# Group work on enablers and barriers, 14 November 2016

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Cameroon, the Gambia, Tanzania, Ghana, Zimbabwe, Rwanda, South Africa, the GDI, WHO

# Cameroon key challenges/barriers

* **Staff shortage:** inadequacy between the number of patients and the dedicated nurses. 40 patients for only 2 nurses
* **Facilities/space/infrastructure challenges**: 1 room for doctors, 1 room for dressing, change, room for the incubators, room for ambulatory unit

# Tanzania key challenges/barriers

* **Human resources** with heavy reliance of nurses, lot of turn over of personnel, few pediatricians

**Potential solutions**:

* **Space issue** with post natal ward and neonatal heal, onsite training for health providers
* **HR issues**: training of mentors using a model where every personnel that in relation with MCH should have notion on KMC
* Innovative: focus more on the services not in the room
* Use curtains to create more rooms space

# ZIMBABWE

CHALLENGES

* **Follow-up is still weak**, no assessment of neurological development
* Referral challenges, and transportation issues, so that babies borne there have also access to KMC
* **Space issue**: partitioning large ward to provide space in KMC and by using part of the post-natal for KMC, make sure that the place is warm; supplied linen, heater to referral hospital
* **The administration is not aware of KMC**, with few trained nurse
* At the national level, only trained 8 nurses
* Development of tools for MCHIP assessment
* Trained 3 nurses out of 20
* **Human resources: turn over** because they are transferred or appointed in other units
* **Supportive supervision is still heavily centralized**, that affect the quality of care
* **Uptake remain low**, because of denominator, because only the babies who have a weigh less than 2000 gr practice KMC
* 40 districts have received training, 20 districts are left
* Supplies: buckets, cups
* **Quality of care - no standards**, need to standardize
* **KMC is mostly based in the public sector**, the private sector still remain difficult to penetrate, because there no incentive for them to practice KMC

**Potential solutions:**

* Decentralize KMC supportive supervision
* have more on the jobs trainings
* determine how the babies can be follow up particularly in the rural areas

# RWANDA

**CHALLENGES**

* **Shortage of staff in neonatal services** which impact onquality of care
* **Low monitoring** which impact the feeding and the weight gain of babies
* Poor outreach: **the follow up of babies who are discharged from the hospital is** not structured yet. It is done on an individual basis depending on the doctors
* Don’t work a lot with psychologists

**How are the barriers addressed?**

* Develop protocols, and created newborn services in districts hospitals
* Develop some indicators as part of the HMIS
* Use **district-based mentors,** who oversee and train personnel in lower health centers
* **Babies are put in KMC position for referral** for transport
* Use the model of “low dose high frequency” to train more staff
* **Have establish partnership with Rwanda pediatricians association**, who started 4 months ago KMC mentorship in hospital, in all the supported districts
* CHWs are following babies in the community help, and refer then

# The GAMBIA, LSHTM

* No KMC, no policy, no guidelines
* No motivation to implement
* High attrition rate, lack of consistency. Care is mostly provided by Cuban doctors

Plan: to implement KMC in a tertiary hospital, work with Unicef, WHO

**General comment** as how to potentially address these barriers

* HR shortage and follow up of nurses on **feeding**, South Africa and Cameroon, shared their experience, where the senior mother will mentor others mothers who are new in the unit. Mothers could also watch each other
* **Use of IT,** particularly WhatsApp group where mothers can help each other
* Creation of perinatal national team to address the care of the newborn
* Establish and optimally use the E**-learning platform** to improve general communication issues

# Looking forward:

* Focus more on
	+ Assessment of **quality**
	+ **Community level** to address follow up, traditional, cultural stigma attached with prematurity
	+ **Communication** of the community to support countries where the KMC uptake is low eg: The Gambia
	+ **Data collection/analysis**
	+ **Human resources**: address staff rotation
	+ **Follow up after discharge** - to a better job at following up
	+ Eyes assessment – ROP