

Saving premature and small newborns:


Introduction and expansion of KMC services in Rwanda

Aida Lo, Country Director, ACCESS/Rwanda
 Joseph de Graft-Johnson, Community Interventions Specialist, ACCESS Program
 Winnie Mwebesa, Reproductive health Advisor, Save the Children
 Juliet MacDowell, Sr. Program Manager, ACCESS Program

Jhpiego in partnership with Save the Children, Constella Futures, The Academy for Educational Development, The American College of Nurse-Midwives and Interchurch Medical Assistance

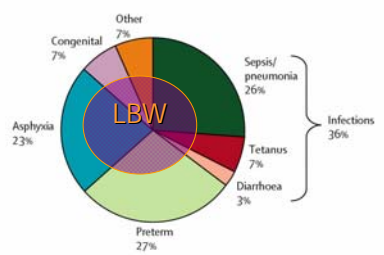
Session Objectives

- Describe the contribution of premature and small babies to neonatal mortality
- Describe the components of Kangaroo Mother Care (KMC)
- Share ACCESS Program experience in introduction and expansion of KMC with focus on Rwanda




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Causes of Newborn Deaths



60-80% Newborn Deaths occur in Low Birth Weight babies

Source: Neonatal Lancet team, March 2005.



3

What is Kangaroo Mother Care?

“early, prolonged and continuous (as allowed by circumstances) skin-to-skin contact between a mother (or a substitute of the mother) and her low birthweight infant, both in hospital and after early (depending on circumstances) discharge, until at least the 40th week of post-natal gestational age, with ideally exclusive breastfeeding and proper follow-up”

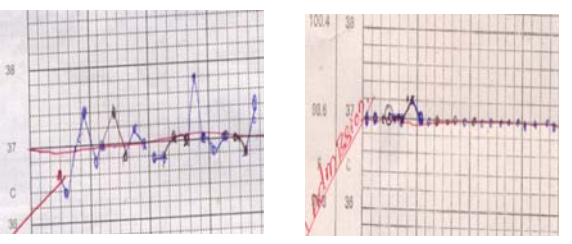


Acta Paediatrica 1998;87:440-5




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No fluctuations in temperature in KMC



“Swings in temperature” “Constant temperature in KMC”

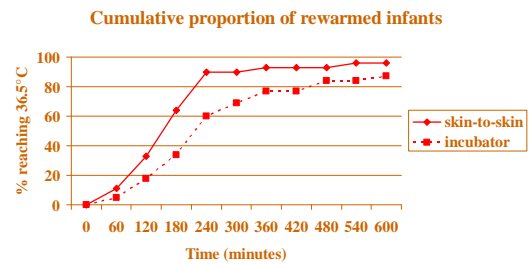



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Skin-to-skin contact for rewarming hypothermic neonates

Christensson K et al. Lancet 1998;352:1115

Cumulative proportion of rewarmed infants

6

Effect on breastfeeding

Better Breastfeeding rates with KMC!

Weight gain

2 RCT's

	KMC	Control
▪ Ramanathan, 2001	15.9	10.6* (g/day)
▪ Cattaneo, 1997	21.3	17.7* (g/day)

- ☞ Weight gain faster in KMC group
- ☞ Earlier hospital discharge by 3-7 days
- ☞ Weight similar at 1 year of age

Delivery Approaches

▪ Facility-Based



▪ Community-based



ACCESS KMC Strategy

Plan for scale-up at design phase

Steps:

- MOH buy-in from the beginning – key leader in implementation with TA from ACCESS
- National KMC sensitization workshop
- Study tour (if necessary & feasible)
- Establishment of national KMC taskforce or advisory committee
- Adaptation of ACCESS global KMC training manual by in-country experts
- Financial support for establishing learning/training center and services in limited number of facilities
- Support to develop national policy/service guidelines

Scaling up KMC

Countries where ACCESS is implementing KMC

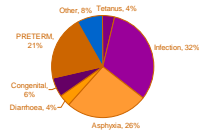
- Nigeria
- Malawi
- Ethiopia
- Nepal
- Bangladesh
- Rwanda

The Rwanda Experience



Rwandan Premature Infant Situation

- Neonatal mortality rate is 37 /1000 of live births
- Temperature monitoring was not systematic
- 70% of newborns admitted in the neonatal unit are hypothermic
- KMC promotion part of C-IMCI



Step I – Consensus Building

- Advocate with MOH & host a national KMC sensitization workshop with attendance from key stakeholders working on maternal & newborn health in country
- Identify prominent well-connected Pediatrician to champion the process
- Share current status of management of preterm babies in Rwanda. Share KMC experiences from other sub-Saharan African countries
- Pledged financial support from interested stakeholders
- Identification of in-country technical resources for the adaptation of KMC materials

Step 2 – Adaptation of Training Manual

- Translation of the ACCESS global KMC manual into French
- “Formation” of a national review group who adapted the manual
- Field tested during first TOT
- Revised for the training of service providers



Step 3 – Learning Center Establishment

- Buy in from Muhima District Hospital authorities
- Provided essential equipment (both teaching and service supplies)
- Conducted TOT (12 trainers and service providers)
- Initiated services at Muhima hospital



Expansion of KMC services in Rwanda

- Conducted needs assessment for 5 more ACCESS supported hospitals and 3 non-ACCESS hospitals (UNICEF and Twubakane)
- Provided equipment for the hospitals (to suit local reality)
- Trained 24 service providers in KMC from the 8 hospitals
- Initiated services at all 8 hospitals within one week of training

Quick results

Muhima 6 month results (130 babies)

- Average daily weight gain augmented (from 9g to 28.5g)
- Reduction in Average length of stay (from 26 days to 19 days)
- KMC unit mortality is 3%

Lessons learned

- Involving stakeholders from the beginning can lead to mobilization of resources for national scale-up
- Having national champion respected by MOH can facilitate introduction
- “Showcasing” the learning center can mobilize additional support and pressure for expansion from other districts
- Developing an expansion plan at the beginning to facilitate actual scale-up
- Countries are ready to improve care for premature/LBW babies but need technical and financial support

Conclusion

When introduced with buy-in from MOH & other stakeholders, and adequately implemented with standardized tools, KMC can be expanded rapidly to many facilities within a short time frame

