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Kangaroo Mother Care implementation research to develop models for accelerating scale-up in India and Ethiopia: study protocol for an adequacy evaluation

KMC Scale-Up Study Group

ABSTRACT

Introduction Kangaroo Mother Care (KMC) is the practice of early, continuous and prolonged skin-to-skin contact between the mother and the baby with exclusive breastfeeding. Despite clear evidence of impact in improving survival and health outcomes among low birth weight infants, KMC coverage has remained low and implementation has been limited. Consequently, only a small fraction of newborns that could benefit from KMC receive it.

Methods and analysis This implementation research project aims to develop and evaluate district-level models for scaling up KMC in India and Ethiopia that can achieve high population coverage. The project includes formative research to identify barriers and contextual factors that affect implementation and utilisation of KMC and design scalable models to deliver KMC across the facility-community continuum. This will be followed by implementation and evaluation of these models in routine care settings, in an iterative fashion, with the aim of reaching a successful model for wider district, state and national-level scale-up. Implementation actions would happen at three levels: ‘pre-KMC facility’—to maximise the number of newborns getting to a facility that provides KMC; ‘KMC facility’—for initiation and maintenance of KMC; and ‘post-KMC facility’—for continuation of KMC at home. Stable infants with birth weight<2000 g and born in the catchment population of the study KMC facilities would form the eligible population. The primary outcome will be coverage of KMC in the preceding 24 hours and will be measured at discharge from the KMC facility and 7 days after hospital discharge.

Ethics and dissemination Ethics approval was obtained in all the project sites, and centrally by the Research Ethics Review Committee at the WHO. Results of the project will be submitted to a peer-reviewed journal for publication, in addition to national and global level dissemination.

Study status WHO approved protocol: V.4—12 May 2016—Protocol ID: ERC 2716. Study implementation beginning: April 2017. Study end: expected March 2019.

Trial registration number Community Empowerment Laboratory, Uttar Pradesh, India (ISRCTN12286667); St John’s National Academy of Health Sciences, Bangalore, India and Karnataka Health Promotion Trust, Bangalore, India (CTRI/2017/07/008988); Society for Applied Studies, Delhi (NCT03098069); Oromia, Ethiopia (NCT03419416); Amhara, SNNPR and Tigray, Ethiopia (NCT03506698).

INTRODUCTION

Globally, each year 15 million neonates are born preterm and consequently at a high risk of mortality.1 2 South Asia and sub-Saharan Africa account for almost two-thirds of the world’s preterm babies.3 Kangaroo Mother Care (KMC) is a low-cost intervention involving early, continuous and prolonged skin-to-skin contact between mother and baby and exclusive breastfeeding.4 KMC has been demonstrated to promote physiologic stability, a thermally supportive environment, reduce risk of serious infections and reduce the mortality among hospitalised, stable preterm and low birth weight (LBW) infants.5 Despite the benefits, coverage of KMC has remained low and implementation has largely been limited to specialised hospitals.5–8
To implement the most promising model in the study, a minimum of at least 8
hours skin-to-skin contact should be provided for as long as possible during day and
night, with a 24-hour period, along with exclusive breastfeeding or breast milk
feeding via tube, spoon or paladai. Based on the available evidence of effectiveness, KMC
will be delayed until they stabilised.

AIMS OF THE IMPLEMENTATION RESEARCH

Aim: To develop a delivery model that will result in high coverage (80%+) and quality of KMC for the target population.

Additional aims
► To design and identify the most promising delivery model through formative research combined with an iterative quality improvement (QI) approach.
► To implement the most promising model in the study facilities and evaluate quality and coverage of KMC in the population they serve.

METHODS/DESIGN

We are undertaking an international, multi-site, implementation study using a mixed-methods design that integrates formative and evaluative components into iterative improvement cycles. Our intervention promotes KMC for babies born <2000g across the community-facility continuum.

Population

The population will be newborns with birth weight under 2000 g born in the geographic area targeted by the intervention. It includes all babies born in health facilities and in the community. For those newborns who are severely sick according to predefined criteria (not tolerating oral feeds, severe respiratory distress including, respiratory rate less than 20 breaths per minute, grunting, central cyanosis, severe chest indrawing, convulsions, unconsciousness and severe hypothermia of less than 32°C), KMC will be delayed until they stabilised.

Intervention

The intervention will be the provision of KMC, defined as skin-to-skin contact with the mother or a replacing caregiver, for as long as possible during day and night, with a minimum of at least 8 hours over a 24-hours period, along with exclusive breastfeeding or breast milk feeding via tube, spoon or paladai. Based on the available evidence of effectiveness, KMC will only be initiated in health facilities.

Comparison

The performance of the interventions will be assessed against a predefined success criterion of 80% or higher coverage of effective KMC at population level.

Outcomes

The assumption that current coverage with KMC initiated at a health facility is low or negligible in the study population will be confirmed by a baseline assessment of facilities.

The primary outcome will be effective coverage of KMC, defined as at least 8 hours of skin-to-skin contact in combination with exclusive breastfeeding in the preceding 24 hours among infants with birth weight <2000g. It will be measured:
► At discharge from the KMC facility (defined as one where staffing, infrastructure and mechanisms are present to initiate and maintain KMC).
► At 7 days after discharge, in the home.

Secondary outcomes include:
► Population-level duration of KMC, that is, mean of how many days KMC was received by infants in the population with birth weight <2000g during the neonatal period.
► Proportion of infants with birth weight <2000g receiving any KMC (any duration in last 24 hours) at discharge, 7 days post-discharge and at 28 days of age.
► Proportion of infants with birth weight <2000g exclusively breastfed (based on 24-hour recall) at discharge, 7 days post-discharge and at 28 days of age.
► Neonatal mortality rate (NMR) (including early NMR) in infants <2000g.
► Cost of the KMC model (measured in some of the sites).

Sample size

We assume that 3%–5% of neonates born in Ethiopia and India will be <2000g and that it will not be possible to evaluate 20% of these newborns because of early death or loss to follow-up. A sample size of 310 newborns per site will allow us to estimate 80% coverage of KMC with site-specific absolute precision of ±5%. All the study sites will have sufficient numbers of births of eligible infants to enrol at least 310 during the evaluation phase. We anticipate the follow-up of a total of at least 2170 newborns <2000g during the evaluation period.

Study sites

The study will be conducted in a total of seven sites in Ethiopia and in India. Ethiopia and India are among the countries in Africa and Asia with the highest proportion of LBW babies. Selection of sites within each country considered the quality of the proposals and the desire to reflect regional diversity.

Ethiopia

In Ethiopia, newborn mortality remains high at 29 per 1000 live births.9 10 The Ministry of Health has spearheaded a major campaign to increase facility births which appears effective.11–15 Results from a recent survey (L10K) in 2015 conducted in 115 districts (woredas) in agrarian regions indicate facility births in the past 12 months to be around 53%.11

Amhara

The study will be conducted in two woredas of West Gojjam Zone, two woredas of South Gondar Zone, and Bahir Dar City Administration, Amhara Region. In West Gojjam Zone, the study includes one primary hospital. In
Bahir Dar City Administration, the study includes a large referral hospital, 1 primary hospital, 19 health centres, 42 health posts and their respective catchment populations. In South Gondar Zone, the study includes 1 general hospital and 1 primary hospital, 14 health centres and up to 59 health posts affiliated with these health centres, along with their respective catchment populations.

**Oromia—Addis Ababa**

The Oromia—Addis Ababa site will implement the study in Akaki Kality sub-city in Addis Ababa and East Shoa Zone in Oromia region. Akaki Kality sub-city, one of the 10 sub-cities of Addis Ababa city administration shares border and culture with East Shoa Zone of Oromia region. The Akaki Kality sub-city has an estimated population of 180,000 living in 11 woredas in the sub-city. Oromia Regional state has an estimated population of 27 million. The study will be implemented in two woredas: Adami Tulu in the East Shewa Zone and Arsi Robe in the Arsi Zone.

**SNNPR**

Southern Nations, Nationalities, and Peoples’ Region (SNNPR) has a facility birth rate of 25.2%. The sites proposed for study are Hawassa city administration, Shebedino woreda and Dale woreda, situated in Sidama Zone. Hawassa is the capital of SNNPR and its administration consists of eight sub-cities with urban and rural kebeles. The two public hospitals in Hawassa city—namely Hawassa University Comprehensive Specialised Hospital and Adare General Hospital—are included in the study. Leku is the capital of Shebedino woreda and consists of urban and rural kebeles. Leku Primary Hospital is the site for Shebedino woreda. Yirgalem is the capital of Dale woreda. Yirgalem General Hospital is the site for Dale woreda.

**Tigray**

According to the Ethiopia Demographic and Health Survey (EDHS) 2016, in the Tigray region, 69% of the women who gave birth 2 years preceding the survey delivered in facilities. The study will be implemented in two zones, namely south-east zone and Mekelle special zone. In the south-east zone, two districts (Enderta and Degu-Tembien woredas) will be included in the study. In the selected districts and Mekelle Zone, there are 1 comprehensive referral hospital, 2 general hospitals, 1 primary hospital, 22 health centres and 5 private health facilities. All these health facilities will be included in the study.

**India**

India accounts for one quarter of newborn deaths in the world. Neonatal deaths represent about 50% of under-five deaths and 70% of its infant deaths. About 27% of all babies are LBW (<2500 g). Haryana

The study will be implemented in one of Haryana’s 22 districts (Sonepat). The LBW rate is 18% in Sonepat. Around 5% of all infants weigh less than 2000 g at birth (information from government records). The institutional delivery rate is 80.5% and 90% of births are conducted by skilled birth attendants. Infant mortality in Haryana is 36/1000, similar to the Indian average. The NMR is 28/1000, a major proportion of infant mortality rate.

**Karnataka**

Infant mortality rate is 28/1000 and NMR is 22/1000 live births. The research project will be conducted in the Koppal district, located 400 km away from Bangalore. This is an under-served, in the northern region of the state identified as a high priority district by the government. The district has a LBW prevalence of about 25%
and a NMR of 42/1000. About 80% of births are institutional deliveries.

**Uttar Pradesh (UP)**

UP is the most populous state in India and accounts for a quarter of India’s burden of neonatal deaths. UP’s NMR of 37/1000 is among the highest in the country. The prevalence of LBW in UP is 25%. The study will be implemented in the Raebareli district with an institutional delivery rate of 93%. The study will cover the district hospital and ten community health centres, along with their catchment blocks.

**Ethical considerations**

Since the intervention will be provided by the government as standard of care for LBW, there will be no request for consent from individuals to receive the intervention. Individual written informed consent will be requested from mothers, caregivers and health workers for the collection of information. For those unable to read, the informed consent form will be read out by the research team member before asking consent.

**Patient and public involvement**

The question addressed by this research project was identified as a priority by the governments of Ethiopia and India. They participated in planning the study through the ministries of health. Patients and communities will play a major role in designing the models developed and tested, as described below under Phase 1—formative research. Results will be disseminated to the communities using channels available to the health system, as well as to the state and national health authorities, and through publication in peer-reviewed journals.

**Study approvals**

Study approvals were obtained at the local, national and international levels.

**Study implementation strategy**

Core framework for KMC implementation

KMC promotion will be implemented at three levels (figure 1):

- **Pre-KMC facility**—the aim at this level is to maximise the proportion of newborns under 2000 g to be born in/brought to KMC implementing health facilities.
- **KMC facility**—the aim at this level is early initiation of KMC and adherence to long duration (>8 hours) skin-to-skin care with exclusive breastfeeding within the facility.
- **Post-KMC facility**—the aim at this level is continuation of effective KMC at home through the neonatal period or until the baby no longer accepts it.

**Study teams**

The KMC intervention will be delivered by health workers who are part of the health system. The research team’s implementation role will be only supportive. This research team will be comprised of three small teams:

- The ‘programme learning team’, to conduct formative research and process monitoring, help formulate the intervention and process evaluation of implementation.
- The ‘implementation support team’ to guide and support the health system so that the environment supports KMC and health workers implementing the intervention.

**Table 1** Description of study implementation teams

| Research                  | Implementation support team | Outcome evaluation team | Government implementation | Health system team |
|---------------------------|----------------------------|-------------------------|----------------------------|--------------------|
| **Programme learning team** | Support government implementation of KMC | In the catchment area of the facilities involved in Phase 1, collect quantitative data on: | Deliver and monitor the KMC intervention |
| Phase 1                   | Conduct formative research to develop the initial KMC delivery model | ▶ Births in facilities and community  
▶ Births <2000g in facilities and community  
▶ Number of newborns receiving KMC at time of discharge from health facility, 7 days post-discharge and at 28 days of age | |
|                           | Conduct programme learning to understand how well the KMC delivery model is working and to redesign the model based on lessons learnt | ▶ Duration of skin-to-skin care | |
| Phase 2                   | Monitor process indicators to learn how implementation of KMC delivery models happens in all study facilities and identify ways to refine the model based on context-specific findings | Assume an advisory role to support government implementation of KMC | Deliver and monitor the KMC intervention |

KMC, Kangaroo Mother Care.
The ‘outcome evaluation team’ to measure the study outcomes in the population acting independently from the other two teams (table 1).

Phases of implementation
The implementation will happen in two phases (Figure 2).

Phase 1: to develop a delivery model for KMC
KMC delivery model cycles of improvement
The initial delivery model will be developed based on the formative research and synthesis of literature. Programme learning from the delivery of this model and outcome measurements will immediately feed into a stage of model review and redesign/refinement, aimed at improving the coverage. We expect that at least three cycles of model development-implementation-evaluation-refinement will be needed until reaching a scalable high coverage model. Each cycle may take 3–4 months. The first cycle may involve one facility but the second and third will be larger, including up to one-third of all study facilities.

At the end of each cycle, findings will be shared with an advisory group of stakeholders and their input will be sought to improve the model. New iterations of the model will be developed and further refined and reviewed with advisors. Figure 3 presents this iterative implementation-optimisation of the model.

Formative research
The study’s first step will be the programme learning research team undertaking formative research to identify and understand barriers and enablers to KMC in the specific context. We will follow the COM-B model to guide understanding of behaviour change in the implementation context, and the development of behavioural targets as a basis for designing interventions with users. It proposes that people need capability (C: psychological or physical ability to enact a behaviour), opportunity (O: physical and social environment that enable a behaviour) and motivation (M: reflective and automatic mechanisms that activate or inhibit a behaviour) to perform a behaviour (B). Domains of the formative research are presented in Table 2. Based on the knowledge gathered, we will develop an initial model of KMC implementation at the study site.

Implementation of KMC test models
The initial model will be implemented in collaboration with facility and community workers with guidance from the implementation support team. Selection of facilities

Figure 2 Logic model for Kangaroo Mother Care scale-up.

Figure 3 Optimisation of implementation model.
| Table 2 | Domains of enquiry for formative research |
|---------|------------------------------------------|
| **Domains of enquiry** | **Activities** |
| **KMC intervention** — to inform the design of the technical package of KMC | ▶ Review KMC scientific literature; existing government guidelines on KMC; experience on implementation of KMC  
▶ Develop guidelines and protocols for health staff in facility and community healthcare workers  
▶ Develop communication materials for communities, pregnant women and their families |
| **Users and implementers** — to understand the barriers and enablers to KMC adoption and adherence | **Mothers/families**  
▶ Explore perceptions of mothers and family members around preterm babies, low birth weight, care-seeking, institutional deliveries, private facilities, perception of quality; understand and explore ideas to generate demand for KMC |
| **Health systems** — to improve the delivery of KMC at the facility and community level | **Health facilities**  
▶ Understand current KMC practices in health facilities; map behaviours that could impact adoption of KMC within these facilities  
▶ Design a KMC facility readiness checklist based on local feasibility and provisions  
▶ Assess physical infrastructure and resources available for KMC |
| **Link between community and facility** | ▶ Assess current engagement between CHWs and health facilities and explore efficient process of engagement  
▶ Assess referral system |
| **Assess data needs, measurement systems and analytics support and its compatibility and adaptability for KMC** | ▶ Assess existing management information system; assess registries that exist at each level of the healthcare system  
▶ Design and test electronic data management systems to guide and accelerate adoption and improvement of KMC |
| **Leadership and policy makers** | ▶ Engage leadership and decision makers for their support of KMC  
▶ Assess need of additional workers and current human resource capacity gap |
| **Other stakeholders** | ▶ Map and engage all professional, organisational, health system, administrative and social networks that may impede or support KMC adoption and spread in the study area |
| **Context** — to develop adaptable delivery models | ▶ Understand perceptions of care of small babies and logistical challenges to care of high risk babies within the setting  
▶ Explore motivations for facility versus home deliveries  
▶ Map relationships between doctors and nurses, CHWs and mothers/families |

CHW, community health workers; KMC, Kangaroo Mother Care.

to implement KMC test models will be based on factors such as number of births, type of health workers, services delivered (eg, presence of newborn intensive care units or special care nurseries) so that they capture a major proportion of deliveries in the study district. Implementation will occur at three levels: pre-KMC facility, KMC facility and post-KMC facility (figure 1).

**Pre-KMC facility**
To effectively implement KMC, eligible newborns need to be identified and cared for in facilities where KMC is initiated. All births should be identified, and babies weighed. Eligible babies, if born outside KMC facilities, will be referred to these facilities through strengthened government transport and linkage mechanisms. The pre-facility level includes efforts to: increase facility deliveries, expand early assessment of those delivered at home, so that eligible newborns are referred to a KMC facility, and create a social norm around the practice of KMC.

**KMC facility**
Facility level activities will aim to strengthen knowledge and skills of health providers and implement KMC protocols so that they provide high-quality care. All stable newborns would be placed in skin-to-skin contact and initiated breastfeeding within the first hour of life. In-born and referred newborns would be screened for KMC eligibility (<2000 g and stable). If meeting eligibility criteria, KMC would be initiated. If the newborn is sick, he/she will be stabilised first and then reassessed for KMC eligibility and initiation.

During the newborn’s facility stay, nurses will do a KMC assessment following a checklist which examines skin-to-skin contact (number of hours) and breastfeeding,
counselling on KMC, and problem-solving if barriers exist. Nurses will document the adoption of KMC. At
time of discharge, mothers and family members will be
counselling so that KMC is continued at home. Facility
staff will notify community health workers (CHWs) about
discharges and discuss how to support continued KMC at
home.

Post-KMC facility
After discharge, CHWs shall visit the home within
24 hours following the post-facility KMC protocol. CHWs
will continue to visit the newborn following the standard
national postnatal care visit schedule. At each visit, CHWs
will perform a KMC assessment using the follow-up check-
list including skin-to-skin duration and breastfeeding,
counselling and problem solving. CHWs will identify and
refer sick newborns to the facility and assist the referral.

Health systems strengthening
Linkages between facility and community will be strength-
thened so that KMC is continued at home. This will be facili-
tated through establishment of communication systems
between facilities and CHWs.

Outcome measurement
The study outcome evaluation team will conduct an inde-
dependent evaluation of the effectiveness of the model in
achieving 80% or higher coverage with KMC among the
target population. Data will be collected at health facili-
ties and the community.

Phase 2: implement and evaluate the chosen KMC delivery
model
The most promising KMC delivery model will be chosen
from Phase 1 based on programme learning findings and
coverage. During Phase 2, the chosen model will be
implemented in all selected facilities and data will be
collected in the study area to measure the coverage with
effective KMC.

Implementation of the KMC delivery model
The model will include KMC guidelines, protocols,
communication and training materials, and tools for
successful implementation. The delivery model will be
implemented by the health system in all study facilities
and their catchment areas. The implementation support
team will continue to be active but now playing only an
advisory role to the government implementation teams.
There will be ongoing mentorship and QI feedback cycles
within each facility.

Implementation activities will include guideline dissemin-
ation, healthcare provider and CHW training, identifi-
cation of LBWs, community awareness and demand
generation, establishment of referral and supervision
systems, monitoring, and continuous feedback loops. Key
activities are further described below.

Community awareness and demand generation: Contacts
between families and the health services will be utilised to
promote awareness of KMC and of KMC units. Pregnant
women and mothers of under-fives, for example, come in
contact with health services during antenatal care, immu-
isation sessions and routine home visits by CHWs. Additional
activities, such as village health promotion days, will be
used. Messages developed will be communicated
through posters, pamphlets, banners and wall paintings
and disseminated at strategic locations in the community
and at facilities with maternity wards, antenatal clinics,
postnatal clinics, paediatrics wards in addition to the
KMC wards. Audiovisual media such as local network for
television channels or local radio may also be used.

Consistent messages from multiple channels, including
interpersonal communication with health providers in
public and private sectors and CHWs, will reinforce the
information. Experience indicates that the endorsement
from doctors seems critical to adoption of KMC. Orienta-
tion sessions will be conducted with all stakeholders and
community representatives likely to influence community
behaviour and norms.

Identification of resources and staffing within the health
system: KMC is a new intervention for most health facil-
ities in Ethiopia and India. Before initiating field work,
discussions with national and local government officials
will be held to promote buy-in. During these meetings, a
landscaping overview of staffing, equipment and supplies
at study health facilities will be completed. Together with
government partners, research teams will meet with the
leadership at study health facilities to introduce the KMC
initiative, discuss their concerns and engage their involve-
ment. We will jointly identify staff to participate in KMC
implementation at each level of the health system.

Development of intervention materials: With Ministries of
Health and country-specific teams, we will develop a stan-
ardised set of KMC protocols, guidelines, training mate-
rials, job tools and checklists to support implementation.
Existing training manuals on newborn care in Ethiopia
and India include KMC training. We will update them to
include strategies to initiate and continue KMC at health
facilities and plans for follow-up care at home. These
study manuals will be used to train care providers in the
selected study health facilities. To support health workers
in implementing KMC, we will develop job-aids, checklists
and data collection forms.

Launch of the KMC implementation programme: A 1 day
workshop will be conducted involving officials and experts
from study sites including regional and district health
offices, health facilities and maternal, newborn and child
health (MNCH) implementing partners. The workshop
will orient stakeholders and strengthen local partnerships
for successful implementation of project activities.

Implementation team training: We will provide an inten-
sive training on KMC for healthcare workers from study
facilities and CHWs from the community. Training will
involve lectures and hands-on training, including tech-
nical updates, counselling skills, follow-up care at health
facility and at home, and documentation of the KMC
services. Trainers will be experienced local paediatricians
and faculty from the site-specific institutions and the pool
of trainers already available in the state. Training components will include advantages of KMC, appropriate KMC techniques, possible barriers and ways to address them, how to support mothers to initiate and sustain KMC and counselling mothers/family members at discharge. Practical training will be coordinated centrally, at a dedicated KMC unit, initially through simulators and subsequently with mothers and their babies. Refresher training sessions will be held. Follow-up with supportive supervision will be set up to ensure that the physicians and nurses translate their learning into implementation at their facilities. The supportive supervision will be initially ensured by the study team.

The CHWs and their supervisors will be trained on essential newborn care. Master trainers will be involved. The monthly meetings of the CHWs will provide opportunities for follow-up re-training and query-solving of problems encountered during their work in the community.

Immediately after training, objective structured clinical examinations will be conducted to test trainees’ knowledge and skills. Mentors’ training will be done at each level of the health system.

Process monitoring
The programme learning team will transition to documenting implementation processes by measuring process indicators. Process indicators for KMC implementation were described in table 3.

### Table 3: Process indicators for KMC implementation

| Process                                      | Indicator                                                                 |
|----------------------------------------------|---------------------------------------------------------------------------|
| Identification of pregnant women             | Proportion of pregnant women identified by CHW in the antenatal period   |
| Exposure to KMC priming interactions in the  | Proportion of identified pregnant women who received KMC information in   |
| antenatal period                             | the antenatal period from CHWs (either at home visits or during planned  |
|                                              | community interactions)                                                   |
|                                              | Proportion of identified pregnant women who received KMC information      |
|                                              | during Antenatal Care (ANC) visits at health facilities                   |
| Delivery in KMC facility                     | Proportion of women who deliver in a KMC facility versus in another       |
|                                              | facility or at home                                                       |
| Weighed at birth                             | Proportion of live born babies who were weighed at birth, overall and by  |
| Identification of newborns <2000 g           | place of birth                                                            |
| Referral                                     | Proportion of newborns <2000 g who were born at home or in non-KMC facility |
|                                              | who were successfully referred to KMC facility for care                   |
| Initiation of KMC                            | Proportion of newborns <2000 g born in KMC facility who were initiated on  |
|                                              | KMC                                                                         |
|                                              | Proportion of newborns <2000 g referred to KMC facility who were initiated |
|                                              | on KMC                                                                     |
| KMC monitoring                               | Proportion of KMC initiated newborns monitored by facility staff          |
|                                              | according to protocol                                                     |
|                                              | Proportion of facility KMC newborns discharged according to criteria;     |
|                                              | left against medical advice; referred out; died before discharge          |
|                                              | Duration of stay in facility                                              |
| KMC follow-up                                | Proportion of newborns discharged from facility receiving KMC who         |
|                                              | received follow-up per protocol                                           |

CHW, community health worker; KMC, Kangaroo Mother Care.

**Outcome measurement**

The outcome measurement team will evaluate the effectiveness of the model in achieving 80% or higher coverage with KMC among the entire study population as described earlier in the outcome measurement section.

**Evaluation**

Effective KMC coverage is defined as the number of newborns receiving KMC divided by the total number of newborns eligible for KMC (<2000 g and stable) in the facilities and in the study population during the evaluation period.

To measure the denominator for effective KMC coverage it is preferred that all facility births be identified by the outcome measurement team during facility visits, review of birth registers, and/or calls to the facilities. In addition, the outcome measurement team will liaise with CHWs to obtain the number of home births and their birth weights.

To calculate the numerator for effective KMC coverage, the outcome measurement team will quantify the number of newborns under 2000 g who received KMC in the study population. All identified newborns under 2000 g will be followed by the outcome measurement team in the facility or at home to collect data at four points that is, day of initiation of KMC, day of discharge from the KMC facility, seven days post-discharge and at age 28 days. At each time point, the team will measure KMC based on records, and/or maternal report, if post-discharge.
research partnerships that will ultimately lead to iterative learning component and strong government-develop models and test them in cycles with an inbuilt one doesn’t yet exist, or to improve existing ones. The findings will have implications for additional actions to strengthen provision of essential newborn care.

Literature on barriers and facilitators of KMC within the existing health system and, in collaboration with the government, to find effective models of implementation guidance for state or nationwide scale-up, if one doesn’t yet exist, or to improve existing ones. The findings will have implications for additional actions to strengthen provision of essential newborn care.

Despite its scientifically documented benefits, scaling up of KMC has proven an elusive goal for about 40 years. With increased awareness of the magnitude of newborn mortality and the clear interest of the governments of Ethiopia and India in making KMC available to all newborns of birth weight below 2000 g, it is timely to implement this project. It provides a great opportunity to weave KMC within the existing health system and, in collaboration with the government, to find effective models of implementation guidance for state or nationwide scale-up, if one doesn’t yet exist, or to improve existing ones. The findings will have implications for additional actions to strengthen provision of essential newborn care.

DISCUSSION

Despite its scientifically documented benefits, scaling up of KMC has proven an elusive goal for about 40 years. With increased awareness of the magnitude of newborn mortality and the clear interest of the governments of Ethiopia and India in making KMC available to all newborns of birth weight below 2000 g, it is timely to implement this project. It provides a great opportunity to weave KMC within the existing health system and, in collaboration with the government, to find effective models of implementation guidance for state or nationwide scale-up, if one doesn’t yet exist, or to improve existing ones. The findings will have implications for additional actions to strengthen provision of essential newborn care.

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Collaborators

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