

The value and limitations of the continuum of care framework

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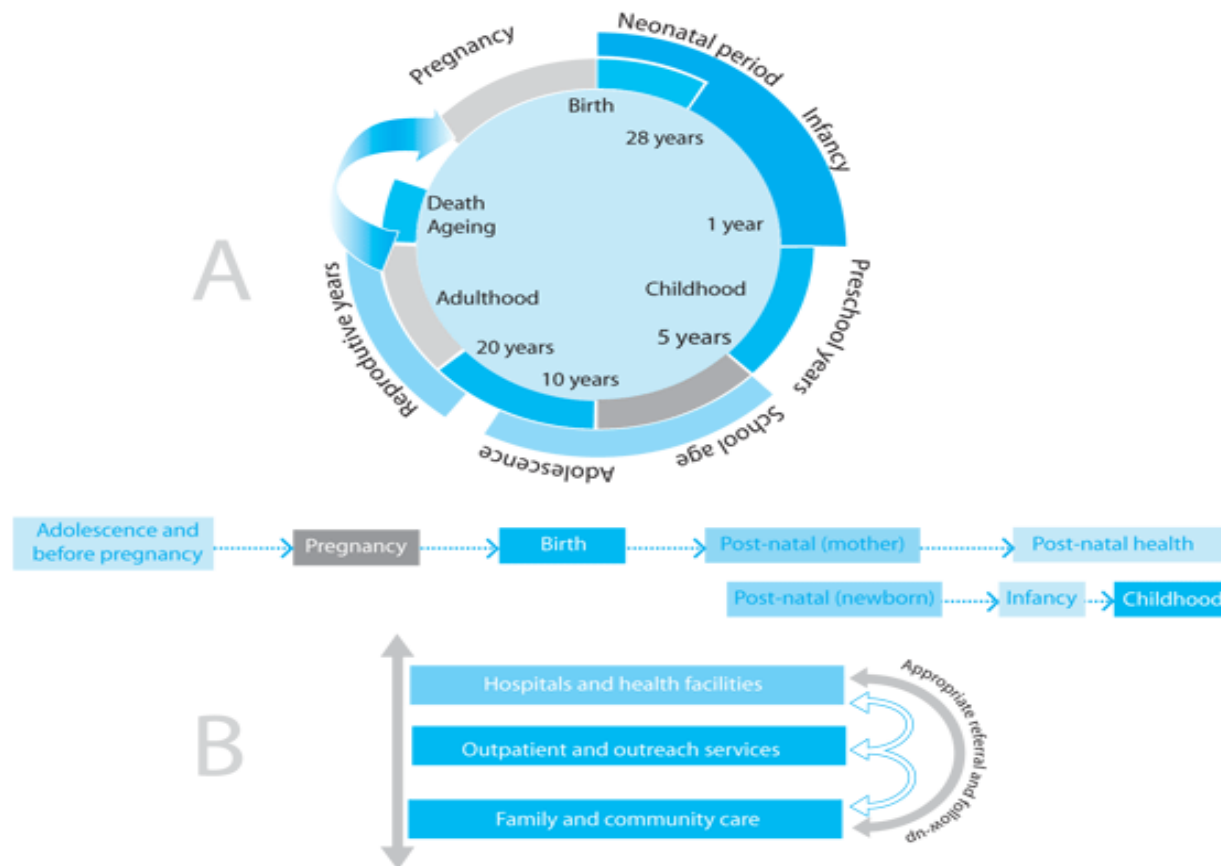
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Integration of Maternal & Newborn Health Care: In Pursuit of Quality

Boston, Sep 9-10, 2014

PMNCH, 2007

Connecting care during the lifecycle (A) and at places of caregiving (B). Adapted from patternship for Maternal, Newborn and Child Health, with permission.



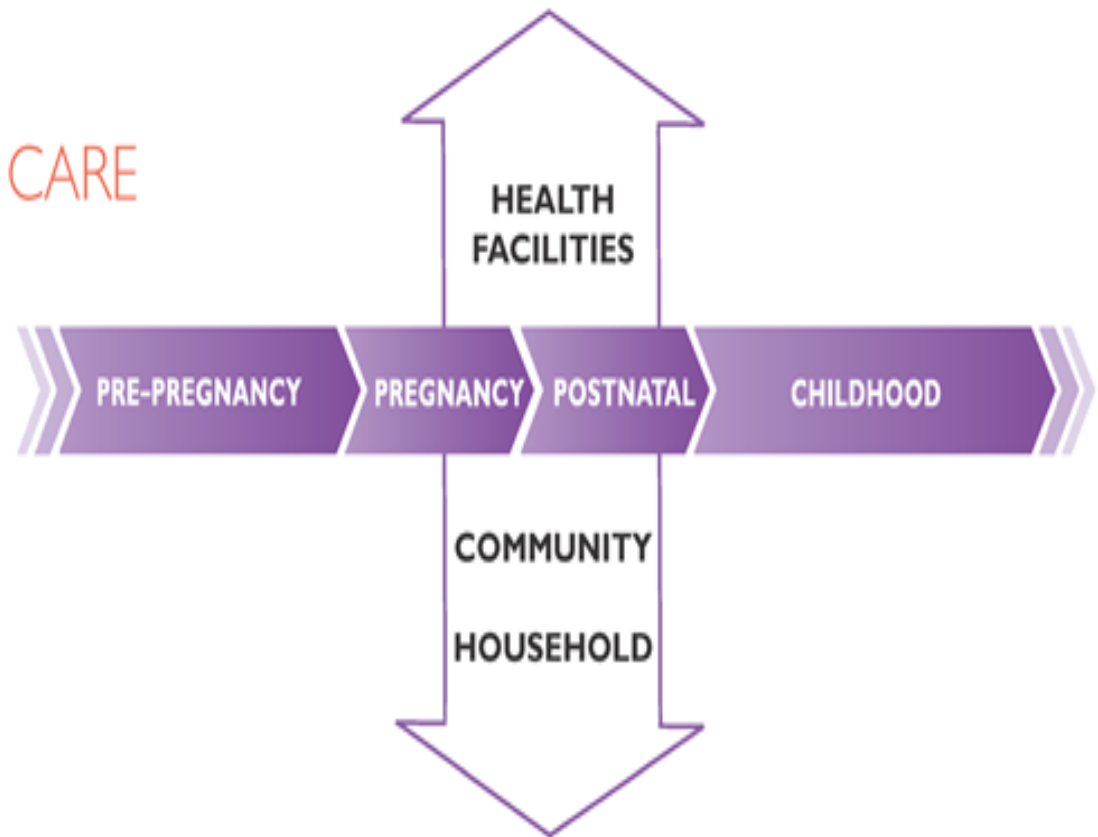
Source: Kevbes, Kate. J., et al., "Continuum of Care for Maternal, Newborn and Child Health: From slogan to service delivery," The Lancet, vol. 370, no. 9595, 13 October 2007, p.1360.

PMNCH, 2011

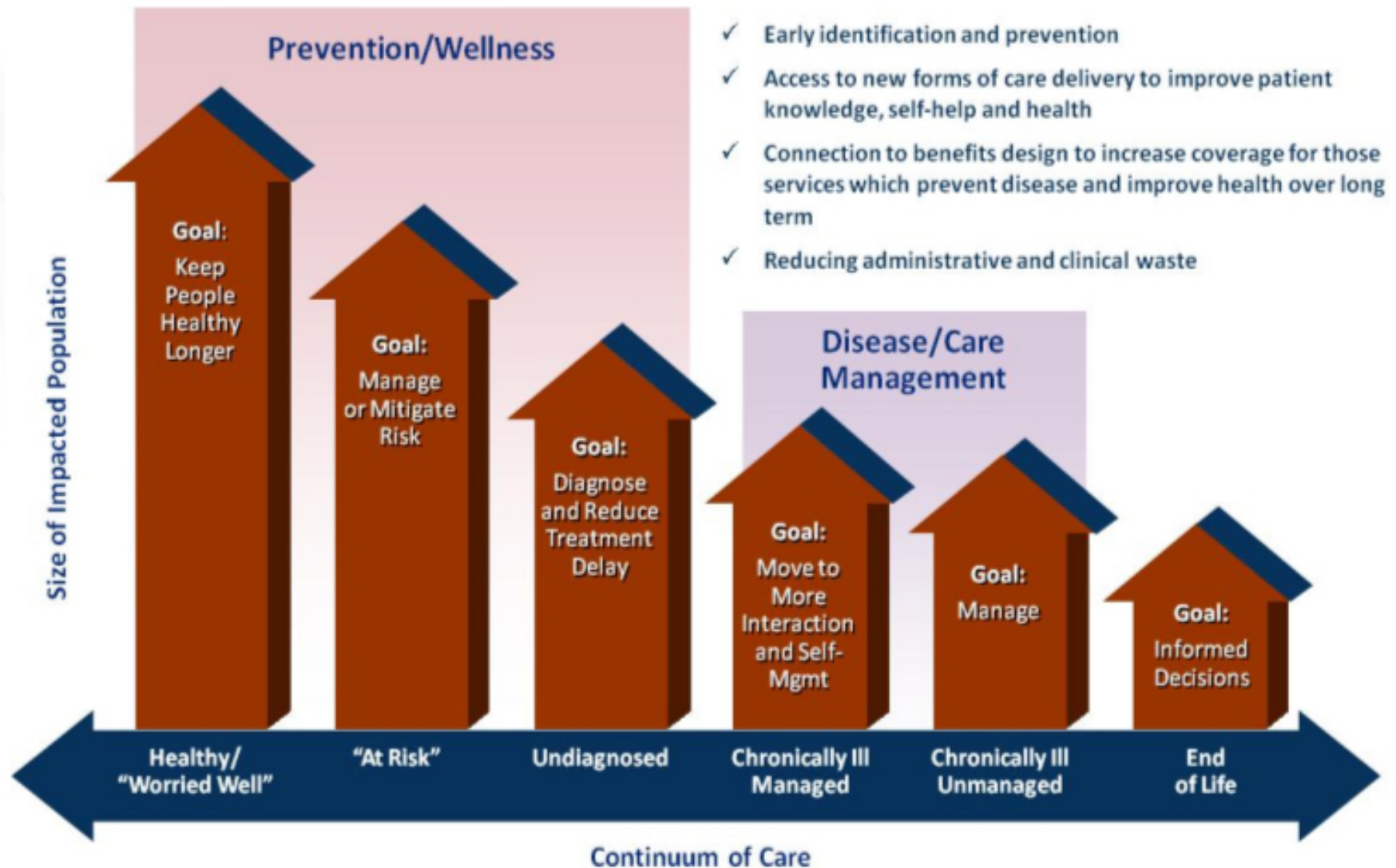
THE RMNCH CONTINUUM OF CARE

The “Continuum of Care” for reproductive, maternal, newborn, and child health (RMNCH) includes integrated service delivery for women and children before and during pregnancy, through delivery, the immediate postnatal period, and childhood. Such care is provided by families and communities, and through outpatient services, clinics, and other health facilities.

-The Partnership for Maternal, Newborn & Child Health (PMNCH) Fact Sheet: RMNCH Continuum of Care, 2011



Medication adherence (2011)



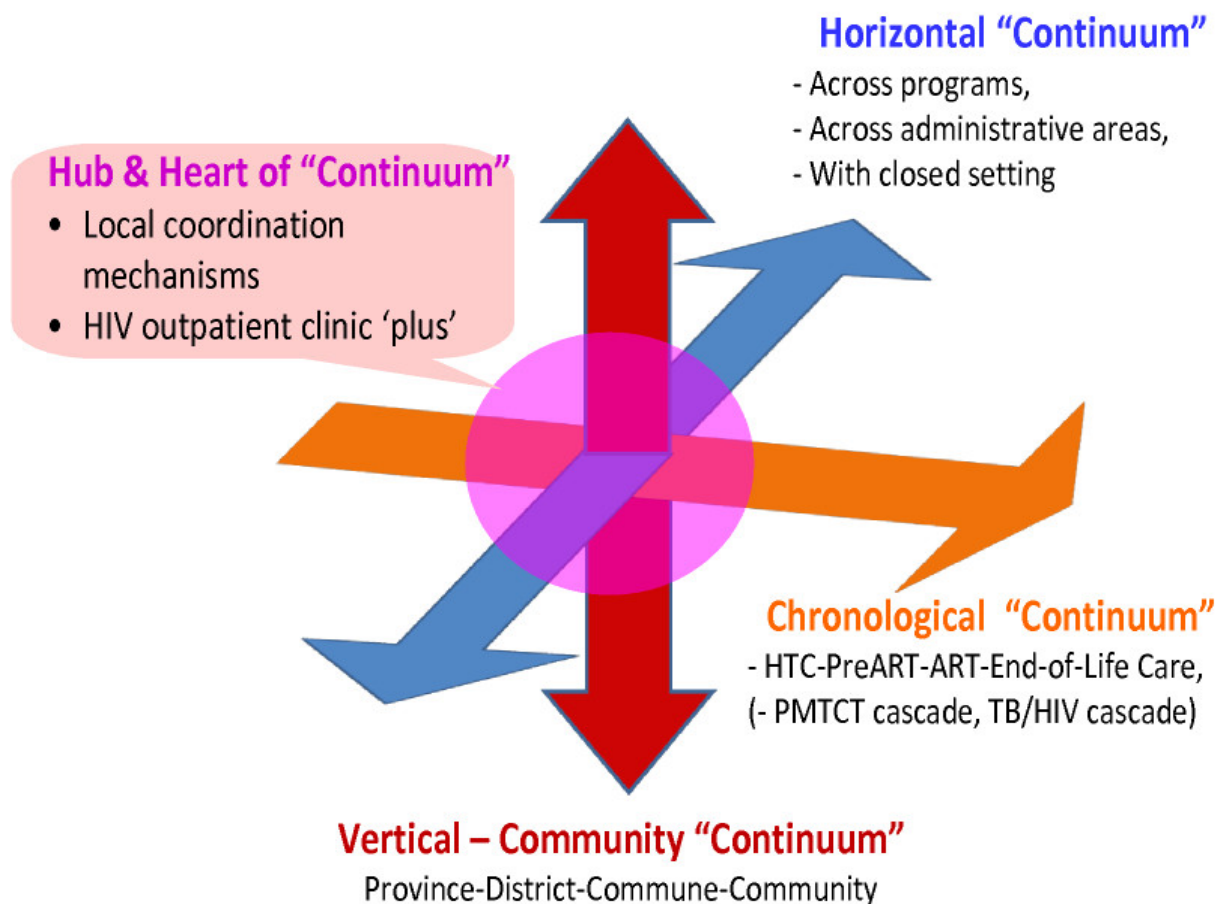
Continuum of Prevention & Care: Viet Nam (2012)

Service Availability (Structure for COPC)

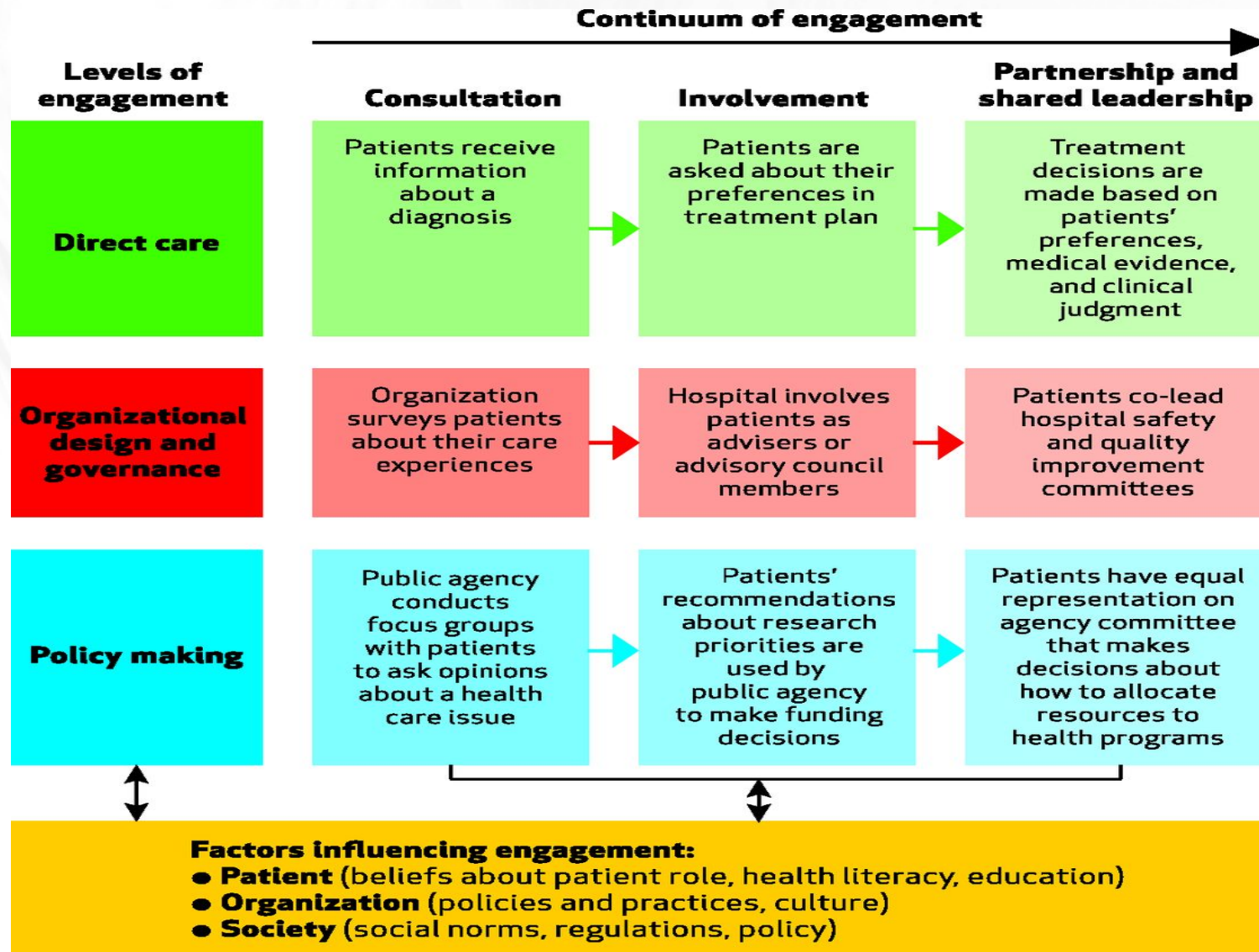
Geographical distribution and decentralization:

- * Province, District, Commune level
- * ART as backbones of HIV health service delivery
- * High-Middle-Low burden provinces
- * Density of ART site, Caseload per site, Distribution of reported cases across districts in a province

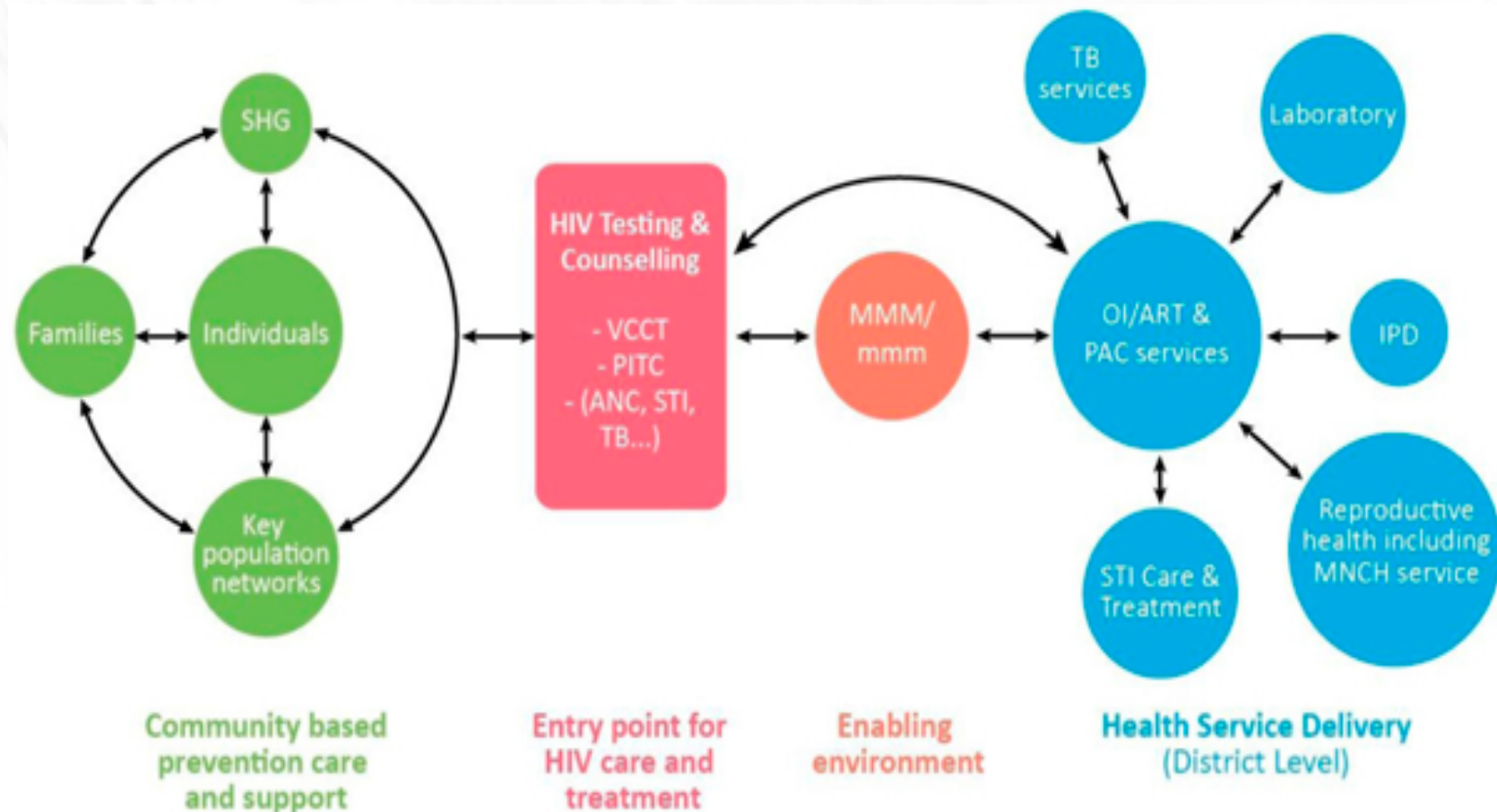
Service Connectedness (Functions of COPC)



Patient & family engagement, USA (2013)



HIV programming in Cambodia (2014)



The value of COC...

- A chronological or life cycle approach allows for appreciation of how problems and interventions during one phase impact a subsequent phase, links preventive to curative interventions
- Health system aspects of the continuum allow for appreciation of the inter-dependence of levels of care, hence can compel cooperation between them
- Community and governance aspects highlight the generic context of social development
- The assemblage of diverse interventions within service packages compel state investments in a more balanced manner

Then where lies the rub?

A multidimensional tool for developing concept, strategy, analysis and/ or operational plans for delivering complex public health interventions across the boundaries of time, institutions and services

Varying emphasis on chronological, health system, community and governance dimensions (or “levels”) of the continuum

COC is operationally delivered by the health system through sets of services (packages)

COC represents a 3D web of actions

Is the challenge one of better linkages (the details) or overarching structure (design)?

Indicators

- For outcome indicators, MDG 5A focused on maternal deaths; MDG 4 focused on infant and under-5 deaths. Perinatal outcomes, esp stillbirths remained under-emphasized
- For example, EmOC as maternal *and perinatal care*; and *neonatal care* during labour remained unappreciated
- The MH rights base discourse did not substantively address rights of the newborn...

Discontinuity across boundaries...

Continuum across levels of the health system imposes greater costs, and is more prone to outages or failure

Addressing it requires a closer look at some transitions:

- » Between routine and emergency care
- » Between outpatient and inpatient care
- » Between rural and urban health care
- » Between less and more skilled providers (or between generalists & specialists)
- » Between public & private sectors

Transitions between routine and emergency care

- **Routine care:** Pulse polio, ANC, immunization, PNC, etc – advance preparations, scheduling and logistics, daytime services, campaign-mode...
- **Emergency care and transport:** 24x7 readiness, concentration of skills, fail-safe logistics, lateral thinking, taking risks... easier to implement in a vertical manner?

Transitions between rural and urban care

- **Rural:** Solo (“round-the-clock”) provider, little or no staff or skill back-up, few referral options, little feedback on treatment or referral decisions, more vulnerable to backlash, personalized operating systems
- **Urban:** Team practitioners with back-up and nearer referral options, feedback better informs decisions, less vulnerable to backlash, larger and more impersonal operating systems

The same clinical management protocols can be interpreted differently in these situations

Transitions between screening/ outpatient and inpatient care

More experienced and skilled facility-based providers move:

- From night to day duties
- From emergency calls to forenoon consultations
- From inpatient to VIP outpatient care
- From clinical duties to managerial or even clerical roles

Screening or outpatient care (ANC, pre-discharge, PNC) can become ritualized and then misses out recognizing complications requiring admission (a routine of denial?)

On discharge (with or without medical advice) following admission for a complication, patients are not reverted to routine outpatient care

Transitions between generalists and specialists

- Transfer of patient care responsibility depends on the interface or relationship between human resource categories
 - from village volunteer to facility staff nurse or doctor
 - from primary care midwife or doctor to referral hospital specialist
- The decision to refer is time & labour intensive and hence stressful
- Early or “premature” referral might invite ridicule, while late or “delayed” referral could invite blame, especially in case of a poor outcome

Specialists on top...

- Male graduate physicians tend to lack hands-on skills in handling women
- Despite limited practical learning opportunities for newborn care/ resuscitation, mannikins or simulation models are rarely used for pre-service training
- Only postgraduate clinical residents or designated midwives can acquire reliable emergency recognition and treatment skills
- Iniquitous opportunities for skill development privilege specialists at the cost of primary care providers
- Specialization is privileged – vertical specialists exert disproportionate control over service protocols

Clinical specialists vs managers

- Facility based MNH care is led by vertical specialists, while outreach and home based care is led by public health managers and trainers – these two groups often have different approaches to observing protocols
- The transition of a woman or newborn from one level of care to the other is influenced by the extent of their coordination and agreement (eg., sterilization camps vs EmOC)

Transitions between public & private sectors

- Where government providers practice in private, the line between public and private practice gets blurred
- Commercial considerations can adherence to override protocols (eg. routine augmentation of labour)
- Free standing licensed or unlicensed practitioners refer patients to public hospitals and to specialists
- Non-existent coordination between sectors makes emergency cross-referral a difficult process for women and newborns

To conclude...

- Implementing a continuum of care is essential for improving quality of MNH services
- However, professional and institutional territorial interests and power inequalities seriously limit the effectiveness of a continuum of care approach
- Global and national policy makers must invest in fostering integration across these boundaries
- There is need for continuing implementation research on what enhances or hinders integration using this approach

Thank you...

