

Togetherness and “zero separation” concept note

Re-Visioning EmONC Project, April 2023

Introduction

Over the last 20 years, the emergency obstetric care (EmOC) indicators and framework have been used extensively to plan and monitor EmOC services at national and subnational levels. The current framework and indicators have provided critical information for data driven approaches to reduce maternal and newborn mortality and stillbirths, set targets, and track progress in strengthening EmOC services. At the same time, health systems have evolved, the evidence base has expanded, and implementation lessons have been collected about what works and what remains challenging across different settings. With these developments in mind, a global initiative led by Columbia University’s Averting Maternal Death and Disability program, the London School of Hygiene and Tropical Medicine, UNFPA, UNICEF and WHO is updating, improving and expanding the EmOC framework and indicators to better meet the needs of countries for the coming decades. Importantly, the revised framework and indicator set seek to integrate obstetric and small and sick newborn care, and provide an increased focus on quality of care in facilities, including experience of care.

Growing attention to quality of care and respectful care in maternal and newborn health has brought with it increased focus on the maternal-newborn dyad and preventing or limiting unnecessary separation after birth. In many cases, this type of togetherness has been promoted by increasing the number of facilities which allow “rooming in” and keeping newborns in maternal recovery rooms or wards instead of separate nurseries. However, the concept of togetherness is broader than the maternal-newborn dyad. There has been extensive recent research on the benefits of allowing birthing people a companion of choice, which also has both clinical and psychosocial benefits. Improving experience of care includes promoting “togetherness” in multiple ways across the continuum of care, from supporting the maternal-newborn dyad, allowing companions of choice, encouraging visitation of family members to intensive care units, providing support to navigate physical and logistical aspects of health care settings, creating systems for health workers to coordinate services and records between wards, and supporting collaborative, respectful interdisciplinary teams of health care workers and communities.

There are many known benefits to keeping newborns with their mothers and families; physiologically, this includes facilitating breastfeeding, skin-to-skin care, thermal regulation, and reducing postpartum hemorrhage, as well as encouraging bonding (including with a non-birthing parent or other caregivers), emotional support, and early developmental care. In most cases, keeping the newborn with the mother, parents, or family or allowing the option is respecting the preferences of women. There may also be “risks” of maternal-newborn or family togetherness. Without proper safety conditions, there could be increased risk of unintentional suffocation, or a reduced ability for a birthing person to recover and rest. For women or family members with postpartum mental health disorders, there could be added stress, and more family involvement could include unwanted family intervention. The health system may have increased costs for space, number of health workers, and additional time needed to train staff or families involved in care. There could be additional costs to families to travel or stay in or near health facilities.

Many aspects of experience of care are more difficult to measure through routine systems than clinical care. Some aspects of experience are widely subjective and difficult to query and/or observe, and may not be well-suited for collection in routine health systems. Many aspects of experience and satisfaction are predicated on expectation, which is influenced by previous experiences as well as social and institutional norms. Depending on the respondent, it may also be difficult to ask about specific components of experiences, such as the amount of time a newborn was separated from family or for the primary reason. Aspects of care related to interpersonal interactions between patients and providers may not be accurately captured by providers themselves; care decisions may need to be made quickly in cases of life-threatening complications and may not be well-explained or well-documented. Many aspects of care are directly influenced by the facility environment and the amount of resources available, in terms of number of staff, amount of equipment, physical space, and other conditions. Further, especially in the case of newborns, the experience of the patient, family members, and providers may not always align.

Togetherness Indicator Review

As part of the Re-Visioning of the Emergency Obstetric and Newborn Care (EmONC) handbook (which includes recommendations for facility, sub-national, and national-level indicators), a review is being undertaken of existing indicators related to togetherness. While there is more consensus around useful indicators for companion of choice, visiting/family inclusion policies, and health worker coordination initiatives that can be measured through health facility assessments, there is no consensus on the best ways to measure maternal-newborn togetherness, family togetherness, or “zero separation”. Previous surveys have asked about separation “without medical indication”; however this definition is open to a wide variety of interpretations. Various efforts have been made to improve and measure “family centered care” but definitions and components vary widely and are sometimes difficult to record consistently over the duration of an inpatient stay. Similar to challenges in improving respectful maternity care more broadly, the ability to provide respectful dyadic and family-centered care depends not only on interpersonal interactions, but also on the physical environment; the available resources of a facility and health budget are important factors in determining the amount of space and optimal configurations to increase togetherness and family involvement, while also providing privacy and medical services, in postnatal care. Therefore, some aspects that influence experience may be able to be captured through health facility assessments or audits, whereas other aspects will require questionnaires and direct observations.

A rapid scoping was undertaken of indicators which have been suggested or used to measure aspects of togetherness. The primary construct reviewed was around maternal-newborn separation (if it occurs, for which reasons, if reasons were understood, and for how long). Data on maternal-newborn separation have mainly been assessed either through maternal exit or follow-up surveys, or observational studies within health facilities. Further, this indicator has mainly been assessed as part of routine, not emergency, care. However, the concept of “family centered care”, which has been implemented in some intensive and special care units, contains elements of togetherness.

Other aspects of togetherness which were considered were around skin-to-skin and breastfeeding (both often used as proxies for no separation), communication/consent (often asked in maternal surveys about maternal care), and rooming-in (although definitions vary). Also included for consideration are examples of indicators related to togetherness for stillborn infants.

Although togetherness related to health care workers and the need for coordination and interdisciplinary teams is critical, related indicators are not included as part of the scope of this exercise, and further research in this area is needed. Indicators around companions of choice are also not included, as there are now widely-accepted indicators; however, they typically ask if there was a companion of choice present, rather than offered, and more research may be needed in this area as well.

Given that most identified indicators were collected either through individual surveys or observational studies, other potential indicators, which could possibly be collected in registers as part of routine data collection are also presented.

Example indicators for review (attached)

The goal of this exercise is to review and recommend indicators for the core and additional sets in the EmONC handbook.

Table 1 includes principles for the process of indicator selection. Although there are not strict criteria for selecting or ranking potential indicators for recommended inclusion in the handbook, these principles may assist in selecting indicators most aligned with others in the EmONC handbook.

Table 2 presents examples of indicator options related to emergency care or small and sick newborns. These may be best suited for the core set. The first set (blue heading) are identified indicators that have been utilized or being tested. The second set (green heading) are additional newly-drafted indicators designed for routine data collection.

Table 3 presents examples example of indicator options related to routine or low-risk newborn care. These may be best suited for the additional set, or changes may be required if being suggested for the core set. The first set (blue heading) are identified indicators that have been utilized or being tested (including many around maternal-newborn separation). The second set (green heading) are additional newly-drafted indicators designed for routine data collection.

Togetherness Convening

We are proposing an informal, virtual convening in April 2023 to discuss possibilities for indicators to be included in the EmONC handbook.

This convening may be followed by either a larger convening or sharing of written proposals with a larger group of experts. The aim is to include core and additional indicators as part of the preliminary suggested set of EmONC indicators (to be beta-launched in May 2023), and to continue refining potential metrics.

It is recognized that some indicators may be aspirational and will need testing for feasibility and validity in various settings.

Table 1. Principles for selecting togetherness indicator(s) for inclusion in EmONC handbook

CORE
<p><i>1 or 2 core indicators</i></p> <ul style="list-style-type: none"> • <i>Should be collectable through RHIS</i> • <i>Should be a flag/tracer indicator that could indicate need for further investigation/study</i>
ADDITIONAL
<ul style="list-style-type: none"> • <i>Supplementary or elaborated indicators (i.e., could require a special study)</i> • <i>Preferred data collection methods are those already planned/utilized (DHS, SPA, etc)</i> • <i>Can also be flag/tracer indicator(s) that indicate further investigation is needed</i>

Table 2. Potential indicators for core set (focused on emergencies/small and sick newborns)

Indicators identified in rapid review

Item	Response choices	Data collection method	Countries used	Author and year	Notes
Family-centered care					
% of mothers (carers) who report they were supported in family-centered care (facility allows companion/ family member, there is place for family member to sleep, place for family member to eat, place for family member to bathe).	Yes/no	NOT YET USED		SPA revision	Compound question
Proportion of eligible mother-infant dyads participating in FCC (key interventions were: (1) unit protocol for FCC with expanded visitation hours; (2) parental education through audio-visual aids, and (3) capacity building through training and peer support)	Yes/No		India	Sivanandan, 2021	Compound question; Small and sick newborns
Infant and family centered newborn care	Yes/no	NOT YET USED (RHIS)		Day, WHO Indicators	Small and Sick newborns only; not yet defined
Mother-baby “togetherness” days					
“Intervention baby-days” delivered by unit per calendar month	#	NOT YET USED		Day, WHO Indicators	Small and Sick newborns only; not yet defined
Skin-to-skin indicators					
% of newborns who experience two or more hours of skin-to-skin care daily during admission	Yes/no	NOT YET USED (RHIS)		Day, WHO Indicators	Small and Sick newborns only
Communication					
% of parents who felt that the staff at the local referring hospital explained the reason for transfer of their baby (only	Yes/No	Mailed questionnaire	UK	Thyagarajan 2018	Newborns with hypothermia

applies if baby was transferred from another unit).					
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Proposed new indicators

Question	Response Choices	Data collection method	Unit of analysis
If newborn is inpatient			
Who else can stay with the baby overnight?	Select all that apply: <ul style="list-style-type: none"> • No one else • Mother • Father • Siblings • Other family members 	Can be asked at a health facility assessment to administrators, but should be verified by observation	Facility
Who has access to the intensive care unit?	<ul style="list-style-type: none"> • Mother 24/7 • Either parent 24/7 • Either parent and designated family/support person 24/7 • Mother during visiting hours • Either parent during visiting hours • Either parent and designated family/support person during visiting hours 	Can be asked at a health facility assessment to administrators, but should be verified by observation	Facility
(As an additional question) Who is responsible for updating the father or other family members?	<ul style="list-style-type: none"> • Health facility staff • Mother herself 	Can be asked at a health facility assessment to administrators, but should be verified by observation	Facility

Table 3. Potential indicators for additional set (focused on routine care/low risk newborns)

Indicators identified in rapid review

Item	Response choices	Data collection method	Countries used	Author and year	Notes
Maternal-newborn separation					
Proportion of women who reported being separated from their baby without medical indication	Yes/No	Cross-sectional Household survey	Pakistan	Azhar 2018	Includes high/low risk
Neonate separated from mother after birth	Yes/No	Observational	Ghana, Guinea, Nigeria	Sacks, 2020 (WHO MOW survey)	Low risk only
Was your baby ever separated from you by doctors, nurses, or other health providers for any reason?	Yes/No	Survey at discharge and follow up at 2-4 or 10 weeks postpartum	Kenya	Nakphong 2021	Includes high/low risk
Was your baby ever separated from you for more than 10 minutes?	Yes/No	Survey at discharge and follow up at 2-4 or 10 weeks postpartum	Kenya	Nakphong 2021	Includes high/low risk
Did the doctors, nurses, or other providers ask you for your permission before doing procedures or examinations on your baby?	Yes/No	Survey at discharge and follow up at 2-4 or 10 weeks postpartum	Kenya	Nakphong 2021	Includes high/low risk
How long were you separated from your baby following delivery?	Never, A little amount of time up to one hour, One to six hours, More than six hours, or The baby did not survive.	Survey among postpartum people (up to one month after delivery)	Dominican Republic	Mitchell 2021	Includes high/low risk
(if yes) Why you and newborn were separated?	The baby had a medical condition, The mother had a medical condition (not COVID related), The mother tested positive for COVID-19, Not provided with a reason or the reason was not understood due to language barrier, Can't remember or	Survey among postpartum people (up to one month after delivery)	Dominican Republic	Mitchell 2021	Includes high/low risk

	unsure, The baby did not survive, Other.				
Providers' perception of the average amount of time birthing people were separated from their newborns following delivery over the previous month	Never, A little amount of time up to one hour, One to six hours, More than six hours, or The baby did not survive.	Survey among health care providers	Dominican Republic	Mitchell 2021	Includes high/low risk
The reason for separation of the last instance they observed of separation	The baby had a medical condition, The mother had a medical condition (not COVID related), The mother tested positive for COVID-19, Not provided with a reason or the reason was not understood due to language barrier, Can't remember or unsure, The baby did not survive, Other.	Survey among health care providers	Dominican Republic	Mitchell 2021	Includes high/low risk
While in the facility, did health care providers ever take the baby to a different room from you? 1. Were you told why? 2. Was a family member able to accompany the baby?	Yes/No	Longitudinal survey (multiple follow ups of postpartum women)	Kenya Gambia	PRECISE-DYAD (Ongoing data collection)	Includes high/low risk
The newborn is separated from mother/parent/caregiver without medical indication	Yes/no	Observational	Ethiopia	Gezahegn, 2023 (under review)	Includes high/low risk
Skin-to-skin indicators					
Immediate skin-to-skin contact with mother	Yes/no	Observational	Ghana, Guinea, Nigeria	Sacks, 2020 (WHO MOW survey)	Low risk, vaginal birth only
Newborns not kept in skin to skin contact with mother immediately after birth (note framing in negative)	Yes/no	Prospective observational cohort study conducted over a period of 18 months in 4	Nepal	Ashish 2021	Newborn had to be spontaneously breathing

		public referral hospitals			
Immediate breastfeeding					
Newborns who were not put to breast within 1 hour of birth <i>(note framing in negative)</i>	Yes/No	Prospective observational cohort study conducted over a period of 18 months in 4 public referral hospitals	Nepal	Ashish 2021	Newborn had to be spontaneously breathing
Newborn breastfed within 30 minutes after birth	Yes/No	Observational	Ghana, Guinea, Nigeria	Sacks, 2020 (WHO MOW survey)	Low risk only
Rooming-in/sleeping location					
When he/she was brought (back) to the floor (unit/ward), your baby was:	1) Always with me in the room, also during the night (in joint accommodation) 2) Mostly with me in the room 3) Mostly in the nursery *Note: Nursery is the hospital department that normally treats healthy newborns 4) Always in the nursery 5) Hospitalized in NICU (neonatal intensive care unit) or (neonatal special care unit)	Online survey of postpartum women who delivered since March 2020	WHO European Region (approx. 20 countries)	Lazzerini 2020-2022 (ongoing IMAGINE survey)	Includes high/low risk
Communication					
While in the facility, did health care providers ever take the baby to a different room from you? Were you told why?	Yes/No	Longitudinal survey (multiple follow ups of postpartum women)	Kenya Gambia	PRECISE-DYAD (Ongoing data collection)	Includes high/low risk newborns
Did you ever feel that it was not necessary for your	Yes/No	Survey at discharge and follow up at 2-	Kenya	Nakphong 2021	Includes high/low risk

baby to be separated from you?		4 or 10 weeks postpartum			
Stillbirth					
After your baby was stillborn, were you given the opportunity to see and hold your baby?	Yes/No	Online survey	Multicountry (High and Middle income countries)	Atkins	Stillbirth
After your baby was stillborn, were you given the opportunity to spend time with your baby?	Yes/No	Online survey	Multicountry (High and Middle income countries)	Atkins	Stillbirth

Proposed new indicators

Question	Response Choices	Data collection method	Unit of analysis
Potential questions for routine care			
Where did this newborn spend most of their time between delivery and discharge?	<ul style="list-style-type: none"> • With mother in a large shared postpartum/recovery ward • With mother only in a private or small shared room • With mother and partner or family in a private or small shared room • With mother or family member in a special kangaroo care unit • In an intensive care/special baby care unit 	Can be asked to mothers/family in a survey or filled out by health care workers in a register	Individual
What is the typical practice for newborns here who do not require special care?	<ul style="list-style-type: none"> • Mostly stay in the nursery until discharge • Mostly stay with mother in a large postpartum/recovery ward • Mostly stay with mother only in a private or small shared room • Mostly stayed with mother and partner or family in a private or small shared room • Multiple options are available from which the mother can choose 	Can be asked at a health facility assessment to administrators, but should be verified by observation	Facility
Does the facility have a general nursery where	Yes/No	Can be asked at a health facility assessment to	Facility

newborns are kept (without family), if they do not need special medical care?		administrators, but should be verified by observation	
Did you feel that the facility staff encouraged you to be with your baby as much as possible between delivery and discharge?	Yes/Sometimes/No	Can only be asked to mother/family in exit or follow up survey	Individual

Note that a module on newborn indicators that can be added to the PCMC (Afulani) scale is also currently undergoing testing.