Summary of the conclusions of the workshop on critical obstacles and key factors for effective dissemination and uptake of KMC

KMC 20 years later, and beyond

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Participants

- About 95, many more than expected (50-70)
- From 33 countries of four continents
- Doctors, nurses, midwives, lactation consultants, nutritionists, physiotherapists, psychologists, anthropologists, biologists, engineers, managers, mothers
- Academics, researchers, students, teachers, clinicians, public health professionals, government officers, international and national agencies, NGOs

What and how

- Round tables and group work on enablers and barriers in countries
- Thematic working groups on:
  - Planning
  - Resources and cost
  - Training
  - Ensuring quality
  - Monitoring and evaluation
- Plenaries

Main barriers

- Resistance from health professionals (often not informed, not trained, not motivated)
  - Conflicts of interests
  - Shortage and turnover of staff
- Inadequate funds and insurance coverage
- Poor monitoring, evaluation, supervision and feedback
- Inadequate structures, scarce materials
  - Unfriendly or uncomfortable environment

Main enablers

- National/local policies and plans (and commitment to implement them)
  - Strong health care system with good quality newborn care
  - Well trained health professional teams
- Centres of excellence, champions
  - Open doors policy (a prerequisite)
  - Good referral and follow up
- Involvement of empowered families and communities
- Adequate budget
- Good management and coordination
- Some operational research

Strategies for change

- Have a good hands-on training programme
  - Include in pre-service training curricula
  - Use e-learning platform
- Develop, update and implement guidelines and standards
  - Ensure quality of care
- Raise awareness among health professionals and in the community
- Include KMC in family-centred developmental care
- Involve families and parents' associations, promote peer support
- Improve data collection, analysis and reporting of results

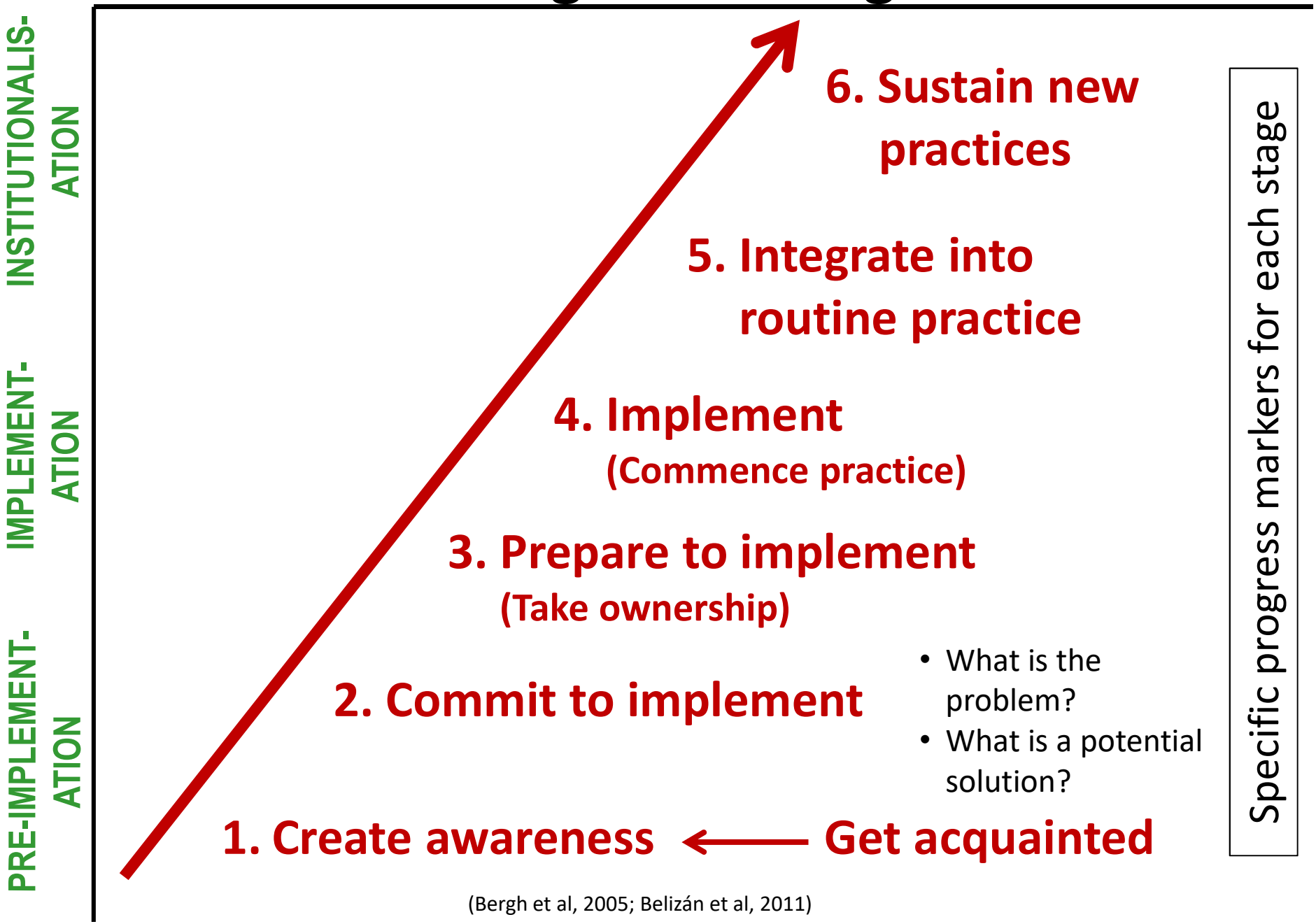
Key priorities for investment

- Increase coverage
  - Develop, test and use appropriate indicators
- Improve quality of care
  - Not only KMC, care for all term and preterm babies
- Ensure follow up
  - At least up to 12 months, ideally up to 3-5 years
  - Medical, but also education and social welfare
- An adequately funded and technically robust "KMC and beyond" initiative may help all the above

Planning

- Integrate into national MNCH programme across all levels of care
  - Embed in government planning documents
- Involve all stakeholders
  - Government, private sector, professional associations, academia, parents' organisations, peer groups, social media, community-based and faith-based organisations, etc
- Develop a policy and a strategic plan
  - Implementation guidelines, standards, protocols
  - Minimum criteria for KMC services
  - Operational plan, timelines, resource allocation, monitoring and evaluation
- Consider all health system building blocks
- KMC components to emphasise may vary between countries

Stages of change



(Bergh et al, 2005; Belizán et al, 2011)

Cost and resources

- A KMC costing exercise is useful addition to the evidence package and a necessary tool for fund raising
  - Excluding what is or will be available as a routine to all preterm babies (irrespective of KMC)
- Include investment and running costs
  - Training (pre- and in-service)
  - Centres of excellence and KMC units
  - Data collection and analysis
  - Awareness activities and campaigns
  - Operational research

Strategies for resource generation and mobilization

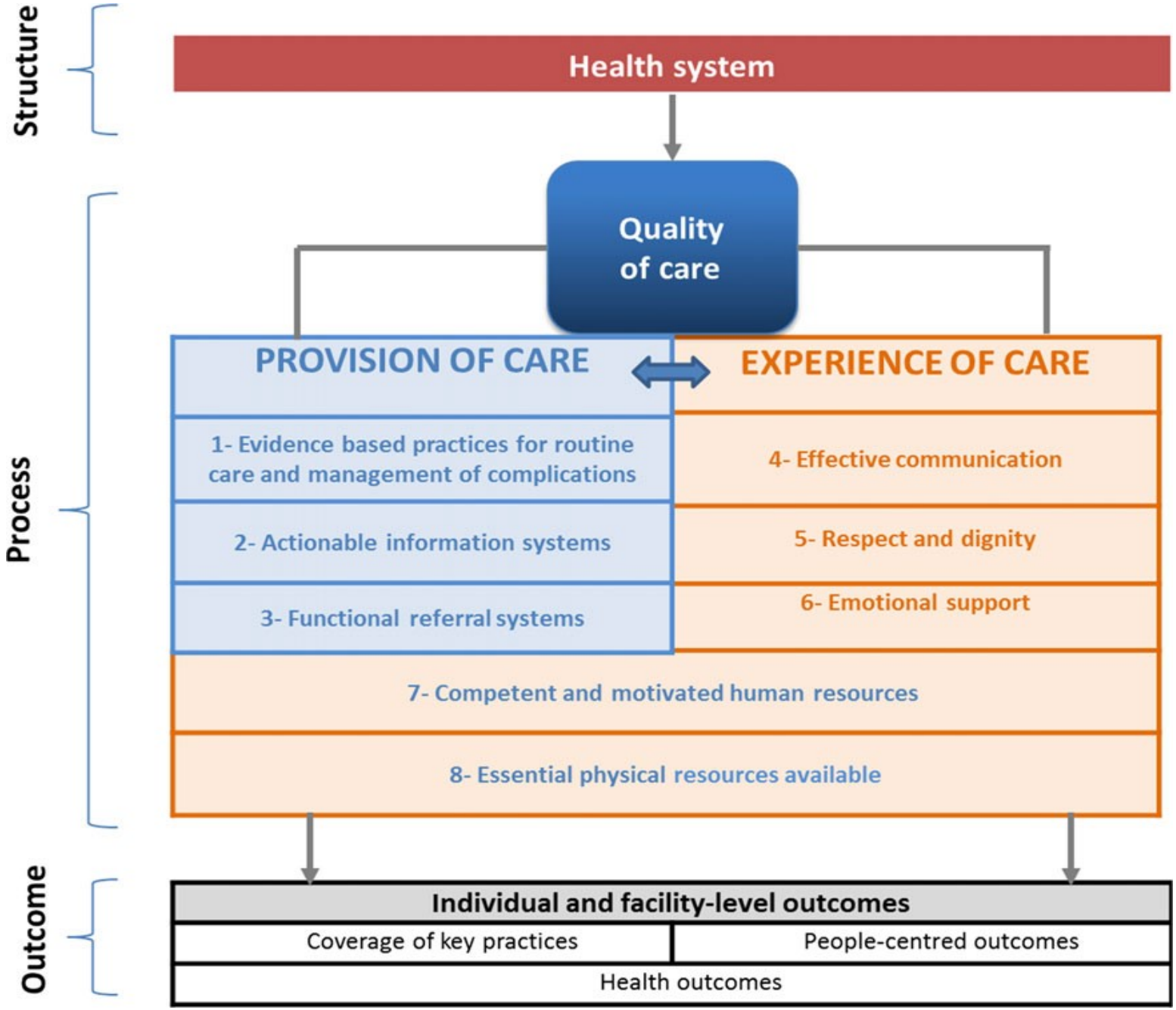
- For sustainability, build into the health system
  - Include in national/local budget
  - Include in insurance packages
- Extra funds needed to initiate a KMC programme
  - Approach potential funders directly or through a specialised agency with a proposal and a budget
  - Look for financial support from global financing initiatives
  - ECD has a huge potential for generation of more funds
  - Generate and show evidence that what your doing is well done and effective (babies are alive and thriving)
  - Build consensus through advocacy and collaboration with partners (healthy newborn initiatives, associations of parents, other sectors involved in ECD)

Training

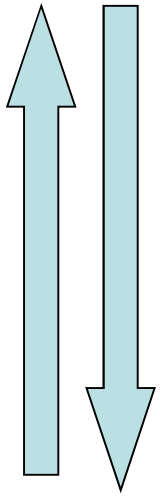
- Minimum requirements for training curricula at 1st, 2nd and 3rd level of care
  - For different categories of health workers
  - Include referral, counter-referral and transport
  - Don't forget communication skills
- Indicators of effective training
  - Knowledge, skills, practices, outcomes
  - Data collection system needed (train to use it)
- Coordinate with medical, nursing, midwifery, psychology and nutrition schools
  - Include in curricula

Ensuring quality of care

- Experiences from countries:
  - India, Brazil, Ethiopia, Rwanda, France, Indonesia, Zimbabwe, South Africa, Bangladesh, Colombia, Philippines
- Some interesting experiences in accepted posters
- Include KMC in WHO initiative on quality of overall maternal, neonatal and child care

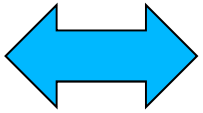

Structure
Health system
Process
Quality of care
PROVISION OF CARE
EXPERIENCE OF CARE
1- Evidence based practices for routine care and management of complications
2- Actionable information systems
3- Functional referral systems
4- Effective communication
5- Respect and dignity
6- Emotional support
7- Competent and motivated human resources
8- Essential physical resources available
Outcome
Individual and facility-level outcomes
Coverage of key practices
People-centred outcomes
Health outcomes

Ensuring continuity of care



- Home
- Community/Outreach
- First Level Health Facility
- Referral Facility

(across units and points of care)



Social services

and

Educational services

Continuity of care (from maternity ward and neonatal unit to KMC unit, from KMC unit to PHC and community) is key to effective KMC!

Monitoring and evaluation

- Should be based on:
  - WHO building blocks for health systems
  - Action-sequence for facility-based KMC
- Key messages:
  - Integrate into existing national monitoring systems, alongside other newborn care indicators
  - Harmonised and comparable sentinel indicators needed
  - Coverage indicators cannot capture content and quality of care and vice-versa – separate indicators needed
  - Facilities need to develop context-specific quality improvement processes – tools exist and can be developed to suit institutional systems

	Numerator	Denominator
Antenatal corticosteroid (ACS) use	All women giving birth in facility <34 weeks who received one dose of ACS	**Denominator = biggest challenge!!** Target population for coverage for that specific intervention: e.g. neonates "needing" kangaroo mother care Other options a) Live births in facility b) Total births in facility (including stillbirths) c) Estimated births (live or total)
Newborn Resuscitation	Number of newborns who were not breathing spontaneously/crying at birth for whom resuscitation actions (stimulation and/or bag and mask) were initiated	
Kangaroo Mother Care (KMC)	Number of newborns initiated on facility based KMC	
Treatment of Serious Neonatal Infection	Number of newborns that received at least one dose of antibiotic injection for PSBI in the facility	

Table adapted from: Moxon *et al.* (2015) BMC Pregnancy and Childbirth. Supplement: Every Woman and Every Newborn

	Identification of LBW/preterm	Initiation of KMC and service provided as per protocol	Continuation of KMC until discharge	Follow up of KMC to graduation
Brazil	LBW/GEST AGE	None	None	High risk follow up
India	NONE	Number admitted to SNCUs that receive KMC	Number discharged from SNCU received any KMC	SNCU follow up completion
Indonesia	LBW but not preterm	None	None	None
Iran	LBW but not preterm	None	None	Yes – all infants and high risk infants follow
Colombia	Gest age and birth weight/live births	Number of enrolled infants/<2500g AND <37WKS	Number of infants that have received KMC/Number enrolled	Screening (neuro/optometry etc)/Number enrolled
Nicaragua	LBW	NUMBER ENROLLED	NONE	NONE
Vietnam	LBW NO GEST AGE	NUMBER INITIATED	NUMBER DISCHARGED	NONE
Canada	Gest age and birth weight/live births	NONE	NONE	NONE
Italy	Gest age and LBW through netwrk	NONE BUT captures ENROLLED IN SPECIAL CARE	DISCHARGED FROM SNCU	HIGH RISK INFANTS UP TO 2 YEARS
Norway	GEST AGE AND LBW	Number initiated in kmc position	None	High risk up to 2 years
Sweden	GEST AGE AND LBW	AGE OF INFANT OF WHEN RECEIVING 4 HRS SKIN TO SKIN	NUMBER DISCHARGED	ALL F/U FOR BABIES <32 WKS

To conclude

- An interesting exercise of sharing experiences from so many different countries
- Reports of working groups will be completed, organised and made available in the website
  - Deadline: some weeks
- A small writing group will try to translate the overall report into something to submit for publication
  - Deadline: some months
- Thanks to all participants
  - Special thanks to moderators and coordinators

Trieste ospita il ventesimo meeting **internazionale** sulla tecnica della **pelle contro pelle** dopo la tappa precedente in Ruanda nel 2014

Una commovente immagine tratta dall'esperienza in giro per il mondo degli esperti riuniti tra oggi e domani al Miela

Il calore delle "mamme canguro" per i loro piccoli nati prematuri

Al Miela congresso dedicato alle incubatrici naturali cui partecipano duecento esperti di 38 paesi. La terapia esordì in Colombia negli anni '70

di Benedetta Moro

Pelle contro pelle, bambino e mamma, crescono insieme. Nessuna incubatrice ma solo il calore umano, quello delle persone che il bimbo prematuro vede appena nato. Basta questo, una tecnica rubata dalla natura. È il metodo delle "mamme canguro", come gli animali portano i cuccioli nelle proprie sacche, le mamme umane invece trascorrono tante ore del giorno con il proprio bambino pretermine appoggiato sulla pancia. Dalla Colombia questa tecnica, nata negli '70, si è diffusa in tutte gli angoli della Terra e all' ospedale Burlo Garofolo è stata recepita negli anni '90 e nel 1996 è stato organizzato a Trieste il primo congresso internazionale coordinato dall'epidemiologo Adriano Cattaneo, medico della Clinica pediatrica, in pensione da tre anni. E nel capoluogo giuliano, al Teatro Miela, si riunisce di nuovo il ventesimo congresso scientifico dedicato a questo metodo naturale che riunisce da oggi a domani 200 partecipanti da 38 Paesi ed esponenti delle principali agenzie internazionali, fondazioni, asso-

Al **Burlo** la tecnica lanciata in Sudamerica è stata recepita negli **anni '90** tanto che nel 1996 il primo **convegno** fu ospitato proprio in questa città

veri si assiste a una diminuzione del 40% delle morti e, in generale, in tutto il mondo i bambini riescono ad avere una maggiore stabilità metabolica, a respirare meglio, sanno leggere meglio, migliorano le relazioni, sono meno deprivati socialmente, hanno una maggiore facilità a trovare lavoro, ma così anche aumenta il vincolo con la mamma e con gli altri membri della famiglia». La tecnica infatti non vede solo la madre a porgersi in aiuto del piccolo, ma anche nonni e papà, il che fa sentire il bambino ben voluto. Distese sulle delle comode sedie reclinabili o a letto, se il bambino ancora non riesce a respirare bene, i vari componenti della famiglia accolgono il neonato sulla pancia e in mezzo al seno, nel caso della mamma, e possono stare lì idealmente anche 24 ore. Insomma per tutto il tempo necessario a crescere più forte. Il bambino resta attaccato alla mamma con semplici fasce di tela, nei paesi più evoluti con borse di lycra.

«Stare in incubatrice è uno stress - spiega Cattaneo -, a causa della posizione, del rumore e