency obstetrics trainings. The challenge is that not all 52 teams are functioning optimally in the 52 districts and in some districts not all of the posts are filled. Where a DCST is incomplete, other members like the obstetrics team (obstetrician-midwife pair) and the primary health care team (family physician-PHC nurse) have to take on some of the tasks.

In my view there are pockets of access to KMC in all provinces (in some provinces in most hospitals, e.g. Gauteng and Western Cape). We have the least information on the Eastern Cape.

• In the Northern Cape there is a strong KMC outreach from Kimberley, although they have difficulties with the vast distances between hospitals.

• Mpumalanga has long-standing KMC programmes in hospitals like Themba (since 2006) and Witbank (since 1999) and there are also special KMC rooms in quite a number of district hospitals. Our medical students rotate in Mpumalanga hospitals and we get feedback from them. They sometimes do their quality improvement projects in KMC. When I visited Delmas hospital a few years ago for another reason, I noticed that they had a new KMC room and there were mothers with babies in the KMC position.

• Our survey in North West Province last year indicated that more than 80% of hospitals had the ability to provide intermittent and/or continuous KMC services (e.g. some form of space and other amenities).

• I don’t have information on all the provinces, but I am aware that some provinces also require the recording of the number of babies going through KMC in their hospitals (e.g. Limpopo and North West). Limpopo and KZN also have KMC checklists that are completed by the DCSTs. What is being done with that information to improve KMC services will probably vary between districts and provinces.

Having the ability to provide services does not actually mean the services are provided in reality to the full extent expected and that is where I think the challenge lies. That should be complemented by questions like: What is the uptake of the KMC services and why? What is the quality of KMC services and practice?

• District hospitals often refer babies <1500g to the regional or tertiary hospitals and staff do not get sufficient regular experience to keep up their skills in the management of small newborns (including KMC).

• The quality of KMC services and practice as part of the overall management of small and sick newborns, is something that has not been interrogated extensively everywhere. This is also part of the mandate of the DCSTs.

• If it is not evident from the record keeping that KMC is practised then the status of KMC practice is very difficult to track. Even if there is a room where mothers and babies stay together for continuous KMC, adherence needs to be constantly monitored.

• Reasons for not providing the services, even if the facilities are available, are varied – professional resistance or lack of commitment (or sometimes fear); poor leadership in and/or management of the neonatal / paediatrics department (including lack of support and guidance from seniors); separation of in-borns and out-borns (BBAs) (which necessitates KMC provision in two separate places in the same hospital – often by different staff). (I tend not to buy the “staff shortages” reason, as we have seen places with dire shortages doing an excellent job with KMC and others with sufficient staff who could not get their act together.)

A few thoughts on enablers:

• I think one of the biggest enablers for the current uptake of KMC where it has not been implemented before and the strengthening or revitalisation where KMC has been practised before is the political will of our Minister of Health. The institution of the DCSTs to reduce maternal and neonatal mortality is one example – plus the documents where KMC is included like the Tshwane Declaration and CARMMA (mentioned in the Feucht article).

• High awareness of the importance of KMC produced over many years:

- Already a recommendation in the 2000 Saving Babies Report (<http://www.hst.org.za/uploads/files/saving_babies.pdf>)

- The provincial scale-up KMC outreaches in KZN, Mpumalanga and Gauteng in the years 2002-2007 (2 articles reported on these) (one attached; other's URL: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2504003/pdf/1478-4491-6-13.pdf>)

- Long-term sensitisation of health professionals with the many reports on KMC presented at the annual Priorities in Perinatal Care conferences; in some years there were even special sessions on KMC - the multiprofessionality of this group also contributed to the consolidation of the positive sentiments towards KMC (obstetricians, paediatricians, midwives, neonatal nurses) (proceedings at <https://www.perinatalpriorities.co.za/proceedings-database/>)

- The inclusion of KMC in the broader newborn care initiatives like the Limpopo Initiative for Newborn Care (LINC) (<http://www.lincare.co.za/>) and in the KZN Initiative for Newborn Care (KINC) (<http://www.kznhealth.gov.za/kinc.htm>)

• More than 90% of deliveries in South Africa are facility based, so women have access to a health facility during child birth. That has the potential of giving preterm/LBW babies access to KMC services if they are established in a facility.

I look forward to see you in Trieste.

Anne-Marie