Improving newborn care in Africa: by staff and by mothers

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A. Care of newborns by staff

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It is good to have an up-to-date review of the worldwide situation for neonates. A key part of Sustainable Development Goals is the 'Every Newborn Action Plan' to ensure that all newborns have the opportunity to survive and thrive. This paper summarises the main points in the World Health Organization's 'Roadmap on human resource strategies to improve newborn care in health facilities in low- and middle-income countries.' [1]

The first key message and three main points to emerge from the roadmap are:

- improving pre-service training,
- building the capacity of existing providers including a recognised certification, and
- the creation of neonatal nurses as a specialty where they do not exist.

Practical issues of care discussed are the need to standardise levels of care: primary, secondary and tertiary. Staff should be able to refer newborns vertically around the three levels effectively and laterally to other experts who can help.

The waste of precious experienced neonatal staff being routinely rotated to other parts of a facility is common in low- and middle-income countries (LMICs). It shows lack of understanding and respect. Staff ratios and skill mix should be well managed and are connected to recruitment and retention.

There still exist inaccurate payroll systems with money allocated to workers who do not work leaving unpaid those who do. Reviewing what happens to resources and strengthening planning policy and regulations is crucial. Strategies should be promoted globally.

The second key message of the roadmap says it is:

"Rights based and family centred: All newborns have the right to high-quality evidence-based nurturing care from health workers with appropriate knowledge and technical and behavioural skills, working in partnership with families".

B. Care of preterm babies by mothers

Felister Ngapomba and Massimo Serventi

The treatment and care of preterm babies in Africa is under constant review and renovation.[2] The World Health Organization has recently produced a roadmap for the purpose.[1] In this, much emphasis is given to the need for trained personnel and essential instruments and devices (see above).

Unfortunately, both are seldom available in many African hospitals. Moreover, sophisticated machinery like incubators may not be suitable particularly where there are few resources because they need reliable power, and have to be used correctly and maintained.

Kangaroo care(where the mother holds the baby skin-to-skin against her chest) has proved to be a valid and effective compromise; the mother becomes a natural incubator with the added advantage of love and tenderness that machines cannot replace. In addition to Kangaroo Care, we feel more could be done by mothers

in caring for, and monitoring their preterm babies' health from the first hours of life.

In our direct experience and observation, mothers, once adequately instructed and empowered, become the best nurses and caregivers. There needs to be a changing attitude to the overall approach to the care of preterm babies in the ward so it is not orientated mainly to medical drugs or protocols but toward more natural care that is always negotiated with the mother. Mothers should be allowed and encouraged to handle and feed their babies in the ward.

In reality, almost all mothers are capable of accurately reporting the small changes and daily progress of their babies, often as well or better than monitors or blood tests upon which we doctors rely.

Mothers looking after pre-term babies regularly wash their hands with soap. They ask anyone else approaching their babies to do the same. For example, staff coming to vaccinate the baby. They learn to express their milk and how to feed it in the best way compatible with the condition of the baby. The use of a nasogastric tube, if needed, should be explained and never imposed but negotiated with the mother

A neonatal ward, that in many places in Africa, is usually a simple heated room with no incubators, can be managed by mothers. Nurses should be there to assist but not to command or impose. In such an ambience the atmosphere is of serenity, where 'young' mothers receive instructions and encouragement from the more experienced ones. If a preterm baby dies the death may be then more easily accepted as a natural event and is not dramatized into a medical debacle.

We believe that African mothers are the best nurses. They 'feel' and know each single aspect of life or of ill health of their babies; in fact, they know that babies 'belong' to them and not to medical staff. This is not the same in some other cultures where for several reasons (war, religion) women often have been deprived of their capacity to care for babies.

Detailed counselling on the entire picture of prematurity: its causes, risk factors, care and possible complications/ outcomes have proved to be effective in helping the mothers to provide the best care for their babies. This gives them a complete sense of responsibility in reducing/ avoiding easily-preventable complications as well as understanding quickly when any problem arises.

Mothers of preterm babies face many challenges. It appears to us that, of these, poor family support and financial setbacks are most important. These are frequently associated with diminished care for the babies because the mothers have long stays in hospital while waiting for their babies to attain the desirable weight. On average, mothers stay for 2 to 3 months. This can result in them having a poor diet and emotional stress, especially if they have other children at home, which, in the end, directly affects the baby. Also, lack of continuing health education upon discharge can result in complications and sometimes death of babies born prematurely.

Some examples

Working as a paediatrician in big hospital wards and small rural dispensaries for 40 years one of us (MS)can recall many episodes where African mothers demonstrated their extraordinary capability and common sense when caring for their vulnerable babies.

I recently witnessed the case of a very small-preterm female baby. She weighed 800g at birth but survived and gained weight thanks to her mother and minimal medical care. Apart from a short time in an incubator and a little oxygen she received 24-hourattention and love, and expressed breast milk, from her young mother. "Wash your hands", constantly reinforced, was the only message given to the mother - nothing more– except for daily words of encouragement and appreciation.

A second case was an orphaned baby who weighed 1.2kg and came into the ward in poor condition - presumably caused by sepsis. A 50-year-old woman agreed to care for the baby using Kangaroo care.

I was able to watch them both in obstetric ward; the 'mother' so carefully and intelligently reported any small signs of change. Antibiotics(iv) was the only medical treatment given, nothing more. The child survived and grew up normally.

References

1. World Health Organization. Roadmap on human resource strategies to improve newborn care in health facilities in low- and middle-income countries. Geneva: World Health Organization; 2020. https://apps.who.int/iris/bitstream/handle/10665/336677/978240015227-eng.pdf?sequence=1&isAllowed=y
2. World Health Organization. Newborns: improving survival and well-being. Fact Sheet September 2020. https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality

Additional Resource

The Healthy Newborn Network. An online community dedicated to addressing critical knowledge gaps in newborn health. https://www.healthynewbornnetwork.org/about-2/