Implementation Workbook for Kangaroo Mother Care

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in collaboration with
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PREFACE

Saving babies in the 21st century is not really about finding cures for diseases, but rather about implementing available knowledge. In developing countries especially, while the know-how to reduce neonatal mortality may be available, the knowledge is often not used. The most usual explanation, which is unfortunately sometimes the true one, is that there are insufficient resources, both human resouces and/or equipment, to apply the current knowledge.

The MRC Maternal and Infant Health Care Strategies Research Unit has as its motto, "Seeking saleable solutions". By "seeking" we mean finding effective methods, based on current research. By "saleable" we mean that the methods we select must be acceptable to our three partners, the patient, the health worker and the health administrator / manager. By "solution" we mean the way in which we take the appropriate, acceptable method and implement it in the health system, and ensure that the beneficial effect is felt by all role players. Our ultimate aim is to make implementation strategies for programmes available that have been proven to decrease maternal and infant mortality and morbidity.

Kangaroo Mother Care (KMC) is a method of caring for neonates that fulfils the above criteria. KMC is effective in reducing neonatal morbidity and mortality, as has clearly been demonstrated by research. It is saleable in that mothers, health workers and administrators find it acceptable - mothers as they are in control of the care of their infants; health workers because this method has been shown to decrease morbidity and mortality and also reduces the work load of the health worker; administrators because KMC is less costly than standard neonatal care. Essentially with KMC everyone is a winner. This is also in line with the message of the Bogota Declaration (1998):

> *Kangaroo-Mother Care should be a basic right of the newborn, and should be an integral part of the management of low birth weight and fullterm newborns, in all settings and at all levels of care and in all countries.*

The problem with KMC is that it requires a paradigm shift on the part of all concerned to allow for its implementation. This workbook facilitates the paradigm shift and the actual introduction of KMC to an institution so that once the system has been introduced the institution will have a functioning KMC programme producing the promised benefits. The workbook has been developed using scientific methods and has been tested in the field. We are confident that once the institution has worked through the book it will have a functioning KMC ward. The questions in the workbook could also be used as part of the continuous monitoring of the implementation process and to assess whether targets and goals are being achieved.

This process is a model for other things to come. There are many saleable solutions out there which, if implemented, would substantially improve maternal and infant care. This workbook is pioneer in such a process. The time has come to change from the paradigm of thinking we do not know what to do, to acknowledging that we know what to do, that is saying that the information is available, we know how to apply it, and are doing what should be done.

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BOGOTA DECLARATION ON KANGAROO-MOTHER CARE (1998)

The Second International Workshop on Kangaroo-Mother Dare, held on the 4th of December 1998 in Bogota, Colombia, with participants representing 30 countries from five continents, hereby makes the following Declaration:

We note that

- The major component of infant mortality in countries represented at the workshop, and worldwide, is related to perinatal and neonatal mortality.
- In many countries there is a high incidence of low birth weight infants and this significantly contributes to the mortality observed.
- These neonates often suffer from neurological sequelae and poor growth and development because currently the care and maintenance of this group is expensive and sometimes impossible to provide.
- Kangaroo-Mother Care is an affordable methodology, because it has yielded good results. Its safety has been documented because it provides the basic requirements for the survival of the newborn: mother's warmth, mother's breast milk and mother's love and protection.

We recommend therefore

- that all governments, through their health ministries, incorporate this methodology as a part of their national health programs for newborns,

- that all international organisations concerned with the welfare of children and their mothers provide support and consider adopting Kangaroo-Mother Care as part of their worldwide programs.

We declare

- that Kangaroo-Mother Care should be a basic right of the newborn,

- and should be an integral part of the management of low birth weight and fullterm newborns , in all settings and at all levels of care and in all countries.

(URL: http://kangaroo.javeriana.edu.co/Bogota_declaration_ing.htm)

ABOUT THIS WORKBOOK

This workbook was originally developed as part of a Kangaroo Mother Care (KMC) implementation package. The target users are mainly the staff of health care facilities, although we also included a short section for officials in health departments or ministries. The aim of this workbook is to help you to avoid many of the pitfalls encountered when a new intervention is introduced. We give some information to help you to understand the process of implementing kangaroo mother care (KMC) and to get the process moving, but we do not attempt to provide answers or guidelines for everything that should be done.

The rest of the workbook consists of questions to which a health care facility has to find the solution that is best suited to the characteristics and capacity of the facility. These questions can be used in different ways. Some implementation teams work through them systematically in workshops over a period of time and write down their solutions and plans of action as they go along. Other health care workers use them to identify issues or items for the agendas of discussions and planning meetings.

At the end of the planning process, all the questions in the workbook should have been answered and further problems solved. New questions will also arise - these can be listed and added under the relevant headings in the workbook. Some of the questions in the workbook may appear obvious and perhaps even silly because you already have a system in place to cater for some of the issues. We included them for the sake of comprehensiveness. They could also serve as a kind of checklist for you to confirm that you have covered all the necessary ground.

Not everybody is going to work through the whole of the workbook. We suggest that a few key people work through it (individually or as a group) before the first meeting of potential roleplayers in order to get a sense of the scope of the issues that you will have to deal with. We give some pointers below on which parts should be worked through by whom.

Anne-Marie Bergh

Purpose of the workbook

- Guiding the implementation of KMC in health care facilities
- Monitoring the quality of KMC provision in health care facilities (important for the sustainability of a KMC programme)

WHO SHOULD READ WHAT?

PART	WHAT IS IT ABOUT?	WHO SHOULD READ IT?
1 Introduction	Hints on how to start the implementation process	• Managers, leaders and facilitators *overseeing* the implementation process • Government officials
2 Understanding the implementation of KMC	Conceptual framework for understanding the implementation of KMC within the broader institutional context	• Managers, leaders and facilitators *overseeing* the implementation process • Government officials
3 Questions for health departments and ministries	Questions to be answered by health departments or ministries in order to support health care facilities	• Government officials involved in health policies and implementation

4 Holistic planning by the health care facility	Where to start - thinking about matters impacting on the health care facility as a whole	• Managers, leaders and facilitators *driving* the whole implementation process
5 Intermittent KMC in the neonatal intensive and high care units	Day-to-day running of a KMC programme - management of intermittent KMC in the neonatal and high care units	• Managers, nurses and doctors in the NICU, high care and KMC wards
6 Inside the KMC ward	Day-to-day running of a KMC programme - management of a separate KMC ward	• Managers, nurses and doctors in the NICU, high care and KMC wards • Managers, doctors and nurses in hospitals acting as a "step-down" facility
7 Looking after KMC babies after discharge	Questions to deal with after the baby has been discharged from hospital	• Managers, doctors and nurses in referral hospitals • Managers, nurses and doctors in maternal obstetric units, primary health care clinics, municipal clinics, etc

WHERE DO YOU START?

Roleplayer group	Relevant sections of workbook	Page numbers
Government officials	Part 1 Introduction Part 2 Understanding the implementation of a KMC programme Part 3 Questions for health departments and ministries	1 - 13 15 - 29 31 - 33
Managers, leaders and facilitators *overseeing* the implementation process	Part 1 Introduction Part 2 Understanding the implementation of a KMC programme Part 4 Holistic planning by the health care facility	1 - 13 15 - 29 35 - 58
Facilitators *driving* the implementation process	Part 1 Introduction Part 2 Understanding the implementation of a KMC programme Part 4 Holistic planning by the health care facility	1 - 13 15 - 29 35 - 58
Nurses, doctors and other health care workers who will be involved with KMC (NICU, high care and KMC wards)	Part 1 Section 1.2 What is kangaroo mother care (KMC)? Part 5 Intermittent KMC in the neonatal intensive and high care units Part 6 Inside the KMC ward Part 7 Looking after KMC babies after discharge	2 - 5 59 - 63 65 - 94 95 - 96
Managers, doctors and nurses in referral hospitals or hospitals acting as a "step-down" facility	Part 1 Section 1.2 What is kangaroo mother care (KMC)? Part 6 Inside the KMC ward Part 7 Looking after KMC babies after discharge	2 - 5 65 - 94 95 - 96
Managers, nurses and doctors in maternal obstetric units, primary health care clinics, municipal clinics, etc	Part 1 Section 1.2 What is kangaroo mother care (KMC)? Part 6 Inside the KMC ward Part 7 Looking after KMC babies after discharge	2 - 5 65 - 94 95 - 96

ARE YOU DRIVING THE PROCESS? - HINTS FOR FACILITATORS

When implementing a new intervention the ideal is for senior and middle management to lead the process. This is not always possible and they may appoint a specific person to **drive** or **facilitate** the process. It may be someone from their ranks, but it may also be the nurse or doctor who is in charge of the neonatal ward or who will be in charge of a separate KMC ward. Or sometimes it may be another person with special experience or qualities. In some facilities, the staff nominate the leader to drive the process.

If you are nominated to drive the process or if you are committed to introducing KMC in your health care facility, here are a few hints which may help you to get the ball rolling:

- Read through the workbook carefully, making notes of all the things about which you are uncertain or which you don't understand.

- Arrange for training at an existing KMC ward if you have not yet attended any seminars or workshops on kangaroo mother care. If possible, at least two or three people from your health care facility should attend. This will give impetus to the process. If this kind of training is not possible, use additional resources to expand your knowledge.

- Get a few interested people to support you and use them as a sounding board for ideas. Persuading people and getting things done is not always easy and the more committed people you are able to recruit, the easier it will be to get through the difficult times. You can also form a study group that meets regularly to discuss the latest developments in KMC. This group's first priority would be to create awareness and a receptive climate in your health care facility.

- If you do not yet have the blessing of senior management, schedule meetings to make them aware of the benefits of KMC and to discuss suggestions for implementing KMC. If you need to convince management of the importance and benefits of KMC, you have to be well informed. Use additional information resources on the importance of KMC. You could even give them some material to read. If you have attended a seminar or workshop on KMC you should have plenty of material with which to back up your arguments.

- If you have been commissioned by senior management to drive the implementation process, schedule regular meetings with the superintendent and nursing service managers to discuss your progress and to get their support in finding answers to persistent problems. To keep the meeting focused, it may help to prepare an agenda or a list of topics to discuss. Make sure that all the issues receive attention.

- Organise workshops with relevant roleplayers to work through certain parts of the workbook. Use the pointers given on the previous pages to help you identify who should be invited to which workshops. Diagram 2 in section 2.2 (pp 19-22) is a useful complementary tool.

- When you hold meetings or workshops, **keep minutes or records** of decisions for future reference. This will be helpful when you are trying to put your final policies and protocols in writing. If possible, use flipcharts when you brainstorm some of the solutions.

- At each meeting or workshop, **take decisions** and allocate the **names of people and deadline dates** to each of the tasks to be done. As the facilitator you may have to **follow up** to help people keep their promises. The example of a plan of action in section 1.4 may help you to develop a system that will *work for you*.

- Study the diagrams and their explanations in Part 2 carefully, especially diagrams 1, 2 and 3. Discuss these diagrams with colleagues to make sure that you understand them. Use them as tools in workshops where necessary. For each diagram, we indicate the question or questions it applies to.

ACRONYMS AND IMPORTANT TERMINOLOGY

Acronyms

CEO	=	Chief Executive Officer
ICU	=	Intensive Care Unit
IMR	=	Infant Mortality Rate
IVAC	=	Intravenous Fluid Therapy Machine
KMC	=	Kangaroo Mother Care
LBW	=	Low Birthweight
NGO	=	Non-Governmental Organisation
NICU	=	Neonatal Intensive Care Unit
PHC	=	Primary Health Care
SWOT	=	Strengths, Weaknesses, Opportunities, Threats

Categories of care

A neonatal ward could provide one or more of the following categories of care, depending on the level of care the hospital is able to provide:

Low or primary care unit or nursery (usually level1 hospitals)
High care (unit) (usually level 2 or secondary hospitals)
Intensive care (unit) (NICU) (usually level 3 or tertiary hospitals)

Health care facility or institution

This usually refers to a hospital, but in some cases could also refer to other types of health care facilities such as maternal obstetric units (MOUs) or community health centres.

Kangaroo position, nutrition and discharge

See section 1.2 (pp 2-3).

KMC philosophy, programme and ward

See section 1.2 (pp 4-5).

PART 1: INTRODUCTION

PART 1
INTRODUCTION

.1 INTRODUCING A NEW INTERVENTION

In most institutions new interventions are introduced from time to time. A new intervention may be a new curriculum in the education system. Or it may be the introduction of kangaroo mother care (KMC) as part of neonatal care.

Introducing new strategies is not easy. There is an ideal - everyone should "reach for the sky". But we are living in the real world, in which one has to make choices, compromises and trade-offs in the process of getting the intervention going. And people don't always embrace a new concept willingly. They may feel unsure or threatened - and no one really wants to move out of their "comfort zone". Sometimes policy decisions are received top down - a facility is told to introduce a particular intervention (more often than not without sufficient additional resources). Sometimes an idea grows bottom up, but the staff on the ground find it difficult to convince the health authorities. Even under ideal circumstances, implementing a new intervention or strategy is a complex undertaking with many facets that have to be attended to.

You want to or have been requested to implement KMC in your health care facility. Careful consideration and planning are very important in the initial stages. The aim of this workbook is to provide some guidelines on all the issues that you will have to address. It is not written in the usual form of directions or guidelines. It merely contains a list of questions or issues that your staff will have to think about or for which they will have to come up with suggestions and policies for structuring and managing the KMC programme in the facility. Each health care facility has a unique context and the way in which KMC is implemented should be adapted accordingly. Your context may be different and you may want to devise an alternative set of guidelines and structures.

The philosophy behind the approach used in this workbook is one of promoting participatory management and transparency in decision making. We see this as essential for creating a climate of change that will improve the quality of care and encourage people to buy into the concept of kangaroo mother care.

1.2 WHAT IS KANGAROO MOTHER CARE (KMC)?

The importance of skin-to-skin contact between newborn and mother has received renewed prominence in health care circles during the last 40 years, primarily as a strategy to improve maternal-infant bonding. This acquired a new meaning with the introduction of kangaroo care in preterm or low birth-weight (LBW) babies, not as a new service but as an extension of existing neonatal services.

Kangaroo mother care was first introduced in Bogota, Colombia, in 1979. According to the initiators, it was "developed as a pragmatic response to overcrowding, cross-infection, poor prognosis, and an extremely high mortality rate for LBW infants" in their Maternal and Child Institute (Gomez et al 1992:55). The objectives of the programme included an improved outcome for LBW infants, more humanised care for them and a reduction in the length and cost of hospitalisation.

KMC can be practised in different forms. A format could be chosen somewhere on the continuum between practising KMC continuously for 24 hours per day and doing it for an hour or two every few days. *Intermittent KMC* refers to practising KMC for a few hours daily or every few days.[*] When the mother is able to stay in hospital and the baby is not ill, she can practise KMC 24 hours a day. This is called *continuous KMC*. During the day the mother can walk about and perform ordinary domestic tasks while the baby remains in the kangaroo position. This aspect of KMC is referred to as *ambulatory KMC* and is particularly relevant once a baby has been discharged from hospital.

When instituting a KMC programme, the ideal is to start with some form of KMC as soon as possible after birth. There are even health care facilities which provide intermittent KMC for ventilated babies as part of their routine care. As soon as all the lines have been removed and oxygen discontinued, continuous KMC should be practised if the mother is available. Although KMC is used primarily in the care of LBW babies, full-term babies can also benefit from being carried in the kangaroo position.

Most KMC programmes distinguish between three elements: kangaroo position, kangaroo nutrition and kangaroo discharge:

1In the literature you may find differing definitions of intermittent KMC. Bergman (1998b), for example, describes intermittent KMC as KMC lasting between 12 and 20 hours per day. Others refer to less frequent episodes of KMC, with no fixed routine or "timetable" as "sporadic KMC".

- The *kangaroo position* refers to skin-to-skin contact. The babies are positioned naked (wearing only a nappy) under their mothers' clothes in an upright position between the mothers' breasts and secured firmly. This resembles the position of a baby kangaroo in its mother's pouch. Babies stay in this position for as much time per day as possible.

- *Kangaroo nutrition* refers to the practice of breastfeeding, which is enhanced by the skin-to-skin contact. Babies who are still unable to suckle receive expressed breast milk and other supplements if necessary. Mothers and babies for whom breastfeeding is contraindicated still practise the KMC position and are appropriately counselled to deal with their situation.

- *Kangaroo discharge* refers to the continuation of KMC at home after being discharged from hospital. These mothers and babies need *special follow-up and support*, as many LBW babies in KMC can be discharged earlier, that is as soon as breastfeeding has been established and the babies are gaining weight, regardless of a specific weight.

All three of the above elements should be underpinned by a *supportive environment* in the health care facility and at home. The graphic representation on the next page illustrates this support.

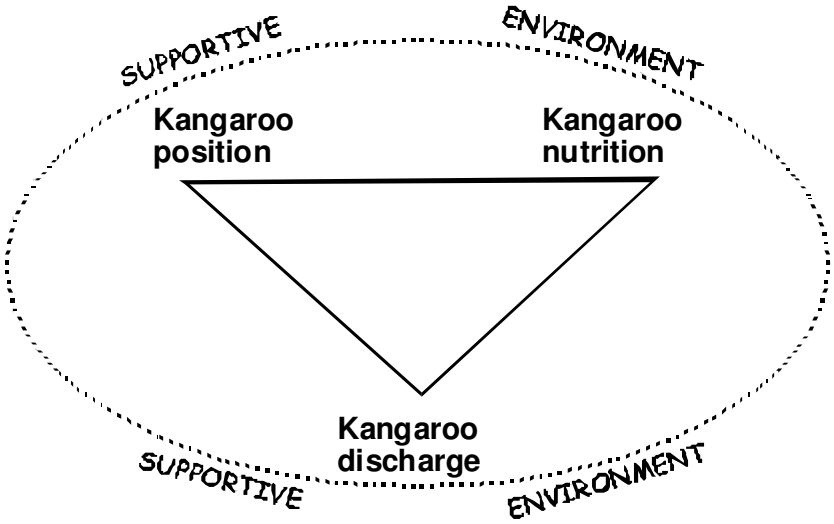
Bergman (1998a:9) summarises the benefits of KMC as follows:

- to the baby: improved cardio-respiratory stability
  faster growth and development

- to the mother: better breastfeeding
  better bonding
  psychological healing and empowering

- to the hospital: significant cost-savings
  improved morale
  better survival (in "Third World" situation)

better quality care (in "First World" situation)



Kangaroo mother care is based on a supportive environment

In conclusion, it is important to distinguish between a KMC "philosophy", a KMC programme and a KMC ward or unit:

- The *KMC philosophy* is part of the broader approach which should underpin all perinatal care, namely the encouragement of skin-to-skin contact and breastfeeding. The diagram above is a visual representation of the KMC philosophy.

  The incorporation of KMC as an integral part of the modern continuum of care for the newborn should be part of the vision of all health care facilities.

- A *KMC programme* refers to the service provided in a particular health care facility and "system", depending on which form of KMC is practised. Introducing and sustaining a KMC programme requires careful planning.

The aim of this workbook is primarily to assist you to put such a system in place or to monitor your current KMC practices to improve your provision of KMC.

- A *KMC ward or unit* refers to the physical space allocated for the practice of KMC. Although it may be a special section inside the neonatal ward, the term often refers to a ward and other facilities created to enable mothers to practise continuous KMC prior to the discharge of a LBW baby. Some hospitals refer to their KMC facility as a "KMC unit" and others use the term "KMC ward". In the rest of the workbook, the term *KMC ward* will be used for both.

1.3 GETTING THE BALL ROLLING

Almost all successful projects are driven by committed individuals. The challenge of introducing a new intervention is to get the right committed individuals together so that they can help drive the process towards a sustainable operation. These people are not always in the positions which the institutional hierarchy dictates should be involved. You will also have to look beyond the traditional conventions and try to be as inclusive as possible. Multidisciplinary team work is one of the cornerstones of a successful KMC programme.

In initiating the process the support and commitment of key people in senior management is very important. Such people would include the CEO, the medical superintendent and the nursing service managers in charge of the neonatal, paediatric and obstetric wards. If the process is driven and overseen at this level initially, other staff will realise that KMC is a priority issue. "KMC should not be treated as an orphan or stepchild", as one of the paediatricians who was instrumental in establishing a KMC ward observed. The involvement of key people also makes it likely that the groundwork will be done well, as these officials have an overview of the functioning of the health care facility as a whole. At the same time, management should be careful not to be too rigid or prescriptive and should merely keep a "watchful eye" over the planning of the ward itself, which should be done by the staff allocated for KMC.

Although the mother is the baby's primary caregiver, KMC has also been called "primarily a nursing intervention with medical support". This means that the nursing staff are the main source of support for the mother and baby in the health care facility, with sufficient medical backup when needed. For this reason it is very important that

nursing and medical staff are convinced of the value of KMC and able to drive the process.

It is advisable to minimise staff rotations in the initial phases (for at least one year). Otherwise no-one is prepared to take responsibility and no one feels accountable. This jeopardises the process of assuming ownership of the KMC programme. Changing staff should go hand in hand with orientation and in-service training to ensure continuous safe patient care. Staff tasked with the implementation of KMC will need basic information on the concept and practice of KMC, as well as on the running of a KMC ward. They should also be involved in the detailed advance planning.

The following educational activities are important prior to implementation and during the initial phases of implementation:

- reading about KMC
- visiting other functioning KMC wards or units (where possible)
- attending KMC training workshops (where possible)

It is desirable to send at least one staff member to attend a training workshop, although much creative thinking can be stimulated if more than one staff member attend the same workshop. Ideally the provincial health authorities should conduct such training workshops from time to time, or other training institutions should develop these as part of their ongoing educational programmes.

1.4 PLANNING THE PROCESS

The implementation of any health care intervention takes place at different levels, including the following:

- national
- provincial
- regional and/or district
- institutional
- ward
- individual

The quality of the planning will eventually determine the success of the undertaking. The implementation of KMC is a process and every aspect cannot be put in place overnight. Planning should take place through a consultative process which is participatory and transparent. Although it may appear tedious and unnecessary, in the

end this process may turn out to be an excellent means of motivating staff, creating a climate of receptiveness and rejuvenating energies.

For each of the above levels there should be "custom-made" policies in place. Most of the readers will probably not be involved in the national, provincial, regional or district level policies. The only condition is that the KMC policies for your facility should not contradict national and provincial policies - something which is not very likely to happen. In a similar manner, KMC policies cannot contradict the overall policies of the health care facility.

Ultimately, your facility should have a *comprehensive, written KMC policy*, covering all relevant areas of management, nursing, education and research. This policy should be integrated with other existing policies, protocols and timetables related to the care of mothers and newborns, especially preterm and LBW babies. Regarding certain aspects, you may find that you can take over what others have already developed, but for many matters you will have to adapt the policy to fit the character and needs of your own facility. You may even need to pioneer new types of protocols and standards from which other health care facilities can eventually benefit.

The ideal would be for provinces or ministries to hold KMC awareness meetings. People who will drive the KMC programmes in future are often "converted" at such information sessions. In the absence of such meetings, the following are a few hints and suggestions on a possible sequence of initial planning activities at the institutional level. The time lapse between the proposed meetings may vary according to the level of implementation readiness of a facility. ***The sooner they follow on each other, the better.*** It is essential that management ensure that *all* roleplayers (or as many as possible) are enabled to attend *all* meetings. Figure 1 gives an idea of the kind of planning meetings that could be held.

For continuity, the same core group of people should always be involved, with others coming and going as they become available. The core subgroup will be the group of nursing and medical staff who will be responsible for the implementation and day-to-day application of KMC. Follow-up meetings where people give feedback on progress, even after implementation has started, are very important so that the process does not lose momentum. They should also not be spaced too far apart. Some health care facilities have found that a short, half-hour meeting every week, on the same day and at the same time, works well.

FIGURE 1: IDEAS FOR THE INITIAL PLANNING OF MEETINGS

FIRST MEETING	Introducing KMC
Purpose	• To make potential roleplayers aware of the KMC concept and what it entails
Participants	• A broad range of potential roleplayers (see diagram 2 for more information)
Format and activities	• A morning and/or afternoon seminar with a speaker or two, a video or slide show, and some group work to get potential roleplayers interested (Handouts and visual material seem to be very effective)
Essential actions	• Distribution of additional material on KMC for further study • Establishment of a steering committee to drive the process

SECOND MEETING (± 1-2 weeks later)	The institution and the roleplayers (see sections 2.1-2.3, pp 15-25 and sections 4.1.1- 4.1.3, pp 36-40 [diagrams 1-3])
Purpose	• To "discover" the structure and functioning of the institution • To decide who is going to do what • To set the process for a situation and needs analysis in motion (in order to make a final choice of implementation model)
Participants	• The same as for the first meeting, with certain key people who have already been identified by management
Format and activities	• A participatory workshop of 3 to 4 hours where participants share their views on the facility and their roles, particularly with regard to KMC. Diagrams 1 and 2 could be used as tools for discussions, in addition to other relevant parts of this workbook (eg the main headings).
Essential actions	• Identification of subareas for further investigation • Establishment of subgroups or task teams to gather the necessary information and to drive the process in each of the particular areas (Who will find out and do what?) as part of the "homework" before the next session

THIRD MEETING (±1-4 weeks later)	Situation analysis and choice of KMC model (see section 2.3, pp 21-25 and section 4.1.3, pp 39-40 [=diagram 3])
Purpose	• To receive reports from the various subgroups/task teams on the needs to be addressed before the implementation of KMC can start • To make a final decision on which KMC model (diagram 3) to implement • To identify areas for which policy has to be developed or integrated into existing policies and protocols
Participants	• The same as at the previous meeting (Some people may have fallen out by now. If they have an essential role to play, it becomes crucial to get them back on board.)
Format and activities	• Either verbal reports which are carefully minuted and distributed to all participants afterwards *or* • Written reports by each subgroup/task team which are discussed in detail (the latter being preferable)
Essential actions	• Prioritisation of future actions into short-term, medium-term and long-term goals • Identification of the essential actions before implementation can start • Drafting of a time frame

One way of trying to get to grips with implementation issues and teasing out broader issues which may impact on the implementation of KMC is by means of a SWOT analysis. This could be done for the health care facility as a whole, to determine how broader issues could impact on KMC practices. It could also be used to identify strengths, weaknesses, opportunities and threats pertaining to the neonatal or KMC ward. In Part 2 we make some suggestions on how to use a SWOT analysis in conjunction with diagram 1. Figure 2 on the next page is an example of a SWOT analysis.

Workshops and meetings are often held without any effective follow-up. To avoid important decisions simply being forgotten, there should be a planning programme. Draw up a written plan of action as an integral part of each meeting, so that everyone is clear on who is responsible for what by which date. The process of introducing KMC, especially after the second meeting, will entail the doing of "homework" - collecting information, making calculations and estimates, talking to people, planning

FIGURE 2: EXAMPLE OF A SWOT ANALYSIS IN A KMC WARD

S **TRENGTHS** – Have worked as a team for quite a while – Well trained staff component How are we going to use these strengths in the implementation of KMC?	**W** **EAKNESSES** – Ineffective communication with mothers – All staff not convinced about the benefits of KMC – Caring ethos sometimes lacking How are we going to try to improve on or avoid these weaknesses in the implementation of KMC?
O **PPORTUNITIES** – Planning projects and implementing new ideas – Study opportunities How can we use these opportunities to provide quality KMC?	**T** **HREATS** – Staff reductions – Funding for some basic expenditures not approved What can we do to minimise these threats in the unit or ward where KMC is practised?

structures, et cetera. Names and dates are important implementation factors and help people to be accountable. Figure 3 (next page) is an example of one page of a plan of action. We also include a blank "shell" at the end of the workbook which you may have to adapt to suit your purposes better. Subgroups can also have separate, more detailed plans of action, and the staff responsible for KMC could also have plans of action to follow after implementation (eg objectives they set for improving care or for acquiring additional resources).

Rome was not built in a day. While you are working through the questions in Parts 4 to 7, prioritise the things to be done first. For example, it is more important to find space and beds for a ward first than to plan a comprehensive educational programme for mothers. But you need to be aware of mothers' educational needs so that you can start thinking and talking about them. While working through the workbook it may be useful to draw up a table with priorities. Figure 4 (p 13) is an example of this. We include a blank "shell" of this table at the end of the workbook.

FIGURE 3: EXAMPLE OF PART OF A PLAN OF ACTION

Action (key word)	What needs to be done?	Responsible person(s)	Deadline for action / Date for report back	Remarks
Meeting with architects from Public Works	- Inspection of facilities - Discuss essential structural changes needed - Discuss cost estimates	Mr Mhlongo (hospital secretary)	20 June 2002	Remember to invite the superintendent, the head matron, the sister in charge of the neonatal ward and Dr Baloyi (paediatrician)
Budget	- Drafting of budget for additional funds	Mr Mhlongo and Mrs Van Vuuren (accountant)	25 July 2002	Consult with CEO and superintendent
Special needs for KMC ward	- Draft a list of special needs for KMC ward - Prioritise items - Get an indication of additional costs	Sister Mankwe (with Sister Maseko and other nursing staff allocated for KMC)	30 May 2002	Remember to invite Matron Mbuli Consult with Dr Baloyi
IMR stats	- Audit for past year	Mr Mhlongo & Mrs Naidoo (neonatal ward clerk)	24 August 2002	Dr Prinsloo will assist

Filing system and forms	- Report on the integration of the existing filing system with new requirements and forms for KMC patients	Mr Mhlongo and Drs Baloyi and Prinsloo	31 August 2002	- Consult with Mrs February (chief administrative officer) - Get more information from Kalafong and Witbank

FIGURE 4: EXAMPLE OF THE PRIORITISATION OF ACTIONS

Action	Must do immediately (within 2 weeks)	Must do within 1 month	Should be completed within 3 months	Things to do later
Physical changes: organise with Department of Works for painting and ablution facilities	Speak to Mr Du Toit	Try to push for completion of job		
Look for spare beds in other parts of the hospital	Get beds	Have legs cut off		
Get extra chairs	Speak to Mr Makwakwa (hospital secretary)	Locate chairs and try to get them over to KMC ward		Get sponsors for arm chairs

Get a locker for each bed		"Spy" in hospital to locate unused lockers elsewhere	Negotiate with Hospital Board at their next meeting	
Recreational and educational programmes for mothers		Raise at a meeting	Allocate responsibilities for developing ideas, "lessons" and materials	Try to finish by the end of October

PART 1: INTRODUCTION

Notes:

PART 2
UNDERSTANDING THE IMPLEMENTATION OF A KMC PROGRAMME

As part of the development of this workbook we undertook qualitative research on the implementation of KMC programmes. The results of that enquiry included the following five diagrams which could be used as tools in preparation for the implementation and maintenance of a KMC programme.

We explain these diagrams first and then go on to offer suggestions on when and how they could be used further on in the workbook. Diagrams 1, 2 and 3 are particularly useful when the concept of KMC is being introduced, and diagrams 4 and 5 can be used over and over again in the process of quality monitoring and improvement.

2.1 MAIN ISSUES IN THE ESTABLISHMENT OF KMC (DIAGRAM 1)

(To be used in conjunction with the questions in section 4.1.1, pp 36-37)

When one introduces a new health care intervention it is useful to start with the health care facility as a whole and to ask questions about how the organisation and running of the institution as a whole will impact on the introduction of a new intervention. There will be a number of things regarding KMC with which you will have to grapple at an institutional level before you can get down to the detailed planning of the KMC programme in the neonatal ward or in a separate KMC ward. Diagram 1 summarises some of the issues that need to be sorted out before detailed planning can commence. Addressing these issues will be part of the situation and needs analysis. It goes far beyond matters related to KMC or neonatal care. It touches the "soul" of an institution and what we sometimes call the "internal politics".

We organised the issues around the concepts of "institutional structure", "management issues", "infrastructure" and "people issues". The visible or possibly not so visible dynamics may have a major bearing on the degree of success with the implementation of KMC. There are matters that need attention which are very visible and even quantifiable (for example, how much should we budget for or how many

beds do we need?). These matters also have equally important unquantifiable dimensions which have a major impact on the quality of care, which we capture in the concept of "institutional climate and ethos" (for example, interpersonal relations, communication and professionalism).

Important facets of institutional climate and ethos

- interpersonal relations
- culture of care and commitment
- respect for human rights
- judicious use of resources

In a sense the neonatal or KMC ward will be like a mirror of what is going on in the rest of the hospital. So it is important to identify the weak points and build improvement into the planning for KMC. One needs to ask: how can we be proactive in ensuring that some of the general institutional problems we encounter do not happen in KMC?

Two particular aspects of diagram 1 ("people issues" and the "KMC ward") are highlighted for further discussion under the next two subheadings (2.2 and 2.3 respectively). They are also useful in situation analyses and for the continuous self-monitoring of the system. They are expressed differently in different health care facilities. Firstly, there is the question of who is involved in the establishment and maintenance of a KMC programme or ward (the "actors" or "agents" - the roleplayers); the second question is which management model would suit a particular facility best. You are encouraged to map the situation in your own institution in terms of diagrams 2 and 3 as well.

2.1.1 Suggested workshop activities

We suggest the following two consecutive activities for workshops. Although they have a more general application, you could ask participants to constantly keep in mind or think about the implications for KMC.

Brainstorming

- Distribute diagram 1 as a handout to all participants or put it up as a transparency on an overhead projector.
- Take each issue in the diagram and brainstorm on it.
- Write everything that is said on flipcharts or a writing board, not necessarily in a logical order.

Brainstorming entails just letting people "spill" what they have on their minds. This can also help management to gauge what the issues are which staff feel strongly about. What comes out of the exercise may also be a reflection of general sentiments about management and organisational issues in the health care facility as a whole.

Organising the issues

- Take the points that emerged from the brainstorming and organise them around certain central ideas.

One way to look at issues is to use a SWOT analysis. Issues brainstormed are classified according to the following four topics: strengths, weaknesses, opportunities and threats.

(We have already given an example of a SWOT analysis for a KMC ward in Part 1 (p 10). At the end of the workbook we include a blank table to photocopy for your own use.)

2.2 ROLEPLAYERS IN KMC (DIAGRAM 2)

(To be used in conjunction with the questions in section 4.1.2, p 38 and section 6.1.1, pp 66-70)

Although KMC is primarily the responsibility of nursing staff and the mothers of the babies, a large multidisciplinary team is involved in sustaining KMC as an intervention

and improving the quality of care. Diagram 2 is a conceptual model of the "people issues" identified in diagram 1. It provides an overview of possible roleplayers and pertains to broad relationships between and the roles of different actors. These are the people who need to be involved in the implementation process right from the start, even the cleaners and kitchen staff. It is vital to have some understanding of the perceptions, attitudes, expectations, professionalism and work ethic of everyone in the institution as a whole, as well as of the people who will be working in the KMC ward.

The diagram is self-explanatory. It divides the roleplayers into three main categories: intervention, care and support; administration and maintenance; and financing and other resources. Some of the actors belong to more than one category and they are positioned on the thick dividing lines in the diagram. The fine dotted lines indicate the interaction that takes place between the different roleplayers and depict the intricate interrelations between roleplayers. One could obviously draw the same kind of lines for the "administration and maintenance" and the "financing and other resources" categories.

Nurses are the main supporters and act as mediators between the mother-infant dyad and the other roleplayers. All KMC wards revolve around the interaction between nurses and doctors, but the roles allocated to other actors may vary from one institution to the next. Your facility may not have posts for all the other roleplayers depicted in the diagram. These other roles are sometimes conceptualised and formulated around the particular interests of an individual or the availability of staff in a particular profession. Apart from the staff, extended family, volunteers and support groups who are directly or indirectly involved in the intervention, care and support in the ward itself, there are also administration and maintenance staff, as well as funding sources involved.

One way of introducing this diagram it is to ask participants to plot their own positions on the diagram and to think about how they relate to all the other roleplayers. Different roleplayers could also be grouped together to discuss the diagram (eg management, nursing and medical staff, allied health care workers, etc). This could include a discussion of the training needs of each staff category. All the ideas that come to the fore should then be discussed in a feedback session. The diagram could be used extensively when discussing the questions in sections 4.2.1 (pp.41-46), 4.2.5 (p 50) and 6.1.1 (pp 66-70).

2.3 INSTITUTIONAL IMPLEMENTATION MODELS OF KMC (DIAGRAM 3)

(To be used in conjunction with the questions in section 4.1.3, pp 39-40)

- Decisions related to diagram 3 are possibly the most important ones you will have to make, as they will determine the future of the entire KMC programme.
- The managerial and organisational implications of a particular model can be vital for the sustainability of the KMC programme.
- Important questions to consider are:
  - What type of space is available?
  - What will the staffing arrangements be?
  - Do we have a lodging facility for mothers or are we going to create one?

The focus now moves from the structure and organisation of the institution as a whole to the choice of a model for the future structure and organisation of the perinatal wards. This will be partly determined by the possible ways of organising existing space. In your deliberations on a choice of implementation model it is advisable to revisit some of the answers you came up with while discussing the questions relating to diagram 1 (see also section 4.1.1, pp 36-37).

Traditionally the neonatal ward only provided incubator and bassinet care for low birthweight babies. It is, however, also possible to introduce intermittent KMC in this ward in the absence of immediate space for introducing continuous KMC or while preparations for a full KMC ward are under way. Model A is depicted in the top block in diagram 3. This is a very common model in European and American hospitals, with voluntary intermittent KMC and no provision for continuous KMC. The same staff are used under a single nursing service manager, whose intimate involvement in the whole process is absolutely vital.

Model B entails the establishment of a KMC ward within the neonatal ward setup. Where continuous KMC is introduced, there is normally a separate room or ward where mothers lodge with their babies and care for them 24 hours per day (see the

second block from the top in diagram 3). The ideal is for this space to be adjacent or very near to neonatal intensive and high care units, with the same staff rotating and

under the supervision of the same nursing service manager. The way in which the admission of mothers and babies to the KMC ward is handled will depend on whether the hospital has a lodger mother facility or not:

- Where a lodger facility is available, mother and baby are admitted to the KMC ward at the earliest possible date. Mothers do most of the caring themselves and babies are often discharged at a lower weight as soon as the mother is confident about caring for the baby alone. Most of them stay in the KMC ward for between two and four weeks.
- Where no lodger mother facilities are available, mothers are mostly discharged, express breast milk if they will be breastfeeding, come in for intermittent KMC as is convenient and are then re-admitted for continuous KMC for a few days before the baby is ready to be discharged. This also affords them the opportunity to establish breastfeeding, get acquainted with all the aspects of caring, and leave the hospital with confidence. These babies are normally a bit heavier and older when they leave the hospital.

The level of qualifications of the staff may vary, according to the criteria set for the commencement of continuous KMC. Where stable babies start with continuous KMC at a lower weight (eg 1100 g), highly qualified staff should be available at all times. Where babies are enrolled into continuous KMC at a higher weight (eg 1500 g), experienced staff with lower qualifications could possibly be utilised. Meticulous supervision by a senior professional nurse is crucial at all times, however.

Model C is depicted in the next set of two blocks in the diagram. In this case the KMC ward is physically far away from the neonatal ward, or even in a separate building. This normally happens where a health care facility has to allocate whatever space is available and there is no ward near the neonatal ward that can be utilised. In the intensive and high care units traditional incubator care is provided and it is also possible to include intermittent KMC for the babies as soon as possible. When the babies are stable they are transferred to the KMC ward. In a case like this the KMC ward is sometimes called a “step-down” unit - the baby proceeds (“steps down”) from high care to low care. Oxygen-dependent babies can also be transferred if the KMC ward has a reliable oxygen supply. These babies are kangaroo-cared intermittently until they are ready for continuous care. Other babies start with continuous KMC immediately.

Two staffing arrangements are possible. The KMC ward shares the same staff and the same nursing service manager with the neonatal ward. There is constant rotation, orientation, training and meticulous supervision. The same criteria for staff qualifications as in Model B will apply. This is the better option for promoting the integration of a KMC programme into the paediatric services. However, where this arrangement is not possible, the neonatal and KMC wards have different sets of staff who could even fall under the supervision of two different nursing service managers. The latter arrangement can be cost-ineffective and can hamper continuity of care, communication and interpersonal relations.

Model D is a variation of Model C which one finds, for example, in Europe. If a low birthweight baby is born, the mother decides at birth whether she wants the baby to receive conventional care or KMC. If she decides on KMC the baby is initially cared for in the NICU of the KMC unit (which is managed separately from the conventional NICU). The mother starts with intermittent KMC - in some hospitals it is even practised with babies on ventilators. Then mother and baby gradually progress until continuous KMC can be practised. After discharge mother and baby are regularly followed up with home visits by health care workers. Model D is very cost-intensive and is not an option for public hospitals in the poorer countries. In private facilities with small NICUs and where mothers have private rooms it may be possible to make some flexible arrangements - the mother stays on in hospital while the baby is in intensive care and continues with continuous KMC until the baby is ready to be discharged.

Models A, B and C are suitable for training and regional hospitals, and other hospitals (eg private clinics) where high-care technology is available. Model E is the one which is used in facilities where no high care is available. Hospitals with a lack of space or no lodger mother facilities could also discharge mother and baby to another low care facility until the baby has gained sufficient weight to be discharged.

Model F is another variation that we call the home-discharge model. Babies are discharged on continuous KMC as soon as they are stable. Mothers bring them to a special clinic every day or twice a week for a checkup. As the baby thrives and continues to grow the visits become less frequent. This model can only work where a reliable ambulatory care system and good public transport are available. Kangaroo discharge is one of the three cornerstones of KMC and a good follow-up after discharge from hospital is the ideal to strive for. This is the area where you will be experiencing most of your problems. (See also Part 7, pp 95-96.)

There are a number of different guidelines for establishing criteria for admission to KMC and discharge from hospital. In South Africa the Western Cape Health Department has its own policy. Cattaneo and associates (1998) also developed a set of criteria which take the nature of the health care facility and the weight and stability of the baby into account. Criteria for discharge will vary between facilities and earlier discharge seems to be associated with higher levels of staff confidence and experience.

2.4 CONTINUOUS SELF-IMPROVEMENT AND SELF-EVALUATION (DIAGRAM 4)

(To be used in conjunction with questions in section 4.2.2, p 47 and section 6.4, pp 92-93)

The institution of a new health care intervention is not sufficient in itself. The intervention needs to be sustained and should be underpinned by quality care. Diagram 4 is a systems model which could be used as a self-reflective tool for the various roleplayers. We see the functioning of a KMC ward in the light of the vision and mission of the national and provincial health departments, the individual health care facility, and the institutional KMC programme itself. The functioning of any health care system or institution is underpinned by a vision and a mission. Neonatal and KMC wards should also have a vision and a mission which should give expression to the institutional vision and mission, but which should also be very specific for the neonatal or KMC ward.

- A *vision* is usually a broad idea or dream. Sometimes it is articulated as a slogan. If you look at the publicity material of pharmaceutical companies you will notice that most of them have some sort of slogan on their literature or letterhead about being the best or being a leader in a certain field. One could say this is part of the vision of those companies. What would you like the KMC ward to be?
- The *mission statement* is normally much more concrete and states how the KMC ward will give expression to the vision.

Both the vision and the mission statements are linked to quality goals. We also consider quality goals in terms of effectiveness and efficiency:

- An *effective* KMC ward functions in such a way that it achieves quality goals in terms of health care and in terms of quality of outcome, namely infant survival and optimal health, client satisfaction and sustainability of the KMC programme. Often we do not know how to evaluate the quality of care in a ward - we refer to the "black box" because we do not really know what is happening in the ward. What people describe as happening in a ward may be the ideal scenario and may not correspond to reality. Reality is usually much more complex and some unexpected shortcomings may emerge.
- An *efficient* KMC ward works well and makes optimal use of available means without unnecessary duplication or waste. It should be in line with what is affordable and sustainable within a particular health care facility and within the provincial and national health care system.

The outcomes or outputs of the implementation of KMC should be the achievement of these quality goals. It is important to remember that quality assurance is not about punishing people or identifying projects where there are problems. The challenge is to use all the results from monitoring and evaluation procedures in a *positive* way and to *plan for improvement* by setting realistic targets and objectives. For example, if it is found that mothers are not complying with the guidelines on practising KMC for 24 hours per day, the staff should sit down first and try to work out why. The importance of continuous KMC may not have been explained to mothers (eg the baby needs the bodily heat of the mother, the upright position is better, walking a lot with the baby in the kangaroo position is good for sensory development, etc). It would also be essential to talk to the mothers to find out why they find it difficult. This should be done in such a way that they do not feel threatened.

Quality of care is mainly what is being evaluated in the "black box", in other words there is an evaluation of what is going on in the day-to-day running of a ward or unit and of the standard of nursing care. Self-monitoring mechanisms may develop spontaneously or may be devised to assess the quality of care in a ward. Encouraging the establishment of such mechanisms becomes very important within the overall context of quality assurance. Quality is assessed not only by means of external and internal audits, but also by way of self-evaluation in the form of reflective processes within the team - "thinking together" as a team. This could also be used as a barometer for the degree of ownership of the concept of KMC and the KMC ward that the health team is willing to embrace.

2.5 QUALITY GOALS RELATED TO THE BENEFITS OF KMC (DIAGRAM 5)

(To be used in conjunction with the questions in section 4.2.2, p 47 and section 6.4, pp 92-93)

Diagram 5 is a graphic representation of the benefits of KMC linked to the quality goals of effectiveness and efficiency. When doing an audit of KMC you should try to operationalise the various benefits so that you can use available data and statistics on your health care facility to measure improvement in terms of effectiveness and efficiency. For example, you would check whether there has been a reduction in infant mortality or the incidence of infection since the introduction of KMC, or whether there has been a reduction in the number of patient days (see the article by Hann et al 1999).

Apart from looking at the ultimate outcomes achieved by KMC, there should initially also be a well supervised monitoring process in place to ensure that the ward and/or programme is functioning well and to address the many smaller and larger problems - the "teething problems" - that will arise in the course of the implementation process. Strong leadership from senior and middle management in the infancy stage of KMC implementation is very important. One could possibly also draw up a plan of action in which different types of evaluation (eg audits, management, staff, client satisfaction) are summarised in a grid (table format) with target dates and responsible people appointed to oversee or carry out certain actions.

Notes:

PART 3
A FEW QUESTIONS FOR HEALTH DEPARTMENTS AND MINISTRIES

➜ Does the province/ministry have a provincial/ministerial KMC policy?
Yes / No

- If there is a KMC policy:
  - How does KMC slot into other existing maternal and child health policies and programmes?
  - How well is the policy implemented?
    Fully / Fairly well / To some extent / Very little / Not at all
  - If not implemented very well: What will be done about the situation?
- If there is NO KMC policy:
  - Should a special KMC policy be put in place? *Yes / No*
    - If a special policy should be put in place:
      - What kind of policy?
      - What will be done about it? Processes to follow?
      - Who will be responsible?/Who will drive the conceptualisation and writing of the policy?
        - Which roleplayers have to be consulted?
        - What are the deadlines?
      - How will the policy be implemented?
        - Who will drive the process?
        - What kind of support is available to departmental officials assigned to drive the policy-making and implementation process?
        - What are the deadlines?
    - If a special policy should NOT be put in place:
      - How should existing maternal and child health policies be changed to accommodate KMC as a priority?
      - Who will be responsible?

- What are the deadlines?

➜ How will the province/ministry monitor the implementation of KMC at the various health care facilities?

➜ Is there a provincial/ministerial policy regarding the transportation of babies in ambulances? *Yes / No*

- If "Yes":
  - What is the policy?
  - Would it be possible to make the kangaroo position (preferably with the baby carried by the mother) the preferred option during transport in some instances?
- If "No":
  - Should directives in this regard be sent out to health care facilities? *Yes / No*
    - If "Yes":
      - Which directives?
      - Who would be responsible for drafting them?

➜ Should there be a provincial/national KMC logo or should each health care facility develop its own? *Yes / No*

- If "Yes":
  - How could it be developed in a participatory way (eg a competition)?
    -How would this be communicated to the health care facilities?
    -What kind of cultural and other sensitivities should be taken into account?
    -Who would be responsible?
    -What are the deadlines?
- If "No":
  - Will the province/ministry provide guidelines to health care facilities regarding cultural and other sensitivities that should be taken into account?

➜ What kind of support will the province/ministry make available to health care facilities that wish to implement KMC in terms of the following:

- Additional financing and material resources?
- Training of key staff (includes in-service training at existing KMC facilities)?
- Organisation of regular seminars (some of which could earn credit for continuing education)?
- Publicity materials for the general public and health care workers (eg brochures, videos)?
- Other?

➜ Additional questions and issues:

Notes:

DIAGRAM 1: MAIN ISSUES IN THE ESTABLISHMENT OF KMC

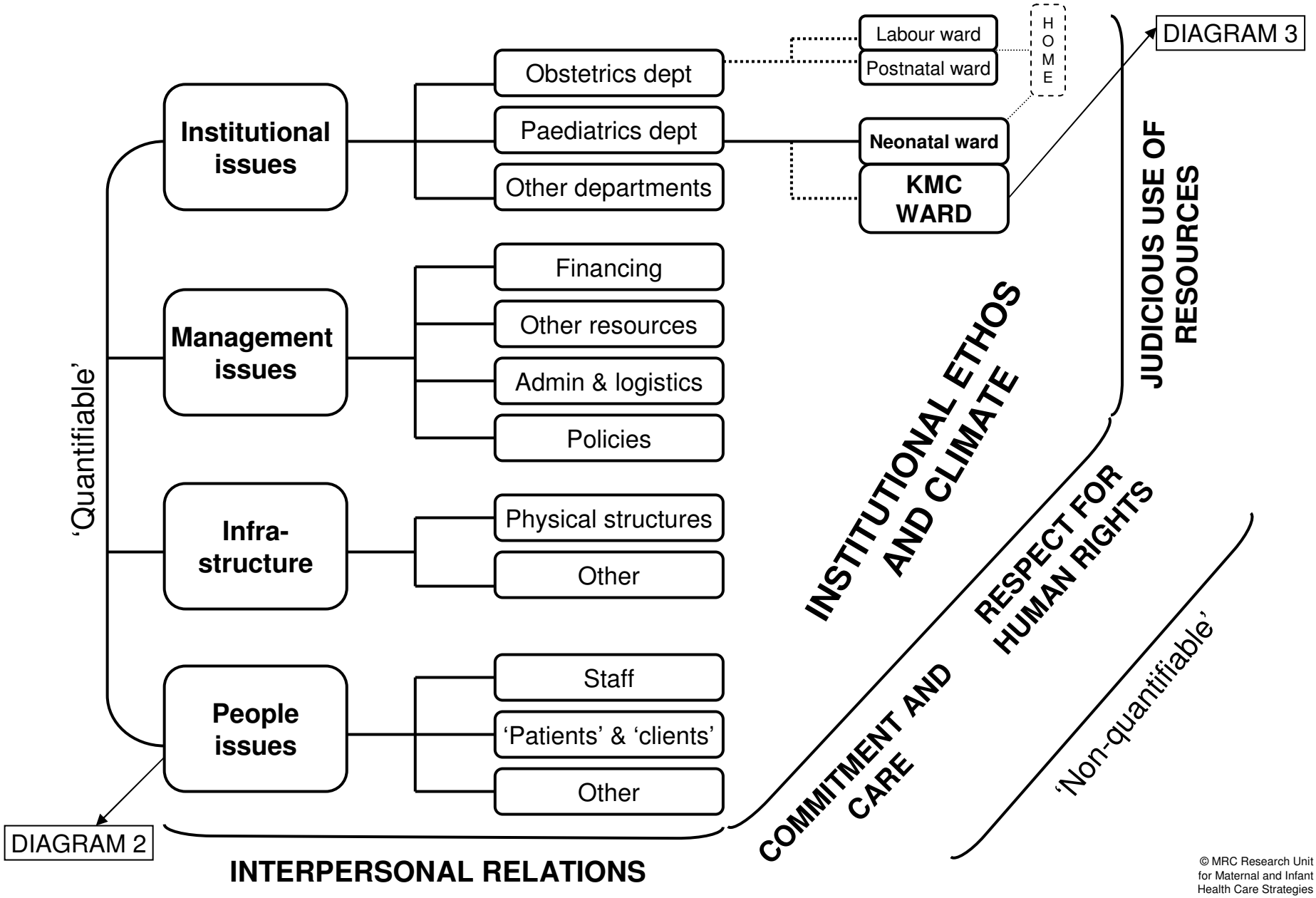


DIAGRAM 2: ROLEPLAYERS IN KMC

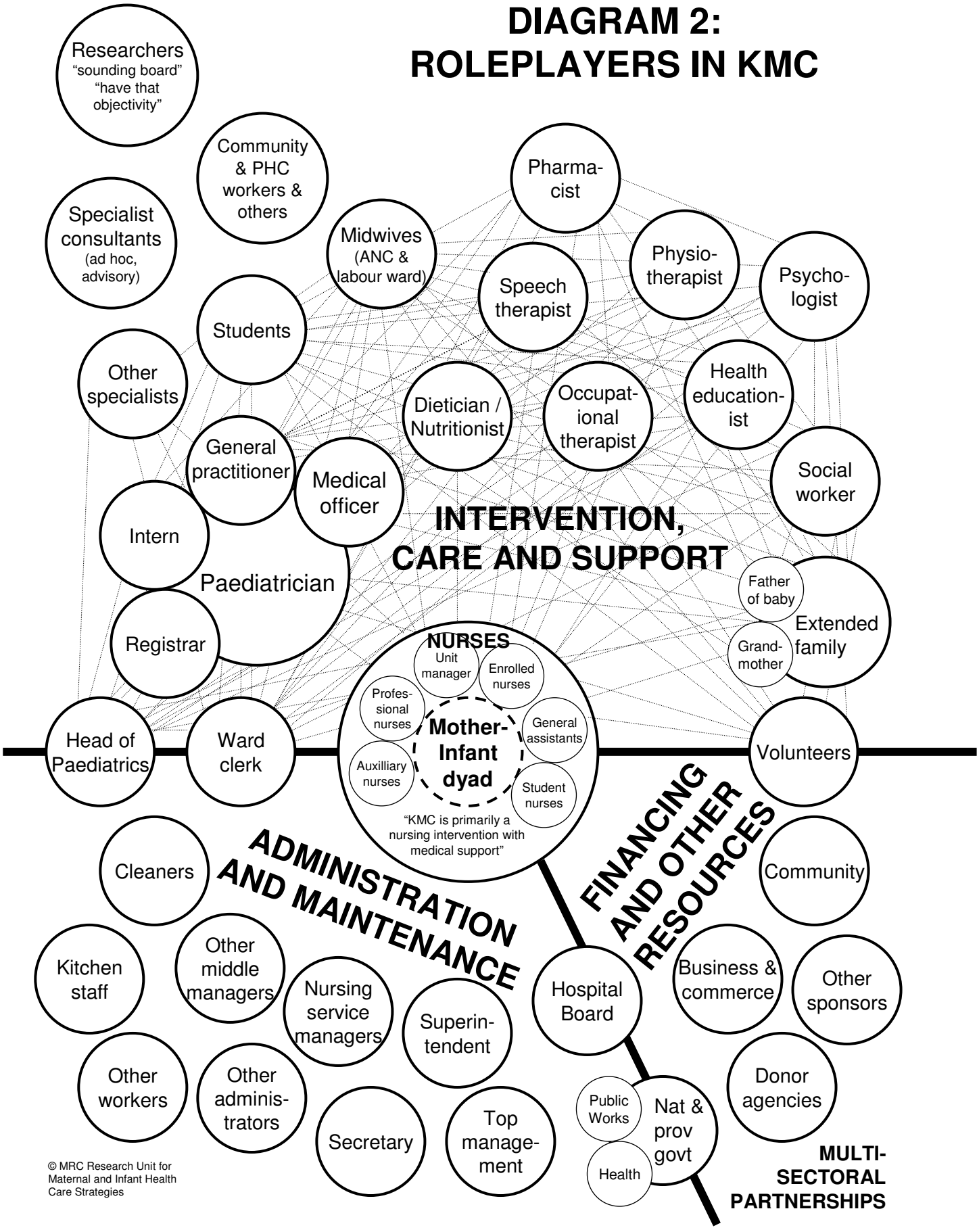
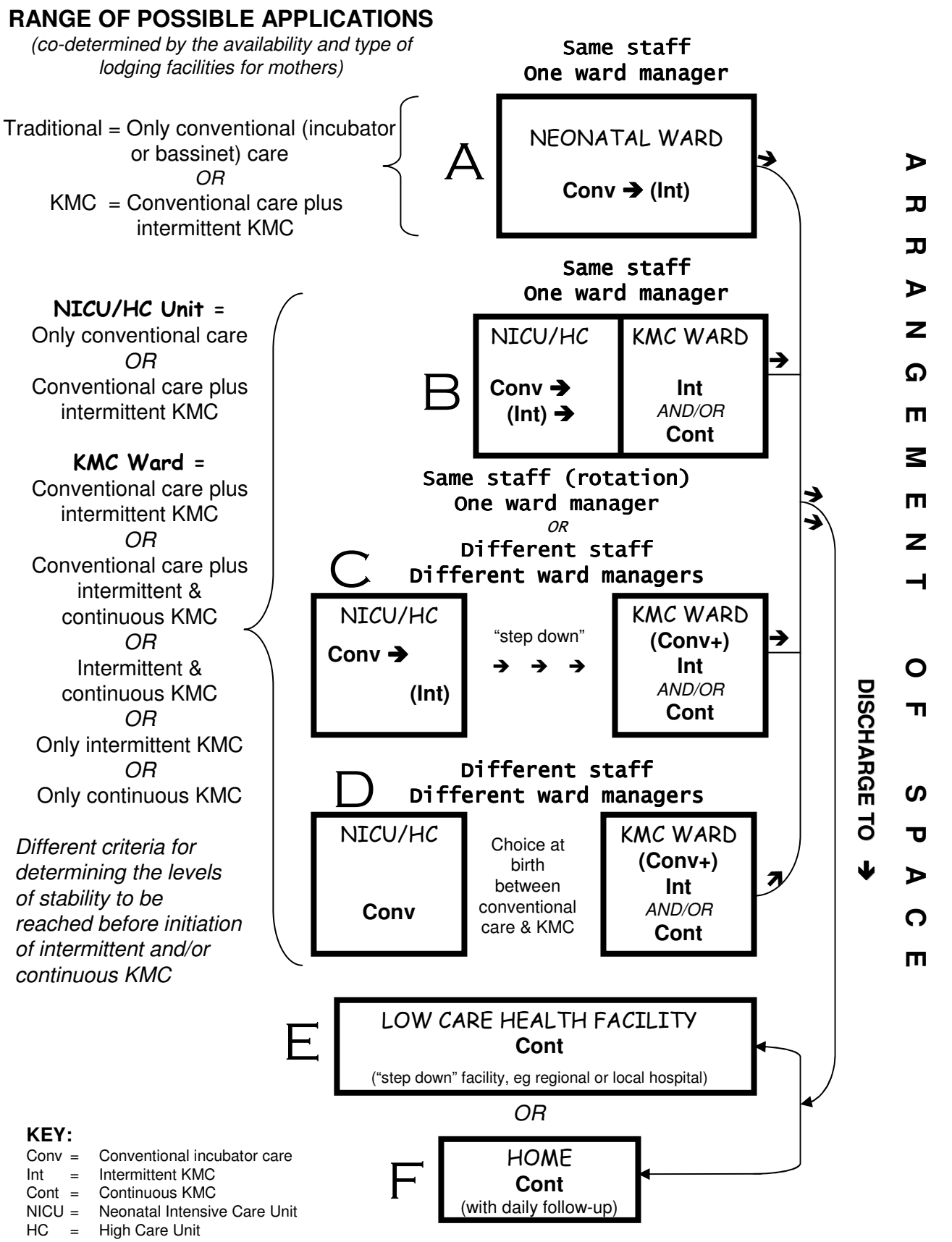


DIAGRAM 3:
INSTITUTIONAL IMPLEMENTATION MODELS OF KANGAROO MOTHER CARE



KEY:

Conv	=	Conventional incubator care
Int	=	Intermittent KMC
Cont	=	Continuous KMC
NICU	=	Neonatal Intensive Care Unit
HC	=	High Care Unit
KMC	=	Kangaroo Mother Care

DIAGRAM 4: CONTINUOUS SELF-IMPROVEMENT AND SELF-EVALUATION

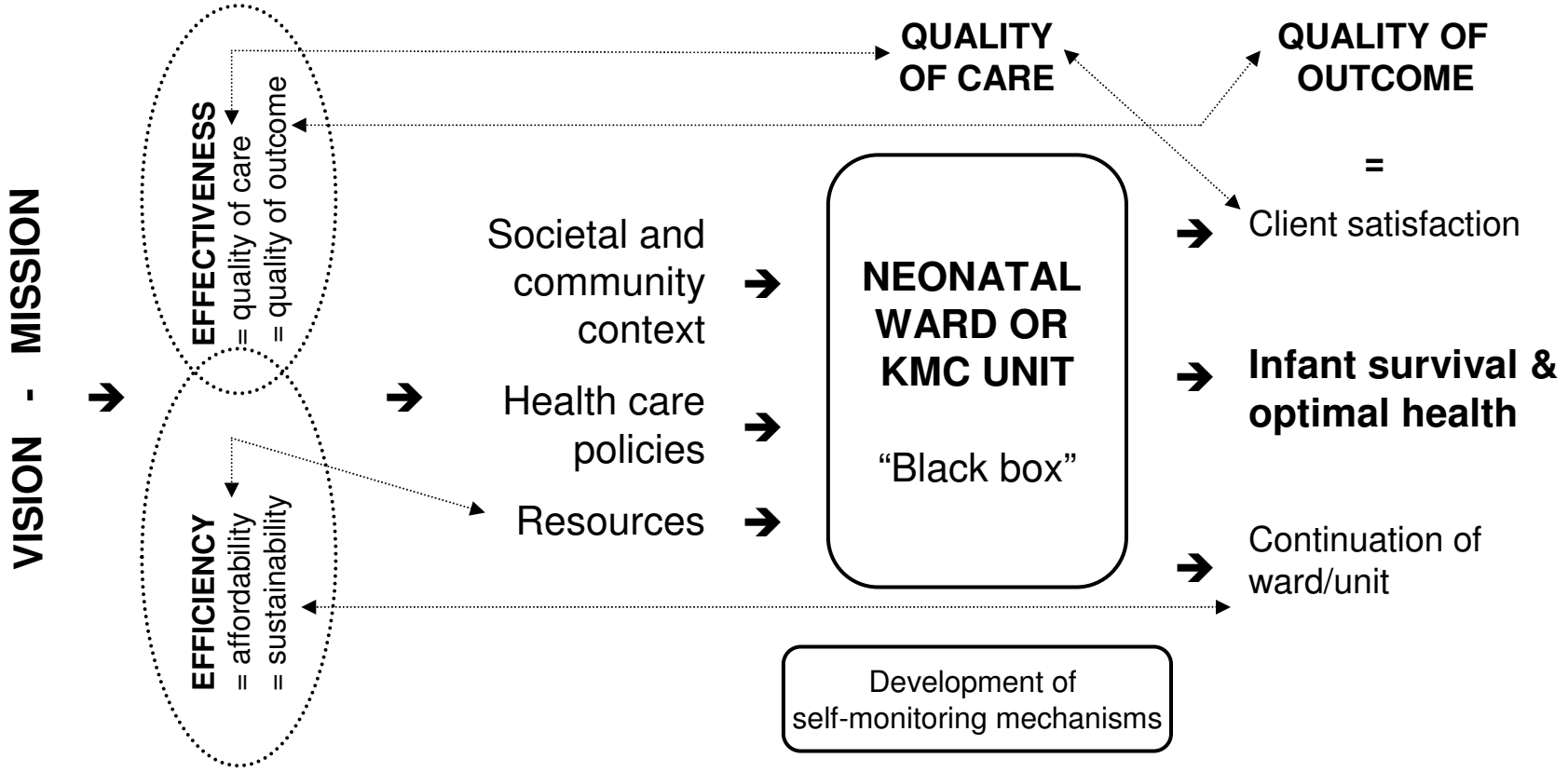
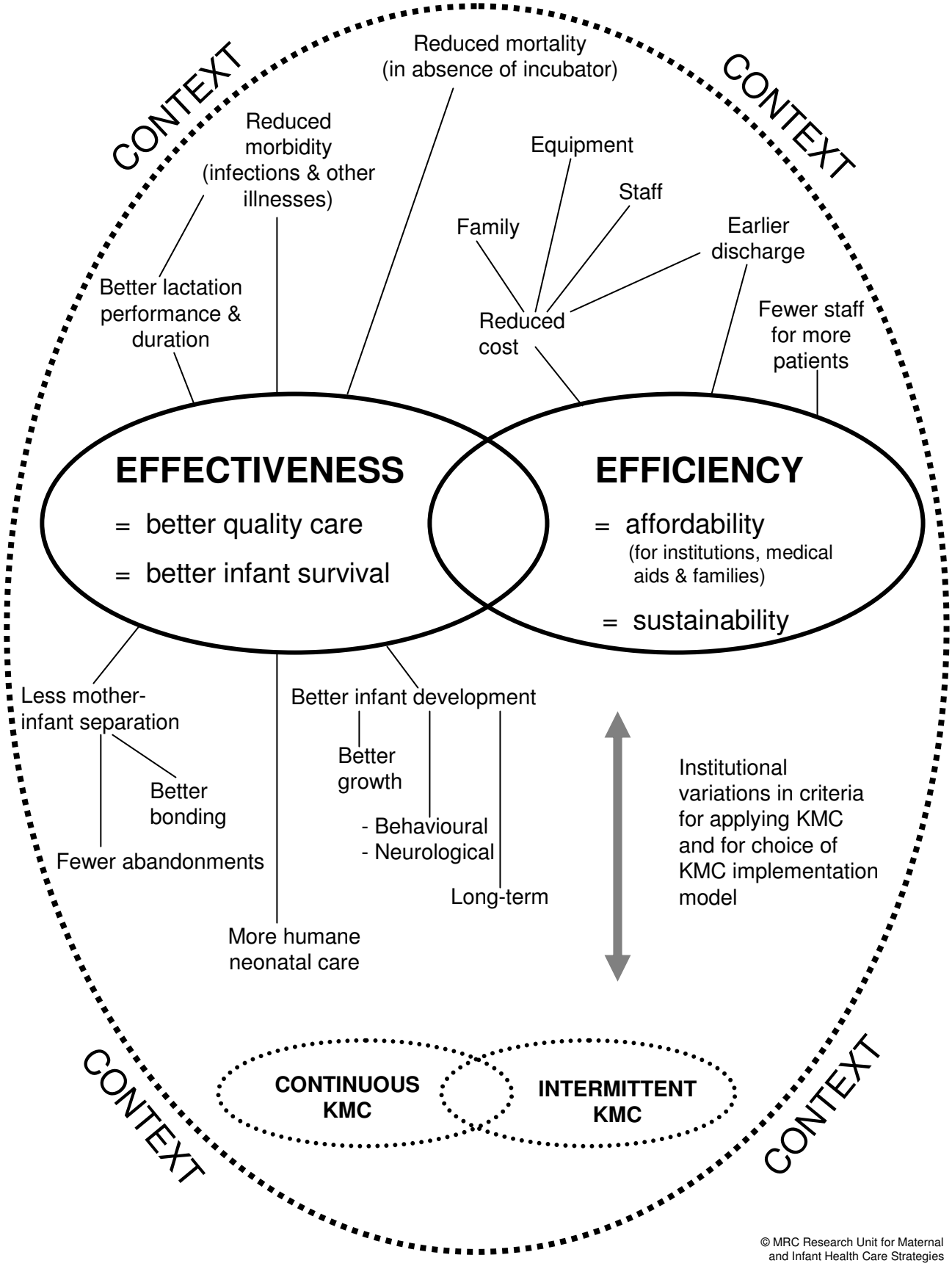


DIAGRAM 5:
QUALITY GOALS RELATED TO THE BENEFITS OF KMC



PART 4
HOLISTIC PLANNING BY THE HEALTH CARE FACILITY

4.1 THE NATURE OF THE HEALTH CARE FACILITY

When one works in a health care facility one becomes involved in the day-to-day running of the institution. One is also emotionally involved in the process and dynamics of everyday events there. The rationale for the questions and activities under the first three subheadings (4.1.1 to 4.1.3) is to help health workers to get some "distance", to "withdraw" from the day-to-day activities and to try to see the bigger picture, and to think about how they fit into the broader institutional, district, regional or provincial set-up. In the process of institutionalising KMC it is crucial to identify the various important links which need to be sustained or strengthened to make a success of the programme. These are the issues which should be addressed at the first three planning meetings suggested in section 1.4 (pp 6-13).

Some of the points and questions in this part overlap with certain aspects listed in the next two parts ("Intermittent KMC in the Neonatal Intensive and High Care Units" and "Inside the KMC Ward"). It is only possible to give provisional answers to some of the questions but after the overview of how the health care facility as a whole is involved in the process of establishing a KMC programme, the answers in Parts 5 and 6 will be better contextualised and more pertinent.

Notes:

4.1.1 What is our institution?

(Use these questions in conjunction with diagram 1 discussed in section 2.1, pp 15-19.)

➜ How does the broader health context and the communities of the patients we serve influence the policies and functioning of our health care facility?

➜ Which provincial structures and policies have a bearing on the way in which KMC is implemented in our hospital/health care facility?

➜ What bearing does the history of our health care facility have on the implementation of KMC?

➜ How could the status and size of our hospital influence the implementation of KMC?

➜ How could institutional arrangements in our facility (eg hierarchies) impact positively and negatively on the implementation of KMC?

➜ How "stable" is our institution and how could that influence the implementation of KMC?

➜ What are the strengths, weaknesses, opportunities and threats in our facility?

- How will these influence the implementation of KMC?
- How can we use the strengths and opportunities to provide quality care in KMC?
- How can we overcome weaknesses and obstacles when implementing KMC?

➜ What other hospital policies should we take into account in the implementation of KMC?

➜ What hospital policies do we need to change if KMC is introduced, and what changes should be introduced (eg transport and transfer of babies in the KMC position, lodging facilities for mothers)?

➜ What data and other information do we need as part of a comprehensive needs and situation analysis?

- Resources? (See also section 4.2.1, pp 41-46.)
- Existing patient : staff ratio?
- Obstetric facilities?
- Caesarean section rate?
- Total deliveries per annum?
- Total of babies for different levels of care?
- Number and functionality of incubators?
- Average birth weight of babies in each group?
- Average discharge weight?
- Average length of hospital stay for each group?
- Infant morbidity and mortality rates?
- Nosocomial infection rate?
- Transport facilities for babies?
- Other?

➜ How would we set up the following committees?

- Initial steering committee to drive the process until KMC is well established?
- Subcommittees or task teams to drive particular aspects of implementation?
- Other permanent and ad hoc committees and other necessary structures?

➜ Additional questions and issues:

4.1.2 Who are the roleplayers?

(Use these questions in conjunction with diagram 2 discussed in section 2.2, pp 18-20.)

➜ How do the different professions expect to be involved in KMC?

➜ If positions are not available for all the different professions, how could other health care workers be used to fulfil some of their functions?

➜ Which are the weak communication channels at the institution?

- How do these weaknesses contribute to poor interpersonal relationships?
- How could communication be improved and some of the existing problems avoided in the KMC ward?

➜ How could personal interests, power relations or power struggles in the institution impact positively or negatively on the implementation process?

➜ How can we influence staff attitudes positively?

➜ How are we going to use specific roleplayers or individuals as agents of change?

➜ How would we deal with resistance to implementation?

➜ How will key appointments, especially those of ward manager(s), be made?

➜ Additional questions and issues:

4.1.3 Which KMC model would we choose?

It is essential to use diagram 3 (section 2.3, pp 22-25) to answer the questions in this section. Some of the questions here are posed to create awareness and to enable you to choose an appropriate implementation model. You will find the details in the sections referred to in brackets.

➜ What levels of neonatal care does our health care facility provide?
Intensive (level 3) / High (level 2) / Low (level 1)

➜ How will these influence the types of KMC that we will practice?
Intermittent only / Continuous only / Both

- If *only* intermittent KMC will be practised (Model A):
  - How will the neonatal ward be organised?
    (See Part 5, pp 59-63 for details.)

- If *only* continuous KMC will be practised (Model E):
  - How will the ward be arranged?
    (See Part 6, pp 65-94 for details.)

- If both intermittent and continuous KMC will be practised:

  - Which model will be used? *Model B / Model C / Model D*

    - If ***Model B*** is selected:
      -What kind of spaces are available?
      -How could they be adapted and fitted? (See also section 4.2.3, p 48 for details.)
      -What staffing and management principles will apply?
      (See section 4.2.5, p 50 and section 6.1.1, pp 66-70 for more detailed questions on staffing issues.)
      -Other special arrangements needed? (See also Parts 5 and 6, pp 59-94 for more detail.)

- If ***Model C*** is selected:
  -What kind of spaces are available?
  -How could they be adapted and fitted?
  (See also section 4.2.3, p 48 for details.)
  -What staffing and management principles will apply?
  (See section 4.2.5, p 50 and section 6.1.1, pp 66-70 for more detailed questions on staffing issues.)
  -Other special arrangements needed?
  (See also Parts 5 and 6 for more detail.)
  - What criteria will be used to determine when a baby is ready to "step down" to the KMC ward? (See also section 6.1.3, pp 72-73 for further questions.)

- If ***Model D*** is selected (very unlikely), what will the criteria be for allocating babies to conventional care and to KMC?

➜ Additional questions and issues:

4.2 NEEDS AND CHANGES

4.2.1 What resources do we need?

Our word-processing program gave the following alternatives for the word "resources": asset(s), budget, capital, finances, funds, money, possession, wealth, worth, belonging, cash, holdings, investments, means, property, revenue, riches. People often categorise resources under the headings of human resources (staff), financial resources (money) and material resources (all the other visible things). So resources include people, money, buildings, furniture, everything needed to get KMC up and running and sustainable over a long period of time - even medicine and everyday things like nappies, soap and toilet paper for which one has a budget should be listed as part of the planning exercise. Some items could be procured from the normal hospital budget, for example consumables like pharmaceutical items and nappies. These are items which would have been on the budget anyway - they are simply being reallocated for use in KMC where necessary. With regard to furniture, there may be enough underutilised items elsewhere in the facility which could be moved to the ward(s) where KMC will be practised. For example, a few existing KMC wards secured unutilised beds for the mothers from the nurses' home. Others cut off the legs of discarded hospital beds. Some beds just needed a coat of paint, which was applied by the hospital maintenance section. In other instances, hospital staff volunteered to do the paint job in their spare time.

It may help to draw up a table to identify which resources will be needed, what will cost extra money, where the money will come from, and how other items will be obtained.

We suggest that you compile two tables. One table will be used for large capital items, recurrent items of expenditure such as staff salaries, and consumables like toilet paper and nappies (see figure 5 on the next page for an example). The second table (figure 6) will be for household and housekeeping items which could be collected over a period of time and do not need to be in place when the KMC ward starts. The ideal is to create a homely atmosphere, as the KMC ward is like a transition between hospital and home. Especially where mothers are staying for a long period of time, they need a little variety and some form of recreation.

FIGURE 5: EXAMPLE OF CAPITAL AND RECURRENT ITEMS OF EXPENDITURE

Item	Any savings? How much?	Additional money needed? (Yes/No/Unsure)	Which funds will be utilised or transferred from another budget?	Remarks
Space - the ward				*For a separate KMC ward:* • Alterations such as ablution and hand washing facilities and toilets, plumbing for laundry facilities • A separate lounge/dining area if feasible (also used for visitors and education) • Useful optional: curtain rails for privacy for each bed or some other form of partition *For the neonatal ward:* • Private area for expressing breast milk
Space - outside				• Whenever possible, a recreational patch outside should be identified for later development. The nearer it is to the ward, the better. It should preferably be fenced in and for security reasons used exclusively by KMC mothers.
Heaters				• Check central heating facilities or there may be other suitable portable heaters elsewhere in the hospital - make sure that a constant heat will be maintained as soon as the ward is operational (This may not always be required if the mother is warm and babies are continuously in the KMC position and not left on beds or in bassinets from time to time.)
Staff expenses				• Salaries • Initial and continuous staff training (may be quite comprehensive if there is high staff attrition or frequent rotation)

Fully lodging mothers (extra catering, linen requirements)				• There may be additional expenses here if your facility does not have a lodger mother facility or other arrangements (eg provision of food) for mothers to stay with their babies

FIGURE 6: EXAMPLE OF EQUIPMENT, FURNITURE AND HOUSEHOLD ITEMS TO BE COLLECTED OVER TIME

Item	Priority	Essential	Good to have	Nice to have	Remarks (justification for choice)	How would we obtain the item?	Who could help in making this item?
For intermittent KMC (eg intensive and high care units)							
Comfortable chair next to each incubator (a reclining chair is a bonus)							
Extra chairs for other visitors							
Refrigeration for EBM							
Wrapping for KMC (eg towels or sheets, wrap around blouses or boob tubes)							
Reading material							
For continuous KMC (eg in a separate ward)							
Technical equipment							
Suction unit							
Oxygen (head box or nasal prongs)							
Resuscitation equipment							

Item	Priority	Essential	Good to have	Nice to have	Remarks (justification for choice)	How would we obtain the item?	Who could help in making this item?
Pulse oxymeter							
IVAC							
Feeding tubes							
Scale							
Emergency equipment							
Breast pumps							
Refrigeration for EBM and other items							
Low beds / Divans							
Mattresses							
Wrapping for KMC (eg towels or sheets, wrap around blouses or boob tubes)							
Dining tables and chairs							
Extra comfortable chairs							
Lockers (ideal = one for each mothers)							
Laundry facilities (eg washing machine and tumble drier)							
Curtains							
Attractive bedspreads and blankets							
Extra towels, sheets and pillowcases							

Item	Priority	Essential	Good to have	Nice to have	Remarks (justification for choice)	How would we obtain the item?	Who could help in making this item?
Mobile screens for privacy							
TV							
Video recorder (can also be used for educational purposes)							
Cups, plates, etc							
Kettle							
Microwave oven							
Stove (two plate or bigger?)							
Toaster							
Reading material							
Posters and other wall decorations							
Educational equipment							

EBM = expressed breast milk

➜ What articles and equipment are essential? (Read from tables)

➜ Which items could be transferred from somewhere else in the hospital or nurses' home/residence/hostel?

➜ What will the hospital have to buy?

- How should we prioritise these items?

➜ Which items will require sponsorship?

- How should we prioritise these items?

➜ What partnerships could we forge to secure some of the items needed?

- With businesses?
- With voluntary organisations?
- With the communities we serve?
- Other?

➜ Who could help us to make some of the items (curtains, wrap around blouses or boob tubes)?

- Staff members who can sew?
- Volunteers?
- Other?

➜ Additional questions and issues:

4.2.2 How will the KMC programme be financed?

If you have gone through the exercise above you should have a pretty good idea of the financial implications of introducing KMC. Some costs will stay the same and will merely be transferred from one ward to another (eg nappies, pharmaceutical items). If the implementation model is chosen judiciously there should be savings on staff, as mothers will be doing most of the caring and a higher staff:patient ratio could be accepted. Earlier discharge of babies could also save patient days (Hann et al 1999). However, the cost of providing accommodation for mothers will be higher, especially if your facility does not have a lodger mother facility. The following are a few summarising questions:

➜ What are essential costs?

- Staff?
- Physical facilities?
- Furniture?
- Training?
- Other?

➜ Which of the costs can be carried by the normal hospital budget?

➜ Is any additional fundraising necessary? *Yes / No / Perhaps (specify)*

- If "Yes":
  - For what?
  - What fundraising activities would we undertake ourselves (eg cake sales)?
  - Who will be responsible for what?
  - If potential donors / sponsors are to be approached, who would they be?
  - Who will be responsible for this?
  - What about an "adopt-a-ward" partnership with a local business?
  - Deadlines for report back?
  - What fundraising will be postponed until a later date?

- How do we make sure our fundraising plans are in line with government policies regarding fundraising by individual health care facilities?

➜ Additional questions and issues:

4.2.3 What physical and structural changes are essential?

The physical and structural changes are sometimes referred to as the organisation of space. Some of these issues have already been reflected in one of the resource planning tables (see figure 5, p 42). The following are a few summarising questions:

➜ Is there a ward that could be converted into a separate KMC ward?
- If "Yes":
  - How far is it from the neonatal ward?
  - How many beds will it accommodate?
  - Will the space be adequate in terms of the size of the facility?
- If "No":
  - How will KMC be accommodated in the existing neonatal ward?

➜ What essential structural changes to the existing facility would be necessary?
- Ablution facilities (showers, toilets, baths)?
- Plumbing for laundry facilities?
- (Central) heating?
- Partitions or mobile screens or curtains for some privacy?
- Other?

➜ What maintenance work is needed (eg painting, plumbing)?

➜ To what extent will the physical and structural changes ensure the safety and security of mothers and babies in KMC?

➜ Additional questions and issues:

4..2.4 What administrative changes do we need to make?

(See also sections 6.2.5.1 and 6.2.5.2, pp 87-88 and section 6.2.2, p 82.)

➜ How are we going to record patient care so that there is an overview of which babies are/were in KMC?

➜ What changes do we need to make to the existing recording and filing systems (eg ward register)?

➜ What additional forms should be created specifically for babies in KMC?

➜ Will the doctor(s) be required to prescribe KMC before it will be practised?

➜ Can we expect an increase or a decrease in administrative work?
Increase / Decrease / No change

- If there is going to be an increase in work: Will any staffing redistribution be needed (eg do we need a clerk to help with the administrative duties)?
- If there is going to be a decrease in work: How will we redistribute existing administrative work?

➜ Additional questions and issues:

4.2.5 What staffing arrangements should we make?

(See also section 6.1.1, pp 66-70.)

➜ What level of care (acuity level) will be needed?

➜ How will we ensure staffing continuity during the implementation process?

➜ Will the KMC ward have its own staff contingent or will there be rotation of the neonatal ward staff?

➜ How often will there be a rotation with staff working in other wards?

➜ How many staff members will be assigned to the KMC ward?

➜ What will their ranks be?

➜ How experienced should they be?

➜ How will the leadership roles and functions be distributed?

➜ What will their job descriptions be?

➜ Additional questions and issues:

4.2.6 What are the training and development needs of the future KMC staff?

It may be a good idea to devise a kind of training plan or programme for KMC staff. It is necessary to attend not only to needs pertaining specifically to the implementation of KMC but also to broader needs, such as training in leadership and management, counselling and conflict resolution, breastfeeding and lactation management, neonatal resuscitation, and child care. It is also advisable to find out what kind of training and expertise the assigned staff members have and what kind of in-service training or upgrading they are busy with. Try to use this to maximise the smooth implementation of KMC and to use as many of the available skills as possible.

The following questions may need some in-depth discussion. Some of them have to be answered immediately after a decision has been made on which implementation model to follow. Others will need in-depth discussion after the KMC staff have been allocated. At this stage senior and middle management should play a leading role in "mapping" the available expertise and identifying additional training needs, which should be guided by safety and continuity in patient care.

➜ How will training needs be identified?

➜ What kind of initial training will be given to which KMC staff?

- Reading required from all?
- Workshops?
- Seminars?
- Special courses?
- In-service training at an existing KMC facility?
- Other?

➜ What schedule should be drafted for training?

➜ What kind of on-going development and support will be needed?

- Discussion meetings?
- Workshops?
- Seminars?
- Special courses?

- In-service training at an existing KMC facility?
- Conferences?
- Other?

➜ How will ongoing development be scheduled?

➜ How can we make the best possible use of our own staff for on-going development and support?

➜ How will we ensure interaction between different professions during training (eg doctors and nurses)?

➜ How will new staff be oriented and trained?

➜ How will the different types of training and development be funded?

➜ How will we ensure that adequate training opportunities are in place and can be sustained?

➜ Additional questions and issues:

4.3 SUSTAINING AND IMPROVING THE KMC PROGRAMME

4.3.1 What support structures should we build into the KMC programme?

While KMC is being implemented everyone needs support, even the officials from the provincial department or ministry. Some institutions have a KMC support or study group where interested people from inside the health care facility, but also from neighbouring facilities, members of the community, students and other volunteers join hands to get some of the planned projects off the ground and to share the latest information on KMC.

Everything cannot be initiated by the provincial or national health department. Your facility, especially if you are a regional hospital, could try to make a contribution by taking the initiative for some activities.

➜ Which of the following support structures should we develop?

- A networking or "buddy" system in the region where staff of different institutions share their experience, information and even some of their resources with each other? *Yes / No*
  - If "Yes":
    - How will it be organised?
    - Who will do what?
- Regular meetings? *Yes / No*
  - If "Yes":
    - How will they be organised?
    - Who will be invited?
- Seminars? *Yes / No*
  - If "Yes":
    - How will they be organised?
    - Who will be invited?
    - Could some be registered for credit hours in continuing education?

- Newsletter? *Yes /No*
  - If "Yes":
    - Who will take responsibility?
    - How often should it appear?
    - In what form will it be distributed?
      Paper / E-mail / Internet / Other (specify)
    - Who should receive copies?
- Other?

➜ How will we ensure that a multidisciplinary support team is in place for staff to discuss problems on a regular basis?

➜ How will individual staff members be supported and counselled (especially during the difficult "teething" period of implementation)?

➜ What kind of research projects should we encourage or undertake?
- Who will help us with these?
- How will we support researchers?

➜ Additional questions and issues:

4.3.2 How will we monitor the implementation process and what kinds of ongoing evaluation and research should we pursue?

(Use these questions in conjunction with diagrams 4 and 5 discussed in sections 2.4, and 2.5, pp 24-30.)

➜ What aspects of KMC need to be monitored at institutional level?

- Initially?
- In the long term?
- Ad hoc?

➜ How will this slot in with existing quality assurance and control measures?

➜ What should be audited regularly and at which level?

➜ Who will monitor and/or audit what?

➜ How often will the results of audits and monitoring be reported and when will this take place?

➜ How will nursing effectiveness management be evaluated?

➜ How will nursing and medical risk management be done (eg legal and ethical issues)? (See also section 6.4.2, pp 93-94.)

➜ What aspects of KMC need to be monitored at ward level?
(See also Part 6, pp 65-93.)

➜ What new self-evaluation mechanisms should be put in place?

- Which ones can be identified immediately? (Others will crystallise over time.)

➜ What kind of continuous evaluation will be employed to establish how KMC is faring?

➜ What will be evaluated? What indicators will be used?

➜ How will the evaluation be done?

➜ Who will administer the evaluation?

- Will there be a person outside the ward to coordinate the evaluation inside the KMC or neonatal ward as well? *Yes / No*
  - If "Yes":
    - Who?
    - What will be expected of this person?
  - If "No":
    - Who inside the ward will take final responsibility for coordinating self-evaluation activities?
    - To whom will this person be accountable?

➜ Who should participate in evaluation exercises?

- Only mothers?
- Fathers?
- Significant others?
- Nursing staff?
- Other staff?
- Other?

➜ Should we write up the history of the KMC implementation process? *Yes / No*

- If "Yes":
  - What would the purpose be?
  - How should we do it?
  - How will we disseminate information?

➜ Additional questions and issues:

4.3.3 How are we going to organise liaison and communication matters?

➜ What kinds of liaison and communication with the outside world do we need?

- With the national health department or ministry?
- With the provincial health department?
- With other facilities with KMC?
- With referring facilities (where applicable)?
- With "step-down" facilities (where applicable)?
- With PHC clinics?
- With the community?
- With the media?
- Other?

➜ How will the responsibilities be divided?

- What belongs at institutional level? Who should be responsible for what?
- What belongs at ward level? Who should be responsible for what?

➜ Will there be an official launch? *Yes / No*

- If "Yes":
  - When?
  - What format?
  - How will it be funded?
  - Who will be responsible for doing what?

➜ How will we sustain publicity and communication with the communities we serve?

➜ How can we market our institution under the KMC banner?

➜ How can we create partnerships to promote KMC?

➜ Should the KMC ward have a logo? *Yes / No*

- If "Yes":
  - Is there a provincial or national logo that we must use?
  - If not, who will design a logo?

- How will it be tested for cross-cultural acceptability?
- Other aspects to consider

➜ What kind of publicity and educational materials will we need?

➜ What kind of special internal communication should be established?

- What is needed initially (eg in terms of creating awareness)?
- What should be part of the ongoing communication process?
- Other?

➜ Additional questions and issues:

PART 5
INTERMITTENT KMC IN THE NEONATAL INTENSIVE AND HIGH CARE UNITS

Very often the introduction of a KMC programme starts with intermittent KMC as a kind of pilot or experimental phase or because the physical space for introducing continuous KMC is not immediately available. This type of KMC is, however, also the most difficult to institutionalise and sustain, as it is much easier to fall back into the "old ways". Getting staff convinced of the benefits of KMC and committed to following through is of vital importance.

A number of the points you need to consider have already been discussed in Part 4 as part of the preparation by the health care facility as a whole. Many of the aspects dealt with in Part 6 ("Inside the KMC Ward") are also applicable in a neonatal ward where only intermittent KMC is applied. It is important to work through those questions as well. Below we merely list the more important questions to which you need to find answers which may be very specific to your context:

5.1 WHAT POLICIES AND PROTOCOLS ARE NEEDED?

➜ What existing policies, protocols and routines should we adapt to include KMC as a philosophy or to assist the mothers with KMC?

- Vision and mission statement?
  (See also section 2.4, pp 24-29 and section 6.1.2, pp 71-72.)
- Staffing arrangements?
  (See also section 4.2.5, p 50 and section 6.1.1, pp 66-70.)
- Ward routines? (See also section 6.2.1, pp 79-81.)
  - How can intermittent KMC be structured so that it does not interfere with essential ward routines?
  - How will we ensure that it takes precedence over non-essential ward routines?
- Feeding of babies?
  - Expression of breast milk?

- Use of formula?
- HIV positive mothers?

▸ Other?

➜ What will our criteria be for changing from intermittent to continuous KMC?

➜ What will our discharge criteria be and what flexibility will we build in so that they can change over time and younger and smaller babies can be discharged to KMC?

▸ What will our criteria be for discharging a baby from high care to the KMC ward?

▸ What will our criteria be for discharging a baby from high care to home care (in the absence of a KMC ward or owing to special circumstances of the mother)?

➜ Should we draw up a special protocol or guidelines for nursing staff? *Yes / No*
(See also section 6.4.2, pp 93-94.)

▸ If "Yes":

- How should this be done to ensure ownership and guarantee implementation?
- What should the protocol contain?
- What kinds of decisions should the doctor take (eg whether baby is stable enough to receive intermittent KMC and for how long)?
- What kind of decisions would nurses take?
- Who would help mothers with KMC and answer their questions?
- What kind of schedule would there be to ensure continuity of care and uniform instruction to mothers?

➜ What other measures may be needed to ensure that the routine practice of intermittent KMC is sustained on a permanent basis?

➜ Additional questions and queries:

5.2 WHAT ARE OUR NEEDS WITH REGARD TO FACILITIES AND PHYSICAL STRUCTURES?

➜ Do we need to make other special arrangements (eg physical alterations or the acquisition of specific items) to introduce intermittent KMC? *Yes / No*

- If "Yes":
  - What is essential? (Use figure 6 in section 4.2.1, pp 43-45 as a guideline.)
  - What is not essential but desirable in the long term (eg reclining chairs for doing KMC or a lounge-like space with comfortable chairs and tables where mothers can sit and relax and at the same time be close to their babies)?
  - How would we go about doing what is needed?

➜ How will we ensure that the fridge used for storing breast milk is maintained optimally?

➜ Is it necessary to create a private space for mothers who want to express breast milk? *Yes / No*

- If "Yes":
  - Where and how?

➜ How will we deal with shortages of clean materials (eg more gowns for mothers, blankets or sheets for tying the baby in the kangaroo position)?

➜ Additional questions and queries:

5.3 WHAT ARRANGEMENTS SHOULD BE MADE FOR MOTHERS?

(See also sections 6.2.2 and 6.2.3, pp 82-84.)

➜ What educational activities should be arranged for mothers?
(See section 6.3, pp 90-91.)

➜ If there is a lodger mother facility (ie the mother stays on the hospital premises):

- Is the quality of the accommodation up to standard? *Yes / No*
  - If "No":
    - What can be done about it?
- How should we liaise with the lodger mother facility in order to ensure a happy and safe stay for the mothers?

➜ If there is no lodger mother facility:

- What can we do to enable mothers from far away to have more contact with their babies and to participate more often in intermittent KMC?
- For mothers who come for the whole day:
  - How can it be arranged that they also receive meals from the kitchen?
  - What can we do to make them more comfortable and make them feel at home?
  - What educational activities should we arrange for them?
  - What other measures can we take?

➜ Additional questions and queries:

5.4 HOW COULD WE USE MOTHERS AS PART OF AN EMPOWERMENT PROCESS?

➜ Are we using mothers optimally in caring for their babies? *Yes / No*

- If "Yes":
  - How will we adapt that to include intermittent KMC?
- If "No":
  - How can we improve the situation?

➜ Can we use the more experienced mothers with babies in intermittent KMC as leader mothers or helpers in cases of staff shortages? *Yes / No*

- If "Yes":
  - How could this be done?
  - What special education do we need to give to these mothers?
  - What kind of supervision and assistance will there be from the nursing staff?
- If "No":
  - Why not?
  - What ways can we think of to change these constraints?

➜ Additional questions and queries:

Notes:

PART 6
INSIDE THE KMC WARD

It is important that the staff who will work in the KMC ward fully understand the KMC implementation model selected from diagram 3. The same kinds of questions which are asked at an institutional level could also be asked with regard to the functioning of the KMC ward. In addition, you will need to work out a variety of policies and duties in detail to ensure that no one is in doubt about what is expected of him or her. As much as possible should be in writing so that procedures and protocols can be standardised. One should work towards a comprehensive ward policy which should be kept on file and should be available for consultation when necessary. This will not only help new nursing staff arriving after KMC has been well established, but it will also facilitate the monitoring of the implementation process and the quality of care.

A comprehensive policy should include a vision and mission statement, address various matters pertaining to staffing and the duties of each staff member, nursing standards, the practice of the different components of KMC (position, nutrition, discharge), household arrangements, the duties of mothers, and guidelines with regard to educational and recreational activities.

Not all the questions below can be answered fully at the start. We suggest that the KMC or neonatal ward staff revisit them as a team every two to three months to check how well they have progressed and which issues are still outstanding or unsatisfactory. The questions could also be used as a tool for identifying weak areas and for continuous quality improvement (see also diagrams 4 and 5). If you are going to record the history of your ward, the heading questions (6.1. to 6.4, pp 66-93) could be used as organisers of information.

6.1 OVERALL PLANNING

6.1.1 What are the staffing arrangements and the roles and duties of the different roleplayers?

(See also section 4.2.5, p 50.)

Some of the questions should already have been answered at institutional level (section 4.2.5), but there are also a number of issues that have to be thrashed out at ward level. The answers to these questions should be written up as part of the ward policy. When answering these questions it is advisable to revisit diagram 2 to confirm which staff members will be involved.

The questions here pertain to:

- *What* should be done?
- *Who* should do what?

In section 6.4 (pp .92-93) there are questions relating to:

- *How well* should these tasks be done?

6.1.1.1 Nursing staff

➜ What level of nursing care will be needed? / What is the patient acuity level?

➜ What is the general job description of each nursing staff rank?

➜ How will this general job description translate into the duties of each staff member?

➜ What system for the allocation of staff duties (timetables, etc) will we use?

- How will the duties be scheduled?
- Who will be responsible for what?

➜ How will the scheduling be done in relation to

- Bed occupancy?

- Nursing activities?
- Other factors such as
  - leave?
  - absence?
  - study?
  - conditions of service?
  - other?

➜ What scheduling system will be used?

- Flexi-scheduling?
- Cyclical scheduling?
- Other?

➜ How will staff members' performance be managed and monitored, and by whom?

➜ What staff development opportunities will be created?
(See also section 4.2.6, pp 51-52.)

➜ Additional questions and issues:

6.1.1.2 Medical staff

➜ What qualifications should doctors working in the ward have?

➜ Which doctors will be working in the ward?
- Medical officers?
- Interns?
- Registrars?
- Paediatricians?
- Other specialists?
- Other?

➜ Should there be a job description for medical doctors?

➜ How will their duties be recorded?

➜ Who will monitor their performance and how?

6.1.1.3 Allied health care staff

➜ Which categories of allied health care staff will be involved in KMC?
- Physiotherapist?
- Occupational therapist?
- Social worker?
- Dietician / Nutritionist?
- Speech therapist?
- Health educationist?
- Pharmacist?
- Other?

➜ What will the duties of each of these members be?

➜ Who will monitor their performance and how?

6.1.1.4 Students

➜ Does our health care facility accommodate students for practical work?

Yes / No

- If "Yes":
  - Who?
    - Nursing students?
    - Medical students?
    - Other?
  - How will they be incorporated into the functioning of the KMC programme?

➜ How should their learning be facilitated?

➜ What kind of education should they receive from the different staff categories?

- What levels and programmes are involved?
- What guidelines should we draft?

➜ Additional questions and issues:

6.1.1.5 Administrative and maintenance staff

➜ Which administrative and maintenance staff members will be involved? (Remember to include the cleaners and kitchen staff.)

➜ What will their duties be?

➜ Who will monitor their performance and how?

➜ Additional questions and issues:

6.1.1.6 Volunteers

➜ Can volunteers be used? *Yes / No*

- If "Yes":
  - Who?
    - From the community?
    - Non-governmental organisations (NGOs)?
    - Mothers who have been through KMC before?
    - Other?
  - How could we use each one?
  - Who would coordinate them?
  - How would we recruit them?
  - How can we ensure some sustainability and keep attrition rates low?

➜ Additional questions and issues:

6.1.1.7 General

➜ How will the various staff categories interact with each other?

➜ Will there be special staff uniform requirements (eg will all staff be required to wear name badges)?

➜ Additional questions and issues:

6.1.2 What kinds of general policies should we develop?

(Use these questions in conjunction with diagram 4 discussed in section 2.4, pp 24-29.)

➜ What is the vision for our ward?

➜ What should be in our mission statement?

➜ How does our mission statement interface with the mission statements of the neonatal ward and the health care facility?

➜ Where and how will we display our mission statement and the patients' rights charter?

➜ How will we evaluate to what extent we are fulfilling our mission?

➜ What issues of and approaches to nursing care should be included as part of a general ward policy?

➜ How will we manage the safety of the babies?

➜ Are there nursing standards available for KMC? *Yes / No*

- If "Yes":
  - How would we use them?
- If "No":
  - What should we do?

➜ What kinds of communication channels and methods will be used?

(See also section 4.3.3, pp 57-58.)

- Inside the KMC ward (among staff)?
- Inside the health care facility?
  - With management?
  - With other wards and clinics?
  - Other?

- Outside the health care facility?
  - Mother's family members?
  - Partners?
  - Community?
  - Other?

➜ How will different components of different policies slot in with existing policies and strategies?

➜ Additional questions and issues:

6.1.3 What would our admission policy be?

(This may change over time.)

➜ What will the criteria for admission to the KMC ward be?
- Will the KMC ward care for certain categories of babies in incubators?
- Will the KMC ward care for stable, oxygen-dependent babies?
- Could the KMC ward receive high care babies in cases of overcrowding in high care?

➜ If applicable:
- What will the criteria be for:
  - Intermittent KMC?
  - Continuous KMC?
- How often will we revise these criteria as it becomes possible in time and experience to admit younger and smaller babies to continuous KMC?

➜ What will the criteria be for referring a baby back to the high-care unit?

➜ What happens to a mother whose baby is referred back to high care?

➜ How will bed occupancy be distributed between the high-care unit and the KMC ward?

➜ Which babies will be received into the KMC ward without their mothers?

➜ Will full-term babies be received into the KMC ward with their mothers?

- If "Yes":
  - Under what conditions?

➜ Should mothers be admitted to the KMC ward a few days before their babies? *Yes / No*

- If "Yes":
  - How would they be treated?
  - What kind of preparation would there be?
  - What kind of direct education and instruction would they receive?
- If "No":
  - What would be done to ensure that they are adequately prepared when they arrive in the ward?

➜ What instruction and education should a mother receive before and during her stay in the KMC ward?

- Before the baby arrives in the ward?
- On arrival in the ward?
- Afterwards?
- Who will provide instruction and education?

➜ What instruction and education will be compulsory for all mothers?
(See also section 6.3, pp 90-91.)

➜ What issues will be dealt with in an ad hoc manner?

6.1.4 What policies pertaining to the three elements of KMC should we devise?

➜ How will we explain the three elements to the mother?
(See also section 6.3, pp 90-91.)

6.1.4.1 Kangaroo position

➜ How should we encourage mothers to practise continuous KMC 24 hours a day?
(This is especially important if the ward is not heated.)

➜ How should we encourage mothers to walk around a lot with the babies in the kangaroo position?

➜ What kinds of demonstrations and instruction should we give mothers with regard to the skin-to-skin position?

➜ How will the babies be secured in the KMC position?

- Hospital towel?
- Hospital sheet?
- Special wrap around blouse?
- Old theatre gowns?
- Boob tube?
- Mother's own button up clothes?
- Other?

➜ Will the babies wear caps? *Yes / No / Sometimes*

- If "Yes" or "Sometimes":
  - What would the criteria for wearing caps be?
  - Where will we get the caps?

➜ Additional questions and issues:

6.1.4.2 Kangaroo nutrition

➜ What training do nursing staff need in breastfeeding and lactation management?

➜ How will we help mothers to breastfeed well?

➜ How will exclusive breastfeeding be promoted?

➜ What guidelines should we devise for the expression of breast milk?

➜ What will the feeding policy be for HIV positive mothers ?

➜ How will we deal with other cases where a mother's or baby's condition may be a contraindication for breastfeeding?

➜ What will the criteria be for giving babies supplements?

➜ What kind of supplement will be given under what circumstances?
- Powdered breast milk fortifier mixed with expressed breast milk?
- Formula?
- Vitamin drops?
- Other?

➜ If direct feeding from the breast is not possible, what would the preferred method(s) of feeding be (for EBM and supplements) and under what circumstances?
- Nasogastric tube?
- Cup?
- Teaspoon?
- Dropper?
- Other?

➜ How will we ensure that all members of staff apply these methods correctly?

➜ Will medication be available for the improvement of lactation? *Yes / No*
- If "Yes":

- What?
- Which mothers will be eligible for receiving the medication?

▸ If "No":

- How will mothers be counselled to ensure optimal lactation?

➜ How will we deal with mothers who, without any good reason, refuse to breastfeed or decide they are unable to breastfeed?

➜ Additional questions and issues:

6.1.4.3 Kangaroo discharge or follow-up

(See also Part 7, pp 95-96.)

➜ What criteria will be used for discharge from hospital?

- ▸ Where can we find information?
- ▸ Should we develop a score sheet to assist us in determining a baby's readiness for discharge?
- ▸ How often will we revise the criteria as it becomes possible, in time and with experience, to discharge younger and smaller babies in KMC from hospital?

➜ Which procedures should be followed on discharge?

➜ After discharge, will there be a follow-up clinic in the neonatal or KMC ward until a baby reaches a certain weight? *Yes / No*

- If "Yes":
  - How will it be organised?
  - Who will be responsible?
  - What additional resources may be needed (eg an extra scale)?
  - What will we do if a mother does not come back?
- If "No":
  - Will the baby receive follow-up care elsewhere in health care facility? *Yes / No*
    - If "Yes":
      - What measures will be taken to ensure continuity of care?
    - If "No":
      - What measures will be in place to ensure that the baby receives adequate follow-up care at the PHC clinics?

➜ Under what conditions will a baby be readmitted after having been discharged from the KMC ward?

➜ Some premature babies have to be followed up for retinopathy of prematurity (ROP):
- Which babies will be referred?
- To which hospital(s) will we refer these babies for follow-up?
- How will we schedule dates and times for each baby at discharge?

➜ Is it possible to create a community network where ex-KMC mothers support new mothers after discharge? *Yes / No*
- If "Yes":
  - What are we going to do about it?
  - Who will be responsible for what?

➜ Additional questions and issues:

6.1.4.4 Special situations

➜ What procedures will be followed in the case of adoption?

➜ What differences will there be in the treatment of twins or triplets?

➜ What adaptations to the KMC policy may be needed for:

- Special conditions of the mother?
  - Breast problems?
  - Postnatal depression?
  - Postnatal psychosis?
  - Other?
- Special conditions of the baby?
  - Functional difficulties (eg neurological conditions)?
  - Organic or anatomical feeding difficulties (eg hare lip, blocked oesophagus)?
  - Other?

➜ Additional questions and issues:

6.2 ORGANISATION OF THE WARD

6.2.1 What will the ward routines be?

Written ward routines (day and night shift), displayed somewhere where mothers can read them, help the mothers to understand the functioning of the KMC ward. It is also important to explain to mothers any routines with which they may be unfamiliar. Giving reasons for certain practices (eg the encouragement of 24-hour continuous KMC) also helps to establish rapport and good interpersonal interaction.

KMC wards will have varying routines, depending on factors like the size of the facility and the roleplayers involved. In some wards specific times (at least every 2-3 hours) are allocated for expressing breast milk for the babies who cannot feed sufficiently from the breast yet. It is often an activity which mothers do together. Babies can also breastfeed in-between according to their needs. Figure 7 is an example of a ward routine.

FIGURE 7: EXAMPLE OF A WARD ROUTINE	
05h00	Mothers - shower -make their beds -wash babies (under supervision of staff) Staff write night report
06h00 - 6h30	Mothers express breast milk (if necessary) and feed babies Staff observe babies
07h00	Handover report to day staff
07h30 - 08h00	Mothers have breakfast Staff - weigh babies -fill in scoring cards -write progress cards -order ward stock and medications (Mondays and Thursdays)
08h00 - 09h30	Mothers express breast milk (if necessary) and feed babies Doctor(s) do(es) ward round Staff observe babies (temperature, pulse rate & oxygen saturation)

10h00 - 10h30	Tea time for mothers and staff
10h30 - 11h30	Staff and mothers take babies (in kangaroo position) for -clinics in other departments -sonars, ex-rays, etc Staff - do health education with mothers -go for in-service training -do follow-up clinic in KMC ward (Thursdays)
11h30 - 12h30	Mothers - express breast milk (if necessary) and feed babies -have lunch Staff - write progress cards -carry out doctor's orders -fill in feeding charts
12h30-13h30	Staff have lunch
13h30-14h30	Mothers - have music therapy (Mondays and Thursdays) -do handcrafts organised by volunteers (Tuesdays and Wednesdays)
15h00 - 15h30	Mothers express breast milk (if necessary) and feed babies
15h30-16h30	Mothers - rest -receive visitors
17h00-18h00	Mothers - express breast milk (if necessary) and feed babies -have supper Staff - observe babies -write progress cards
18h00 - 18h30	Staff - write day reports -fill in statistics
19h00	Hand over to night staff
20h00 - 21h00	Mothers express breast milk (if necessary) and feed babies Staff - observe babies -write progress cards
21h00 - 05h00	Mothers feed babies two- or three-hourly Staff do observations at same time

➜ When and how will we accommodate the following in the mother's routine?
(See also section 6.2.3, pp 83-84.)

- Meals and tea breaks?
- Shower?
- Making beds?
- Washing baby?
- Feeding baby?
- Taking baby to other clinics and departments for treatment or examinations?
- Health education?
- Rest periods?
- Visitors?
- Other?

➜ When and how will we accommodate the following in the staff routine?

- Weighing (daily or alternative days)?
- Handing out of medications?
- Observations? (How often?)
- Writing of progress cards?
- Writing of reports (hand over and other)?
- Filling in of statistics?
- Ordering of stock and medications?
- Health education?
- In-service training?
- Follow-up clinic?
- Other clinics, sonars, ex-rays, etc?
- Meals and tea breaks?

➜ Additional questions and issues:

6.2.2 How should assessments be done and nursing interventions recorded?

Most of the patient recordings will be done by the nurses working in the KMC ward. In some KMC wards mothers record some of the routine observations and feeding times and methods themselves. As part of the empowerment process it is important to use mothers as much as possible, under staff supervision.

➜ Which of the following documents and record forms will we use?

- Bed charts?
- Assessment records?
- Nursing care plan?
- Progress reports and notes?
- Flow charts?
- Growth chart?
- Pre-discharge scoring sheets?
- Discharge records and notes?
- Follow-up record charts?
- Other?

➜ For which of the above can we use existing record forms and for which do we need to devise a new form?

➜ How do we make sure that we do not create unnecessary forms and records?

➜ Additional questions and issues:

6.2.3 What matters pertaining to mothers should we address?

➜ What will the duties of mothers be?
- In caring for the baby?
- Recording observations and procedures?
- In the general housekeeping of the KMC ward?
- Other?

➜ Will the mothers be wearing hospital clothes or will they be encouraged to bring their own clothes?
- If they are to bring their own clothes, what kind of clothing will mothers be advised to bring?

➜ What else should a mother be requested to bring along to the KMC ward (eg own towels and bedding)?

➜ Should we make special catering arrangements for KMC mothers?
Yes / No
- If "Yes":
  - What?
  - How will we establish that?

➜ What measures will be taken to ensure continuous good interpersonal relations between mothers and nursing staff?

➜ What are our views on the well-being of mothers and how will we deal with issues concerning their own health?

➜ How are we going to identify the health needs and problems of mother and baby within the family context and how are we going to deal with them?

➜ How can we ensure that we have good relations with the mothers' families and significant others?

➜ How are we going to deal with language and cultural differences?

➜ How will we explain the concept of KMC to mothers for whom the linking of an animal phenomenon with human beings is not appropriate?

➜ How are we going to look after the psychological well-being of the mothers?

➜ How are we going to look after the spiritual well-being of the mothers?

➜ What kind of support should there be for mothers?
- Cultural?
- Religious and spiritual?
- For psychological problems?
- For social, economic and family problems?

➜ Should we pay special attention to teenage mothers? *Yes / No*
- If "Yes":
  - What should we do?
  - How should we do it?
  - Who should be responsible for what?

➜ Should we pay special attention to mothers with unwanted pregnancies? *Yes / No*
- If "Yes":
  - What should we do?
  - How should we do it?
  - Who should be responsible for what?

➜ What nursing and supervision arrangements will be in place when a mother is very uncooperative or behaves irresponsibly?

➜ Additional questions and issues:

6.2.4 How will the social and recreational life of the ward be organised?

➜ Which non-staff members and volunteers will help with social activities and recreation?

➜ How will nurses assist mothers with social activities and recreation and how will other staff members be involved?

➜ Is there an area outside the ward which could be used as a recreational area?
- If "Yes":
  - For what purposes (eg walking, relaxation, vegetable garden)?
  - What should be done to create some privacy for mothers there?
  - What additional security measures should be put in place?

➜ What kind of activities should we organise?
- Making reading material available (magazines, books, newspapers)?
- Handcraft (needlework, knitting, etc)?
- Television and videos?
- Music therapy?
- Exercises?
- Other?

➜ What will the visiting policies be?
- Who will be allowed to visit?
- Where will visitors be received?
- What rules will there be for visitors?
- What will the visiting hours be?

➜ Will mothers be allowed to take a day or a weekend out (while nursing staff care for the baby in the KMC ward)? *Yes / No*
- If "Yes":
  - What will the conditions and "rules" be?
  - What do we do if a mother does not return?

- If "No":
  - How will mothers be counselled and cared for when they feel a need to visit home?

➜ May a mother take her baby (in the kangaroo position) out of the ward inside the hospital premises? *Yes / No*

- If "Yes":
  - For what reasons?
    - For medical reasons only?
    - To make telephone calls?
    - To visit the kiosk/cafeteria?
    - Other?
  - What kind of supervision will be in place (eg who must know about it)?

➜ May a mother take her baby (in the kangaroo position) outside the hospital premises before discharge? *Yes / No*

- If "Yes":
  - For what reasons?
  - What kind of supervision will be in place (eg who will accompany the mother)?

➜ Additional questions and issues:

6.2.5 What other organisational and control matters should we attend to and what guidelines should we develop?

(See also Part 4, pp 35-58.)

6.2.5.1 What administrative system should be in place?

(See also section 4.2.4, p 49.)

➜ What new forms should be devised to
- monitor the progress of the babies?
- record the nursing processes?

➜ Who will take responsibility for drafting each of the forms?

➜ Do we need an additional filing system for the ward? *Yes / No*
- If "Yes":
  - What form should it take?
  - What do we need to do to get it in place?
  - Who will be responsible for what?
- If "No":
  - Are adaptations of the existing hospital filing system necessary?
  - How easy will it be to retrieve files from administration (eg for audit purposes)?
  - How will we record KMC babies in the ward and/or admissions register?

➜ How should we keep a record of the history of the KMC ward (eg press clippings, research reports, etc)?

➜ Additional questions and issues:

FIGURE 8: EXAMPLE OF ENTRIES IN A DAILY WEIGHT REGISTER

WARD REGISTER, FEBRUARY 2002																
Name	**Birth weight & date**	**01/02**	**02/02**	**03/02**	**04/02**	**05/02**	**06/02**	**07/02**	**08/02**	**09/02**	**10/02**	**11/02**	**12/02**	**13/02**	**14/02**	**15/02**

Mpho Mokoena	1590 (20/1)	1620 KMC	1650 KMC	1675 KMC	1680 KMC	1700 KMC	1725 KMC	1740 KMC	1760 KMC	1780 Disch.						
Shareen Naidoo	1565 (26/1)	1500 KMC	1510 KMC	1505 KMC	1515 KMC	1520 KMC	1535 KMC	1555 KMC	1580 KMC	1580 KMC	1610 KMC		1670 KMC	1705 Disch.		
Sibongile Zulu	1645 (2/2)			1620 KMC	1610 KMC	1600 KMC	1585 KMC	1575 KMC	1550 KMC	1555 KMC	1560 KMC	1570 KMC	1590 KMC	1600 KMC	1630 KMC	1660 KMC

Patience Mahlangu	1435 (3/2)				1420	1410	1390 IntKMC	IntKMC	1395 IntKMC	IntKMC	1430 KMC	KMC	1450 KMC	1470 KMC		1510 KMC
Jan du Toit	1825 (8/2)									1815 KMC	1805 Disch.					
Nkosi Dlamini	1695 (11/2)												1655 IntKMC	1635 IntKMC	1635 IntKMC	1640 KMC

Thandi Mda	1420 (12/2)													Not weighed	Referred	
Nevu Makhado	1732 (13/2)														1720 KMC	1715 KMC
Natasha April	1760 (14/2)															1750 (KMC)

6.2.5.2 How should ward meetings be conducted?

➜ How often?

➜ Who should attend?

➜ What time would be most convenient?

➜ Who should lead the meetings?

➜ How will the meetings be minuted?

➜ What items should be permanently on the agenda?

➜ How can we ensure that decisions are executed?

➜ How can we use the meetings to promote the sharing of information among staff members?

6.2.5.3 How will stock and property be kept, controlled and secured?

➜ What additional items will be needed and how much/many?

- Consumables (eg nappies, toilet paper, disinfectant, etc)?
- Once-off expenditures (eg extra towels, etc)?

➜ Who will be in charge of stocks?

➜ What will the procedures be when one staff shift hands over to the next?

➜ What other security measures need to be put in place?

➜ Additional questions and issues:

6.2.5.4 How could we make the ward as homely as possible?

➜ What kind of decorations will we use?
- Plants?
- Posters?
- Pictures?
- Other?

➜ How will we communicate information about the ward?
- Bulletin board?
- Other?

➜ How can the daily activities be organised to create a homely atmosphere?

➜ How will we encourage mothers to wear their own clothes and not to wear nighties during the day?

➜ Additional questions and issues:

6.3 EDUCATIONAL MATERIALS AND ACTIVITIES

➜ What educational materials do we need and on which topics?
- Informational posters?
- Brochures and handouts?
- Videos?
- Slides?
- Other?

➜ What kind of educational materials are available?
- At no cost?

- If at a cost, where will the funds come from?

➜ What educational materials should we develop ourselves?
- What are the priorities?
- What will the cost be?
- How are we going to do it?
- Who will do what?

➜ How will we ensure cultural sensitivity in the materials we acquire or develop?

➜ How will we ensure that mothers do not get confusing or mixed messages?

➜ What educational activities will be conducted on a regular basis (eg talks)?
- Which topics should we include?
- What should the content of each topic be?
- How will it be done?
- When?
- How often?
- Who will be responsible for what?

➜ How can we use special health days and weeks in our educational activities?

➜ What educational equipment is needed?
- What is essential?
- What can we make ourselves?

➜ What kind of additional training is needed to help staff in preparing talks and other educational activities?

➜ How can we use mothers as active participants in our educational activities?
- Role plays?
- Songs?
- Poems?
- Art?
- Other?

➜ How will the educational activities be evaluated?
➜ How will staff strive to constantly improve the quality of their teaching and education?

➜ Additional questions and issues:

6.4 MONITORING QUALITY

(Use in conjunction with diagrams 4 and 5 in sections 2.4 and 2.5, pp 25-29 and the questions in section 4.3.2, pp 55-56.)

This section pertains to the question of *how well* the KMC ward is functioning and how well the nursing process is being carried out.

6.4.1 How should we monitor the functioning of the ward?

➜ How will the quality be evaluated and recorded?

➜ What measures should be in place to maintain quality of care over time?

➜ How much flexibility can we build into the organisation and functioning of the KMC ward?

➜ What are the potential communication and relationship problems with other departments or wards?
- How will these affect our work?
- How can we avoid some of the problems?

➜ How can we ensure that the effective functioning of a KMC ward does not depend solely on certain (committed) individuals, but on a collective spirit of working towards a common goal and common vision?

➜ How will team work be promoted?

➜ How could staff members support each other?

➜ How can staff motivation be sustained?

➜ How will the nursing team be supported psychologically in cases of trauma or critical incidents (eg an unavoidable or unexpected death)?

➜ How will patients' rights be protected?

➜ How effective is our KMC nursing plan?
(See section 6.4.2, p 93 for details.)

➜ What other kind of research or evaluation will we conduct?
- On a regular basis?
- On an ad hoc basis?

➜ Additional questions and issues:

6.4.2 How should we monitor the nursing process?

Because KMC is primarily a nursing intervention, the nursing staff also need to sit down separately to plan the nursing process and put mechanisms in place to ensure quality of care. Some of the issues have already been dealt with in other sections, but the following are some other prominent issues in the nursing process which may need attention:

➜ What model of nursing care will be used in the ward?
- Holistic care?
- Task-oriented care?
- Other?

➜ What nursing care system will be used?
- Functional nursing?
- Team nursing?
- Primary nursing?
- Other?

➜ What factors may influence the delegation of nursing care in KMC?

➜ How will the following aspects of the nursing process be dealt with and evaluated:
- Assessment of patients?
- Planning of interventions?
- Execution of interventions?
- Evaluation of outcomes?

➜ How are we going to maintain a therapeutic clinical environment?

➜ What are the potential risks in a KMC ward and how will they be managed?
- Methods?
- Resources?
- Interventions?

➜ How will legal and ethical issues of nursing be dealt with?

➜ How will other disciplinary and governance issues be dealt with?

➜ Additional questions and issues:

PART 7
LOOKING AFTER KMC BABIES AFTER DISCHARGE

(See also section 6.1.4.3, pp 76-77.)

7.1 WHAT DISCHARGE AND FOLLOW-UP ROUTES WILL WE FOLLOW?

➜ Do we need to liaise at a district or regional level regarding our discharge policies?

➜ Will some babies be discharged to another low-care facility? *Yes / No*

- If "Yes":
  - Where to?
  - What will the discharge criteria be?
    (See also section 6.1.4.3, pp 76-77.)
- If "No":
  - What will the criteria be for discharging a baby straight home?
    (See also section 6.1.4.3, pp 76-77.)

➜ If a baby is sent home, will our facility follow up the KMC babies immediately after discharge? *Yes/ No*

- If "Yes":
  - Consult the questions in section 6.1.4.3 (pp 76-77).
- If "No":
  - Where will they be followed up?
  - What kind of communication will we have with these facilities (eg MOUs and clinics)?
  - What documentation will we give the mother to take along to the hospital or clinic that will do the follow-up?
  - How will we ensure regular and effective communication with these facilities?

➜ Additional questions and issues:

7.2 WHAT KIND OF SUPPORT DOES THE MOTHER HAVE AT HOME?

➜ What is our responsibility to ensure that a mother has adequate support at home?

➜ What can we do to ensure that mothers continue with continuous KMC at home?

➜ How can we use existing systems (eg voluntary community workers) to support mothers at home?

➜ How will we minimise the effects of confusing or mixed messages mothers might get once they have left our health care facility?

➜ Additional questions and issues:

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HANDOUTS FOR WORKSHOPS

☐ Plan of action

☐ SWOT analysis

☐ Prioritising actions

☐ Equipment, furniture and household items to be collected over time

☐ Diagram 1: Main issues in the establishment of KMC

☐ Diagram 2: Roleplayers in KMC

☐ Diagram 3: Institutional implementation models of KMC

☐ Diagram 4: Continuous self-improvement and self-evaluation

☐ Diagram 5: Quality goals related to the benefits of KMC

Make one copy for each participant.

It may be useful to make transparencies if you prefer to use an overhead projector instead of flipcharts or a blackboard.

PLAN OF ACTION

Action (key word)	What needs to be done?	Responsible person(s)	Deadline for action / Date for report back	Remarks

SWOT ANALYSIS

S TRENGTHS How are we going to use these strengths in the implementation of KMC?	W EAKNESSES How are we going to try to improve on or avoid these weaknesses in the implementation of KMC?
O PPORTUNITIES	T HREATS

PRIORITISING ACTIONS

Action	Must do immediately (within 2 weeks)	Must do within 1 month	Should be completed within 3 months	Things to do later

EQUIPMENT, FURNITURE AND HOUSEHOLD ITEMS TO BE COLLECTED OVER TIME

Item	Priority	Essential	Good to have	Nice to have	Remarks (justification for choice)	How would we obtain the item?	Who could help in making this item?
For intermittent KMC (eg intensive and high care units)							
Comfortable chair next to each incubator (a reclining chair is a bonus)							
Extra chairs for other visitors							
Refrigeration for EBM							
Wrapping for KMC (eg towels or sheets, wrap around blouses or boob tubes)							
Reading material							
For continuous KMC (eg in a separate ward)							
Technical equipment							
Suction unit							
Oxygen (head box or nasal prongs)							
Resuscitation equipment							
Pulse oxymeter							
IVAC							

Item	Priority	Essential	Good to have	Nice to have	Remarks (justification for choice)	How would we obtain the item?	Who could help in making this item?
Feeding tubes							
Scale							
Emergency equipment							
Breast pumps							
Refrigeration for EBM and other items							
Low beds / Divans							
Mattresses							
Wrapping for KMC (eg towels or sheets, wrap around blouses or boob tubes)							
Dining tables and chairs							
Extra comfortable chairs							
Lockers (ideal = one for each mothers)							
Laundry facilities (eg washing machine and tumble drier)							
Curtains							
Attractive bedspreads and blankets							
Extra towels, sheets and pillowcases							
Mobile screens for privacy							
TV							

Item	Priority	Essential	Good to have	Nice to have	Remarks (justification for choice)	How would we obtain the item?	Who could help in making this item?
Video recorder (can also be used for educational purposes)							
Cups, plates, etc							
Kettle							
Microwave oven							
Stove (two plate or bigger?)							
Toaster							
Reading material							
Posters and other wall decorations							
Educational equipment							

EBM = expressed breast milk