MSF Paediatric Days 2022
Poster N°51

TOWARDS "ZERO SEPARATION" IN A LOW RESOURCE SETTING IN THE CENTRAL AFRICAN REPUBLIC: A FAMILY-CENTERED NATIONAL STAFF-DRIVEN APPROACH

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BACKGROUND AND AIMS

How do we encourage immediate Kangaroo mother care (KMC) amongst mothers and national staff (NS) in order to advance zero separation and reduce neonatal mortality in low resource settings? This question was the starting point for making over the Bossangoa District Hospital's neonatal ward in Central African Republic. Supported by MSF since 2013, in 2020 the neonatal admission mortality rate was 20%, well above MSF's internal target of 10%.
Unlike top-down implementation strategies, the focus was the family by asking mothers and national staff to identify barriers and needs in supporting zero separation. The neonatal ward was restructured based on theses *bottom-up* recommendations.

METHOD

Qualitative focus group discussions (FGD) allowed participants to express their perspectives in an open, secure and framed setting. Two target groups (hospitalized mothers (M) and national staff (NS)) were questioned in their national language using a prepared question guide. Recommendations were developed into an action plan.

Mothers were asked three open questions:

1A In your opinion, what currently reduces zero separation between you and your baby?
1B Is there anything you are missing, or which is needed so you can spend more "skin-to-skin" time with your baby?
1C How can MSF help make it easier for you to spend as much skin-to-skin time as possible with your baby?

For the NS-FGD two open questions were prepared:

2A How can care for preterm babies be improved?
2B How can the intrahospital referral system be improved to maintain the body temperature?

Picture 1: Area for premature and very sick newborns

RESULTS

FGD with Mothers:

The most common response from mothers was a lack of caregiver support. For example, mothers take care of their own food and laundry, preventing them from being with their babies. MSF's current transport rules only includes the baby and mother. Additionally, due to insecurity, family members are often unable to come to the hospital independently.
Therefore, a clear recommendation is, that the transportation rules for mothers and newborns should be made analogous to the rules for pregnant mothers (here, another family member may be transported on the MSF motorcycle).

FGD with NS:

Based on the suggestions from the NS-FGD, the neonatal ward was reconstructed to allow the separation of premature infants *(see picture 1)*. Three KMC beds were also added , allowing the mother to lie next to their baby *(see picture 2)*.

Picture 2: the new KMC Area

In Bossangoa, only neonatology is supported by MSF, not maternity. Therefore, sick newborns were previously referred from maternity via the MSF emergency room and then admitted to the neonatology ward. The FGD made it possible to reconsider and abolish this long-established referral triangle. Now, newborns are transferred directly to the neonatology ward.
To ensure this direct referral, a well-equipped resuscitation and examination table for the neonatal ward was constructed (*see Picture 3 and 4)*.

Picture 3: A new table is build!

Picture 4: The „result" in place and ready to use!

After implementation of these recommendations, a decrease in hypothermia on admission was already observed. We look forward to understanding the impact of these changes on mortality.

CONCLUSION

Family-centred care, with the aim to support zero separation begins by asking mothers about their needs. We were surprised, that mothers expressed a lack of social support as the key barrier, as rather expected spatial or functional obstacles (e.g. uncomfortable chair, no possibility to put down own belongings like something to drink...). Using FGDs gave us the opportunity to understand why it was so difficult to implement KMC and zero separation in the first place.
This participatory approach allowed us also to identify and soften established, yet impractical organizational structures. A top-down modification of this rigid system would have been unimaginable before, but our bottom-up-style made it possible.

As far as we know, this is the **first time of a bottom-up design of restructuring a neonatal ward in an MSF project** rather than the usual top-down approach. We want to motivate other projects to adopt this **low-cost, culture sensitive and efficient approach**, since the results can be surprising.

All persons shown in the pictures have previously consented to their publication
Ethics statement: Exemption granted by OCA Medical Director