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Sustaining interventions to respectful care for newborns, infants and young children up to two years in Bungoma and Nairobi, Kenya

The COVID-19 response

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Background

- Quality of care (QoC) remains central to newborn and child health outcomes (WHO MNH and Child Health, Small and Sick Newborn QoC frameworks & recently COVID 19 MNCH guidance).
- Increasing coverage of interventions alone will not deliver outcomes needed to reach mortality reduction targets.
- Care for newborn and young child is addressed well in standards for "provision of care", but little attention is given to "experience of care".
- Limited evidence exists on how to include parents and family in caring for their sick baby or child up to 2 years in low resource settings.
- COVID 19 may effect of experience of care for newborns and children.

Formative Research (Nov- Dec 2019)

a) Determine the manifestations, and types of mistreatment of young children up to 2 years old in 2 counties of Kenya.

b) Identify and explore drivers of mistreatment

c) To understand how family engagement influence experience of care

d) Prioritize program activities to improve experience of care

Mistreatment by Age Group

Newborns (0-28 days)

- Delays
- Neglect/abandonment
- **Verbal abuse**
- Poor pain management
- **Unconsented care**
- **Lack of communication**

Infant/Young Child (29 days to 2 years)

- Repeat tests without explanation
- **Verbal abuse**
- **Lack of communication**
- **Unconsented care**
- Discrimination

Examples of Mistreatment

"there is a time two babies born at five months were brought in for referral, and I heard the nurse say these ones are not going to survive no matter what we do; so they just looked at the babies and decided they won't live… they left the two babies even though they had been brought in before the full-term baby and by the time they got back to the twins, they didn't even survive, they just died"

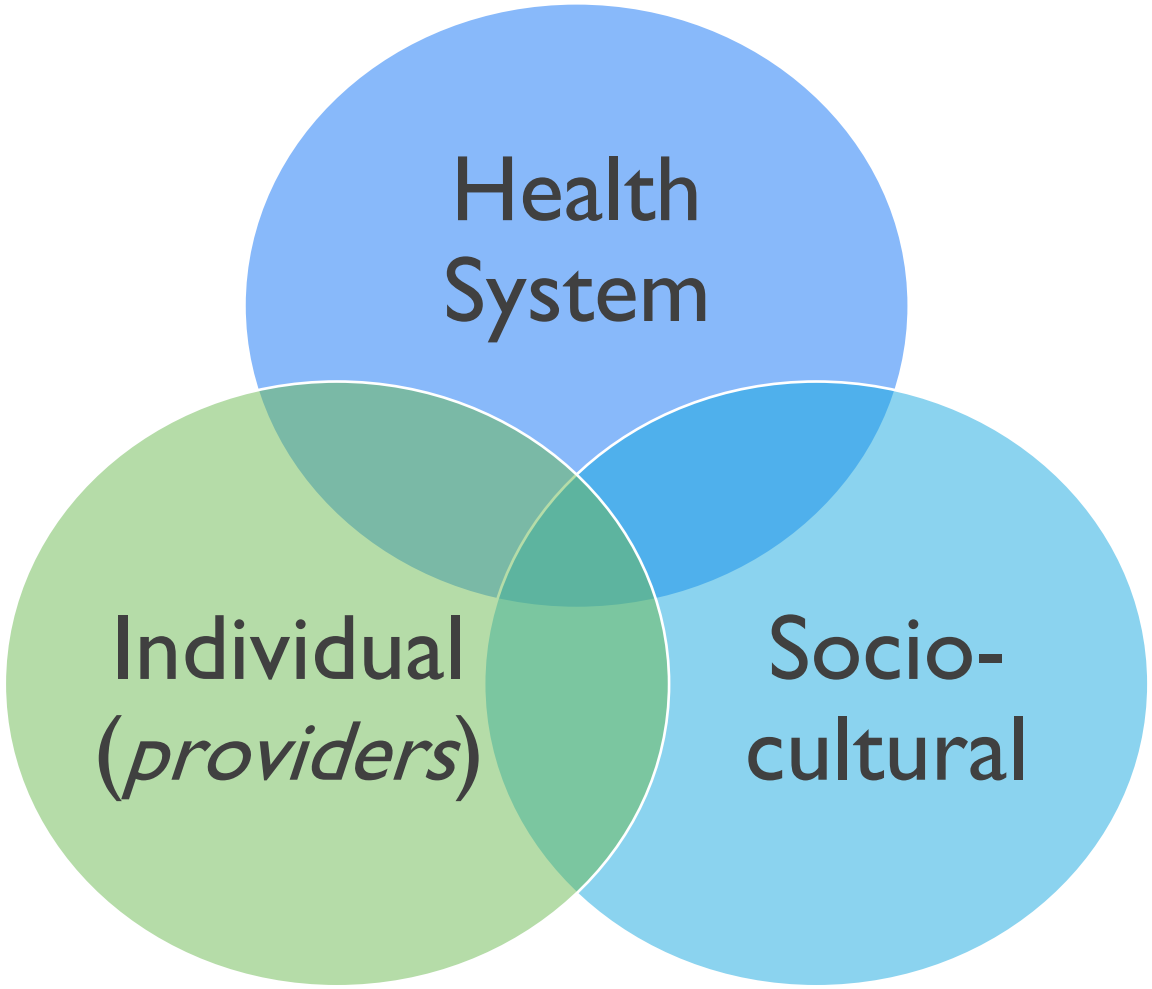
-IDI with both parents

As he was putting the line and the baby was pierced several times. I tried to express the pain of the baby, but the doctor was like 'leave me to do my work' so he was harsh… I felt so bad because the pricking was too much without success.

— Mother, IDI with both parents

Formative study findings

Drivers of Mistreatment - Overlapping Issues



Formative study findings

Provider drivers

- Lack of qualifications and experience (leads to poor diagnoses, unnecessary tests, and incorrect dosing of drugs)
- Insufficient emotional support/counseling skills (leads to negative caregiver and newborn/young child experience)
- Provider distractions and inattentiveness (e.g. phone, TV)
- Heavy workload and inadequate supervision
- Poor communication between doctors and nurses
- Poor/inconsistent remuneration
- Provider belief that increased family engagement results in more infections.

Communication from all perspectives

- Provider–caregiver power dynamics: fear of providers, inadequate/ non-responsive, powerlessness

When the doctors starts to treat your child, he can't accept you ask him a question… They don't want to be asked questions now and then.
-FGD, Women with young children

When you are attended to at a time like this when the life of your kid is in the balance you need encouragement, attention, and assurance but now that one has not been forthcoming. …even by the body language I feel I am bothering her [nurse].
— IDI with both parents

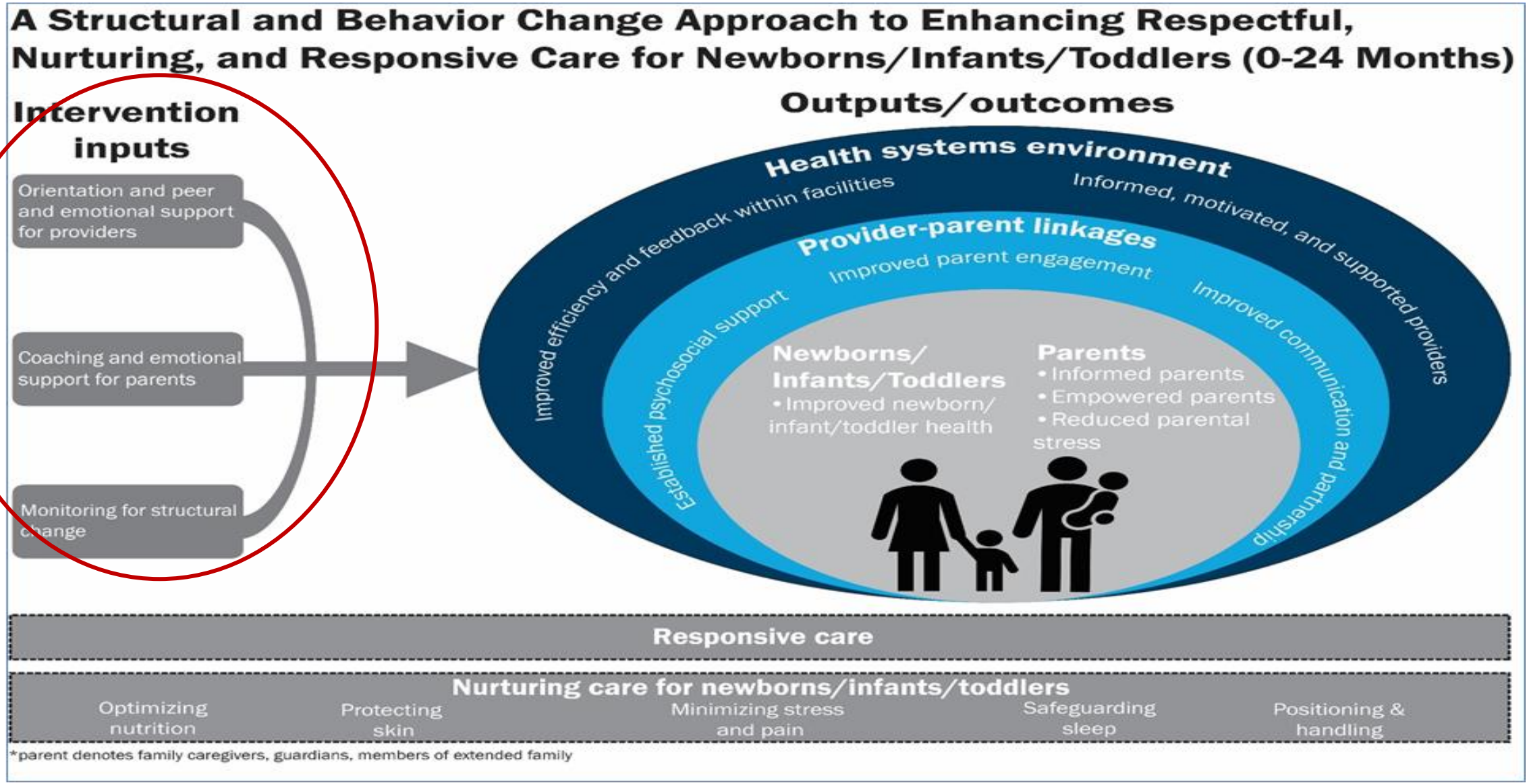
- Role of men in caregiving

In that paediatric ward you will not find a man…The men are willing to stay and care for the baby but because of space he cannot be allowed, we tell him to go and bring even the aunt of the baby to stay with the baby. —IDI, Healthcare Provider

Barriers to family engagement

- Lack of knowledge/ ignorance
- Parents lack technical skills
- Uncooperative caregivers/not ready to learn
- Lack of mutual respect between providers and family members
- System does not allow parents to do certain things (e.g. fathers)
- Provider failure to demonstration on “how” especially for parents with no previous experience of caring for a sick baby/child
- Provider are too harsh on parents/ negative attitude

Theory of change and intervention (start Oct 2020)



COVID 19 Concerns and fears

Providers

- Fear of infection (self and family)
- Inadequate PPE
- Psychological psychical stress associated in long working hours
- Separation from family
- Stigma of COVID

Parents/family

- Fear of infection (delay in seeking care/ hospital admission)
- Some facilities closed or sub- optimal operations
- Reduced income affect expenditure on health
- Stigma of COVID 19

Health systems

- Resources shift to Covid-19 response
- Human resource constraints
- Mistrust of health care facilities

Intervention implementation in COVID-19

- Online orientation of providers via zoom:

  Modules in pocketbook guides

  WhatsApp group to facilitate information sharing.

- Emotional support for parents and providers:

  Providers monthly psychological debriefing meetings: via zoom/online

  Counseling and emotional support for parents: through providers

- Increase parents (including men)involvement and decision making for their sick child: A communication wall chart and WhatsApp group for parents

- Monitoring for structural change through feedback to facility QITs:

  Electronic self-administered peer and parent/caregiver feedback forms

Intervention implementation in COVID-19

Intervention input	COVID-19 Modification (TBC)	Outputs/Outcomes
Orientation and peer support to providers: modules administered through workshop(s) supported by pocketbook guides; peer support in sharing information **Emotional support to providers** through monthly psychological counseling/debriefing sessions	Transitioned to online format (zoom) and WhatsApp groups to facilitate peer interaction of providers	Informed, motivated and supported providers; improved provider-parent communication & partnership Established psychosocial support for providers
Coaching and emotional support to parents: through providers and including flyers developed to align with orientation modules Increase parents (including men) involvement and decision making for their sick child using communication wall charts and linking parents	Unchanged modality; increased use of digital resources for parents WhatsApp group to link parents	Improved parent-provider communication, engagement, and partnership (shared decision-making); empowered and less stressed parents; improved newborn/child health
Monitoring for structural change: through provider/peer and parent/caregiver feedback to facility QITs	Feedback forms will be administered electronically.	Conducive health systems environment

THANK YOU

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