SOCIAL FINANCE

MARCH 2021

CAMEROON

KANGAROO MOTHER CARE (KMC) DIB

LESSONS FROM DELIVERY FOR SCALE

Glossary

CAD	Canadian Dollars
CHW	Community Health Worker
CoE	Centre of Excellence
CPD	Continuing professional development
DEC	Data Entry Clerk
DIB	Development Impact Bond
EBF	Exclusive breastfeeding
FCAF	Financial Community of Africa Franc
GCC	Grand Challenges Canada
IRESCO	Institut de Recherche et des Etudes de Comportements
KFC	Kangaroo Foundation Cameroon
KMC	Kangaroo Mother Care
LBW	Low birth weight
MoPH	Cameroon Ministry of Public Health
MoU	Memorandum of Understanding
NI	Nutrition International
NNU	Neo-natal Unit
PBF	Performance-based finance
SF	Social Finance
TBA	Traditional birth attendant
USD	United States Dollars

Introduction

Cameroon KMC DIB: key stakeholders and timeline

The Cameroon KMC DIB is a social outcomes partnership between the Cameroon Ministry of Public Health (MoPH), Grand Challenges Canada (GCC), Nutrition International (NI) and the Kangaroo Foundation Cameroon (KFC). It builds on a two-year kangaroo mother care pilot in Cameroon funded by GCC and led by the Fundación Canguro in Colombia.

GCC, as the investor, provided CAD 1 million (USD 780k) of upfront capital to KFC, the lead service provider, which they used to roll out and fund the initial delivery of the programme. Service delivery targeted an improvement in neonatal health outcomes through the delivery of quality Kangaroo Mother Care (KMC) in 9 public hospitals and 1 private hospital across 5 regions of Cameroon.

MoPH and NI, as outcomes funders, committed up to USD 2,430k to pay for outcomes once they had been independently verified to have been achieved. If successful, outcomes payments from MoPH and NI will cover the remainder of programme delivery costs and the repayment of GCC's capital investment.

The KMC DIB was officially launched on 17th December 2018 when outcomes contracts between the investor (GCC) and the two outcomes funders (NI & MoPH) were signed. Upfront funding was mobilised through the signature of a loan agreement between GCC and KFC on the 5th February 2019. A tripartite Memorandum of Understanding (MoU) between GCC, NI and MoPH was signed in April 2019.

KMC delivery started in the existing KMC Centre of Excellence (Laquintinie Hospital in Douala) once the tripartite MoU was in place. Subsequent hospitals were enrolled once MoUs with KFC had been agreed. The programme was originally due to complete delivery at the end of March 2021, but has been granted a six-month no-cost extension to September 2021 in light of reduced enrolments due to Covid-19 in spring/summer (April-August) 2020.

Cameroon KMC DIB: Programme Objectives

Contractual programme objectives linked to outcome payments focus on three areas:

- Payment Metric A: hospitals are equipped and trained to deliver quality KMC (one-off assessment);
- Payment Metric B: number of infants receiving quality KMC at programme hospitals (quarterly verification); and
- Payment Metric C: number of babies showing appropriate nutrition and weight gain at 40 week follow-up appointments at programme hospitals (quarterly verification).

In addition, the programme targeted the embedding of KMC expertise in the public health system with the ambition to certify three additional programme hospitals as Centres of Excellence and to create a pool of qualified KMC trainers among public sector clinicians in Cameroon.

Lessons from delivery for scale report: methodology & objectives

This review of lessons learnt from delivery for scale is based on a review of key documents, detailed analysis of operational and financial data, and interviews with over 30 key programme stakeholders undertaken by Social Finance in December 2020 and January 2021.

The review is combined of two parts, of which this report covers the first:

1) A reflection of lessons learnt from KMC roll-out to date including recommendations for implementation at scale in Cameroon; and
2) A reflection on lessons learnt from outcomes-based programme delivery using a DIB structure.

We expect lessons from this first report to inform the development of a National Strategy for KMC in Cameroon. Lessons may also be included in a second report to share results and reflect on the potential of outcomes-based contracts to drive improvements in neonatal health in Cameroon and beyond.

Next steps and priorities

This document provides recommendations to support the Government of Cameroon to integrate and roll-out KMC as part of their revised national strategic plan for reducing maternal, neonatal and infant-child mortality,[1] potentially including a mechanism for financial incentivisation of quality KMC practices through the World Bank-funded Performance-Based Financing.

We worked with Cameroon Ministry of Public Health (MoPH) to identify a short list of immediate next steps that should be carried out as soon as possible:

1. **MoPH** to convene a multi-stakeholder working group as soon as possible to help build and sustain momentum around a national roll-out of KMC and facilitate the implementation of recommendations.
2. The **Kangaroo Foundation Cameroon (KFC)** to work with **MoPH** to define its role in supporting a national roll-out of KMC after the DIB, including the identification of funding to enable the Foundation's ongoing involvement. As a hub of KMC expertise and training in Cameroon, KFC will be an important partner to government during the national roll-out of KMC.
3. **MoPH** and **KFC** to engage with the Cameroonian Society of Paediatrics (SOCAPED) to develop a national KMC protocol.
4. **MoPH** and **KFC** to develop KMC training modules to be added to MoPH training for nurses and community health workers.
5. **KFC** to work with the **MoPH PBF Team** to support the identification of KMC metrics to for inclusion in the PBF programme, to incentivise both hospital and community-level KMC delivery.

The recommendations included in this report were discussed and agreed during an online workshop involving key individuals from MoPH, GCC, NI, KFC, SF, UNICEF and the World Bank on Wednesday 27th January 2021. A full list of contributors can be found at the end of this document.

This review was led by Louise Savell (Director, Social Finance) with support from Marie-Alphie Dallest (Manager, Social Finance) and Chloe Eddleston (Analyst, Social Finance). The review was funded by Grand Challenges Canada as part of their investment in ensuring the sustainability of the impact generated by the Cameroon KMC DIB. Social Finance is grateful to the cooperation and contributions of the Kangaroo Foundation Cameroon team, particularly Hortance Manjo (DIB Programme Manager) who was instrumental to releasing key data and coordinating interviews with local stakeholders.

[1] Plan stratégique multisectoriel de lutte contre la mortalité maternelle, néonatale et infanto-juvénile 2014-2020

SUMMARY OF RECOMMENDATIONS FOR SCALE

1.1 Hospital selection and engagement

- Ensure strong Ministry involvement and support for embedding KMC roll-out in the national strategic plan for reducing maternal, neonatal and infant-child mortality.[2]
- Focus on embedding KMC in clinical practice at all levels of neonatal healthcare, with a particular focus on secondary (regional) hospitals.
- KFC to support MoPH to review neonatal health needs and resources across Cameroon to identify priority areas for KMC roll-out.
- Review minimum hospital requirements for successful KMC delivery in terms of availability of staff, space and clinical equipment.
- Adapt KMC readiness form to assist identification and selection of priority hospitals – acknowledge need to balance patient needs with hospital readiness.
- Clarify articulation of the clinical and value-for-money benefits of KMC for hospital management and patients. Include patient stories and case studies.
- Strengthen hospital-level MoUs to ensure clarity around respective roles and responsibilities of all implementing partners during KMC set-up and delivery.

1.2 Hospital infrastructure and equipment

- MoPH to adapt the existing KMC readiness form to support the strengthening of neonatal care at different levels of the health system.
- Extend the scope of the KMC readiness form to support the assessment of hospital-specific facilities, equipment and processes for neonatal care.
- Assess hospital / health centre infrastructure and equipment needs no more than six months prior to the commencement of programme works.
- KFC to ensure robust documentation for all equipment and consumables (requests and provision), including terms and conditions for appropriate usage (e.g. restrictions of generators to NNU use) and consequences for misuse.
- Build the capacity of hospital management to effectively manage, operate and maintain infrastructure and assets.
- Ensure equipment maintenance responsibilities and / or costs are agreed and documented with hospital management ahead of equipment supply.

1.3 Clinician allocation and training

- Government of Cameroon to work with KMC practitioners (clinicians, data entry clerks and hospital management) to develop and publish an official national protocol for KMC practice including data, clinical and outcomes standards.
- Define appropriate metrics for monitoring quality of neonatal care including, but not limited to KMC.

[2] Plan stratégique multisectoriel de lutte contre la mortalité maternelle, néonatale et infanto-juvénile 2014-2020

- Embed KMC training and accreditation into existing pre-service and in-service clinical training curricula (basic, specialist and continuing professional development) for neonatal healthcare professionals, including modules for clinical specialists (e.g. paediatric physiotherapists and psychologists).
- Encourage recognition and promotion of KMC practices by relevant professional associations in Cameroon.
- Formalise processes of ongoing mentoring and support for neonatal practitioners including, supporting increased clinical shadowing and/or mentoring time following initial clinical training.[3]
- Establish systems and processes to develop and sustain strong communities of practice at national and regional levels, including potentially an annual national KMC practitioner meeting.

1.4 Clinician incentives, turnover and ongoing support

- Embed supportive supervision and planned refresher training for neonatal clinicians as a core part of a national KMC roll-out.
- Develop smartphone platforms and resources to support continuing professional development for neonatal clinicians. Ensure ongoing monitoring of effectiveness.
- Consider how clinician incentives could be included within the broader performance-based finance (PBF) framework for maternal and neonatal healthcare in Cameroon to support the roll-out of KMC practices.
- Partner with MoPH, Regional Health Delegates and hospital management to slow the high rates of doctor turnover within neo-natal care units in Cameroon and ensure hospital-level neonatal practice is resilient in the face of GP turnover.
- Map and engage KMC-trained clinicians who have moved on from programme hospitals as a potential resource base to support national roll-out of KMC.

1.5 Community engagement and follow-up

- Embed community KMC referral and follow-up processes – including data collection to support patient tracking and advocacy to promote community KMC – in the training curriculum for community health workers.
- Centre community referral and follow-up processes in newborn care training curricula and KMC roll-out strategy.
- Explore sources of funding – including performance-based finance – to support community KMC provision: awareness raising, KMC equipment, communities of practice and continuing professional development (CPD).
- Consider strategies for engaging and training traditional birth attendants to support early referral of at risk mothers, promote family support for KMC and ensure appropriate follow-up.

[3] Explore the potential to extend the existing national mentoring scheme for Obstetrics and Gynaecology to include neonatal care.

1.6 Hospital delivery of quality KMC

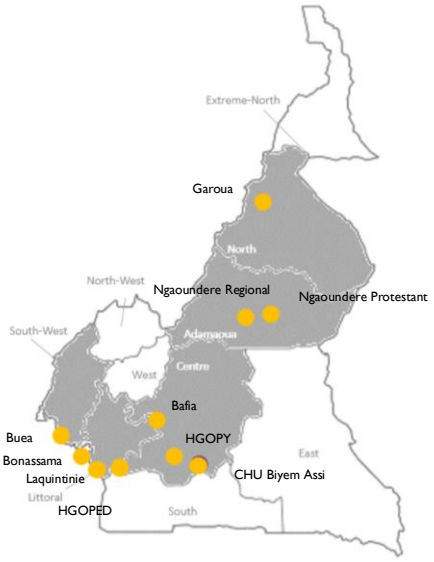
- Where possible engage multiple caregivers (mothers, fathers, other family members and, potentially, volunteers) in the provision of skin-to-skin KMC care for each pre-term or low birth weight baby.[4]
- Analyse the cost of care for premature and low birthweight babies in Cameroon to inform a potential minimum package of financial support for families.
- Investigate ways to systematically support families to meet the costs of hospital care and post-discharge follow-up for pre-term and low birth weight babies, potentially through a minimum package of financial support for neonatal care, as part of KMC roll-out.
- Consider how the availability of core neonatal health infrastructure and equipment can be strengthened as a prerequisite for enabling quality KMC in Cameroon.
- Support the translation of national KMC protocols (see 1.3) into hospital-specific protocols for neonatal care.
- Embed robust clinical data collection, analysis and data review as a driver for improving hospital KMC practice.

1.7 Embedding KMC in the Cameroon health system

- Create a multi-stakeholder advisory group to oversee the embedding of KMC within the Maternal, Child and Neonatal Health Strategy – to include MoPH, Ministry of Higher Education, Ministry of Finance, Kangaroo Foundation Cameroon, and other relevant professional associations (such as the Cameroonian Society of Paediatrics).
- Embed KMC as a core neonatal health tool in hospitals and community health facilities within the national maternal, child and neonatal health strategy.
- Analyse KMC programme cost data to identify the cost of embedding KMC within neonatal health units in Cameroon.
- Support active Communities of Practice to provide informal and structured support, and continuing professional development to neonatal clinicians.
- Consider the role of KMC Centres of Excellence and specialist KMC trainers in supporting the roll-out of KMC practice in Cameroon.
- Include KMC in neonatal practitioner career development, training and support pathways.

[4] N.B. this may require multiple sizes of KMC lycra bands to be available for each baby as they are sized to each caregiver. Consider also the potential to harness volunteers to support skin-to-skin care in hospitals.

1.1 Hospital selection and engagement



Name/ City	Region	Type	Urban/ Rural	Pilot	MoU signed
Laquintinie / Douala	Littoral	Reference hospital	Urban	X	May 2019
HGOPED / Douala	Littoral	Obstetrics and Gynaecology hospital	Urban		Jun 2019
Bonassama / Douala	Littoral	District hospital	Urban	X	Aug 2019
HGOPY /Yaounde	Centre	Obstetrics and Gynaecology hospital	Urban		May 2019
Centre Hospitalier Universitaire Biyem Assi / Yaounde	Centre	Teaching hospital	Urban		Dec 2019
District Hospital Bafia	Centre	District hospital	Rural		May 2019
Buea Regional Hospital	South-West	Regional hospital	Urban		Sep 2019
Garoua Regional Hospital	North	Regional hospital	Rural	X	Jun 2019
Ngaoundere Regional Hospital	Adamaoua	Regional hospital	Rural		May 2019
Ngaoundere Protestant Hospital	Adamaoua	Faith-based hospital	Rural		Aug 2019

FIGURE A: Cameroon KMC DIB Programme Hospitals

1.1 Overview: hospital selection and engagement

Programme hospitals were selected prior to DIB contracting through a four phase process. An initial long-list of 40 hospitals across all regions of the country was shortened with a focus on reference and regional hospitals with a view to ensuring the availability of specialist paediatric clinicians and establishing a solid foundation for future KMC roll-out in Cameroon. District hospitals that receive high volumes of pre-term and low birth weight (LBW) babies were retained at this stage. The short-list was whittled down to 24 hospitals in five priority regions based on government priorities, population needs and feasibility considerations (including security and minimum levels of infrastructure). The final 10 programme hospitals were identified based on:

- Minimum levels of existing neonatal infrastructure, clinical staffing and clinical space for in-patients and out-patients;
- Expected volume of pre-term and LBW babies during implementation;
- Estimated cost of essential infrastructure upgrades prior to KMC implementation; and
- Considerations of balance to ensure a good mix of rural and urban hospitals, and public, public-private and faith-based facilities.

Once DIB outcomes contracts had been signed, a framework agreement was put in place between KFC (as a representative of GCC) and MoPH. This document outlined the respective responsibilities of KFC and MoPH in relation to DIB implementation and included a letter from MoPH authorising hospital engagement with the KMC programme; details of the process for clinical staff recruitment, requirements and pay; and authorisation for the programme to access hospital records for the purposes of programme management and outcomes verification.

KFC then used the MoPH framework agreement to put in place Memoranda of Understanding (MoU) between the foundation and each of the 10 programme hospitals. Hospital level MoU's outlined:

- Expected DIB-funded infrastructure upgrades, equipment provision and maintenance responsibilities;

- KMC unit staffing requirements including recruitment, pay (including a KMC bonus) and availability for training;
- Data collection and data protection provisions; and
- Where applicable, clauses around anticipated Centre of Excellence (CoE) accreditation outlining which programme hospitals the CoE would then be responsible for training.

1.1 Lessons from implementation: hospital selection and engagement

Potential impact of including faith-based and secondary hospitals in future roll-out

KFC management emphasised that patient access should be considered when selecting future KMC programme hospitals. KFC management is keen to see future inclusion of independent faith-based hospitals, particularly in the West and South West, where they are high quality and have high levels of patient trust. KFC management also emphasised the potential impact of focusing on secondary (regional) hospitals for KMC roll-out as they are closer to communities and have the right skills.

The importance of Ministry authorisation and support to effective hospital engagement

Hospital managers and KFC staff were quick to note the critical importance of the Framework Agreement between KFC and MoPH. It is clear that this Ministerial agreement underpinned the Foundation's ability to engage hospital management with the KMC programme.

Limitations to KFC's ongoing engagement with hospital management

Hospital managers see KMC primarily as an opportunity to increase patient numbers whilst decreasing clinical costs. It is unclear to what extent they value programme impact on infant mortality and morbidity.

Hospital managers noted that, once programme implementation had commenced, they had not been kept regularly updated by KFC staff. KFC management confirmed that they were unsure whether equipment receipt sheets went to hospital management. Ongoing engagement has been particularly challenging when personnel have changed mid-programme. The hospital managers we interviewed could not clearly articulate the financial or in-kind contributions made by the KMC programme to their facilities.

Need to extend the scope of hospital MoUs to include implementation

KFC staff and hospital management noted that KFC's Memoranda of Understanding with hospitals were focused more on initial programme requirements, in terms of clinical staff, space and facilities, than on the ongoing roles and responsibilities of the hospital vs. KFC during programme implementation. KFC management noted that the inclusion of a requirement for an annual contract review meeting with hospital directors would have been helpful.

KFC management confirmed that subsequent equipment requests and variations to agreements around maintenance responsibilities have been largely undocumented and based on verbal agreements. Hospital commitments have been difficult to enforce in some instances, particularly in smaller (district) hospitals with limited resources and large tertiary hospitals where they have a significant number of partners and projects running in parallel.

1.1 Recommendations for implementation at scale: hospital selection and engagement

- Ensure strong Ministry involvement and support for embedding KMC roll-out in the national strategic plan for reducing maternal, neonatal and infant-child mortality.[5] Focus on embedding KMC in clinical practice at all levels of neonatal healthcare, with a particular focus on secondary (regional) hospitals.
- KFC to support MoPH to review neonatal health needs and resources across Cameroon to identify priority areas for KMC roll-out.
- Review minimum hospital requirements for successful KMC delivery in terms of availability of staff, space and clinical equipment.
- Adapt KMC readiness form to assist identification and selection of priority hospitals – acknowledge need to balance patient needs with hospital readiness.
- Clarify articulation of the clinical and value-for-money benefits of KMC for hospital management and patients. Include patient stories and case studies.
- Strengthen hospital-level MoUs to ensure clarity around respective roles and responsibilities of all implementing partners during KMC set-up and delivery.

[5] Plan stratégique multisectoriel de lutte contre la mortalité maternelle, néonatale et infanto-juvénile 2014-2020

1.2 Hospital infrastructure and equipment

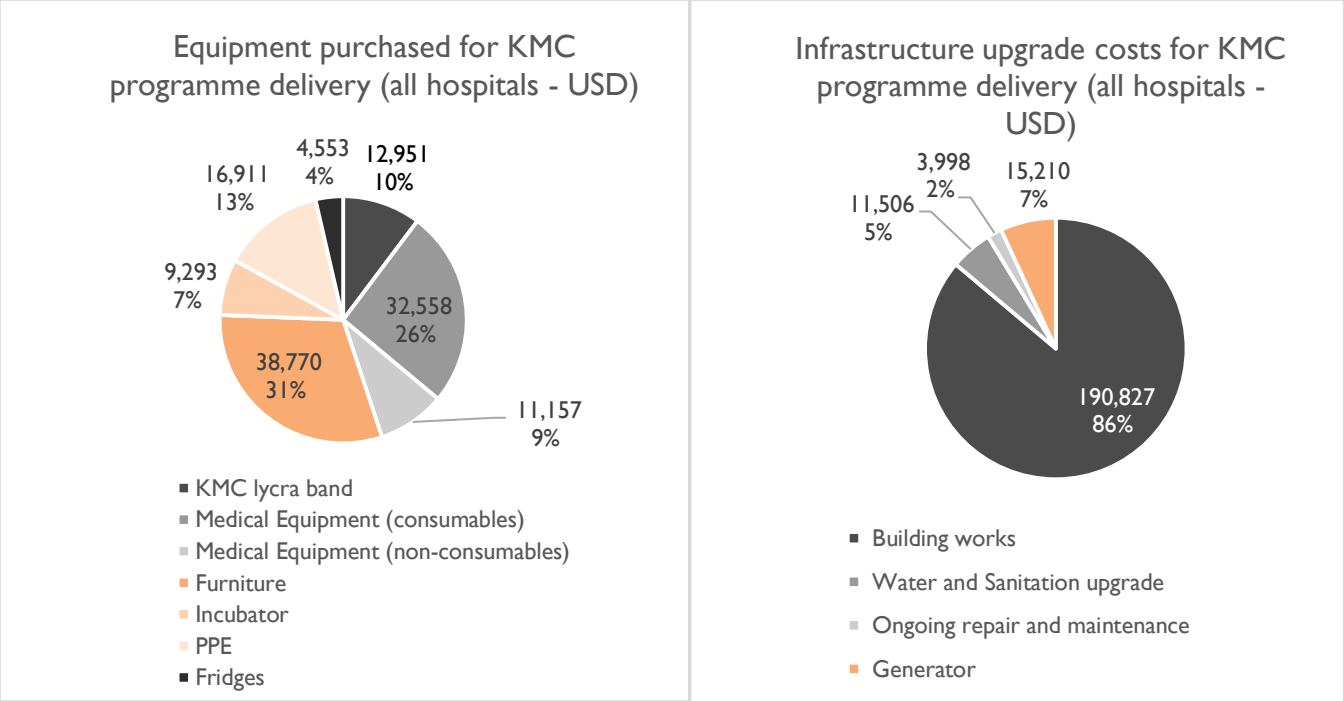


FIGURE B: Infrastructure & equipment spend in KMC programme hospitals to date[6]

1.2 Overview: hospital infrastructure and equipment

During the KMC DIB design and mobilisation phase KFC assessed the needs of each programme hospital using a KMC readiness form (Appendices 1.2c & 1.2d *in French*). This assessment captured existing neonatal unit (NNU) capacity, infrastructure and equipment, in addition to data on likely patient enrolment volumes.

The resulting plan for each hospital included provisions to ensure appropriate clinical infrastructure and equipment was in place ahead of KMC delivery commencing. Each hospital's budget was appended to their MoU with KFC, along with detailed floor plans for clinical spaces to be renovated or constructed.

Across the programme, infrastructure investment focused primarily on the renovation of neonatal units and the creation of dedicated KMC wards in programme hospitals. Works to ensure the availability of safe water and sanitation, and to ensure reliable electricity were also significant.

The KMC DIB also funded the provision of KMC-specific equipment in programme hospitals including angled KMC chairs, foam wedges to angle hospital beds and clinical consumables including lycra bands, feeding syringes and cups. Basic medical equipment was also provided in most instances including electronic scales, infantometers, fridges, gastric tubes, cannulas, etc. Computers, data registers, internet dongles and phones were provided to all programme hospitals to facilitate data capture and programme monitoring.

[6] A hospital level breakdown of infrastructure and equipment spending can be found in Appendix 1.2.a. Unforeseen items are listed in Appendix 1.2.b

Infrastructure investment per hospital ranged from $0 to $50,000 (median $20,000). Equipment spend per hospital, to the end of December 2020, ranged from $7,000 at HGOPY to $34,000 at Laquintinie (median $9,500) of which approximately 35% was KMC-specific consumables.

In addition to planned spending, the KMC DIB has also funded a number of items that were not originally budgeted for. These include personal protective equipment for clinical staff at Laquintinie (in response to the Covid pandemic), mechanical scales, baby height scales, otoscopes, antibiotics and, more materially, 2 incubators (Laquintinie) and 2 generators (Bonassama and Bafia). Requests to KFC for additional equipment, or to flag maintenance needs, tended to be made directly by the clinical KMC 'focal point' or Data Entry Clerk (DEC) in each hospital, rather than by hospital management. Equipment spending at Laquintinie hospital [USD 34k] was more than double the mean for other programme hospitals [USD 13k]. This was largely driven by the provision of incubators and PPE for KFC clinical staff who use this hospital as a base.

1.2 Lessons from implementation: hospital infrastructure and equipment

Delays between hospital needs assessments and infrastructure investment created challenges

KFC management highly rated the KMC readiness form, but noted that hospital-level DIB programme budgets were often significantly out of date by the time infrastructure improvement work was undertaken.

Initial hospital budgets were based on needs assessments undertaken by KFC in the latter half of 2017 during the DIB design phase; 18-24 months before DIB delivery commenced. In the intervening period there had often been significant changes for better or worse, sometimes necessitating significant changes to planned works and related costs.

Importance of coordination with hospital-specific processes, facilities and improvement works

KFC management noted the KMC programme's interdependencies on facilities (e.g. pharmacies), programmes and infrastructure upgrade work that were often out of the KMC DIB programme's control. Often these related to infrastructure investment in programme hospitals funded by MoPH or other donors. On some occasions this created efficiencies, but as often led to delays. KFC management highlighted the importance of understanding the full programme of planned improvements ahead of delivery in any given hospital to ensure appropriate coordination. KFC management also noted the importance of capturing the details of hospital-specific patient engagement and resource allocation processes as part of pre-implementation needs assessments.

Need to strengthen documentation of infrastructure and equipment investments and responsibilities

When DIB-funded equipment is delivered to hospitals, a document is signed by hospital staff to confirm safe receipt. These sheets are added as an appendix to hospitals' MoU with KFC. The ongoing management of DIB-funded equipment and consumables is then managed through the DEC and the KMC focal point in each hospital who liaise with the KFC team to reorder stock or arrange for maintenance if necessary. KFC management confirmed that ongoing roles and responsibilities, relating to equipment maintenance and the provision of non-KMC-specific consumables, have tended to be verbally agreed by KFC management rather than formally documented with the hospital. Social Finance (SF) noted that the absence of consistent, auditable documentation makes it difficult for programme stakeholders to assess the effectiveness and appropriateness of DIB programme spending.

1.2 Recommendations for implementation at scale: hospital infrastructure and equipment

- MoPH to adapt the existing KMC readiness form to support the strengthening of neonatal care at different levels of the health system.

- Extend the scope of the KMC readiness form to support the assessment of hospital-specific facilities, equipment and processes for neonatal care.
- Assess hospital / health centre infrastructure and equipment needs no more than six months prior to the commencement of programme works.
- KFC to ensure robust documentation for all equipment and consumables (requests and provision), including terms and conditions for appropriate usage (e.g. restrictions of generators to NNU use) and consequences for misuse.
- Build the capacity of hospital management to effectively manage, operate and maintain infrastructure and assets.
- Ensure equipment maintenance responsibilities and / or costs are agreed and documented with hospital management ahead of equipment supply.

1.3 Clinician allocation and training

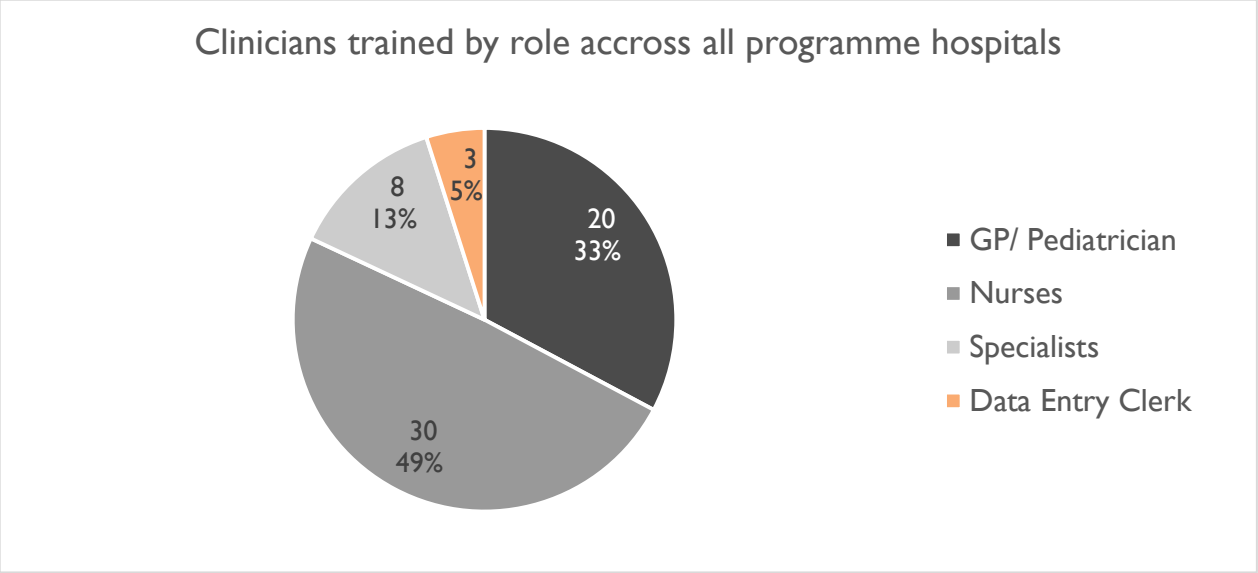


FIGURE C: KMC trained clinicians by role[7]

1.3 Overview: clinician allocation and training

KFC staff work with hospital management to select KMC clinicians for training based on a number of considerations including their employment status (permanent vs. temporary contracts), intention to remain in their current hospital, relevant clinical skills and their individual interest in KMC. The number of clinicians selected for training from any given hospital varies according to the capacity of the neonatal unit, with larger facilities sending more staff for training. A minimum of 1 doctor and 2 nurses are trained in any given programme hospital, but KFC prefer to train more where possible to reduce risk of programme disruption due to staff absence / transfer.

For newly enrolled hospitals, KMC clinicians undertake an initial two-week residential training (including a weekend on call) at Laquintinie hospital (see KMC training agenda Appendix 1.3.b *in French*). Classroom and hands-on training take-place across the two weeks. A web-based Cross Knowledge platform is used to deliver proprietary curriculum materials including slideshows, videos, tests and revision modules.

The training curriculum covers KMC-specific clinical training, DIB-specific training (e.g. patient eligibility, data collection and analysis), and relevant softer skills around KMC advocacy and parental engagement. KMC clinician training and implementation evaluation by the KFC team has cost just under USD $5,000 per programme hospital (Appendix 1.3.c).

Clinicians joining KMC teams after hospital enrolment either join a planned training at Laquintinie (if scheduled) or are trained on the job at their own hospital by a KFC clinician on secondment.

The Cross Knowledge online training platform has recently been updated to make it more intuitive, interactive and tailored to different clinical roles. A module has been added on data collection. The platform now includes an online forum for sharing questions and experiences, as well as a library of relevant articles and evidence for KMC. The platform has also recently been updated to improve accessibility on smartphones.

[7] A breakdown of clinicians trained by role and programme hospital can be found in Appendix 1.3.a

1.3 Lessons from implementation: clinician allocation and training

Potential value to increasing clinical shadowing time after theoretical KMC training

Hospital clinicians noted that the KMC training felt too short. In particular, they would have valued more clinical shadowing time after their theoretical training. Hospital clinicians specifically mentioned feeling underprepared in terms of some of the softer skills, for example how best to communicate the benefits of KMC to engage mothers and other caregivers with the approach.

Need for development of bespoke training content for clinical specialists

KFC and hospital clinicians noted the important role of clinical specialists, like physiotherapists and psychologists, in delivering quality KMC. However, they also noted the need to develop specific KMC training content for such specialist clinicians. Previously training for specialists has happened through clinical shadowing and was not specifically covered in training materials. However, this has now been added to the updated Cross Knowledge platform and will be trialled in January 2021.

Benefits of updated Cross Knowledge training platform

Overall, KFC management and clinicians seem happy with the updates to the Cross Knowledge training platform. The revised platform will be used for the first time to deliver a full two-week training in January 2021, which will be jointly delivered with the Pool of Trainers. Some KFC clinicians suggested that the pace of video content needed to be slowed to ensure maximum benefit. KFC clinicians were pleased to see the inclusion of a KMC evidence and resources library as a tool to support broader advocacy for the KMC approach.

Importance of the training cohort for ongoing peer support

Hospital clinicians noted that the residential training format enabled them to develop strong relationships with clinicians from other hospitals enabling post-training collaboration and valuable peer support to help KMC delivery. This is facilitated by a cohort WhatsApp group.

1.3 Recommendations for implementation at scale: clinician allocation and training

- Government of Cameroon to work with KMC practitioners (clinicians, data entry clerks and hospital management) to develop and publish an official national protocol for KMC practice including data, clinical and outcomes standards.
- Define appropriate metrics for monitoring quality of neonatal care including, but not limited to KMC.
- Embed KMC training and accreditation into existing pre-service and in-service clinical training curricula (basic, specialist and continuing professional development) for neonatal healthcare professionals, including modules for clinical specialists (e.g. paediatric physiotherapists and psychologists).
- Encourage recognition and promotion of KMC practices by relevant professional associations in Cameroon.
- Formalise processes of ongoing mentoring and support for neonatal practitioners including, supporting increased clinical shadowing and/or mentoring time following initial clinical training.[8]

[8] Explore the potential to extend the existing national mentoring scheme for Obstetrics and Gynaecology to include neonatal care.

- Establish systems and processes to develop and sustain strong communities of practice at national and regional levels, including potentially an annual national KMC practitioner meeting.

1.4 Clinician incentives, turnover and ongoing support

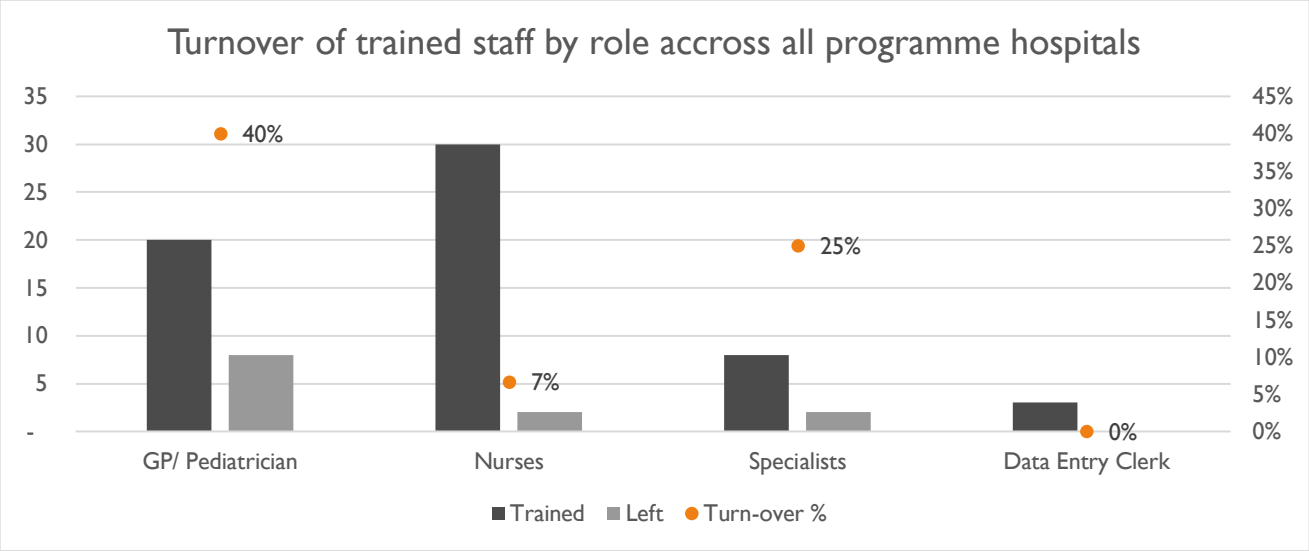


FIGURE D: KMC hospital clinician turnover by role[9]

1.4 Overview: clinician incentives, turnover and ongoing support

Staff incentives

Once trained, hospital clinicians are eligible for performance-based incentives (bonuses) funded by the KMC DIB. Hospital-level KMC bonuses are calculated based on the number of babies receiving quality KMC as assessed in the independent verification report. 50% of the total bonus for each hospital is allocated equally among neonatal unit staff, 20% is allocated based on level of seniority, and the final 30% is allocated based on each individual's perceived efficiency and effectiveness as evaluated by the Head of Department (or a PBF score where available). See Appendix 1.4.b.

Bonuses are disbursed directly to staff by KFC using a mobile payment app (Orange Money and MTN Mobile Money) following approval by each hospital's Head of Department. Individual staff payments per quarter distributed following the first two verification rounds ranged from USD $24 to $301 per person according to the number of staff in each neonatal unit and each hospital's quality KMC performance score.[10]

The intention was initially that KFC would have a contract with each hospital clinician clarifying their roles, responsibilities and the basis for any bonus payments in relation to KMC. In practice, these were not put in place because KFC did not have the authority to do so. Instead KMC clinicians are required to sign an engagement letter committing them to practice KMC in line with the KFC training.

Clinical staff turnover

Turnover of clinical staff has been an issue across all hospitals over the course of the DIB to date, with some hospitals (e.g. Bafia) losing as many as 75% of KMC-trained staff since joining the

[9] Clinician turnover by role and programme hospital can be found in Appendix 1.4.a. Data Entry Clerks are funded by the DIB, but trained in all aspects of KMC and often perform additional nursing functions.

[10] Data taken from the three programme hospitals included in verification rounds 1 & 2. SF is awaiting additional data from KFC for verification rounds 3 & 4. See Appendix 1.4.c for a hospital-level variance.

programme. Doctors (General Practitioners and Paediatricians) are significantly more likely to move out of programme hospitals than nurses or other specialists. To date 40% of KMC-trained doctors have moved out of programme hospitals compared to just over 10% of other clinical staff (nurses and clinical specialists). This is thought to be because doctors may need to move hospital to access further medical training. Younger GPs may also want to relocate for personal reasons.

High levels of turnover among key personnel have impacted programme delivery capacity. They have also driven increased costs and logistical complexity for KFC as new hospital clinicians needed to be trained and mentored outside of scheduled trainings. When necessary KFC has arranged for staff secondments by KFC clinicians in order to enable continuity of KMC delivery while new staff were trained. Efficient retraining has been complicated by the fact that all KFC clinicians are currently based out of Laquintinie hospital in Douala.

KFC has not systematically kept in touch with KMC-trained staff that have moved to non-programme hospitals. KFC staff are now working to contact and map their current locations as a foundation for implementing a national KMC strategy.

Ongoing support to KMC clinicians

There is currently no structured programme of refresher training, nor systematic post-training mentoring and support in place for KMC-trained clinicians. Once trained, clinicians from all programme hospitals have access to the Cross Knowledge training platform and a KMC WhatsApp group where they can post questions when they arise. They can also call KFC clinical staff members for specific advice.

Since December 2020, KFC has put in place a rota for KFC clinicians to proactively contact the focal point at each programme hospital at least once a fortnight. This system is still bedding in and proactive outreach and support is not yet systematic.

1.4 Lessons from implementation: clinician incentives, turnover and ongoing support

KMC staff bonuses are seen as critical for clinician motivation

KFC and hospital management and clinicians regard performance-related bonuses as critical to the motivation and ongoing engagement of clinical staff. This financial incentive was perceived as being more important to staff motivation than adequate equipment and facilities. However, some hospital clinicians felt that the system for calculating individual staff bonuses did not reflect individual contributions to achieving KMC outcomes.

The KFC clinical team is seen as accessible and knowledgeable

Hospital clinicians praised the accessibility, experience and knowledge of the KFC clinical team. They feel comfortable reaching out to them when they have a question or concern and are happy with the quality of reactive support they receive.

KFC clinical staff do not regard proactive clinical support as part of their role

KFC clinicians do not currently regard proactive mentoring and systematic support for hospital clinicians as one of their key responsibilities. Instead they focus their time on their own clinical practice in Laquintinie, providing initial training for new KMC clinicians and undertaking 'evaluation' visits to programme hospitals (2 visits in the first 12 months for each hospital). Hospital management highlighted the need for regular refresher training to maintain clinician skills around KMC. Hospital clinicians technically have ongoing access to the Cross-Knowledge KMC training resources, but admitted to accessing the platform very infrequently, if at all, since their initial training.

High levels of staff turnover have created challenges for delivering quality KMC

KFC management believe that their MoU with hospitals has reduced staff movement within each hospital, but has not had an impact on external movement. They reflected that strong engagement with Regional Health Delegates can support staff retention within the region. KFC management believe that careful selection of KMC clinicians based on their interest in developing and promoting KMC practice may support future retention.

1.4 Recommendations for implementation at scale: clinician incentives, turnover and ongoing support

- Embed supportive supervision and planned refresher training for neonatal clinicians as a core part of a national KMC roll-out.
- Develop smartphone platforms and resources to support continuing professional development for neonatal clinicians. Ensure ongoing monitoring of effectiveness.
- Consider how clinician incentives could be included within the broader performance-based finance (PBF) framework for maternal and neonatal healthcare in Cameroon to support the roll-out of KMC practices.
- Partner with MoPH, Regional Health Delegates and hospital management to slow the high rates of doctor turnover within neo-natal care units in Cameroon and ensure hospital-level neonatal practice is resilient in the face of GP turnover.
- Map and engage KMC-trained clinicians who have moved on from programme hospitals as a potential resource base to support national roll-out of KMC.

1.5 Community referral and follow-up

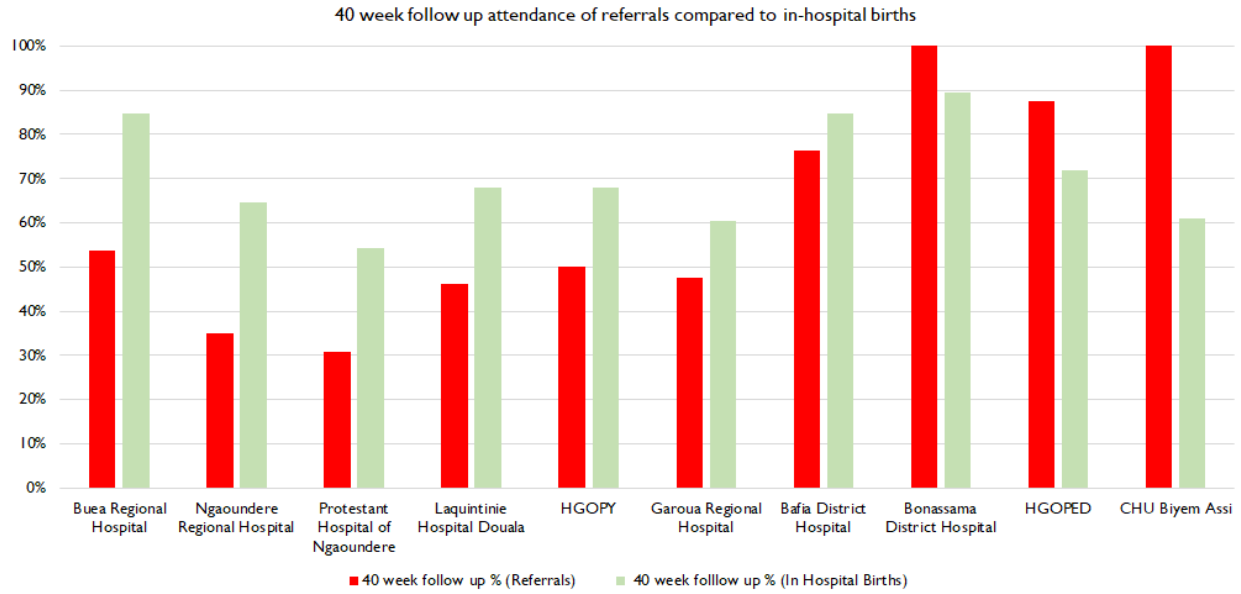


FIGURE E: % mothers returning for 40 week follow-up: referred babies vs. hospital births

1.5 Overview: community referral and follow-up

Around 25% of babies enrolled within the DIB to date have been referred to programme hospitals after birth. However, the percentage of referrals vs. hospital births is notably higher in more rural programme hospitals like Garoua (42%), and Bafia (36%) – see Appendix 1.5.a.

In Buea, Ngaoundere Regional, Ngaoundere Protestant and Laquintinie, babies who were referred were significantly less likely to return for their 40 week follow up appointment than babies born in those hospitals (Figure E). Referred babies are also likely to arrive in a worse state of health and are at higher risk of poor outcomes. Hospital data shows that 16% of referred babies are discharged dead, compared with 7% of babies born in the hospital where they receive KMC.

DIB-funded community engagement activities have so far been undertaken in the Littoral region, the North, Adamaoua and Bafia (Buea is currently too unstable). Community engagement activities have had three foci to date:

1. **Community KMC sensitisation:** Many Community Health Workers (CHW), staff from non-programme health centres and community leaders were previously unaware of KMC and, in some areas, there are perceived to be cultural and social barriers to implementation related to modesty concerns about skin-to-skin care and a reluctance to allow women to stay overnight in hospitals without their husbands. KFC worked with programme hospitals in 2020 to organise awareness raising events to promote the core principles of KMC including the value of skin-to-skin care and exclusive breastfeeding (EBF) for low birth weight and pre-term babies.

2. **Safe referral of low birth weight and preterm infants to KMC facilities:** Community health workers play a key role in ensuring low birth weight and preterm infants are identified, appropriately referred and safely transported to specialist KMC centres. When possible, referral of high-risk mothers is encouraged before birth. KFC has worked with programme hospitals to organise trainings for community health professionals to highlight warning signs, identify referral hospitals and promote skin-to-skin transportation of referred babies. Trained health workers are provided with KMC lycra bands and PPE to promote safe referral.

3. **Community KMC follow-up:** Community health workers are trained to monitor the progress of KMC babies post-follow-up with a particular focus on encouraging extended skin-to-skin care for babies once back in the community and supporting appropriate and adequate infant nutrition (EBF where possible). While other check-ups can be carried out in the community, within the DIB-funded programme mothers are required to bring their infants to the KMC programme hospitals weekly until their 40 week follow-up appointment.

DIB-funded community engagement activities have targeted a wide range of stakeholders including neighbouring hospitals, faith-based health centres, community leaders, traditional birth attendants, and community health workers. A total of 121 people have been trained in community KMC at 6 programme hospitals to date, at an average cost of USD $472 per person (range USD $319-$696). We would expect costs per person trained to reduce over time as local trainers become more experienced at leading training sessions. Costs included accommodation, travel and meals for trainers and participants (Appendix 1.5.b).

1.5 Lessons from implementation: community referral and follow-up

Ease and cost of transport is a significant barrier to post-discharge follow-up of KMC babies

The most common reason given by mothers, for not returning to KMC programme hospitals for their baby's 40 week follow-up appointment, is the cost of transport.[11] For some programme hospitals, nearly 50% of patients live more than one hour away, with around 10% of patients over two hours away. KFC clinicians noted that the DIB-funded phones in each KMC programme hospital have facilitated post-discharge contact with families, who have been encouraged to return for follow-up appointments where possible.

Cultural barriers can also be a barrier to effective post-discharge follow-up

Mothers discharged from the two Ngaoundere hospitals cited cultural barriers as their biggest challenge to attending follow-up appointments. Data analysis indicates that babies not returning for their 40 week follow-up appointments tend to have mothers who are younger, have lower education levels and lower income professions. Hospital clinicians noted that these factors may increase the likelihood that it is not the mother's decision as to whether their baby is brought to a follow-up appointment. KFC clinicians noted the importance of communicating the benefits of follow-up appointments to fathers and grandparents. Hospital clinicians believe that mothers are less likely to come back if their babies seem to be doing well.

KMC and hospital staff see significant potential in community referral and follow-up

KFC and hospital staff (management and clinical) see significant value in increasing community KMC referrals and follow-ups as a mechanism to increase the uptake of KMC and to ensure the health of babies post-discharge. Currently 40 week follow-up appointments that take place outside KMC programme hospitals do not qualify for DIB outcomes payments, however KFC and hospital staff expect community KMC to be an important component of national scale-up. Referral rates have increased overall since community engagement activities were undertaken in 2020.

Appropriate data collection is needed to support referrals and post-discharge follow-up

KFC Data Entry Clerks highlighted the importance of appropriate data collection processes to support community referrals and follow-ups. Data Entry Clerks and KFC management noted the

[11] Sample of five hospitals: Garoua, Laquintinie, HGOPY, Ngaoundere Regional and Ngaoundere Protestant.

importance of regular two-way communication between community referrers and KMC programme hospitals to check capacity and support follow-up appointments post-discharge.

1.5 Recommendations for implementation at scale: community engagement and follow-up

- Embed community KMC referral and follow-up processes – including data collection to support patient tracking and advocacy to promote community KMC – in the training curriculum for community health workers.
- Centre community referral and follow-up processes in newborn care training curricula and KMC roll-out strategy.
- Explore sources of funding – including performance-based finance – to support community KMC provision: awareness raising, KMC equipment, communities of practice and continuing professional development (CPD).
- Consider strategies for engaging and training traditional birth attendants to support early referral of at risk mothers, promote family support for KMC and ensure appropriate follow-up.

1.6 Hospital delivery of quality KMC

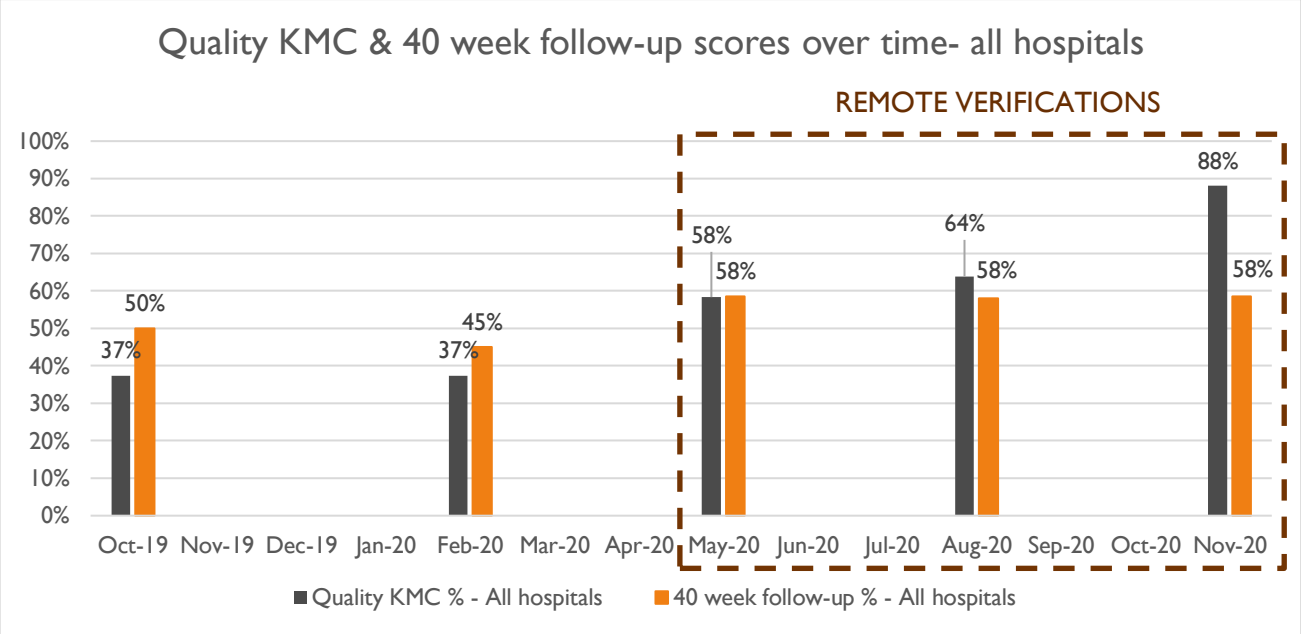


FIGURE F: Quality KMC & 40 week follow-up scores over time – all hospitals[12]

1.6 Overview: hospital delivery of quality KMC

The ten KMC programme hospitals have already exceeded patient enrolment targets for the programme overall (1,535 babies enrolled by end of December 2020 out of 1,520 forecast for the programme overall). With all but two hospitals (Buea and CHU) exceeding hospital-level enrolment targets.

During the term of the DIB, the quality of KMC care provided in programme hospitals is monitored by the clinical team at the KFC with support and additional monitoring visits from members of their parent organisation, the Fundación Canguro in Colombia.

Additionally, the quality of KMC care is independently assessed by IRESCO every three to four months using a quality KMC assessment tool (Appendix 1.6.c). KMC quality assessments combine interviews with mothers with verification agent observations (pre-Covid) to assess:

- Number of hours babies are kept in skin-to-skin care each day;
- Appropriateness of infant nutrition; and
- Appropriateness of hospital discharge.[13]

KMC babies in the neonatal unit are expected to be in skin-to-skin care for at least 8 hours a day with babies placed in a heating device or incubator when not in KMC position. Babies on a KMC ward are expected to be in skin-to-skin care for at least 20 hours a day. All babies are expected to be

[12] See Appendices 1.6.a and 1.6.b for verification results by programme hospital.

[13] N.B. It was not possible to assess this component of quality KMC delivery during the remote verification period.

exclusively breastfed unless there is a documented medical constraint. Babies are required to demonstrate good health and a minimum level of weight gain to qualify for appropriate discharge.

The average length of hospital stay for KMC babies in the DIB-funded programme is 10 days (Appendix 1.6.e). However, this is significantly higher in some hospitals such as HGOPED (18 days) and HGOPY (12 days), both specialist obstetric and gynaecology hospitals with more critical cases, than others such as the Ngaoundere hospitals where the average length of stay is just under 6 days. It is thought that mothers from more rural settings may be required to return home earlier because of their domestic responsibilities.

The mortality rate at discharge for KMC babies has fluctuated over time, but tends to follow the same trend as the mortality rate for non-KMC babies in programme hospitals, so is likely driven by seasonal factors and neonatal ward infection rates (Appendix 1.6.f). Mortality rate at discharge varies significantly between hospitals, but tends to be consistently lower than that for non-KMC babies (KMC mortality rate 6.2% vs. non-KMC mortality rate 18.2% across all programme hospitals in 2020).

1.6 Lessons from implementation: hospital delivery of quality KMC

Appropriate nutrition has been consistently delivered across all programme hospitals

Mothers are required to exclusively breastfeed KMC infants unless there is a medical constraint. To date, across KMC programme hospitals 86% of babies were exclusively breastfed at the point of discharge, and 80% of babies who returned for their 40 week follow up appointment had gained an appropriate amount of weight according to the WHO Child Growth Standards.

Extended skin-to-skin care is the biggest challenge for quality KMC delivery

Independent verification data shows that the primary challenge for ensuring quality KMC criteria are met is ensuring that babies spend sufficient time in skin-to-skin KMC care each day. KFC and hospital clinicians noted that this is particularly challenging because mothers often have to leave the hospital to find food (patient meals are not routinely provided in Cameroon) and buy medication. Babies with multiple caregivers (mothers, grandmothers, fathers and aunts) are more likely to spend sufficient time in KMC than those with a single caregiver. KFC clinicians mentioned the value of mothers seeing healthy children that had received KMC care as infants, as a motivator to encourage them to use extended skin-to-skin care.

High cost of care is a significant driver of inappropriate discharge

Financial difficulties and an inability to pay for in-patient care, is the primary reason cited by families discharging their babies against medical advice. Secondary reasons include family pressure for mothers to resume household and economic duties outside the hospital. In some cases it has been possible to avoid pre-emptive discharge by providing mothers with food or supporting them to cover the costs of neonatal medicines like antibiotics. Around 10% of babies enrolled in KMC have been discharged against medical advice to date (Appendix 1.6.f).

Limited availability of incubators and radiant warmers has also been a challenge for quality KMC

Limited availability of heat pads and incubators (and reliable electricity to power them) in KMC neonatal units has been a challenge for delivering quality KMC in some programme hospitals. Babies in neonatal units are required to be in incubators or radiant warmers when not in skin-to-skin care. KFC management reported that in 1 hospital the DIB had to fund two additional incubators to enable this. 2 hospitals required generators to support reliable electricity supply to their neonatal units.

Monthly review of clinical data and outcome verification results drives quality improvement

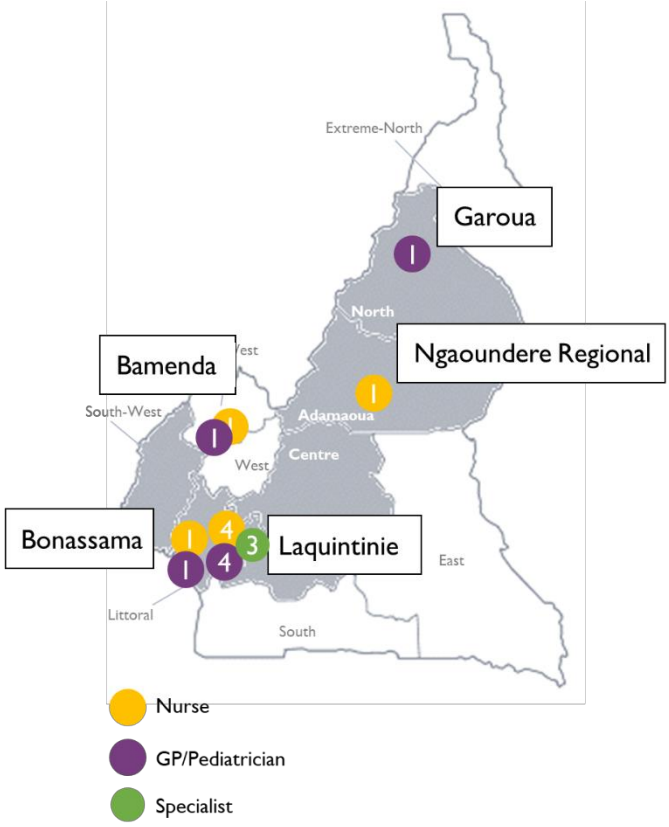
Data Entry Clerks and hospital clinicians noted the importance of consistent data capture and regular monthly reviews of key clinical data to inform improvements in the quality of hospital KMC care.

1.6 Recommendations for implementation at scale: hospital delivery of quality KMC

- Where possible engage multiple caregivers (mothers, fathers, other family members and, potentially, volunteers) in the provision of skin-to-skin KMC care for each pre-term or low birth weight baby.[14]
- Analyse the cost of care for premature and low birth weight babies in Cameroon to inform a potential minimum package of financial support for families.
- Investigate ways to systematically support families to meet the costs of hospital care and post-discharge follow-up for pre-term and low birth weight babies, potentially through a minimum package of financial support for neonatal care, as part of KMC roll-out.
- Consider how the availability of core neonatal health infrastructure and equipment can be strengthened as a prerequisite for enabling quality KMC in Cameroon.
- Support the translation of national KMC protocols (see 1.3) into hospital-specific protocols for neonatal care.
- Embed robust clinical data collection, analysis and data review as a driver for improving hospital KMC practice.

[14] N.B. this may require multiple sizes of KMC lycra bands to be available for each baby as they are sized to each caregiver. Consider also the potential to harness volunteers to support skin-to-skin care in hospitals.

1.7 Embedding KMC in the Cameroon health system



Base hospital	GP or paediatrician	Nurse	Specialist
Laquintinie (all KFC employees)	4	4	3
Bonassama	1	1	
Bamenda (from KMC pilot)	1	1	
Ngaoundere Regional	1		
Garoua	1		
Total	**8**	**6**	**3**

FIGURE G: Number and location of KMC trainers in Cameroon

1.7 Overview: embedding KMC in the Cameroon health system

In addition to rolling-out the delivery of quality KMC in 10 programme hospitals, the Cameroon KMC DIB also targeted the certification of four programme hospitals as Centres of Excellence as a mechanism for embedding KMC within the health system in Cameroon. KMC Centres of Excellence would act as referral, training and support hubs for surrounding hospitals, clinicians and community health workers.

One programme hospital, Laquintinie in Douala, was designated a Centre of Excellence by KF Columbia prior to programme commencement following its involvement in the two-year pre-DIB pilot phase. To date, this hospital has been used as the location for all two-week residential training sessions for KMC clinicians and is the usual place of work for KFC clinicians.

It was originally envisaged that Ngaoundere Regional, Garoua and HGOPY hospitals would also become Centres of Excellence over the course of the KMC programme. In practice this has not been possible due to staff shortages, high rates of KMC clinician turnover and delays to programme delivery due to infrastructure upgrades.

Instead, KFC has changed tack to focus on the creation of a 'Pool of Trainers' drawn from across programme hospitals. KMC trainers receive extra training and are judged by the KMC team to have a good level of clinical KMC experience. The hope is that, in time, these trainers will both host group residential trainings in their own hospitals and travel to other hospitals to train individuals where key staff have moved on.

In the course of the DIB, 9 additional KMC trainers have been trained across KFC and 3 programme hospitals. There are now 17 KMC trainers in Cameroon as a whole – 11 KFC employees, and 6 within public hospitals. In 2020 several were involved in delivering community engagement awareness raising and training sessions in five regions. In January 2021 hospital KMC trainers will jointly deliver a two-week KMC core training alongside KFC clinicians at Laquintinie Hospital.

Trainers receive a stipend for delivering trainings, but have no formal agreement with KFC at present. To date doctors have received $400 for preparation and delivery of three days of training; nurses $200.

1.7 Lessons from implementation: embedding KMC in the Cameroon health system

Establishing functioning KMC units takes time; establishing Centres of Excellence takes longer

KFC clinicians were optimistic about the potential for a number of programme hospitals to become Centres of Excellence in time, but noted that they needed to first demonstrate consistently high delivery of quality KMC over time and, before hosting and leading KMC training, KMC trainers would need to have first supported KMC training at other hospitals.

Staff shortages can make it difficult to release KMC trainers from clinical duties

KFC management noted that it can be difficult to release KMC trainers from their clinical duties in their home hospitals. This has limited their involvement in delivering KMC training for new practitioners to date.

1.7 Recommendations for implementation at scale: embedding KMC in the Cameroon health system

- Create a multi-stakeholder advisory group to oversee the embedding of KMC within the Maternal, Child and Neonatal Health Strategy – to include MoPH, Ministry of Higher Education, Ministry of Finance, Kangaroo Foundation Cameroon and other relevant professional associations (such as the Cameroonian Society of Paediatrics).
- Embed KMC as a core neonatal health tool in hospitals and community health facilities within the national maternal, child and neonatal health strategy.
- Analyse KMC programme cost data to identify the cost of embedding KMC within neonatal health units in Cameroon.
- Support active Communities of Practice to provide informal and structured support, and continuing professional development to neonatal clinicians.
- Consider the role of KMC Centres of Excellence and specialist KMC trainers in supporting the roll-out of KMC practice in Cameroon.
- Include KMC in neonatal practitioner career development, training and support pathways.

Acknowledgments

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CAMEROON KANGAROO MOTHER CARE (KMC) DIB

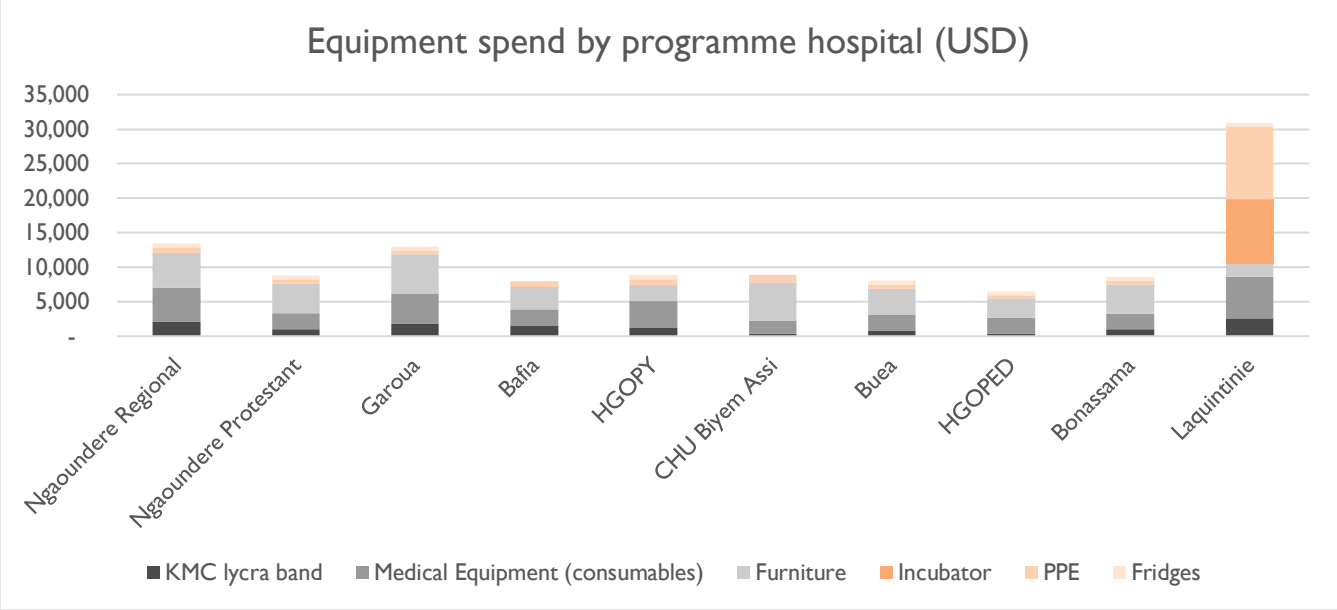
SUPPORTING APPENDICES FOR LESSONS FROM DELIVERY FOR SCALE

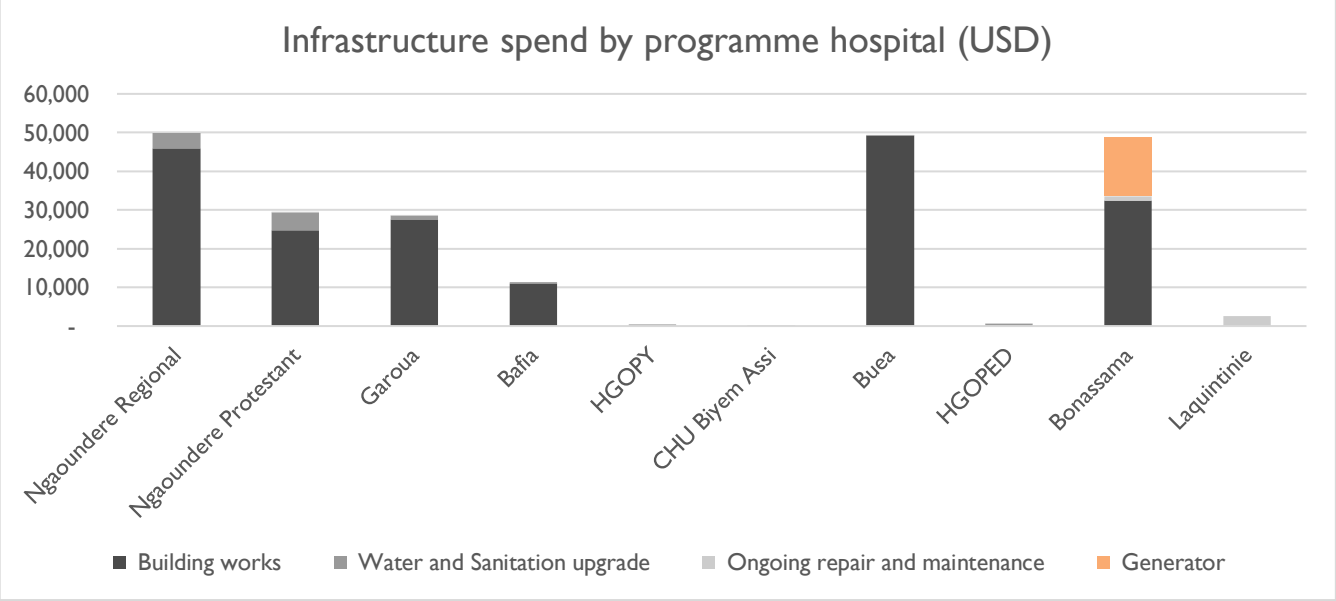
MARCH 2021

List of appendices

APPENDIX 1.2

1.2.a Infrastructure and equipment spend per hospital (February 2019 to January 2021)





1.2b Non-budgeted items (February 2019 to January 2021)

	Total (USD)	Comments
Incubator	8,503	
Infrastructure	23,068	Generator, water reservoir and filter
Furniture	7,645	Plastic chairs, benches, cupboard
PPE	13,099	
Single used items	2,912	Disposable glove, tongue depressor, consultation sheet, hygiene cap, lab coat
Medical equipment	7,058	Scales, otoscopes, oximeter
Equipment for specialists	1,340	
Total	**63,625**	

1.2c KMC readiness form – complete

Privé et confidentiel

QUESTIONNAIRE DE VISITE DE L'HÔPITAL

Évaluation des prérequis MMK

Information sur l'hôpital

Nom de l'établissement :

Question	Réponses
Désignation (urbain/rural)	
Type d'établissement *(central, district, autre ...)*	
Type d'hôpital *(gouvernemental, privé (à but lucratif), Semi-autonome, ONG, Autre...)*	

Volumes et capacité

Volumes actuels de nouveau-nés à faible poids de naissance et prématurés

Unité néonatale		Notes / Source d'information
# enfants admis au service de néonatologie		**Nombre d'enfants nés à l'hôpital?** **Nombre d'enfants référés à l'hôpital?**
Au cours du dernier mois		
Au cours des 12 derniers mois		

Nombre de nourrissons à faible poids de naissance ou prématurés admis dans l'unité		
Au cours du dernier mois		
Au cours des 12 derniers mois		
Nombre de nourrissons à faible poids ou prématurés décédés à l'hôpital dans l'unité		
Au cours du dernier mois		
Au cours des 12 derniers mois		
Durée moyenne du séjour en salle de soins néonataux pour les nourrissons à faible poids de naissance / prématurés		

Volume prévu de nourrissons à faible poids de naissance ou prématuré (demande)

Le but de cette section est de rassembler des informations qui permettront de savoir comment nous allons estimer la croissance du programme MMK (c'est-à-dire volume prévu pour 2018 à 2022)

Population / références	Notes
Combien de nourrissons sont référés de ces établissements, et combien d'autres pourraient être référés lorsque le service MMK sera disponible dans cet hôpital ?	
Combien de nourrissons référez-vous à d'autres hôpitaux ? Combien d'entre eux pourraient être traités ici une fois le service MMK disponible ?	
Y a-t-il d'autres facteurs qui pourraient affecter les volumes attendus dans cet hôpital (exemples : l'hôpital peut devenir inaccessible pendant certaines saisons, il y a un taux très élevé de naissances à domicile dans le district) ?	

Capacité maximale du programme MMK (offre)

Le but de cette section est de comprendre les contraintes de capacité de l'hôpital (c'est-à-dire quel est le nombre maximum de nourrissons qui pourraient être inscrits dans le programme MMK)

Salle d'accouchement et salle néonatale	Notes / Source d'information
L'établissement offre-t-il des soins obstétriques et néonataux 24 heures par jour, 7 jours par semaine ?	
À quelle distance se trouve l'hôpital de référence le plus proche avec des soins chirurgicaux ?	
Combien de lits d'accouchement sont disponibles ?	
Combien y a-t-il d'incubateurs fonctionnels ?	
Combien de nourrissons peuvent être soignés dans le service de néonatologie **à n'importe quel moment** ? Et **par mois / année** ?	
Combien de lits y aura-t-il dans la salle de soin MMK actuelle / proposée ?	
Combien de nourrissons pourront être soignés dans cette salle de soin MMK par mois / année?	
Autres facteurs qui limiteront le nombre de nourrissons qui pourraient recevoir un soin MMK à l'hôpital.	

Infrastructure et équipement

Évaluation de l'infrastructure

Unité néonatale		Notes - description des mises à niveau requises
Le service de néonatologie est-il opérationnel ?		
Le service de néonatologie est-il séparé du service de pédiatrie ?		
Est-ce que le service de néonatologie à:		
Un incubateur de travail / une unité chauffante		

Un approvisionnement en oxygène		
Améliorations requises dans le service de néonatologie :		*[Veuillez donner des détails sur le travail requis, le cas échéant, et les devis ou source d'estimation associés]*
Coût (matériaux)		
Coût (main d'œuvre)		
Salle de soin MMK / Salle de suivi		**Notes / Source d'information**
Y a-t-il suffisamment d'espace à l'hôpital pour créer un service MMK?		
Distance entre la salle néonatale et la salle de soin MMK (proposée)		
Mises à niveau requises pour créer une salle de soin MMK		*[Veuillez donner des détails sur le travail requis, le cas échéant, et les devis ou source d'estimation associés]*
Coût (matériaux)		
Coût (main d'œuvre)		
Eau, Assainissement et Hygiène		**Notes / Source d'information**
Cette formation sanitaire a-t-elle de l'eau courante pour des fonctions telles que la prévention des infections, l'utilisation du patient et du personnel, etc. ?		
Quelle est la principale source d'eau? *(l'eau canalisée, le forage, le puits, la rivière, d'autres ...)*		
Y a-t-il de l'eau courante actuellement disponible ?		
Dans le service néonatal ?		
Dans l'unité MMK proposée ?		
Au cours du dernier mois, combien de jours avez-vous été sans eau?		
Coût des mises à niveau nécessaires pour		*[Veuillez donner des détails sur le travail*

relier le service néonatal / MMK à l'eau courante :		*requis, le cas échéant, et les devis ou source d'estimation associés]*
Coût (matériaux)		
Coût (main d'œuvre)		
Eau potable		**Notes / Source d'information**
Est-ce que cette formation sanitaire a accès à de l'eau potable ?		
Quelle est la principale source d'eau potable ? *(réservoir d'eau, autre ...)*		
Y a-t-il de l'eau potable actuellement disponible :		
Dans le service néonatal?		
Dans l'unité MMK proposée ?		
Coût des mises à niveau requises pour raccorder le service néonatal / MMK à l'eau potable :		*[Veuillez donner des détails sur le travail requis, le cas échéant, et les devis ou source d'estimation associés]*
Coût (matériaux)		
Coût (main d'œuvre)		
Au cours du dernier mois, combien de jours étiez-vous sans accès à de l'eau potable ?		
Électricité		**Notes / Source d'information**
Quelle est la principale source d'électricité ? *(lignes électriques, générateur, solaire, autre ...)*		
Y a-t-il un générateur de secours disponible ?		
Le générateur de secours est-il fonctionnel ?		
Au cours du dernier mois, combien de jours avez-vous passé sans électricité ?		

Collecte de données et communication		Notes / Source d'information
Comment les dossiers sont-ils généralement capturés et stockés à l'hôpital? *(registres dans les salle d'accouchement et néonatale, autre ...)*		
Qui enregistre et conserve ces enregistrements ?		
Les informations suivantes sont-elles enregistrées à la naissance / à l'entrée à l'hôpital ?		
Poids à la naissance		
L'âge gestationnel		
Y at-il une connexion internet disponible à l'installation ?		*[Veuillez commenter la fiabilité de la connexion internet]*
Y a-t-il un téléphone disponible dans l'établissement (que le personnel peut utiliser pour les rendez-vous de suivi) ?		
Coût de la mise à niveau de la connexion Internet et téléphonique		
Coût (matériaux)		
Coût (main d'œuvre)		

Évaluation de l'équipement

L'équipement doit être fonctionnel

Article	Coût par article (CAF)	# actuellement disponible (a)	# requis pour MMK (b)	# à acheter = (b) - (a)
Balance pour le poids (avec une précision d'au moins 10g)			2	
Horloge pour la salle de soin MMK			2	
Infantomètre pour le programme de			1	

suivi				
Bandes de Lycra				
Tube gastrique néonatal				
Canule nasale néonatale				
Chaises avec dos et accoudoirs pour salle néonatale			*[À évaluer en fonction de la capacité]*	
Lits pour l'unité MMK			*[À évaluer en fonction de la capacité]*	
Table d'examen pour le suivi			1	
Réfrigérateur pour stocker le lait maternel			1	

Personnel

Paiements		**Notes / Source d'information**
Combien de personnes occupent les postes suivants pour les salles d'accouchement et le service de néonatologie (équivalent temps plein pour le temps consacré aux soins néonataux ?)		
Pédiatre		
Médecin généraliste		
Infirmière		
Commis aux données		
Sont les spécialistes suivants disponibles ou proches de la formation sanitaire ?		
Psychologue		
Physiothérapeute		
Ophtalmologiste		

Serait-il possible pour un pédiatre de superviser les activités dans les unités néonatal et MMK?		
Quelle est la base salaire standard pour le personnel suivant (si connu) ?		
Pédiatre		
Médecin généraliste		
Infirmière		
Quelle est la prime hospitalière standard payée pour le personnel suivant?		
Pédiatre		
Médecin généraliste		
Infirmière		
Nous estimons que le programme MMK requière 1 pédiatre (ou médecin généraliste) + 2 infirmières à plein temps. Quelle est l'exigence du personnel dans cet hôpital vu le personnel déjà disponible ?		

Politiques et paiement pour les services

Politiques institutionnelles

Politiques		Notes / Source d'information
L'établissement a-t-il une politique institutionnelle de MMK ?		
L'établissement a-t-il une politique d'allaitement maternel ? *[veuillez noter si la politique encourage l'allaitement maternel exclusif]*		
L'établissement autorise-t-il l'accès des parents au service		

de néonatologie 24h / 24?		
L'établissement fait-il partie de l'Initiative Hôpitaux Amis des Bébés ?		
La formation sanitaire fait-elle partie ou est-elle désignée pour faire partie du programme PBF (Performance Based Financing) mise en place en collaboration avec la Banque Mondiale? *[Si elle n'est pas encore dans le programme PBF, veuillez noter la date de début prévue]*		
Tous autres commentaires sur les politiques susceptibles d'affecter la mise en œuvre de la MMK dans l'établissement		

Paiement pour les services

Paiements		**Notes / Source d'information**
Y a-t-il un paiement formel à l'hôpital avant la consultation / le traitement ?		
En cas d'urgence, le paiement est-il requis avant qu'une femme puisse recevoir un traitement ?		
En cas d'urgence, demande-t-on à la femme ou à sa famille d'acheter des médicaments ou autres provisions avant le traitement ?		
Y a-t-il un barème d'honoraires pour les services affichés dans un endroit visible et public ?		*[Si possible, obtenir ce barème]*
Existe-t-il un système **formel** de renonciation aux frais de maternité pour les femmes pauvres ?		
Y a-t-il un système **informel** en place pour que les femmes pauvres bénéficient d'une dérogation des frais pour les		

services de maternité?		
Quel est le tarif normal pour les services suivant :		
Frais d'admission		
Soin prénatal		
Accouchement normal		
Séjour en unité néonatale (par jour)		
Lit pour la mère (par jour)		
Nourriture (par jour)		
Soins MMK (si disponible)		
Rendez-vous de suivi (si disponible)		
Y a-t-il d'autres frais chargés dans la salle d'accouchement, le service de néonatologie ou le service MMK?		

1.2d KMC readiness form – simplified

Fondation Kangourou Cameroun

Evaluation des besoins d'une Unité Kangourou : Cameroon Newborn DIB Program (onboarding time) hopital regional de Garoua

(Data clerk needs)	Libellé	Nombre	Etat	Observation
Informatique	Laptop			
	Onduleur			
	Parasurtenseur			
	Antivirus			

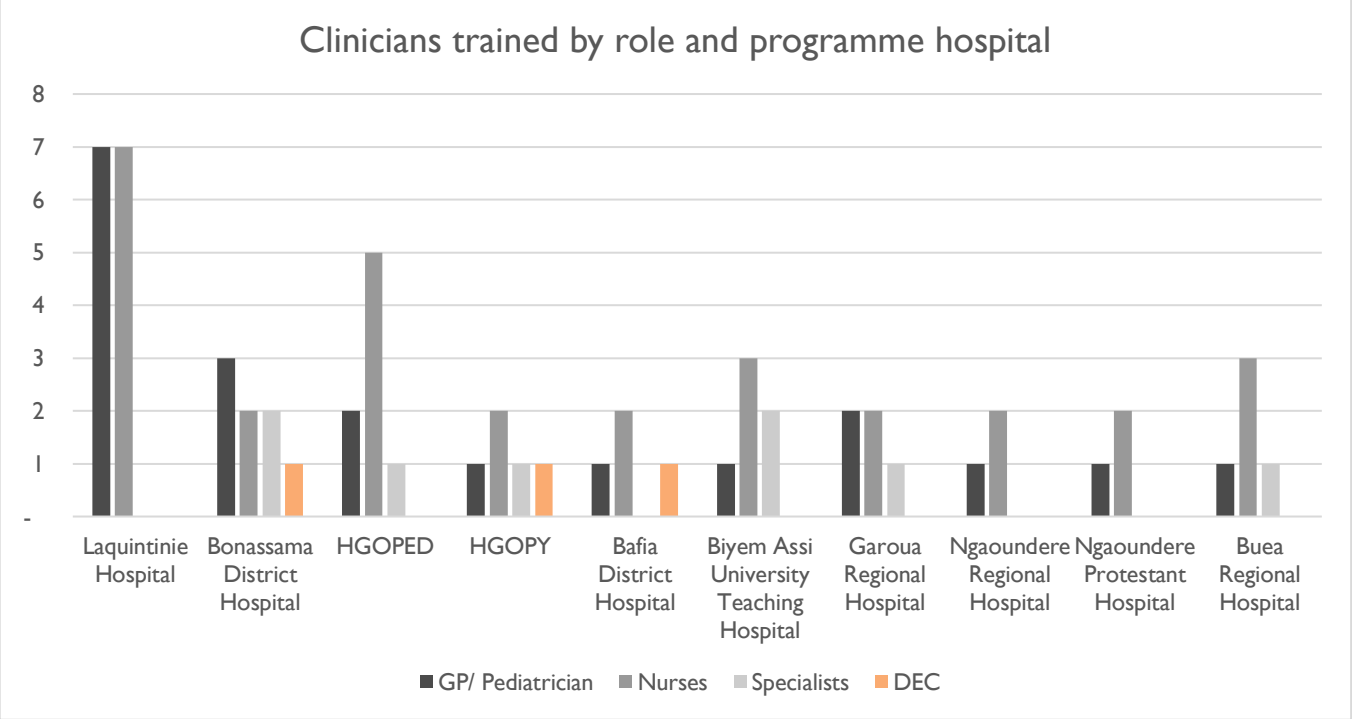
	Sacoche			
	Modem internet			
	souris			
	haut-parleur			
Mobilier	table de consultation			
	matelas pour table de consultation			
	chaise de consultation			
	armoire de rangement			
	banc de consultation			
	Table, banc, matelas + natte pour Griffith			
	chaise pied de couveuse (des mamans)			
Médical	Incubateur			
	Radiante			
	Photothérapie			
	pèse bébé			
	lunettes à oxygène			
	sonde gastrique n°5 ou 6			
	oxymètre			
	Infantomètre			
	Frigo			
	Plan incliné			
	Séringue			

	huile de massage			
Divers	poche en lycra			
	casaque			
	horloge murale			
	registre			
	0			
	bouilloire			
Wash	Réserve d'eau			
	filtre à cartouche			
	cartouche de rechange			
Infrastructure	Salle de repos des mamans			
	Salle des incubateurs			
	Salle mère-enfant			
	Salle des infirmières			
	Unité de soins intensifs			
	Salle de suivi ambulatoire			
	Point d'eau			
	Casiers			
Personnel	Pédiatre			
	Médecin généraliste			
	Infirmier			

	Auxiliaire de soins			
	Psychologue clinicien			
	Kinésithérapeute			
	Ophtalmologue			

APPENDIX 1.3

1.3.a Clinicians trained by role and programme hospital



1.3.b KMC training agenda

REPUBLIQUE DU CAMEROUN
PAIX – TRAVAIL – PATRIE

MINISTERE DE LA SANTE PUBLIQUE
HOPITAL LAQUINTINIE DE DOUALA
SERVICE DE NEONATOLOGIE
CENTRE D'EXCELLENCE DE FORMATION A LA METHODE MERE KANGOUROU
BP: 5517 – DOUALA CAMEROUN
E-mail: fondationkangouroucameroun@gmail.com
Tél.: (237) 233 43 64 64

REPUBLIC OF CAMEROON
PEACE – WORK – FATHERLAND

MINISTRY OF PUBLIQUE HEALTH
LAQUINTINIE HOSPITAL DOUALA
NEONATOLOGY UNIT
CENTER OF EXCELLENCE IN TRAINING KANGAROO MOTHER CARE
BP: 5517 – DOUALA CAMEROON
E-mail: fondationkangouroucameroun@gmail.com
Tél.: (237) 233 43 64 64

Formation au Programme Mère Kangourou (PMK)

Personnel des formations sanitaires ci-après :

- **Centre Hospitalier Universitaire de Yaoundé**
- **Hôpital Protestant de Ngaoundéré**

Du 20 au 31 Janvier 2020

Hôpital Laquintinie de Douala

PROGRAMME

Horaires	Activités	Formateurs
	Lundi 20/01/20	
08 h 30	Accueil des participants	Dr GUIFO Dr MOUDZE Personnels Kangourou de l'HLD
08 h 45	Présentation des intervenants Présentation des apprenants : leurs attentes par rapport à cette formation ; la situation des prématurés dans leur formation sanitaire.	
09 H 30	Présentation du projet DIB	Mme MANJO
10 h 00	Théorie : Utilisation et technique de rechange des cartouches de filtre au niveau des points d'eau	M. FEUWA
10 h 15	**PAUSE CAFE**	
10 h 30	Présentation de l´Unité Kangourou du Centre d'Excellence Visite du département de Pédiatrie Visite de la maternité Ashanti – Diamant Visite pavillon ETOO	Dr GUIFO Dr MOUDZE Major du service des prématurés
11h 15	Présentation du calendrier de la formation Signature des lettres d'engagement par les apprenants	Dr GUIFO Dr MOUDZE
11 h 30	Pré-test de connaissance de la MMK	
12 h 00	**Présentation de la Plateforme E-learning** : Introduction à la plateforme. Parcours de la formation : étapes 1 et 2, programme de collecte des données, boîte à outils.	M NGADOM
12 h 45	Module ***QQQDO*** (épidémiologie, Concepts, historique MMK, objectifs, Philosophie).	Dr GUIFO Dr MOUDZE
13 h 30	**PAUSE DEJEUNER**	
14 h 15	**Avant de débuter la MMK** : - Niveaux de soins de l'institution, ce que l'on peut faire. - Terminologie : Age gestationnel ; âge chronologique ; âge corrigé, test de Ballard. Les besoins pour la mise en œuvre de la MMK selon les niveaux de soins.	Dr GUIFO Dr MOUDZE
15h00	Quand déclarer officiellement un prématuré ?	M. EPICHOP
15 h 15	Pratique dans le service: - Découverte du matériel basique du Centre d'Excellence. - Enregistrement des entrants en néonatologie.	Dr GUIFO Dr MOUDZE

16 H 00	- Chaque apprenant choisi un bébé qu'il suivra durant toute la formation. - <u>Médecins</u> : s´entrainer au Test de Ballard en néonatologie. <u>Théorie :</u> - Quizz niveau de soins – partie 1 - Quizz Besoins niveaux de soins – partie 2 - Rubrique : « En savoir Plus » de la Plateforme, Boîte à outils (Ballard, Lubchenco). **Point sur l'organisation des permanences et des gardes du week-end.**	Dr MOGUEM M. MOGUEM Dr GUIFO Dr MOUDZE
16 h 30	**FIN DE LA JOURNÉE**	
Mardi 21/01/20		
07 h 30 08 h 00	Rapport d'activité de la veille / Echanges Théorie sur les connaissances de bases : ➢ **Premier principe : La Position Kangourou (PK)** - A qui proposer la Position Kangourou ? - Pourquoi ? - Les bénéfices de la Position Kangourou - La prise en charge du prématuré en soins intensifs - Pratique de la Position Kangourou.	Apprenants Dr GUIFO Dr MOUDZE
10 h00	**PAUSE CAFE**	
10 h 15 10 h 45	<u>Pratique en salle ambulatoire</u> : Utilisation et technique de rechange des cartouches de filtre au niveau des points d'eau <u>Pratique dans le service</u> : - Prise de contact avec les mères, mise en confiance - Education collective et individuelle sur la MMK (PK) - Hygiène et alimentation de la maman kangourou - Examen du nouveau-né - Critères d'éligibilité du prématuré candidat à la MMK - Importance de l'identification des bébés candidats à la MMK dans la maternité (ceux qui ne sont pas hospitalisés) et dans le service de néonatologie (ceux qui sont prématurés de plus de 2500g) - Adaptation à la PK en soins intensif et intermédiaires dans le service. <u>Médecins</u> : Ronde médicale auprès des bébés de l'Unité néonatale, salle des prématurés, examen des histoires cliniques, mise en PK des candidats éligibles, pratique de mise en PK pour évaluer les habilités de l'apprenant <u>Infirmières</u> : Eligibilité des familles et Adaptation Kangourou intrahospitalièr <u>Apprenants</u> : Présentation du bébé choisi la veille	M. FEUWA Dr GUIFO Dr MOUDZE Dr MOGUEM Dr TCHATCHOUANG Mme POKAM Mlle NGWANA Mlle EDAN
12 h 30	**PAUSE DEJEUNER**	

13 H 00 14 h 30	<u>Pratique dans le service:</u> - Adaptation à la PK dans la salle mère-enfant - Critère d'éligibilité pour la sortie - Signe danger de la mauvaise Position Kangourou <u>Médecins</u> : - Examen du nouveau-né prématuré ou de PPN : les entrants - Examen des histoires cliniques, mise en PK des candidats éligibles, pratique de mise en PK pour évaluer les habilités de l'apprenant. <u>Infirmières</u> : Détails de la PK et adaptation kangourou intrahospitalier <u>Théorie :</u> - Quizz sur la Position kangourou 1 et 2 - Rubrique « Boîte à outils » (Position Kangourou)	Dr GUIFO Dr MOUDZE Dr MOGUEM Dr TCHATCHOUANG Mme POKAM Mlle NGWANA Mlle EDAN Dr GUIFO Dr MOUDZE Dr MOGUEM
15 h 30	**FIN DE LA JOURNÉE**	
Mercredi 22/01/20		
07 h 30 08 h00	Rapport d'activité de la veille ➢ **Deuxième principe : La Nutrition Kangourou** - Les principes de la nutrition kangourou - Les objectifs de la nutrition kangourou ❖ ***La mise en pratique de la Nutrition Kangourou*** - Soutien aux parents - Comprendre la succion du prématuré - Les suppléments nutritionnels - Extraction et conservation du lait maternel - Les différentes techniques d'alimentation - Quizz sur l'alimentation ❖ ***Adaptation Kangourou intrahospitalière.***	Apprenants Dr GUIFO Dr MOUDZE Dr MOGUEM
10 h 00	**PAUSE CAFE**	
10 h 15	<u>Pratique dans le service:</u> - Hygiène, Nutrition Kangourou et adaptation dans l´Unité de néonatologie : couple mère-enfant - <u>Médecins</u> : Programmation de la journée nutritionnelle de chaque bébé. <u>Infirmières</u> : évaluation de la succion de chaque bébé ; décision du type d'alimentation individuelle des bébés, pratique du type d'alimentation choisi.	Dr GUIFO Dr MOUDZE Dr MOGUEM Dr TCHATCHOUANG Mme POKAM Mlle NGWANA Mlle EDAN
12 h 15	**PAUSE DEJEUNER**	

13 h 00 14 h 30	<u>Pratique dans le service</u> : - Causerie éducative par rapport à la santé - Etablissement des critères de sortie - Nutrition individuelle et quotidienne dans la Salle Mère-enfant - Contrôle de la maîtrise des critères de sortie - Sortie du bébé du jour. <u>Théorie :</u> - Quizz *Nutrition Kangourou (parties 1 et 2)* - Quizz *Adaptation Kangourou* - Rubrique : « Boîte à outils » (Nutrition Kangourou, Adaptation Kangourou).	Dr GUIFO Dr MOUDZE Dr MOGUEM Dr TCHATCHOUANG Mme POKAM Mlle NGWANA Mlle EDAN
15h 30	**FIN DE LA JOURNÉE**	
Jeudi 23/01/20		
07 h 30 08h 00	Rapport d'activité de la veille <u>Théorie sur les connaissances de Bases</u> : ➢ **Troisième principe : Le Suivi Ambulatoire Kangourou** **<u>Le suivi ambulatoire 1</u>** : Avant 40 semaines d'âge corrigé.	Apprenants Dr GUIFO Dr MOUDZE
10 H 00	**PAUSE CAFE**	
10 h 15	<u>Pratique en salle ambulatoire</u> : - Causeries éducatives avec les mamans - Consultation suivi ambulatoire - Adaptation kangourou ambulatoire - Calcul : âge gestationnel, âge corrigé, âge chronologique. - Report des mesures anthropométriques sur les courbes de Fenton et OMS. - Tenue des carnets médicaux. - Examen clinique complet du bébé de la tête au pied. - Programme kangourou ambulatoire, suivi jusqu'à 40 semaines. Test d'INFANIB	Dr GUIFO Dr MOUDZE Dr MOGUEM Dr TCHACHOUANG Mlle NGWANA Mlle EDAN
12 h 15	**PAUSE DEJEUNER**	

13 h 00	Pratique dans le service *:* - Nutrition (Technique d'extraction du lait maternel) et technique de gavage - Adaptation intra-hospitalière - Education des mères (Hygiène du couple mère-bébé) - Discussion sur les critères de sortie à la maison - médecins : Ronde médicale auprès des bébés ; vérification de l'évaluation clinique des bébés mis en PK depuis 03 jours (vérifier la tolérance, vérifier le gain de poids et le type d'alimentation) ; sortie du bébé du jour. - Infirmières : Accompagnement de l'infirmière dans ses tâches quotidiennes de l'Unité des prématurés et du PMK. Technique de soins du jour : expression et conservation du lait maternel.	Dr GUIFO Dr MOUDZE Dr MOGUEM Dr TCHATCHOUANG Mme POKAM Mlle NGWANA Mlle EDAN
15 h 00	**FIN DE LA JOURNÉE**	
Vendredi 24/01/20		
07 h 30 08 h 00	Rapport d'activité de la veille Théorie sur les connaissances de bases ➢ **Troisième principe : Le Suivi Ambulatoire Kangourou** **Le suivi ambulatoire 2** : - Suivi à haut risque de 40 semaines à un an d'âge corrigé. - Tenue des carnets médicaux - Utilisation des courbes de Fenton et de l'OMS	Apprenants Dr GUIFO Dr MOUDZE Dr MOGUEM
10 h 00	**PAUSE CAFE**	
10 h 15	Vidéo : INFANIB d'Amiel TISON Pratique : - Visite de la maternité, salle d'accouchement - Echange sage-femme/apprenants sur la PK et la NK dans les 30 premières minutes de vie Echange sur les accouchements survenus la nuit	Dr GUIFO Dr MOUDZE Major du service
12 h 15	**PAUSE DEJEUNER**	
13 h 00	- Bilan de la semaine - Reprendre les points qui n'ont pas été bien assimilés durant la semaine	Dr GUIFO Dr MOUDZE Dr MOGUEM Mlle NGWANA Mlle EDAN
15 h 00	**FIN DE LA JOURNÉE**	
Samedi 25/01/20		Permanence / garde (Apprenants)
Dimanche 26/01/20		

Lundi 27/01/20		
07 H 30 08 h 30	Rapport de la journée du vendredi 07/06/19 Rapport de la permanence/garde du week-end Echanges sur le déroulement des permanences - gardes Le suivi ambulatoire : Vidéos	Apprenants Dr GUIFO Dr MOUDZE Dr MOGUEM
10 H 00	**PAUSE CAFE**	
10 H 15	<u>Pratique en salle ambulatoire</u> : - Consultation suivi ambulatoire part les apprenants (groupe 1) - Evaluation complète du bébé à l'admission à la consultation ambulatoire - Report des mesures anthropométriques sur les courbes de Fenton-OMS par les apprenants - Programmation du suivi jusqu'à 40 semaines et suivi à haut risque jusqu'à 01 an d'âge corrigé par les apprenants (groupe 2) <u>Médecins</u> : Test d'INFANIB (par les apprenants) <u>Pratique dans le servie</u> : technique d'expression du lait maternel, massage des bébés	Dr GUIFO Dr MOUDZE Dr MOGUEM Dr TCHATCHOUANG Mme POKAM Mlle NGWANA Mlle EDAN
12 h 15	**PAUSE DEJEUNER**	
13 h 00	<u>Théorie</u> : - Quizz Suivi Ambulatoire (Parties 1 et 2) - Rubrique « Boîte à outils » (Suivi ambulatoire) - Rubrique « en savoir plus » (Examen neurologique, vidéo, etc.)	Dr GUIFO Dr MOUDZE Dr MOGUEM
15 h 00	**FIN DE LA JOURNÉE**	
Mardi 28/01/20		
07 h 30 08 h 00	Rapport d'activité de la veille <u>Théorie</u> : Thérapie physique ambulatoire	Apprenants M. NJINANG
10 H 00	**PAUSE DEJEUNER**	
10 H 15	<u>Théorie - Pratique</u> : Contrôle de qualité du PMK - Ramassages des données - Indicateurs de résultats du PMK Utilisation des formats Excel	M. CHE M. NGADOM
12 h 15	**PAUSE DEJEUNER**	

13 h 00	<u>Pratique dans le service</u> : Observation de la structure, de l'éducation donnée aux mamans, activités pratiques des Médecins et des infirmières dans les soins kangourou. ❖ **Première phase d'évaluation pratique des apprenants**	Dr GUIFO Dr MOGUEM Dr TCHATCHOUANG Mlle NGWANA Mlle EDAN
15 h 00	**FIN DE LA JOURNEE**	
Mercredi 29/01/20		
07 h 30 08 h 00	Rapport d'activité de la veille <u>Théorie :</u> Suivi Ambulatoire Développement psychomoteur, Test de Griffiths	Apprenants M. NDJOMO
10 H 00	**PAUSE CAFE**	
10 15	<u>Théorie</u> : Conditions requises pour le PMK hospitalier Conditions requises pour le PMK ambulatoire Assurance – qualité du PMK	Dr GUIFO Dr MOGUEM
12 h 15	**PAUSE DEJEUNER**	
13 h 00 15 h 00	<u>Pratique en salle ambulatoire</u>: - Entraînement au Test de Griffiths <u>Théorie</u> : - Quizz du module Aspect sociaux et émotionnels - Rubrique : « Boîte à outils » (aspect sociaux) - Rubrique : « En savoir plus » (examen psychomoteur, vidéo Griffiths)	M. NDJOMO Dr MOGUEM
15 h 30	**FIN DE LA JOURNÉE**	
Jeudi 30/01/20		
07 h 30	Rapport d'activité de la veille **PAUSE CAFE**	Apprenants
08 H 30	<u>Pratique en salle de Suivi ambulatoire</u> - Causeries éducatives avec les mamans - Consultation suivi ambulatoire par les apprenants (groupe 2) - Calcul : âge gestationnel, âge corrigé, âge chronologique. - Calcul des gains de poids des bébés (g/kg/jr) - Report des mesures anthropométriques sur les courbes de Fenton et OMS. - Tenue des carnets médicaux. Examen clinique complet du bébé de la tête au pied. - Programmation du suivi jusqu'à 40 semaines et suivi à haut risque	Dr GUIFO Dr MOGUEM Dr TCHATCHOUANG Mme POKAM Mlle NGWANA Mlle EDAN

11 H 30	jusqu'à un an d'âge corrigé par las apprenants (groupe 1). - Test d'INFANIB <u>Pratique dans le service</u> : technique d'expression du lait maternel, massage des bébés par les apprenants. - **Deuxième phase d'évaluation pratique des apprenants**.	
13 h 00	**PAUSE DEJEUNER**	
14 h 00	- Elaboration du plan d'action de mise en œuvre du PMK dans les trois prochains mois : Forces – Faiblesses – Opportunités – Moyens (FFOM). - Revue des besoins : équipements et matériels pour la nouvelle unité kangourou.	Mme MANJOH Dr GUIFO Dr MOGUEM
15 h 30	**FIN DE LA JOURNEE**	
Vendredi 31/01/20		
07 h 30	Rapport d'activité de la veille **PAUSE CAFE**	Apprenants
08 H 30	<u>Théorie-Pratique</u> : Dans le service - Révisions des gestes pratiques dans les 3 salles du PMK intra hospitalier : unités des prématurés, salle mère enfant et consultations ambulatoires (sous la supervision des médecins et infirmières de la salle). - Bilan de la semaine - Reprendre les points qui n'ont pas été bien assimilés durant cette deuxième semaine	Dr GUIFO Dr MOGUEM Dr TCHATCHOUANG Mme POKAM Mlle NGWANA Mlle EDAN
12 h 00	**PAUSE**	
13 h 00	Post test Evaluation de la formation **CLÔTURE DE LA FORMATION**	
15 h 00	**FIN DE LA JOURNÉE**	

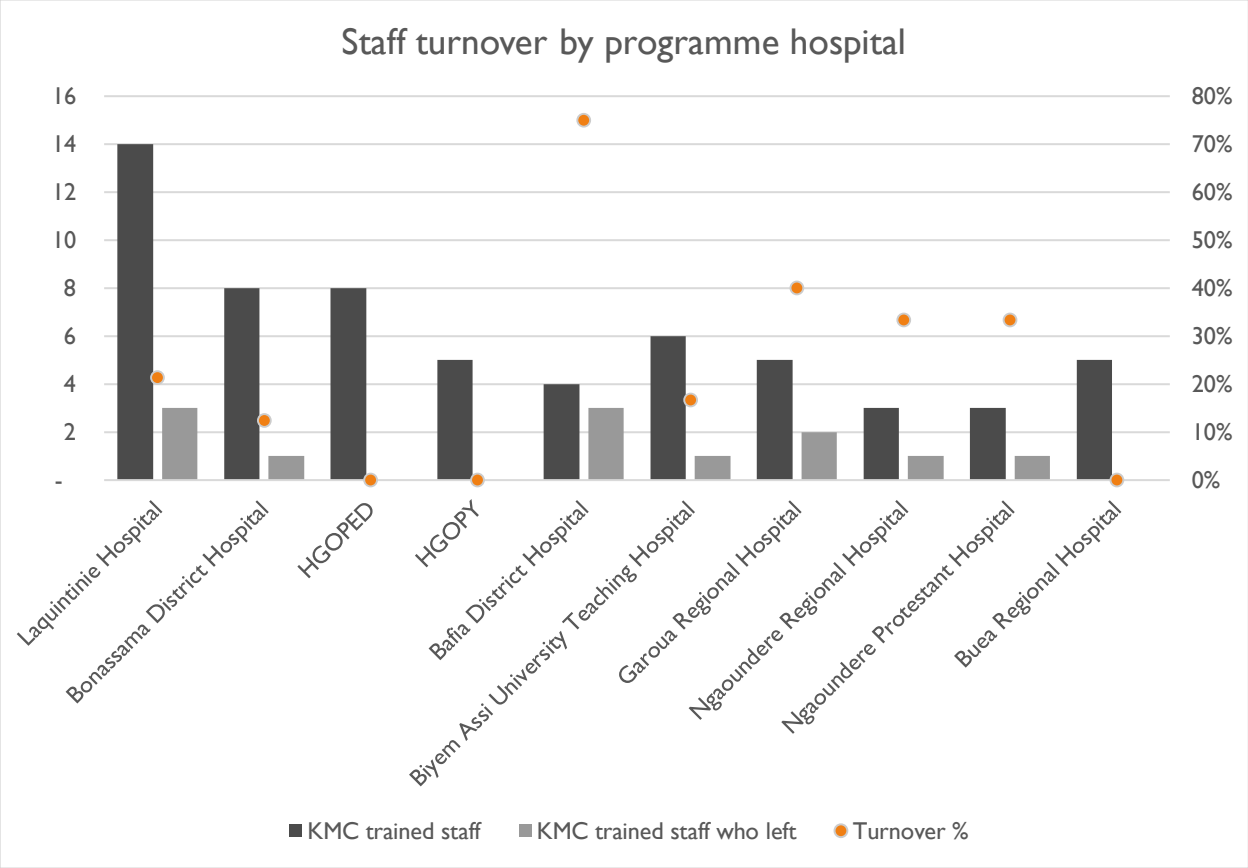
NB: L'évaluation des gestes techniques de soin (gestes effectués par l'apprenant sous la supervision du formateur) se fait à partir du lundi de la deuxième semaine. Les apprenants seront divisés en groupe à croiser.

1.3.c Cost of clinician training and clinical practice evaluation

Training and evaluation costs	*Units*	Cost	Number of clinicians trained
Bonassama District Hospital	*USD*	2,854	8
HGOPED	*USD*	2,182	8
HGOPY	*USD*	4,143	5
Bafia District Hospital	*USD*	4,629	4
Biyem Assi University Teaching Hospital	*USD*	5,924	6
Garoua Regional Hospital	*USD*	5,358	5
Ngaoundere Regional Hospital	*USD*	5,911	3
Ngaoundere Protestant Hospital	*USD*	5,856	3
Buea Regional Hospital	*USD*	5,992	5
Total training and evaluation cost	***USD***	**42,848**	**47**
Average cost per programme hospital	***USD***	**4,761**	**5.2**
Average cost per clinician trained	***USD***	**911**	**1**

APPENDIX 1.4

1.4.a Staff turnover per hospital (February 2019 to January 2021)



1.4.b Bonus calculation process

After each verification cycle which covers a quarter. The list of staff who worked during the period verified is submitted to the foundation by the head of unit of each hospital. The list is usually made up of the following headings:

- Name
- Telephone number
- Period worked
- Qualification
- Performance score

The last 3 elements are then used to inform the distribution of the amount owing per hospital according to their performance in the independent verification that quarter. When the verification report is submitted by IRESCO the number of validated babies receiving quality KMC is multiplied by 75,000 FCFA. This amount represents the lump sum to be divided among all those who were present and working in the Neonatal Unit.

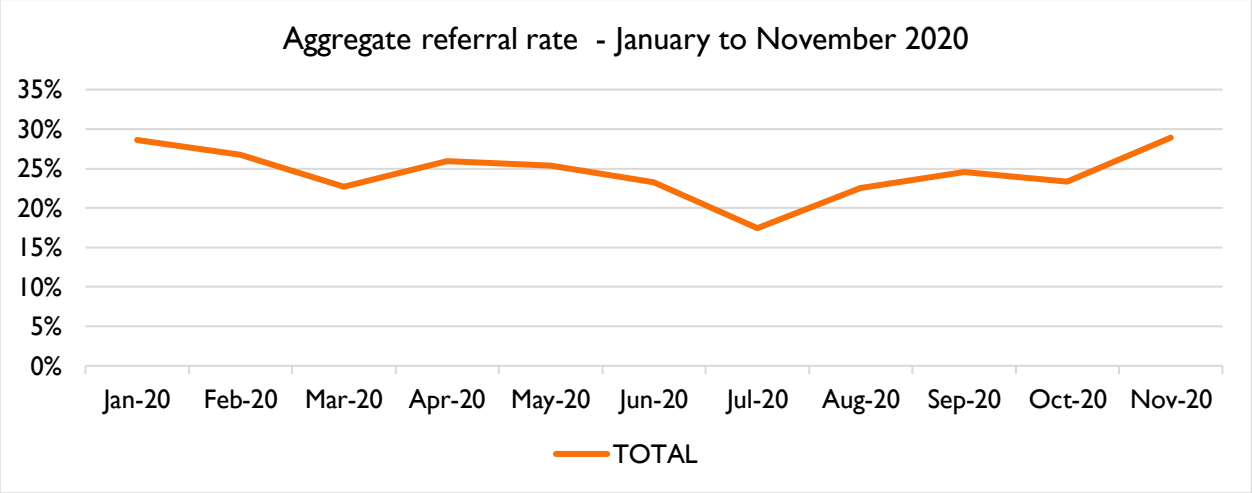
Once the proposed bonus distribution by staff member has been calculated by KFC, the list is sent back to the Department Head in each hospital for review ahead of payment. Once approved, payments are made by KFC directly to each staff member using mobile money platforms.

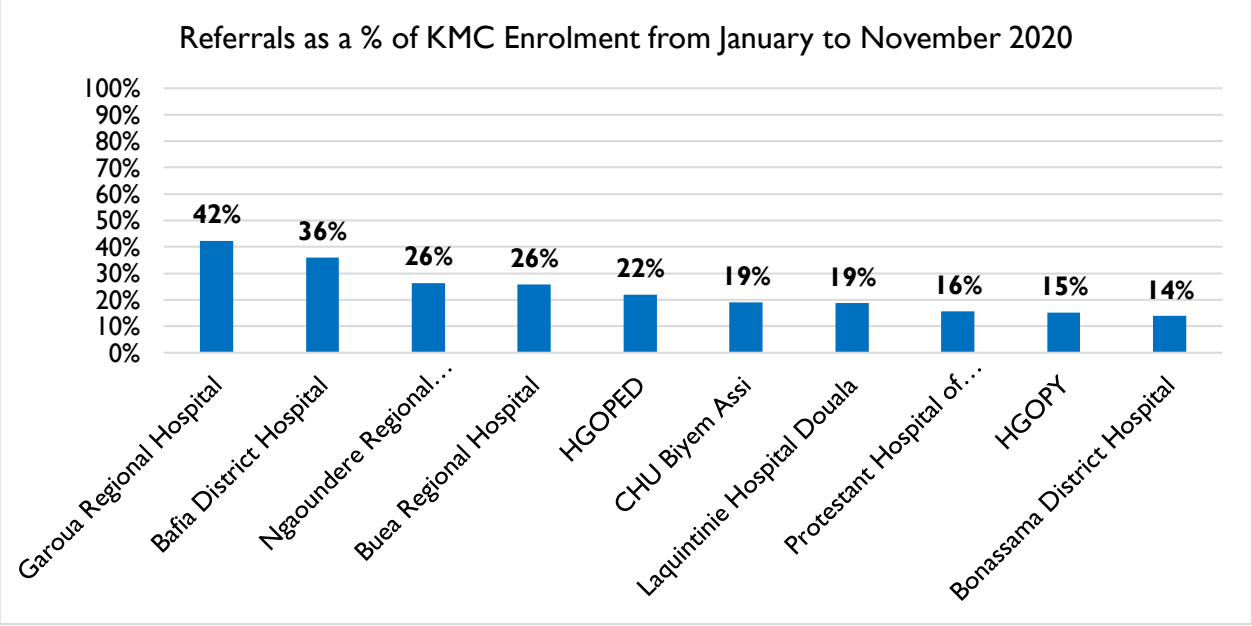
1.4.c Bonus analysis (February 2019 to January 2021)

Hospital	Number of babies	Total quaterly bonus	Lowest Bonus (Quaterly)	Highest Bonus (Quaterly)	Median (Quaterly)	Average Bonus (Quaterly)
Garoua	36	$ 2,160.00	$ 39.01	$ 248.16	$ 138.97	$ 127.06
HGOPY	11	$ 1,042.16	$ 24.82	$ 81.38	$ 32.69	$ 35.94
Laquintinie	70	$ 5,245.84	$ 31.50	$ 301.07	$ 48.92	$ 95.38

APPENDIX 1.5

1.5.a Referral analysis (February 2019 to January 2021)



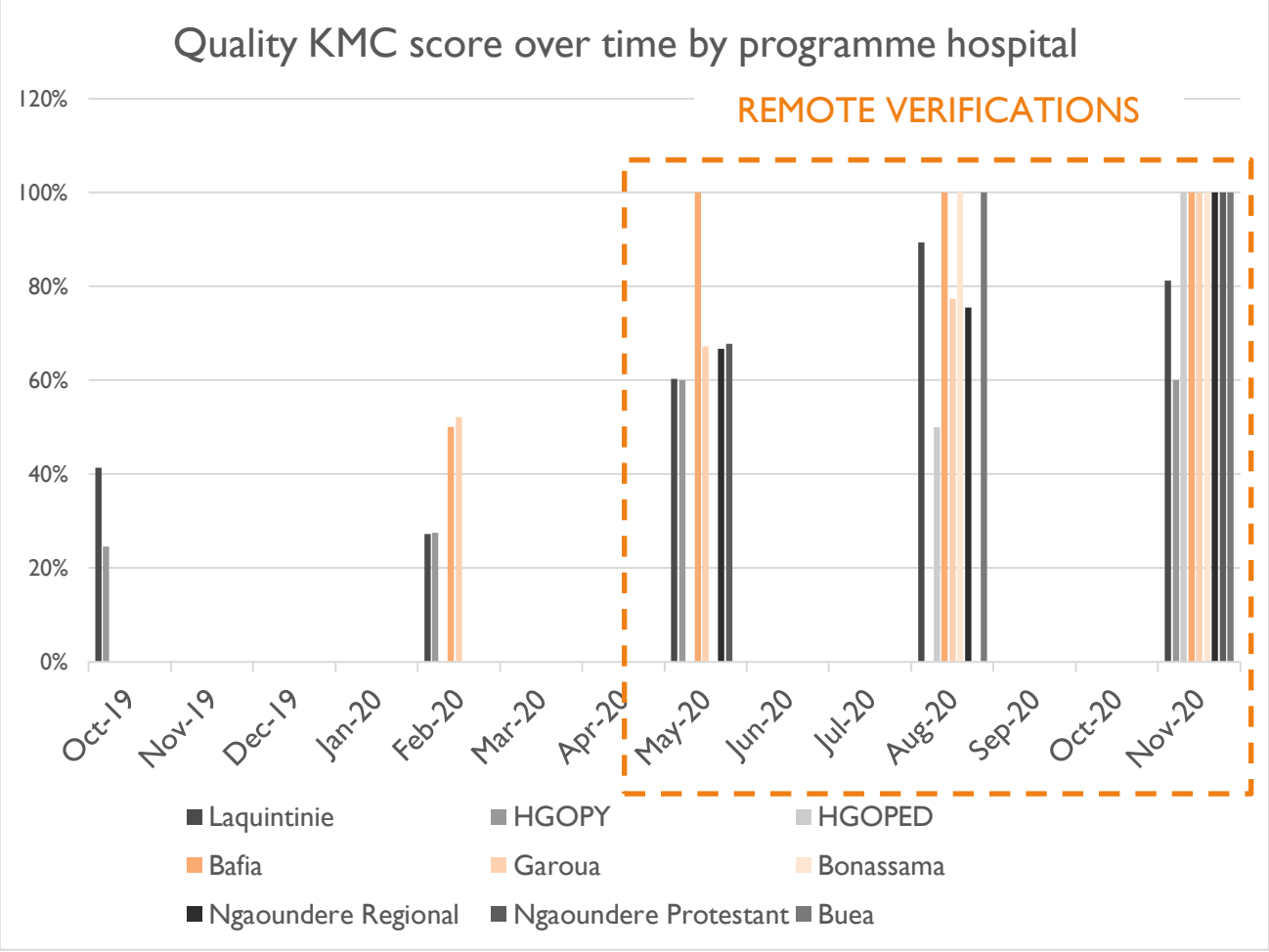


1.5.b Community engagement cost analysis

Training session	Number of participants	Average cost of training per participant
Training of trainers *(NB Session lasted 4 days in total)*	9	$ 1,341
Laquintinie and Bonassama	36	$ 319
Ngaoundere Regional	20	$ 546
Ngaoundere Protestant	20	$ 457
Garoua	25	$ 464
Bafia	20	$ 696
Average cost of training *(excludes Training of trainers)*	121	$ 472

APPENDIX 1.6

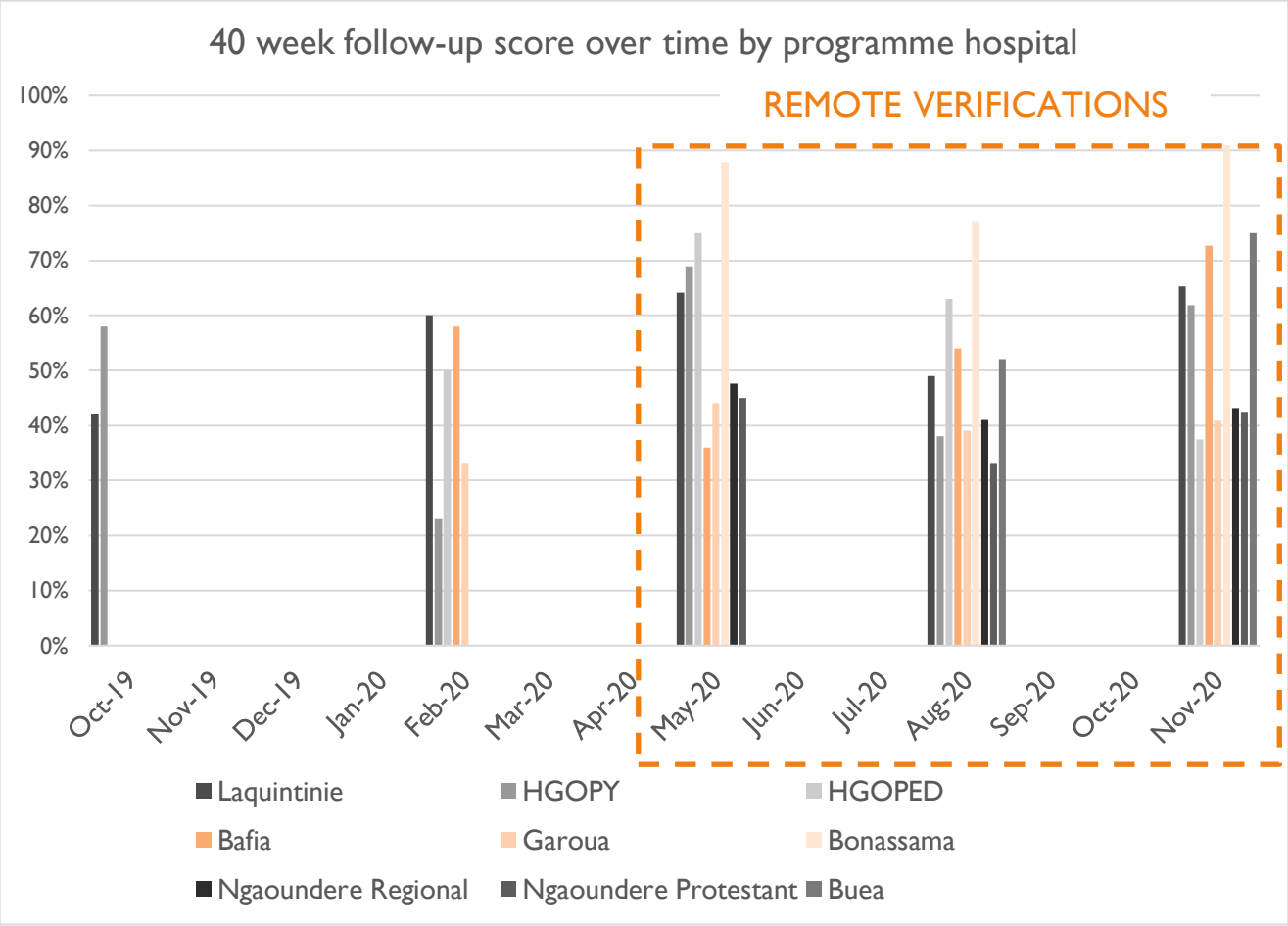
1.6.a Quality KMC score over time by programme hospital



NB: The sample size of mothers interviewed significantly reduced during the remote verification, and some sections of the survey, like appropriate discharge, were not possible to carry out remotely. Results from remote verification cannot be directly compared with the in-person

verification results. Furthermore, these results do not constitute the final programme results and two additional verification cycles will be carried out before the end of the programme.

1.6.b 40 week follow-up score over time by programme hospital



NB: The sample size of mothers interviewed significantly reduced during the remote verification, and some sections of the survey were not carried out such as the observation of appropriate discharge. Therefore, these results cannot be directly compared with the in-person verification results. Furthermore, these results do not constitute the final programme results and two additional verification cycles will be carried out before the end of the programme.

1.6.c Outcomes verification grids (English)

Schedule 4 – Payment Metric A

Payment Metric A – Prerequisites	
Date of Survey	

Hospital Name	
Assessor Name	

Category	Items needed	Minimum quantity needed	Quantity available at the hospital
Equipment	Lycra bands (or similar support materials)	1 per mother	_____ bands/ _____ mothers currently enrolled in KMC
	Functional weight scales (mechanical or electronic) with a precision of 10 g or lower	2 *(1 for the KMC ward and 1 for the KMC follow-up programme)*	_____
	Neonatal gastric tube	5	_____ neonatal gastric tubes
	Neonatal nasal cannula	5	_____ neonatal nasal cannulas
	Infantometer or baby mattress wedge or ramp with height measurement unit for the KMC Follow-up Programme	1	_____
	Cups and Syringes	4 (of either)	_____
	Soap	Sufficient for mothers and staff use	Yes / No
Staff	Nurse or professional midwife trained and accredited in KMC by KF Cameroon or by a KF Cameroon-trained healthcare provider	1	_____
	Paediatrician or general physician trained and accredited in KMC by KF Cameroon or by a KF Cameroon-trained healthcare provider	1	_____
Infrastructure	Separate KMC Ward	1	Yes / No

	Separate area for the follow-up unit	1	Yes / No
	Chairs with backs and armrests for mothers or caregivers in the neonatal unit	For Laquintinie, HGOPY, HGOPED, Yaounde CHU, Garoua, Ngaoundere Regional and Ngaoundere Protestant: 6 For Bonassama, Bafia and Buea 4	_____chairs
	Beds for mothers in the KMC Ward	For Laquintinie, HGOPY, HGOPED, Yaounde CHU, Garoua, Ngaoundere Regional and Ngaoundere Protestant: 6 For Bonassama, Bafia and Buea 4	_____ beds
	On-site running water and free drinking water for the KMC Ward	N/A	Yes / No
	Access to sanitation (toilet and shower) for the mother	N/A	Yes / No
	Examination table for the KMC Follow-up Programme	1	_____
Administrative / hospital policy	Institutional KMC policy, including KMC protocols for the neonatal unit, the KMC ward and the follow-up unit	N/A	Yes / No
	Parental access to the neonatal unit 24 hours a day	N/A	Yes / No
	Access to rapid HIV test for mothers	N/A	Yes / No
Summary	**Has the hospital met all the requirements for KMC?**		**Yes / No**

Schedule 5 and 6 – Payment Metric B

KMC Appropriate Skin-to-Skin Contact and Appropriate Nutrition Questionnaire		
Patient (infant) name		
Date of survey		
Hospital Name		
Assessor Name		
Which part of the programme are they in	Select one: ☐ Neonatal unit ☐ KMC ward	
Skin-to-Skin contact		
1. **Questions to ask the mother or other caregiver (please note who the caregiver is if different from the mother)**	1.1. Is there anyone supporting you to care for your baby? If so, who is the other main caregiver? (Single answer, unprompted) *[This question does not count towards the assessment and is used only to gather additional information on gender issues]*	Select one: ☐ Baby's father/male partner ☐ Other male family member ☐ Male friend ☐ Mother's mother ☐ Other female family member ☐ Female friend
	1.2. How long are you (and/or other people supporting you) keeping your baby in KMC position each day? o *This should be 8 hours per day if in the neonatal unit;* o *At least 20 hours per day if in the KMC ward or if no incubator or radiant warmer is available in the neonatal unit.*	___ hours
	What are the things that can prevent a mother/caregiver including you to practice KMC at night? *Tell the mother/caregiver: Because of the factors above it may happen that you do not care for the baby exactly as expected. So, for the next questions on SSC at night, SSC over time and incubator; tell me what happened exactly. even if it was not exactly as recommended by the doctor.* *[This question does not count towards the assessment but is used to put the mother at ease]*	List factors
	1.3. How often do you (and/or other people supporting you) practice SSC at night? Every night, some nights	Select one: ☐ Every night

	or not at all?	☐ Some nights ☐ Not at all
	1.4. How often do you (and/or other people supporting you) practice KMC? Every day, 5-6 days per week, 3-4, 1-2? ○ *Every day is the required answer for appropriate KMC*	Select one: ☐ Every day ☐ 5-6 days a week ☐ 3-4 days a week ☐ 1-2 days a week ☐ Not at all
	1.5. If the mother is in the neonatal unit: When your baby is not being held skin-to-skin / in KMC position, where is the baby? ○ *The infant should be placed in an incubator or under a radiant warmer when not in KMC position*	Select one: ☐ In an incubator or under a radiant warmer ☐ Somewhere else e.g. bed, table, chair ☐ Well wrapped in a cot, away from draughts and covered by a warm blanket ☐ N/A (Not in the neonatal unit)
2. IVA to observe mother's practices	2.1. If the mother is in the neonatal unit: Is the baby placed in an incubator or under a radiant warmer when not in KMC position?	☐ Yes ☐ No ☐ No but the baby is well wrapped in a cot, away from draughts and covered by a warm blanket ☐ N/A (Not in the neonatal unit)
	2.2. In the KMC ward, when a mother is not performing SSC, is someone else performing it for her?	Select one: ☐ Yes ☐ No ☐ N/A (Not in the KMC ward)
	2.2.1. If the response to 2.2. is no, then for how many hours was the mother not performing KMC? *If the mother is evidently absent from the KMC Ward for more than 4 hours (and if no one else is performing KMC on her behalf), the infant is not deemed to have received appropriate KMC*	___ hours
	2.3. Is the infant correctly positioned when in SSC? *(Answer should be yes to all the following questions)*	

	2.3.1. The infant is kept upright when in KMC position, with body and cheek against the mother's chest ("frog" position)	Yes / No
	2.3.2. The baby is secured on the mother's chest with an appropriate support system (lycra band or other available cloth).	Yes / No
	2.3.3. The baby's head is covered with a cap to avoid temperature loss. The baby is also wearing socks and a diaper.	Yes / No
Summary	Has the baby received appropriate SSC? *The baby has received appropriate SSC if:* • *They are in the neonatal unit and the answer to 1.2 is >8 hours; OR they are in the KMC ward and the answer to 1.2 is >20 hours;* • *The answer to 1.3 is 'Every night'; UNLESS they are in the neonatal unit and the answer to 1.2 is >8 hours* • *The answer to 1.4 is 'Every day';* • *The answer to 1.5 is 'In an incubator or under a radiant warmer' OR 'N/A (Not in the neonatal unit)';* • *The answer to 2.1 is 'Yes' OR 'N/A (Not in the neonatal unit)';* • *The answer to 2.2 is 'Yes' OR 'N/A (Not in the KMC ward)'; OR the answer to 2.2 is 'No' and the answer to 2.2.1 is '<4 hours'; and* • *The answers to 2.3.1, 2.3.2 and 2.3.3 are all 'Yes'.*	Yes / No

Nutrition		
1. Questions for the mother (to be asked in this order) to check if she has, she exclusively breastfed her child in the last 24 hours	*What are the things that can prevent a mother/caregiver including you to feed the child according to the doctor's instruction?* *Tell the mother/caregiver: Because of the factors above it may happen that you do not feed the baby exactly as expected. So, for the next questions on breastmilk, water, other milk, anything else; tell me what happened exactly. even if it was not exactly as recommended by the doctor.* *[This question does not count towards the assessment but is used to put the mother at ease]*	List factors
	1.1. In the last 24 hours, did you give your baby breastmilk? (either through oral,	Yes / No

	tube, syringe, or cup/spoon feeding)	
	1.2. In the last 24 hours, did you give your baby water?	Yes / No
	1.3. In the last 24 hours, did you give your baby any milk other than breastmilk?	Yes / No
	1.4. In the last 24 hours, did you give anything else to your baby?	Yes / No Please specify: _____
2. If the mother has exclusively breastfed her child in the last 24 hours (question 1), has she exclusively breastfed her child since starting KMC?	2.1. Since starting KMC, have you given your baby breastmilk? (either through oral, tube, syringe, or cup/spoon feeding)	Yes / No
	2.2. Since starting KMC, have you given your baby water?	Yes / No
	2.3. Since starting KMC, have you given your baby any milk other than breastmilk?	Yes / No
	2.4. Since starting KMC, have you given anything else to your baby?	Yes / No Please specify: _____
3. Observation of feeding other than breastfeeding?		Yes / No If Yes: ☐ Artificial Milk ☐ Water ☐ Other _____
4. Why did the infant receive anything other than breastmilk? *[Ask the mother and double check with the medical staff]*		It is medically advised for the mother not to breastfeed (select all that apply): ☐ Mother has human t-cell lymphotropic virus type I or II ☐ Mother has other disease or condition. Please specify: _____ ☐ Mother is receiving cancer chemotherapy agents ☐ Mother uses illicit drugs ☐ Mother is HIV-positive and has chosen not to breastfeed after counselling Other reasons:

<table>
<tr><td colspan="2"></td><td colspan="2">☐ Mother refuses to breastfeed or insists on using formulas. Please provide reason for this: _____</td></tr>
<tr><td colspan="3">5. The paediatrician has documented in the infant's file the reason for substituting or supplementing breastmilk with artificial milk.</td><td>Yes / No

Please provide the reason documented:

_____</td></tr>
<tr><td>Summary</td><td colspan="2">Has the baby received appropriate nutrition?

The baby has received appropriate nutrition if:

• The answers to 1.1 and 2.1 are 'Yes' AND the answers to 1.2, 1.3, 1.4, 2.2, 2.3, 2.4, and 3 are 'No' OR
• If answers to 1.3 or 2.3 are 'Yes' (regardless of answers to 1.1 and 2.1) AND answers to 1.2, 1.4, 2.2 and 2.4 are all "No", AND answer to 3 is either "No" or "Yes – Artificial Milk", AND there is a medical reason for the mother not to breastfeed in 4; OR
• If answers to 1.3 or 2.3 are 'Yes' (regardless of answers to 1.1 and 2.1) AND answers to 1.2, 1.4, 2.2 and 2.4 are all "No", AND answer to 3 is either "No" or "Yes – Artificial Milk", AND there is no medical reason for the mother not to breastfeed in 4, AND the answer to 5 is 'Yes' and the reason documented is provide;. OR
• The answers to 1.1 and 2.1 are 'Yes' AND the answers to 1.2, 1.3, 1.4, 2.2, 2.3, and 2.4 are 'No' AND answer to 3 is "Yes – Artificial Milk" AND there is a medical reason for the mother not to breastfeed in 4; OR
• The answers to 1.1 and 2.1 are 'Yes' AND the answers to 1.2, 1.3, 1.4, 2.2, 2.3, and 2.4 are 'No' AND answer to 3 is "Yes – Artificial Milk" AND there is no medical reason for the mother not to breastfeed in 4, AND the answer to 5 is 'Yes' and the reason documented is provided

If the mother says (or is observed) that she is feeding her infant with anything other than breastmilk or artificial milk, then the baby has not received appropriate nutrition.</td><td>Yes / No</td></tr>
<tr><td colspan="3">Has the baby received both appropriate skin-to-skin contact and nutrition?</td><td>Yes / No</td></tr>
</table>

An infant can be discharged home directly from the neonatal unit or from the KMC ward. Some of the criteria will differ based on where the infant is discharged from. The Independent Verification Agent needs to survey the medical staff and the mother using the following questionnaire.

KMC Appropriate Discharge Questionnaire		
Patient (infant) name		
Date of survey		
Hospital Name		
Assessor Name		
Which part of the programme are they in	Select one: ☐ Neonatal unit ☐ KMC ward	
1. Status of the infant *Ask nurses or doctors and check against hospital records where possible*	1.1. The child is stable and able to regulate temperature on his own.	Yes / No
	1.2. The child required a feeding tube in the last 3 days.	Yes / No
	1.3. The child has demonstrated adequate weight gain, i.e.: o If the child is older than 10 days, it has gained weight in the last 2 days (based on hospital record) . o If the child is 10 days or less, it has not lost more than 10% of its birth weight	Yes / No
	1.4. The child presented episodes of apnea or had oxygen desaturation during at least one week	Yes / No
	1.5. There is clinical suspicion of sepsis or infection.	Yes / No
	1.6. The child completed his/her treatment, if any.	Yes / No
2. Mother's or Carer's ability to care for the child *Combination of questions for the mother and questions for the nurse/doctor*	2.1. Circle the appropriate answer: SSC is accepted and applied (Yes if answers to 2.1.1 to 2.1.3 are appropriate)	Yes / No
	What are the things that can prevent a mother/caregiver including you to practice KMC? *Tell the mother/caregiver: Because of the factors above it may happen that you do not care for the baby as expected. So, for the next questions on Kangaroo position, SSC at night, KMC over time and KMC ability at home; tell me what happened exactly. even if it was not exactly as recommended by the doctor.* *[This question does not count towards the assessment but is used to put the mother at ease]*	List factors
	2.1.1. In the last two days, how long on average have you put your baby in the Kangaroo position	___ hours (per day)

	each day? *Mother (and/or other people supporting the mother) should provide SSC >20 hours per day if in the KMC ward, >8 hours per day if in the neonatal unit.*	
	2.1.2. How often do you (and/or other people supporting you) practice SSC at night? Every night, some nights or not at all? *Answer should be 'every night' in order for SSC to be considered accepted and applied*	Select one: ☐ Every night ☐ Some nights ☐ Not at all
	2.1.3. How often do you (and/or other people supporting you) practice KMC? Every day, 5-6 days per week, 3-4, 1-2? *Answer should be 'every day' in order for SSC to be considered accepted and applied*	Select one: ☐ Every day ☐ 5-6 days a week ☐ 3-4 days a week ☐ 1-2 days a week ☐ Not at all
	2.2. Ask the mother/carer: Do you feel able to care for your child using KMC (position and nutrition) at home?	Yes / No
	2.3. Ask the nurse/doctor: Does this mother/carer need to be regularly reminded to provide continuous SSC?	Yes / No
	2.4. Ask the nurse/doctor: Is the mother /carer well enough to practice SSC?	Yes / No
3. Mother's ability to breastfeed	3.1. Ask the mother: "Are you exclusively breastfeeding?" *If "yes": please ask question 3.2 and 3.3, if "no" go directly to 3.4.*	Yes / No
	3.2. If the answer to 3.1 is "yes", check if the mother places her baby at her breast on her own, without any help required and can feed them on her own.	Yes / No
	3.3. If the answer to 3.1 is "yes", check if the mother is able to express milk (ask the mother and/or check with the medical staff)	Yes / No
	3.4. If the answer to 3.1 is "no", check with medical staff and medical record: It is medically advised for the mother to use mixed or artificial milk?	Yes / No
4. Support of the family	4.1. Ask the mother: Will you receive help from another person at home? (includes family members, friends, neighbours, etc.). *[This question does not count towards the assessment and is used*	Yes / No

	only to gather additional information on gender issues]	
	4.2. If yes to 4.1, then who is the main person helping you? (Single answer) *[This question does not count towards the assessment and is used only to gather additional information on gender issues]*	Select one: ☐ Baby's father/male partner ☐ Other male family member ☐ Male friend ☐ Mother's mother ☐ Other female family member ☐ Female friend
5. Ask the nurse/doctor: Is this person free of infectious or contagious disease, skin disease, fever, and physically and mentally able to manage the child under KMC?		Yes / No

Summary	**Has the infant been appropriately discharged?**
	
	The infant has been appropriately discharged if
	
	• Answers to 1.2., 1.4, 1.5 and 2.3 are "No" AND answers to 3.1 is "No" and 3.4 is "Yes", OR,
	• Answers to 1.2., 1.4, 1.5 and 2.3 are "No" AND answers to 3.1 is "Yes" and 3.2 and 3.3 are "Yes",
	• AND all the others are "Yes", with:
	  ○ The answer 2.1 being is considered a "Yes" if:
	  ▪ Answer to 2.1.1 is >20 hours in the KMC ward and >8 hours in the neonatal unit, AND
	  ▪ Answer to 2.1.2 is "Every Night", AND
	  ▪ Answer to 2.1.3 is "Every Day"
	
	The answers to 4.1 and 4.2 do not count towards the scoring of this screening guide.
		Yes / No

Schedule 8 – Payment Metric C

KMC Adequate Nutrition Questionnaire at Follow-Up Appointment		
Patient (infant) name		
Caregiver relationship to infant (father, mother, aunt, etc.)		
Date of survey		
Hospital Name		
Assessor Name		
1. Questions to ask the mother (in this order) to check if she has, she exclusively breastfed her child in the last 24 hours.	*What are the things that can prevent a mother/caregiver including you to feed the child according to the doctor's instruction?* *Tell the mother/caregiver: Because of the factors above it may happen that you do not feed the baby exactly as expected. So, for the next questions on breastmilk, water, other milk, anything else; tell me what happened exactly. even if it was not exactly as recommended by the doctor.* *[This question does not count towards the assessment but is used to put the mother at ease]*	List factors
	1.1. In the last 24 hours, did you give your baby breastmilk? (either through oral, tube, syringe, or cup/spoon feeding)	Yes / No
	1.2. In the last 24 hours, did you give your baby water?	Yes / No
	1.3. In the last 24 hours, did you give your baby any milk other than breastmilk?	Yes / No
	1.4. In the last 24 hours, did you give anything else to your baby?	Yes / No Please specify: _____
2. If the mother has exclusively breastfed her child in the last 24 hours (question 1), has she exclusively breastfed her	2.1. Since you left the hospital, have you given your baby breastmilk? (either through oral, tube, syringe, or cup/spoon feeding)	Yes / No
	2.2. Since you left the hospital, have you given your baby water?	Yes / No
	2.3. Since you left the hospital, have you given your baby any milk other than breastmilk?	Yes / No

child since starting KMC? *The recall in this case is much poorer so the mother might reply that she has only breastfed her child when she hasn't. The verification agent should therefore observe mothers while visiting the hospital and record any instances during which the mother fed her child with anything other than breastmilk.*	2.4. Since you left the hospital, have you given anything else to your baby?	Yes / No Please specify: _____

3. Observation of feeding other than breastfeeding?	Yes / No If Yes: ☐ Artificial Milk ☐ Water ☐ Other _____
4. **Why did the infant receive anything other than breastmilk?**	It is medically advised for the mother not to breastfeed (please select all that apply): ☐ Mother has human t-cell lymphotropic virus type I or II ☐ Mother has other disease or condition. Please specify: _____- _____ ☐ Mother is receiving cancer chemotherapy agents ☐ Mother uses illicit drugs ☐ Mother is HIV-positive Other reasons ☐ Mother refuses to breastfeed or insists on using formulas. Please provide reason: _____
5. The paediatrician has recommended artificial milk to the mother and has documented this reason in the infant's file.	Yes/ No Please provide the reason given: _____

Summary	Has the baby received appropriate nutrition? *The baby has received appropriate nutrition if:*	Yes / No

	• *The answers to 1.1 and 2.1 are 'Yes' AND the answers to 1.2, 1.3, 1.4, 2.2, 2.3, 2.4, and 3 are 'No' OR* • *If answers to 1.3 or 2.3 are 'Yes' (regardless of answers to 1.1 and 2.1) AND answers to 1.2, 1.4, 2.2 and 2.4 are all "No", AND answer to 3 is either "No" or "Yes – Artificial Milk", AND there is a medical reason for the mother not to breastfeed in 4; OR* • *If answers to 1.3 or 2.3 are 'Yes' (regardless of answers to 1.1 and 2.1) AND answers to 1.2, 1.4, 2.2 and 2.4 are all "No", AND answer to 3 is either "No" or "Yes – Artificial Milk", AND there is no medical reason for the mother not to breastfeed in 4, AND the answer to 5 is 'Yes' and the reason documented is provided.* • *The answers to 1.1 and 2.1 are 'Yes' AND the answers to 1.2, 1.3, 1.4, 2.2, 2.3, and 2.4 are 'No' AND answer to 3 is "Yes – Artificial Milk" AND there is a medical reason for the mother not to breastfeed in 4;* • *The answers to 1.1 and 2.1 are 'Yes' AND the answers to 1.2, 1.3, 1.4, 2.2, 2.3, and 2.4 are 'No' AND answer to 3 is "Yes – Artificial Milk" AND there is no medical reason for the mother not to breastfeed in 4, AND the answer to 5 is 'Yes' and the reason documented is provided* *If the mother says (or is observed) that she is feeding her infant with anything other than breastmilk or artificial milk, then the baby has not received appropriate nutrition.*	

1.6.d Outcomes verification grids (French)

Indicateur de Paiement A - Grille de vérification

Indicateur de paiement A - Prérequis			
Date de l'enquête			
Nom de l'hôpital			
Nom de l'évaluateur			
Catégorie	**Éléments nécessaires**	**Quantité minimum nécessaire**	**Quantité disponible à l'hôpital**
Équipement	Bandes de lycra (ou matériel de support similaire)	1 par mère	_____ bandes / _____ mères actuellement inscrites à la MMK
	Balances en état de marche (mécaniques ou électroniques) avec une précision d'au moins 10g	2 *(1 pour la salle MMK et 1 pour le programme de suivi MMK)*	_____
	Tubes gastriques néonatals	5	_____ tubes gastriques néonatals
	Canules nasales néonatales	5	_____ canules nasales néonatales
	Infantomètre ou plan incliné avec toise pour le programme de suivi MMK	1	_____
	Tasses et Seringues	4 (de l'un ou l'autre)	_____
	Savon	Suffisant pour les mères et le personnel	Oui / Non
Personnel	Infirmière ou sage-femme professionnelle formée et accréditée à la MMK par la FK Cameroun ou par un autre professionnel de santé formé par la FK Cameroun	1	_____
	Pédiatre ou médecin généraliste formé et accrédité à la MMK par la FK Cameroun ou par un autre professionnel de santé formé par la FK Cameroun	1	_____

Infrastructure	Salle MMK séparée	1	Oui / Non
	Zone séparée pour le programme de suivi MMK	1	Oui / Non
	Chaises avec dossier et accoudoirs pour mères ou autres proches aidant(e)s dans l'unité néonatale	Pour Laquintinie, HGOPY, HGOPED, Yaoundé CHU, Garoua, Ngaoundéré Régional et Ngaoundéré Protestant: 6 Pour Bonassama, Bafia et Buea 4	_____ chaises
	Lits pour les mères dans la salle MMK	Pour Laquintinie, HGOPY, HGOPED, Yaoundé CHU, Garoua, Ngaoundéré Régional et Ngaoundéré Protestant: 6 Pour Bonassama, Bafia et Buea 4	_____ lits
	Eau courante et eau potable gratuite sur place pour la salle MMK	N/A	Oui / Non
	Accès aux installations sanitaires (toilettes et douche) pour la mère	N/A	Oui / Non
	Table d'examen pour le programme de suivi MMK	1	_____
Politique Administrative de l'hôpital	Politique institutionnelle en matière de MMK, y compris les protocoles MMK pour l'unité néonatale, la salle MMK et le programme de suivi	N/A	Oui / Non
	Accès parental à l'unité néonatale 24 heures par jour	N/A	Oui / Non
	Accès au test rapide du VIH pour les mères	N/A	Oui / Non
Résumé	**L'hôpital a-t-il satisfait tous les prérequis pour la pratique de la MMK ?**		**Oui / Non**

Indicateur de Paiement B - Grilles de vérification

Questionnaire Contact Peau-à-Peau Approprié et Nutrition Appropriée pour la MMK		
Nom du patient (nourrisson)		
Date de l'enquête		
Nom de l'hôpital		
Nom de l'évaluateur		
Dans quelle partie du programme sont-ils ?	Choisir une option : ☐ Unité néonatale ☐ Salle MMK	
Contact Peau-à-Peau		
1. **Questions à poser à la mère ou à un autre proche aidant(e) (veuillez noter le nom de l'aidant s'il est différent de la mère)**	1.1. Y a-t-il quelqu'un qui vous soutient dans la prise en charge de votre bébé ? Si oui, qui est ce ou cette proche aidant(e) ? (Une seule réponse, spontanée) *[Cette question ne compte pas pour l'évaluation et sert uniquement à recueillir des informations supplémentaires sur les questions de genre]*	Choisir une option : ☐ Le père du bébé / partenaire masculin ☐ Autre membre masculin de la famille ☐ Un Ami ☐ La mère de la mère ☐ Autre membre de la famille de sexe féminin ☐ Une amie
	1.2. Pendant combien de temps maintenez-vous (et / ou les autres personnes qui vous soutiennent) votre bébé en position MMK chaque jour ? ○ *Cela doit être 8 heures par jour si le nourrisson est dans l'unité néonatale ;* ○ *Au moins 20 heures par jour si le nourrisson est dans la salle MMK ou si aucun incubateur ou unité chauffante n'est disponible dans l'unité néonatale.*	___ heures

	Quels sont les facteurs qui peuvent empêcher une mère ou autre proche aidant(e), y compris vous, à pratiquer la MMK la nuit ? *Dites à la mère / au proche aidant(e) : En raison des facteurs ci-dessus, il peut arriver que vous ne preniez pas soin du bébé exactement comme prévu. Donc, pour les prochaines questions sur le CPP (contact peau-à-peau) la nuit, le CPP dans le temps et utilisation de l'incubateur ; dites-moi ce qui s'est réellement passé, même si ce n'était pas totalement en ligne avec les recommandations du médecin.* *[Cette question ne compte pas pour l'évaluation mais sert à mettre la mère à l'aise]*	Liste des facteurs
	1.3 À quelle fréquence pratiquez-vous (et / ou les autres personnes qui vous soutiennent) le CPP la nuit ? Chaque nuit, certaines nuits ou pas du tout ? o *Chaque nuit est la réponse requise pour la MMK appropriée*	Choisir une option : ☐ Chaque nuit ☐ Certaines nuits ☐ Pas du tout
	1.4 À quelle fréquence pratiquez-vous (et / ou les autres personnes qui vous soutiennent) la MMK ? Chaque jour, 5-6 jours par semaine, 3-4, 1-2 ? o *Chaque jour est la réponse requise pour la MMK appropriée*	Choisir une option : ☐ Chaque jour ☐ 5-6 jours par semaine ☐ 3-4 jours par semaine ☐ 1-2 jours par semaine ☐ Pas du tout
	1.5 Si la maman est dans l'unité néonatale : Où se trouve votre bébé lorsqu'il n'est pas maintenu en position MMK / peau-à-peau ? o *Le nourrisson doit être placé dans un incubateur ou sous une unité chauffante lorsqu'il n'est pas en position MMK*	Choisir une option : ☐ Dans un incubateur ou sous une unité chauffante ☐ Quelque part ailleurs, par exemple lit, table, chaise ☐ Bien envelopé dans un berceau, à l'abri des courants d'air et recouvert d'une couverture chaude. ☐ N/A (Pas dans l'unité néonatale)

2. Observation des pratiques de la mère par l'AVI	2.1. Si la maman est dans l'unité néonatale : Le bébé est-il placé dans un incubateur ou sous une unité chauffante lorsqu'il n'est pas en position MMK ?	☐ Oui ☐ Non ☐ Non mais le bébé est bien envelopé dans un berceau, à l'abri des courants d'air et recouvert d'une couverture chaude. ☐ N/A (Pas dans l'unité néonatale)
	2.2. Dans la salle MMK, lorsqu'une mère n'effectue pas le CPP, est-ce que quelqu'un d'autre le fait pour elle ?	Choisir une option : ☐ N/A (Pas dans la salle MMK) ☐ Oui ☐ Non
	2.2.1. Si la réponse à 2.2. est non, alors pendant combien d'heures la mère n'a-t-elle pas pratiqué la MMK ? *Si la mère est manifestement absente de la salle MMK pendant plus de 4 heures (et si personne d'autre n'effectue la MMK à sa place), le bébé n'est pas considéré comme ayant reçu une MMK appropriée.*	___ heures
	2.3. Le bébé est-il correctement positionné lorsqu'il est en CPP ? (*La réponse à toutes les questions suivantes doit être « Oui »*) 2.3.1. Le nourrisson est maintenu droit en position MMK, le corps et la joue contre la poitrine de la mère (position « grenouille »).	Oui / Non
	2.3.2. Le bébé est maintenu sur la poitrine de la mère avec un système de soutien approprié (bande de lycra ou autre tissu disponible).	Oui / Non
	2.3.3. La tête du bébé est couverte d'un bonnet pour éviter une perte de température. Le bébé porte aussi des chaussettes et une couche.	Oui / Non
Résumé	Le bébé a-t-il reçu un CPP approprié ? *Le bébé a reçu un CPP approprié si :* • *Ils sont dans l'unité néonatale et la réponse à 1.2 est >8 heures ; OU ils sont dans la salle MMK et la réponse à la question 1.2*	Oui / Non

	est >20 heures ; • *La réponse à la question 1.3 est « Chaque nuit » ;* • *La réponse à la question 1.4 est « Chaque jour » ;* • *La réponse à la question 1.5 est « Dans un incubateur ou sous une unité chauffante » OU « N/A (Pas dans l'unité néonatale) » ;* • *La réponse à la question 2.1 est « Oui » OU « N/A (Pas dans l'unité néonatale) » ;* • *La réponse à la question 2.2 est « Oui » OU « N/A (Pas dans l'unité néonatale) » ; OU la réponse à la question 2.2 est « Non » et la réponse à la question 2.2.1 est « <4 heures » ; et* • *Les réponses aux points 2.3.1, 2.3.2 et 2.3.3 sont toutes « Oui ».*	
Nutrition		
1. Questions à poser à la mère (dans cet ordre) pour vérifier si elle a allaité son enfant exclusivement au sein au cours des 24 dernières heures	*Quels sont les facteurs qui peuvent empêcher une mère/autre proche aidant(e), y compris vous-même, de nourrir l'enfant conformément aux instructions du médecin ?* *Dites à la mère / proche aidant(e) : En raison des facteurs ci-dessus, il peut arriver que vous ne nourrissiez pas le bébé exactement comme prévu. Donc, pour les prochaines questions sur le lait maternel, l'eau, un autre lait, ou autre ; dites-moi ce qui s'est réellement passé, même si ce n'était pas totalement en ligne avec les recommandations du médecin* *[Cette question ne compte pas pour l'évaluation mais sert à mettre la mère à l'aise]*	Liste des facteurs
	1.1. Au cours des dernières 24 heures, avez-vous donné du lait maternel à votre bébé ? (Soit par voie orale, par sonde, avec une seringue ou une tasse/cuillère)	Oui / Non
	1.2. Au cours des dernières 24 heures, avez-vous donné de l'eau à boire à votre bébé ?	Oui / Non
	1.3. Au cours des dernières 24 heures, avez-vous donné à votre bébé un lait autre que le lait maternel ?	Oui / Non
	1.4. Au cours des dernières 24 heures, avez-vous donné autre chose à votre bébé ?	Oui / Non Veuillez préciser :

		_____
2. Si la mère a allaité exclusivement son enfant au cours des dernières 24 heures (question 1), a-t-elle allaité son enfant exclusivement depuis le début de la MMK ?	2.1. Depuis que vous avez commencé la MMK, avez-vous donné à votre bébé du lait maternel ? (Soit par voie orale, par sonde, avec une seringue ou une tasse/cuillère)	Oui / Non
	2.2. Depuis que vous avez commencé la MMK, avez-vous donné de l'eau à boire à votre bébé ?	Oui / Non
	2.3. Depuis que vous avez commencé la MMK, avez-vous donné à votre bébé du lait autre que le lait maternel ?	Oui / Non
	2.4. Depuis que vous avez commencé la MMK, avez-vous donné autre chose à votre bébé ?	Oui / Non Veuillez préciser : _____
3. Observation d'une alimentation autre que l'allaitement ?		Oui / Non Si oui : ☐ Lait artificiel ☐ Eau ☐ Autre _____
4. Pourquoi le bébé a-t-il reçu autre chose que du lait maternel ? *[Demander à la mère et revérifier avec le personnel médical]*	Il est conseillé médicalement à la mère de ne pas allaiter (cochez toutes les réponses appropriées) : La mère a le virus lymphotrope humain à cellules T de type I ou II La mère a une autre maladie ou condition. Veuillez préciser : _____ ☐ La mère reçoit des agents de chimiothérapie anticancéreuse ☐ La mère utilise des drogues illicites ☐ La mère est séropositive et a choisi de ne pas allaiter après une séance de conseil Autres raisons : ☐ La mère refuse d'allaiter ou insiste pour utiliser des préparations artificielles. Veuillez fournir la raison : _____	
5. Le ou la pédiatre a documenté dans le dossier du nourrisson la raison pour substituer ou compléménter le lait maternel avec du lait artificiel.		Oui / Non Veuillez bien vouloir fournir la raison donnée :

		_____
Résumé	Le bébé a-t-il reçu une nutrition appropriée ? *Le bébé a reçu une nutrition appropriée si :* • *Les réponses aux points 1.1 et 2.1 sont « Oui » ET les réponses aux points 1.2, 1.3, 1.4, 2.2, 2.3, 2.4 et 3 sont « Non » ; OU* • *Si les réponses à 1.3 ou 2.3 sont « Oui » (quelles que soient les réponses à 1.1 et 2.1) ET les réponses à 1.2, 1.4, 2.2 et 2.4 sont toutes « Non », ET la réponse à 3 est « Non » ou « Oui – Artificielle ». Lait », ET il y a une raison médicale pour la mère de ne pas allaiter à 4 ; OU* • *Si les réponses à 1.3 ou 2.3 sont « Oui » (quelles que soient les réponses à 1.1 et 2.1) ET les réponses à 1.2, 1.4, 2.2 et 2.4 sont toutes « Non », ET la réponse à 3 est « Non » ou « Oui – Lait Artificiel », ET il n'y a aucune raison médicale justifiant le fait que la mère n'allaite pas son enfant à 4, ET la réponse à 5 est « Oui » et la raison documentée est fournie ; OU* • *Les réponses aux points 1.1 et 2.1 sont « Oui » ET les réponses aux points 1.2, 1.3, 1.4, 2.2, 2.3 and 2.4 sont « Non » ET la réponse au point 3 est « Oui – Lait Artificiel » ET il y a une raison médicale pour la mère de ne pas allaiter au point 4 ; OU* • *Les réponses aux points 1.1 et 2.1 sont « Oui » ET les réponses aux points 1.2, 1.3, 1.4, 2.2, 2.3 and 2.4 sont « Non » ET la réponse au point 3 est « Oui – Lait Artificiel » ET il n'y a pas une raison médicale pour la mère de ne pas allaiter au point 4 ET la réponse au point 5 est « Oui » et la raison documentée est fournie.* *Si la mère dit (ou s'il est observé) qu'elle nourrit son enfant avec autre chose que du lait maternel ou artificiel, le bébé n'a pas reçu une alimentation appropriée.*	Oui / Non
Le bébé a-t-il reçu un contact peau-à-peau et une nutrition appropriée ?		Oui / Non

Un nourrisson peut sortir de l'hôpital directement de l'unité néonatale ou de la salle MMK. Certains critères varieront selon le lieu de sortie du nourrisson. L'Agent de Vérification Indépendant doit interroger le personnel médical et la mère à l'aide du questionnaire suivant.

Questionnaire Sortie de l'Hôpital Appropriée		
Nom du patient (nourrisson)		
Date de l'enquête		
Nom de l'hôpital		
Nom de l'évaluateur		
Dans quelle partie du programme sont-ils ?		Choisir une option : ☐ Unité néonatale ☐ Salle MMK
1. Statut du nourrisson *Demandez aux infirmières ou aux médecins et vérifiez avec les dossiers de l'hôpital si possible*	1.1. L'enfant est stable et capable de régler lui-même sa température.	Oui / Non
	1.2. L'enfant a eu besoin de sonde d'alimentation au cours des 3 derniers jours.	Oui / Non
	1.3. L'enfant a pris du poids de manière adéquate, c'est-à-dire : o Si l'enfant a plus de 10 jours, il a pris du poids au cours des 2 derniers jours (selon les dossiers de l'hôpital). o Si l'enfant a 10 jours ou moins, il n'a pas perdu plus de 10% de son poids de naissance.	Oui / Non
	1.4. L'enfant a présenté un épisode d'apnée ou de désaturation en oxygène pendant la semaine dernière.	Oui / Non
	1.5. Il y a une suspicion clinique de septicémie ou d'infection	Oui / Non
	1.6. L'enfant a terminé son traitement, le cas échéant.	Oui / Non
2. Capacité de la mère / autre proche aidant(e) de prendre soin de l'enfant *Combinaison de questions pour la mère et de questions pour*	2.1. Encerclez la réponse appropriée : le CPP est accepté et appliqué (oui si les réponses aux points 2.1.1 à 2.1.3 sont appropriées)	Oui / Non
	Quels sont les facteurs qui peuvent empêcher une mère / proche aidant(e), y compris vous, de pratiquer la MMK ? *Dites à la mère / proche aidant(e) : En raison des facteurs ci-dessus, il peut arriver que vous ne preniez pas soin du bébé exactement comme prévu. Donc, pour les prochaines questions sur la position kangourou, CPP la nuit, la MMK au fil du temps et la capacité de pratiquer la MMK à la maison ;*	Liste des facteurs

l'infirmière / le médecin	*dites-moi ce qui s'est passé exactement même si ce n'était pas totalement en ligne avec les recommandations du médecin.* *[Cette question ne compte pas pour l'évaluation mais sert à mettre la mère à l'aise]*	
	2.1.1. Au cours des deux derniers jours, pendant combien de temps en moyenne avez-vous mis votre bébé en position de kangourou chaque jour ? *La mère (et / ou les autres personnes qui la soutiennent) doit faire du CPP > 20 heures par jour si elle se trouve dans la salle MMK, > 8 heures par jour si elle se trouve dans l'unité néonatale.*	___ heures (par jour)
	2.1.2. À quelle fréquence pratiquez-vous (et / ou les autres personnes qui vous soutiennent) le CPP la nuit ? Chaque nuit, certaines nuits ou pas du tout ? *La réponse doit être « Chaque nuit » pour que le CPP soit considéré comme accepté et appliqué*	Choisir une option : ☐ Chaque nuit ☐ Certaines nuits ☐ Pas du tout
	2.1.3. À quelle fréquence pratiquez-vous (et / ou les autres personnes qui vous soutiennent) la MMK ? Chaque jour, 5-6 jours par semaine, 3-4, 1-2 ? *La réponse doit être « Chaque jour » pour que la MMK soit considérée comme acceptée et appliquée*	Choisir une option : ☐ Chaque jour ☐ 5-6 jours par semaine ☐ 3-4 jours par semaine ☐ 1-2 jours par semaine ☐ Pas du tout
	2.2. Demandez à la mère / autre proche aidant(e) : Vous sentez-vous capable de prendre soin de votre enfant en utilisant la MMK (position et nutrition) à la maison ?	Oui / Non
	2.3. Demandez à l'infirmière / au médecin : cette mère / proche aidant(e) doit-elle être rappelée régulièrement qu'elle doit fournir un CPP continu ?	Oui / Non
	2.4. Demandez à l'infirmière / au médecin : La mère / proche aidant(e) se porte assez bien pour pratiquer la MMK ?	Oui / Non
3. Capacité de la mère à allaiter	3.1. Demandez à la mère : Allaitez-vous votre enfant de manière exclusive ? *Si la réponse est « Oui », posez les question 3.2 et 3.3.* *Si la réponse est « Non » posez uniquement la question 3.4.*	Oui / Non

	3.2. Si la réponse a 3.1 est « Oui », vérifiez si la mère place elle-même son bébé sur son sein, sans aucune aide et peut le nourrir seule.	Oui / Non
	3.3. Si la réponse a 3.1 est « Oui », vérifiez si la mère est capable de produire du lait. (Demandez à la mère et / ou vérifiez auprès du personnel médical)	Oui / Non
	3.4. Si la réponse a 3.1 est « Non », vérifier auprès du personnel medical et du dossier médical : Est-il conseillé médicalement à la mère de ne pas allaiter de manière exclusive et d'utiliser du lait artificiel ?	Oui / Non
4. Soutien de la famille	4.1. Demandez à la mère : recevrez-vous de l'aide d'une autre personne à la maison ? (Incluant les membres de la famille, les amis, les voisins, etc.). *[Cette question ne compte pas pour l'évaluation et sert uniquement à recueillir des informations supplémentaires sur les questions de genre]*	Oui / Non
	4.2. Si oui à 4.1, alors qui est la principale personne qui vous aidera ? (Une seule réponse) *[Cette question ne compte pas pour l'évaluation et sert uniquement à recueillir des informations supplémentaires sur les questions de genre]*	Choisir une option : ☐ Le père du bébé / partenaire masculin ☐ Autre membre masculin de la famille ☐ Un Ami ☐ La mère de la mère ☐ Autre membre de la famille de sexe féminin ☐ Une amie
5.	**Demandez à l'infirmière / au médecin : Cette personne est-elle à l'abri de maladie infectieuse ou contagieuse, de maladie de la peau, de fièvre et est-elle physiquement et mentalement capable de prendre en charge l'enfant en utilisant la MMK ?**	Oui / Non
Résumé	**L'enfant est-il sorti de l'hôpital de manière appropriée ?** Le nourrisson est sorti de l'hôpital de manière appropriée si : - les réponses aux questions 1.2, 1.4, 1.5 et 2.3 sont « Non » ET les réponses à 3.1 est « Non » et à 3.4 est « Oui » - les réponses aux questions 1.2, 1.4, 1.5 et 2.3 sont « Non » ET les réponses à 3.1 est « Oui » et à 3.2 et 3.3 sont « Oui » - ET toutes les autres sont « Oui ». La réponse 2.1. est considérée comme un « Oui » si :	**Oui / Non**

	- La réponse à la question 2.1.1 est > 20 heures dans la salle MMK et > 8 heures dans l'unité néonatale, ET - La réponse à la 2.1.2 est « Chaque nuit », ET - La réponse à la 2.1.3 est « Chaque jour » Les réponses aux questions 4.1 et 4.2 ne comptent pas pour la notation de ce guide de sélection.	

Indicateur de paiement C - Grille de vérification

Questionnaire sur la Nutrition Appropriée pour la MMK au rendez-vous de suivi à 40 semaines		
Nom du patient (nourrisson)		
Relation avec le nourrisson (père, mère, tante, etc.)		
Date de l'enquête		
Nom de l'hôpital		
Nom de l'évaluateur		
1. Questions à poser à la mère (dans cet ordre) pour vérifier si elle a allaité son enfant exclusivement au sein au cours des 24 dernières heures	*Quels sont les facteurs qui peuvent empêcher une mère/autre proche aidant(e), y compris vous-même, de nourrir l'enfant conformément aux instructions du médecin ?* *Dites à la mère / proche aidant(e) : En raison des facteurs ci-dessus, il peut arriver que vous ne nourrissiez pas le bébé exactement comme prévu. Donc, pour les prochaines questions sur le lait maternel, l'eau, un autre lait, ou autre ; dites-moi ce qui s'est réellement passé, même si ce n'était pas totalement en ligne avec les recommandations du médecin* *[Cette question ne compte pas pour l'évaluation mais sert à mettre la mère à l'aise]*	Liste des facteurs
	1.1. Au cours des dernières 24 heures, avez-vous donné du lait maternel à votre bébé ? (Soit par voie orale, par sonde, avec une seringue ou une tasse/cuillère)	Oui / Non
	1.2. Au cours des dernières 24 heures, avez-vous donné de l'eau à boire à	Oui / Non

	votre bébé ?	
	1.3. Au cours des dernières 24 heures, avez-vous donné à votre bébé un lait autre que le lait maternel ?	Oui / Non
	1.4. Au cours des dernières 24 heures, avez-vous donné autre chose à votre bébé ?	Oui / Non Veuillez préciser : _____
2. Si la mère a allaité exclusivement son enfant au cours des dernières 24 heures (question 1), a-t-elle allaité son enfant exclusivement depuis le début de la MMK ?	2.1. Depuis que vous avez commencé la MMK, avez-vous donné à votre bébé du lait maternel ? (Soit par voie orale, par sonde, avec une seringue ou une tasse/cuillère)	Oui / Non
	2.2. Depuis que vous avez commencé la, avez-vous donné de l'eau à boire à votre bébé ?	Oui / Non
	2.3. Depuis que vous avez commencé la MMK, avez-vous donné à votre bébé du lait autre que le lait maternel ?	Oui / Non
	2.4. Depuis que vous avez commencé la MMK, avez-vous donné autre chose à votre bébé ?	Oui / Non Veuillez préciser : _____
3. Observation d'une alimentation autre que l'allaitement ?		Oui / Non Si Oui : ☐ Lait artificiel ☐ Eau ☐ Autre _____

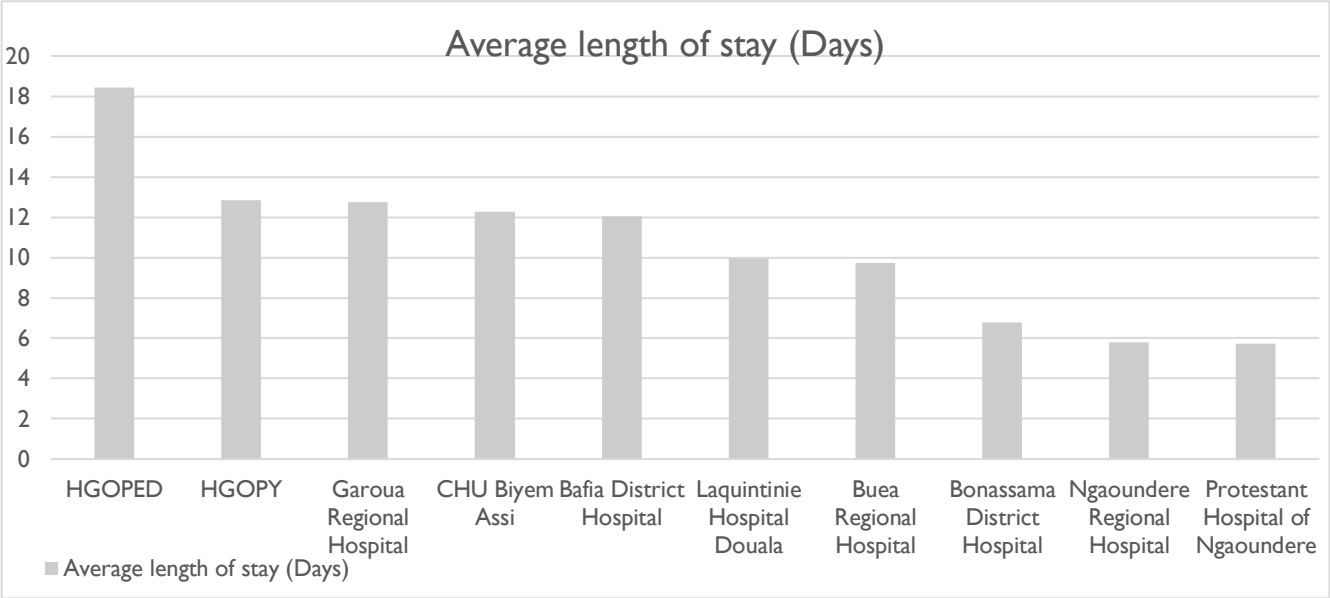
4. Pourquoi le bébé a-t-il reçu autre chose que du lait maternel ? *[Demander à la mère et revérifier avec le personnel médical]*	Il est conseillé médicalement à la mère de ne pas allaiter (cochez toutes les réponses appropriées) : La mère a le virus lymphotrope humain à cellules T de type I ou II La mère a une autre maladie ou condition. Veuillez préciser : _____ ☐ La mère reçoit des agents de chimiothérapie anticancéreuse ☐ La mère utilise des drogues illicites ☐ La mère est séropositive et a choisi de ne pas allaiter après une séance de conseil Autres raisons : ☐ La mère refuse d'allaiter ou insiste pour utiliser des préparations artificielles. Veuillez fournir la raison : _____

5. Le ou la pédiatre a documenté dans le dossier du nourrisson la raison pour complémenter le lait maternel avec du lait artificiel.	Oui / Non Veuillez bien vouloir fournir la raison donnée : _____

Résumé	Le bébé a-t-il reçu une nutrition appropriée ? *Le bébé a reçu une nutrition appropriée si :* • *Les réponses aux points 1.1 et 2.1 sont « Oui » ET les réponses aux points 1.2, 1.3, 1.4, 2.2, 2.3, 2.4 et 3 sont « Non » ; OU* • *Si les réponses à 1.3 ou 2.3 sont « Oui » (quelles que soient les réponses à 1.1 et 2.1) ET les réponses à 1.2, 1.4, 2.2 et 2.4 sont toutes « Non », ET la réponse à 3 est « Non » ou « Oui – Artificielle ». Lait », ET il y a une raison médicale pour la mère de ne pas allaiter à 4 ; OU* • *Si les réponses à 1.3 ou 2.3 sont « Oui » (quelles que soient les réponses à 1.1 et 2.1) ET les réponses à 1.2, 1.4, 2.2 et 2.4 sont toutes « Non », ET la réponse à 3 est « Non » ou « Oui – Lait Artificiel », ET il n'y a aucune raison médicale justifiant le fait que la mère n'allaite pas son enfant à 4, ET la réponse à 5 est « Oui » et la raison documentée est fournie ; OU* • *Les réponses aux points 1.1 et 2.1 sont « Oui » ET les réponses aux points 1.2, 1.3, 1.4, 2.2, 2.3 and 2.4 sont « Non » ET la réponse au point 3 est « Oui – Lait Artificiel » ET il y a une raison médicale pour la mère de ne pas allaiter au point 4 ; OU* • *Les réponses aux points 1.1 et 2.1 sont « Oui » ET les réponses aux points 1.2, 1.3, 1.4, 2.2, 2.3 and 2.4 sont « Non » ET la réponse au point 3 est « Oui – Lait Artificiel » ET il n'y a pas une raison médicale pour la mère de ne pas allaiter au point 4 ET la*	Oui / Non

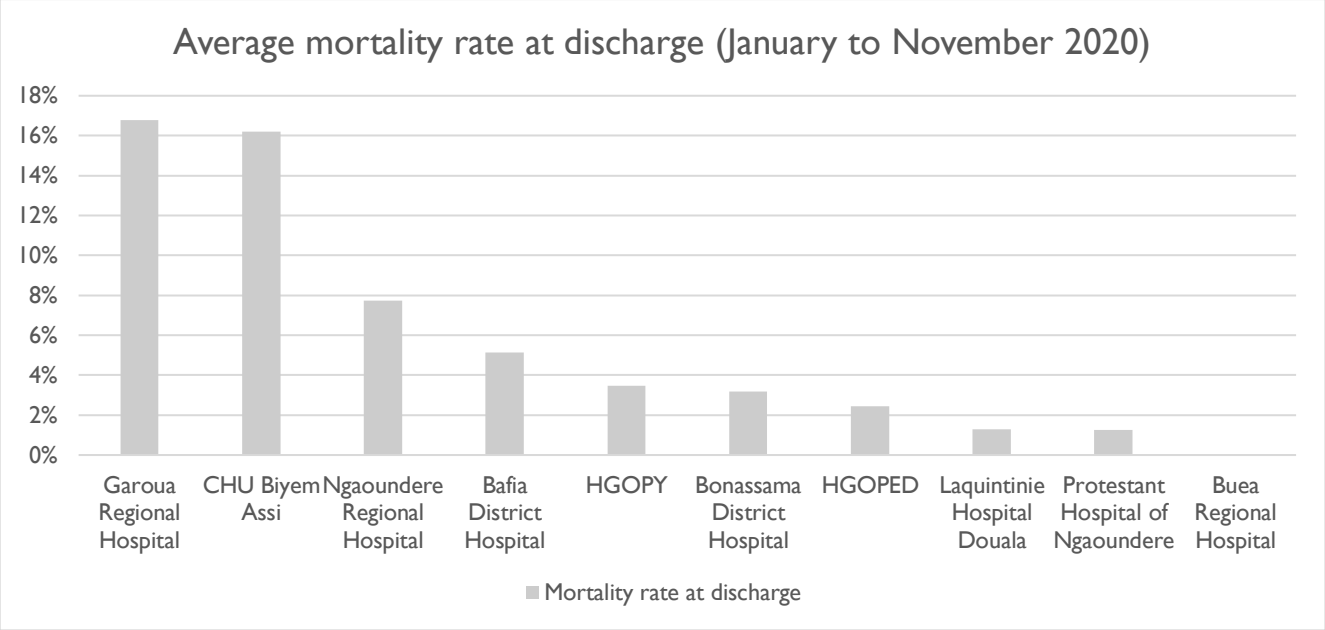
	réponse au point 5 est « Oui » et la raison documentée est fournie. *Si la mère dit (ou s'il est observé) qu'elle nourrit son enfant avec autre chose que du lait maternel ou artificiel, le bébé n'a pas reçu une alimentation appropriée.*	

1.6.e Average KMC hospital stay by programme hospital

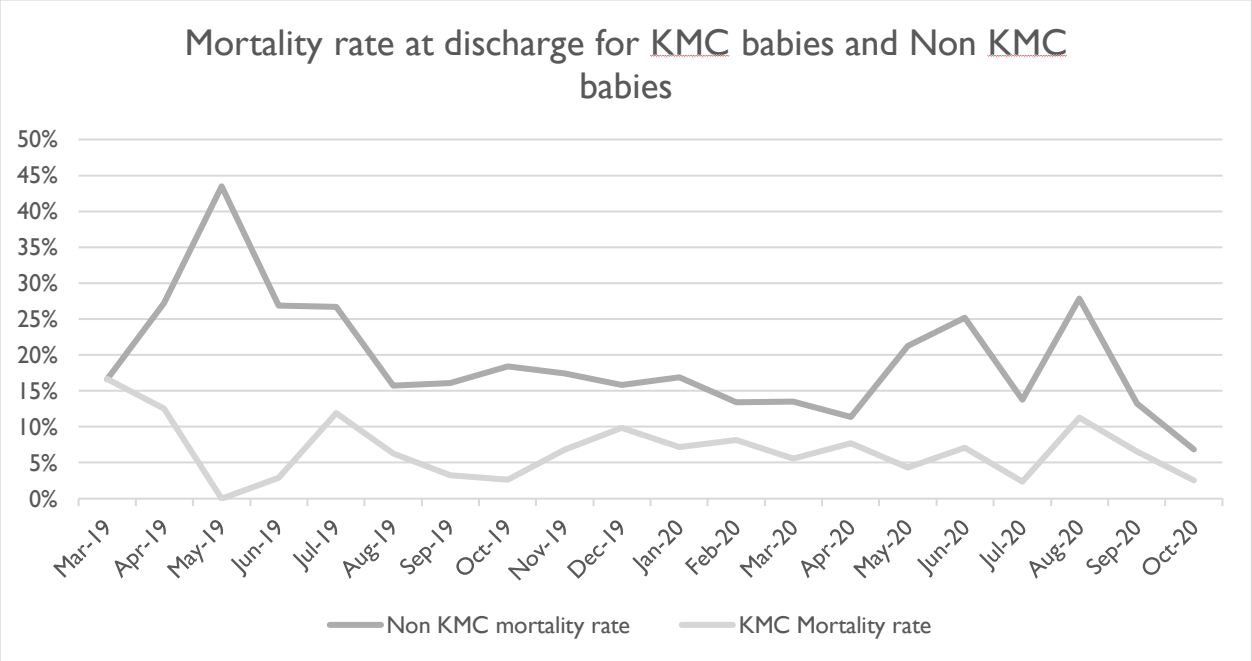


NB: This data spans the period of April 2019 to March 2021 and data collection is still underway at the time of publication.

1.6.f Average KMC mortality rates at discharge

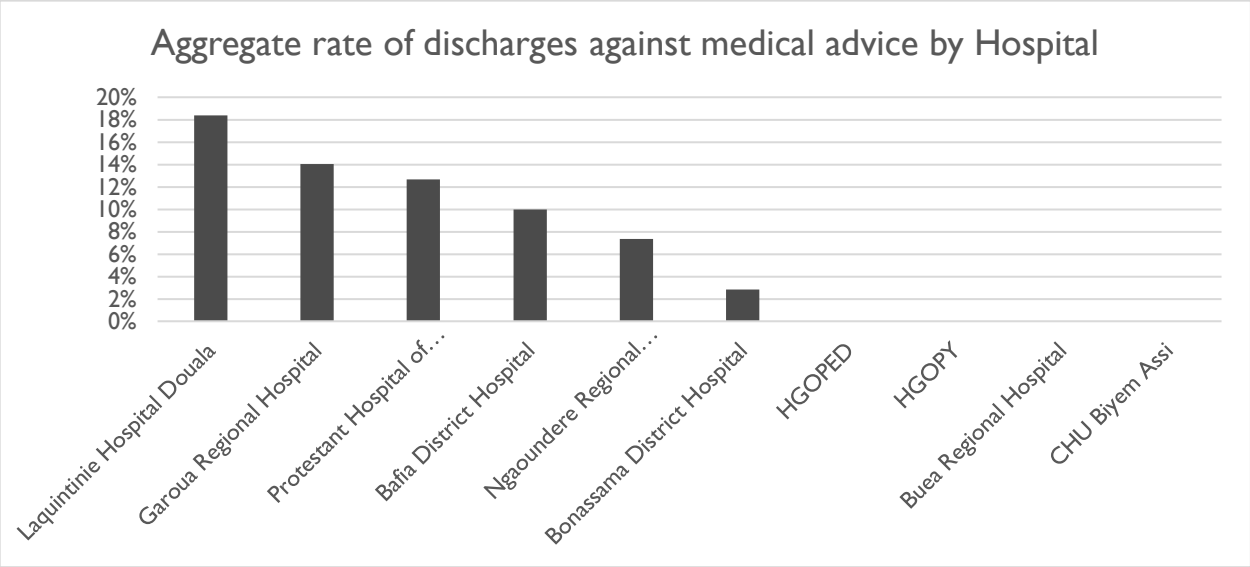


NB: This data spans the period of January to November 2020 and data collection is still underway at the time of publication.

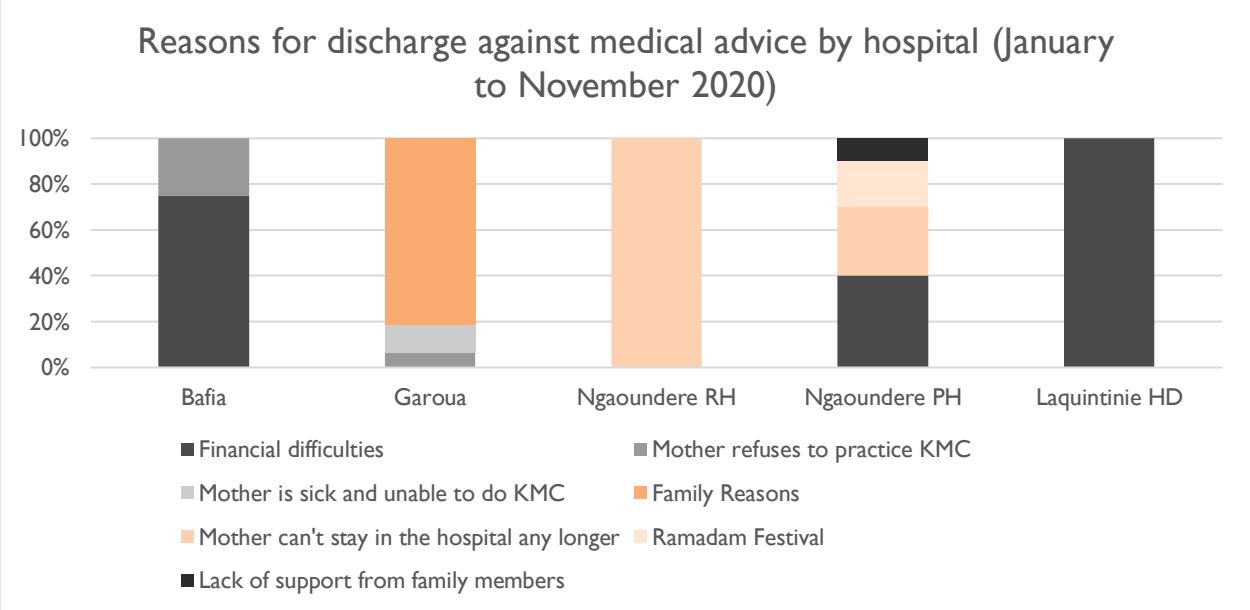


NB: Babies are not randomly allocated to KMC. Non-KMC babies may have underlying conditions or an unstable medical status that prevented them from being enrolled in the KMC programme.

1.6.g Discharge against medical advice by programme hospital



NB: This data spans the period of April 2019 to March 2021 and data collection is still underway at the time of publication.



NB: This data spans the period of January to November 2020 and data collection is still underway at the time of publication.