**Group work on enablers and barriers, 14 November 2016**

**India and Brazil**

**Human Resources:**

Challenges:

* **Inadequacy** of staff (nursing and medical, counsellor)
* Poor staff: patient ratio, increased work load
* Remuneration of KMC staff
* Training is not hands-on, skill-based, so there is **low confidence around KMC**
* A person is trained in KMC, but is not in a role where they can apply the training
* Social workers, obstetricians, administrators **need training**
* **High turnover**
* **Motivation**
* Administrators in the hospitals don’t know what KMC is, so it’s very difficult to trickle down. In India, the main need is to train all pediatricians sp. private practitioners & policy makers, professional organizations – IAP, NNF, TNAI, FOGSI
* **Need policies and finances to support staff: enabling environment**
* India: nurses dedicated to KMC specifically initially, but question

Opportunities:

* **Motivation.** Brazil has had a similar difficulty with engaging professors of university hospitals; they need to be brought on board because they train medical staff. We asked the University to conduct a survey comparing the outcomes of babies with and without KMC, they learned KMC is safe and effective at improving breastfeeding and follow up.
* **Training coupled with standards:** Over the years Brazil conducted 102 courses in hospitals and additional in primary care centers. 2500 people have been trained. This changed ideas about KMC, but did not necessarily change practice**. The ordinance requiring hospitals to have KMC beds has changed the practice**.
* **Empowerment of staff, especially nurses: Who decides which babies get KMC?** In Brazil, a neonatologist works with a multidisciplinary team to decide. In India, an obstacle is that the attending doctor may not authorize nurses to initiate KMC, and the nurses are not in a position to make that decision. Would like an award system to incentivize workers to begin KMC, empowering nurses is especially important.
* **Acknowledging that there are two ways to inspire staff change on a wide level: motivation or mandate**, need both.
* **Pre-service training: the way forward.** In Brazil, we are embedding KMC in pre-service training for multiple categories of staff.

**Empowerment of families to provide good KMC:**

* Across India, a major problem is initiation & prolonged practice instigating KMC for more than 18 hours a day. A nurse is attending 10+ babies, so initiating KMC is not always a priority. Lack of confidence with feeding, benefits of KMC not well understood, reluctance of other family members despite counseling, pressure for early discharge, poverty, girl child, relatives; care of elder siblings at home; other reasons used as pretext; difficulties for clients from remote locations.
* Mozambique, Philippines, Vietnam: has seen it at different points of introduction, understand the issue as having a KMC unit doing KMC for almost the entire day. You need a **hospital policy for it, staff to be encouraging to the mother**, **peer support/observation** of other mothers in the ward. In Philippines, Dr. Socorro puts a veteran mother in a bed next to a new mother so she can assist. Climate is also an issue in the heat/humidity.
* Importance of the centrality of the woman: empower/enable mothers to do KMC in a **comfortable environment**. Sleep, privacy, facilities. We need to write empowerment of mothers explicitly, learning from the breastfeeding experience.
* **KMC is a treatment: requires cognitive skills and practical skills.** Ex. In India, fathers are not allowed to stay in NICU, but we bring fathers in scheduled times before and after work, so there is at least 3 hours time when fathers are doing care. Intensive counseling with mothers in law as well. **Prescribe minimum and maximum dose based on the baby’s weight.**
* **Sharing responsibilities: “Kangaroo Family Care” rather than Kangaroo Mother care.**

**Policy and resources for scale up:**

* **Need an implementation plan that is monitored, funded and progresses.**
* Government and development partners, including UNICEF, have not necessarily kept a focus. Increase in facility delivery overtook KMC—n**eed to keep KMC as a national/state priority.**
* When India began the ENAP, but policy didn’t **translate to a budget and plan for implementation**, that is what is missing and needs to be supported by one development partner. No one partner had taken on expanding KMC throughout the country.
* **Set of defined indicators.**
* Brazil is in a big financial crisis, so the ordinance provides the beds but it’s not enough. **Intensive care is reimbursed by the government more than KMC**, so there is a need to change that policy/behavior.
* **Establishing a budget for COEs to conduct training**, and not remain stand-alone.

**Infrastructure:**

* In India - i) Not having space/insufficient: this is a barrier that can be addressed creatively. Need to adjust plans but also make sure that the necessary facilities are there. Space without staff and chairs doesn’t help. ii)distance between NICU & post natal ward. iii) Insufficient and uncomfortable chairs. iv)poor availability of KMC bag (pouch), lack of privacy & proper toilet facility, no recreation or educational opportunities.

**Leadership:**

* Brazil has 40 consultants, 1 or 2 is responsible for each of 27 states. They have a monitoring system.
* **Having at least person dedicated to forwarding KMC on** a national and sub-national level with accountability and funding for those positions.
* **Cultivate leaders** at the sub-national and regional level: with limited resources, what scale up can we do? **Providing simple tools, equipment that is low-cost.** It would be good if we had some **guidance** of these are some simple things we should do.
* Wahida from Bangladesh: **Our own mindset can be a barrier: it’s an easy process and a difficult to adapt.** We should formulate a commitment to implement this, and once we commit we don’t have a barrier to this.
* **Think about this as a mass campaign**, such as the **eradication of polio**: take on the media to raise awareness

Additional notes:

* There is also an issue with the switch from tube feeding to cup feeding.
* In Brazil, we leave it to the mothers to decide how much to do, but never less than 1-2 hours at a time in the position. In the NICU, the condition of the baby depend, but in the second level we encourage mothers to have the baby in KMC all the time. In feeding, the nurse gives the gavage to the mother.
* How do we document the amount of time spent in KMC? Brazil is researching this, understand the point where it makes a difference: 5 hours, 4…? Conducting an observation study now, but the literature is not there now.
* In a study in India, on average small babies were getting 5-6 hours where ever it is done. Breastfeeding is a norm, but KMC is not, yet. To scale a program across a state/nation, should think about approaches beyond prescriptive.
* Brazil: in the course of sensitization, the most important part is about both father and mother, and the mother can’t be obligated, she needs to be respected.
* KMC care in Brazil has 3 phases: NICU, then secondary care, then after discharge.
* Ordinance 930,466: dictates the proportion of KMC beds to neonatal beds in a hospital. It’s a federal regulation to allow mothers and fathers to stay free. In NICU they don’t have beds, only chairs, but in the Kangaroo unit there are beds/reclining chairs.
* Financing: need a dedicated plan and activity line for space, training, HR, and dissemination within the budget of the national government.

Matt’s group:

* Communication
* Staff rotation
* Community follow-up