Family Participatory Care
Implementation Model Development

PROCESS DOCUMENT
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD</td>
<td>Aspirational District</td>
</tr>
<tr>
<td>CH</td>
<td>Child Health</td>
</tr>
<tr>
<td>DH</td>
<td>District Hospital</td>
</tr>
<tr>
<td>DHH</td>
<td>District Health Hospital</td>
</tr>
<tr>
<td>DSC</td>
<td>Developmentally Supportive Care</td>
</tr>
<tr>
<td>DTO</td>
<td>District Technical Officer</td>
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<tr>
<td>FBNC</td>
<td>Facility Based Newborn Care</td>
</tr>
<tr>
<td>FCC</td>
<td>Family Centered Care</td>
</tr>
<tr>
<td>FPC</td>
<td>Family Participatory Care</td>
</tr>
<tr>
<td>GOI</td>
<td>Government Of India</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resource</td>
</tr>
<tr>
<td>ICT</td>
<td>Information And Communication Technology</td>
</tr>
<tr>
<td>KMC</td>
<td>Kangaroo Mother Care</td>
</tr>
<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>NHM</td>
<td>National Health Mission</td>
</tr>
<tr>
<td>QED</td>
<td>Quality, Equity And Dignity</td>
</tr>
<tr>
<td>RIMS</td>
<td>Rajendra Institute of Medical Sciences</td>
</tr>
<tr>
<td>RMNCH+A</td>
<td>Reproductive, Maternal, Newborn, Child Health And Adolescent</td>
</tr>
<tr>
<td>SDH</td>
<td>Sub-District Hospital</td>
</tr>
<tr>
<td>SNCU</td>
<td>Special Newborn Care Units</td>
</tr>
<tr>
<td>TOT</td>
<td>Training Of Trainer</td>
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<tr>
<td>USAID</td>
<td>United States Agency For International Development</td>
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</table>
Executive Summary

In India around 361,600 children under five die due to direct preterm complications and around 3,341,000 babies are born too soon each year. India has established more than 600 facilities especially for new born care and has initiated home based new born care. In spite of these initiatives, 10% Newborns die in facilities and the same number die even after discharge. The various national health surveys have shown that coverage of evidence based interventions—Kangaroo Mother Care (KMC), Exclusive Breast Feeding (EBF), complementary feeding, hand washing and ORS use rates in addition to full immunization rates have stagnated in India for the last 20 years. Lancet Series on child development 2007 reports that less than 40% mothers interact sufficiently with their babies. An assessment of 13 District Hospitals across 4 states conducted by Ministry of Health & Family Welfare (MoHFW) highlighted poor breast feeding & Kangaroo Mother Care for low birth weight amongst mothers of babies admitted in the facilities. Further a Rapid Survey of Children report highlights that counselling of mother and families is provided to only 13 percent of newborn born at home. These facts highlight the need that behavior of mothers/families need to be improved in India through close engagement with the newborn, in addition to expanding its current initiatives.

Family Participatory Care (FPC) is a program launched by the Government of India in 2017 based on 3 guiding principles: Quality Equity and Dignity (QED) to improve the skills of caregiver for neonatal care after discharge. Mother, parents or family members (Caregivers) are trained and involved in decision making for neonatal care and survival.

Vriddhi Project in selected states and under support to Aspirational District programs has piloted FPC in 30 SNCUs established in district hospitals in the state of Jharkhand, Uttarakhand, Punjab, Haryana, Chhattisgarh and Himachal Pradesh. National Health Mission has provided the operational guidelines for budgeting, HR placement and capacity building on their website. A sensitization meeting was done for the senior officials of NHM and SNCU in-charge for concept of involving mothers in neonatal care in SNCU. Vriddhi project provided technical support to the states for gap finding & closure, capacity building and hand holding in implementation and documentation. The states were quick to adopt FPC in targeted SNCUs and requested to scale up FPC to other SNCUs within one year of implementation. In the Vriddhi intervention states FPC was scaled up to all the SNCUs of the states. The monthly report collection, analysis and feedback mechanisms have also been institutionalized in the states.

In Haryana & Jhakhand, state NHM with Vriddhi’s support implemented FPC in few NBSUs as pilot.

References:
1. India Profile of Preterm And Low Birth Weight Prevention And Care, USAID, PCI, GAPP, American College of Nurse-Midwives, 2015
2. Two Years Progress Report of SNCUs in India, Child Health Division, Ministry of Health and Family Welfare, Government of India, April 2018
6. Assessment of Quality of Care for Children in District Hospitals in India, 2014, (www.nipi.org.in)
Background

The National Health Mission (NHM) in India provides unprecedented focus and resources to newborn care under RMNCH+A strategy. In the last decade, India has established Special Newborn Care Units (SNCU) in more than 800 facilities across the country. These facilities are primarily established at District Hospitals (DHS), Medical Colleges and also at few Sub-District Hospitals (SDHs) where the delivery load is very high. Gradually, it was observed that the small and sick newborns which were saved in SNCUs were eventually lost to follow up after discharge. It was also observed that morbidity and mortality remained high in the community. It was then that Family Centered Care was felt to be essential. The model was adopted in India as the Family Participatory Care (FPC). It empowers parents with knowledge and do-able essential newborn skills needed for child’s survival, development and growth. Mother being the primary caregiver becomes the focal receiver of new learnings. At the FPC sessions, the anxiety and frustration that parents experience due to separation from their sick baby can also be addressed. Initially, FPC was piloted in select SNCUs in 2014 and based on this experience, Government of India (GoI) formulated operational guidelines with partners (Including USAID) support. These were released in 2017 and it was launched as a national program. The FPC is based on three guiding principles; Quality, Equity and Dignity (QED).

Staff nurses in SNCUs facilitate an FPC video session followed by demonstration of practices like hand-washing, importance of infection prevention, protocol for entry to nursery, Developmentally Supportive Care (DSC), breastfeeding, Kangaroo Mother Care (KMC) and recognizing danger signs. FPC empowers mothers and caregiver with knowledge and skills through audio-visual aids. Under this program, the parents are allowed inside the SNCU after capacity building to touch their sick/small baby and witness the care provided to their baby by Doctors and Nurses inside the SNCU. This helps in building trust and improves the relationship between community and health system. Under the FPC program, the mother also practice learned skills in the presence of medical staff initially, which makes her confident to practice the same at home after the discharge of her baby. It increases the chance of newborn survival during treatment and after discharge.

USAID Vriddhi project supported the GoI’s initiative by including FPC as part of ‘nurturing support’ to mothers of small and sick newborns in Aspirational District (ADs). Several states which wanted to start FPC in their SNCU sought operational and hand holding support from USAID Vriddhi. Since the team members had experience of implementing FPC in other states like Odisha, Madhya Pradesh, Bihar and Rajasthan, Vriddhi team provided all technical support while the states used their NHM budget to meet the operational training costs. These 6 states, namely (Jharkhand, Uttarakhand, Chhattisgarh, Haryana, Punjab and Himachal Pradesh) have 35 ADs out of which 30 districts have SNCU. 5 districts of Jharkhand are in the process of establishing SNCU in their District Health Hospital (DHH).
FPC Implementation

Implementation of FPC can be divided into three categories:
• Pre-implementation phase – Advocacy and planning
• Implementation phase – Capacity building and initial follow up
• Post-implementation phase – Reporting started on sessions conducted

PRE-IMPLEMENTATION ACTIVITY: OPERATIONALIZATION OF FPC

The objective of this work was to have understanding of the approach and availability of necessary logistics. Following activities were conducted during pre-implementation phase:
• Advocacy at state and district level highlighting FPC approach and its advantages
• Development and design of IEC & related documents
• Conducting gap assessments and ensuring HR, logistics, audio-visuals and furniture availability in FPCs.

ADVOCACY

At first, state and district level health officials were oriented on FPC intervention. Evidences and experiences from other states like Odisha, Bihar, Madhya Pradesh and Rajasthan were also shared. The states were supported in budgeting and proposal preparation for including FPC in their PIPs (Program Implementation Plan). The PIPs were approved and most states got approval for including FPC in all their SNCUs.

Initially the district facilities were not aware about the program or budgetary provisions of FPC. With Vriddhi facilitation, they obtained the operational guidelines from State NHM. Additionally, most of the districts did not have audio-visual equipment, KMC chairs and many of them did not have any identified space for KMC room or mother room for organizing video sessions.

Gap assessment revealed infrastructural and knowledge gaps. Several health providers believed that KMC and allowing some mothers to breastfeed is all that is needed under FPC. They were not very conversant with ‘Developmentally Supportive Care’ and creating favorable ambience and maternal need components of the program. Vriddhi team provided specifications as per national operational manual for getting all logistics in place. Simultaneously, advocacy at district level was done to ensure adequate infrastructure at SNCU to conduct FPC video sessions and address needs of mothers while inside the unit. To facilitate this, Vriddhi team prepared a comprehensive list of commodities essential for FPC implementation (Refer Annexure 1). Space and infrastructure was a common challenge. In order to address this, infrastructural enhancement was planned while simultaneously

Training session conducted in Hisar district, Haryana
reorganizing work flow to enable conducting of sessions.

The support provided to Himachal Pradesh was slightly different. The state already had KMC units but the staff were not trained in FPC and they required support for facilitation skills for FPC sessions. Therefore upon request by the state, Vriddhi team provided training to staff of all the SNCUs of the state.

**DESIGNING IEC AND REGISTERS**

In addition, Vriddhi team provided support to the states to develop IEC materials in local language for display at facilities. Registers, record formats for duty roaster KMC duration registers were also developed jointly. States printed and provided the following stationeries to their respective facilities.

**LOGISTICS AND HR FACILITATION**

State NHMs were guided to instruct districts with procurement guidelines as per GoI operational guidelines. DTOs (District Technical Officers) at the districts also facilitated in procurement process as per specifications. Staff nurses were identified to be trained on FPC and to implement it from the month of April 2019. Punjab Haryana, Himachal Pradesh completed this process by the first week of April 2019. Jharkhand completed by the end of May 2019 and Chhattisgarh process was completed by July 2019.

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**Table 1. IEC Materials designed for beneficiaries**

<table>
<thead>
<tr>
<th>POSTERS FOR MOTHERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• FPC Concept Poster</td>
</tr>
<tr>
<td>• Breastfeeding Poster</td>
</tr>
<tr>
<td>• KMC Poster</td>
</tr>
<tr>
<td>• Counseling Before Discharge</td>
</tr>
<tr>
<td>• Infection Preventions Poster</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BROCHURES FOR STATE, DISTRICT &amp; FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• FPC advocacy — Brochure</td>
</tr>
</tbody>
</table>

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![Image of IEC materials design](image-url)
### RAPID ASSESSMENT AND GAP FILLING SUPPORT

Table 2. State wise details of gaps identified and addressed

<table>
<thead>
<tr>
<th>STATES</th>
<th>GAPS IDENTIFIED</th>
<th>GAPS ADDRESSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jharkhand (14 SNCUs)</td>
<td>Inadequate space for KMC</td>
<td>Civil work done by state/district facilitated by Vriddhi team in 10 SNCUs from hospital management funds</td>
</tr>
<tr>
<td></td>
<td>Non availability of audio-visual equipment</td>
<td>Procurements facilitated in 11 facilities through NHM PIP</td>
</tr>
<tr>
<td></td>
<td>Non availability of KMC chairs, FPC related consumables and furniture</td>
<td>Procurement facilitated in 13 SNCUs as per operational guidelines of GOI</td>
</tr>
<tr>
<td></td>
<td>Shortage of staff nurses</td>
<td>Advocacy by Vriddhi led to HR procurement in 3 of SNCUs</td>
</tr>
<tr>
<td></td>
<td>Non availability of recording and reporting formats in SNCUs</td>
<td>Vriddhi team supported development of necessary tools as per GOI FPC Guidelines in 14 SNCUs</td>
</tr>
<tr>
<td>Chhattisgarh (10 ADs)</td>
<td>Space constraints in SNCU (Particular to Kanker, Korba, Narayanpur)</td>
<td>Restructuring and relocation done with technical support from Vriddhi team</td>
</tr>
<tr>
<td></td>
<td>Budget provision for FPC training was not available in PIP</td>
<td>Vriddhi coordinated with MD and Nodal person to re-appropriate the budget available</td>
</tr>
<tr>
<td></td>
<td>Inadequate SNCU infrastructure in 3 SNCUs (Kondagaon, Bilaspur, Rajnandgaon)</td>
<td>Vriddhi team provided support in defining SNCU layout and provision of KMC rooms through advocacy with state and district authorities</td>
</tr>
<tr>
<td></td>
<td>Shortage of essential items and resources for FPC (KMC chair, Audio-visual, Apron, Hand Sanitizers, Lockers etc.)</td>
<td>Procurement facilitated in 10 SNCUs as per operational guidelines of GoI</td>
</tr>
<tr>
<td></td>
<td>No dedicated SN in-charge in 2 of SNCUs (Mahasamund and Narayanpur)</td>
<td>Leverage the support from Civil Surgeons and Hospital Managers to identify a full time SN in-charge at both the SNCUs</td>
</tr>
<tr>
<td></td>
<td>Recording, reporting and documentation was not in place in the state</td>
<td>Registers and formats were printed with support from Vriddhi and made available to all the SNCUs for reporting on KMC and FPC</td>
</tr>
<tr>
<td>HP (1 AD)</td>
<td>Audio-visual equipment not available</td>
<td>Procurements were done with support from Vriddhi team</td>
</tr>
<tr>
<td></td>
<td>Reporting and documentation was not in place in the state</td>
<td>Registers, formats and training on filling up of formats was done</td>
</tr>
<tr>
<td>Haryana (1 ADs)</td>
<td>Locker, slippers, consumables funds not available</td>
<td>Provisions were made through PIP funds and Vriddhi team facilitated support at state and at district</td>
</tr>
<tr>
<td>Punjab (2 AD)</td>
<td>Audio-visual equipment (LED), non-availability of KMC chairs and room temperature maintenance in KMC room in SNCU of district Ferozepur and Moga</td>
<td>Vriddhi facilitated procurement by doing advocacy from hospital funds under PIP.</td>
</tr>
<tr>
<td></td>
<td>Space Constraint: proper space &amp; room were not available for FPC sessions Moga and Ferozepur</td>
<td>Civil work done by district hospital. Technical support by Vriddhi team based on GoI operational guideline done</td>
</tr>
<tr>
<td>Uttarackhand (2 ADs)</td>
<td>Space constrain in DH Rudrapur</td>
<td>Civil work done and restructuring done through advocacy with hospital administration by Vriddhi team</td>
</tr>
<tr>
<td></td>
<td>Audio-visual equipment not available in Rudrapur and Haridwar</td>
<td>Procured and installed from district funds through facilitation by Vriddhi team</td>
</tr>
<tr>
<td></td>
<td>HR shortage in Rudrapur</td>
<td>Process has been initiated</td>
</tr>
</tbody>
</table>
Implementation Phase

This phase was actively supported by USAID Vriddhi from April 2019 to August 2019. Haryana and Punjab were quick to implement FPC in April and started reporting on session plans from May 2019. Himachal Pradesh implemented in May 2019, Jharkhand and Uttarakhand in June 2019 whereas Chhattisgarh implemented FPC by 2nd week of August. These states started reporting on session plans from July 2019 onwards, since Chhattisgarh started reporting from its facilities since September, 2019. Some of the facilities of Chhattisgarh and Jharkhand started reporting from October due to delay in district trainings.

CAPACITY BUILDING ACTIVITIES

The nodal officer in Child Health Division of the states were briefed in detail about the training preparation and the master trainers were identified. Training calendars were prepared, training venues and methodology were finalized. All the logistics related to skill stations were shared with the states so that the trainings are conducted smoothly. A detail checklist was also prepared to ensure that all preparations are done in time. Vriddhi team members facilitated formulation of a training plan for the states in cascade method. Master trainers were selected from faculty of medical colleges and state NHM. The initial training was provided by Vriddhi national team members and faculties from RML Medical College, New Delhi. The swift and efficient conduct of training was facilitated by:

- Availability of technical and operational guidelines from GoI
- Availability of budgetary provisions in NHM PIP
- Availability of technical resource persons in Vriddhi project at national and state level with experience of FPC implementation in different states of India.
- Availability of Vriddhi team consultants in aspirational districts of 6 states for hand holding support.

TRAINING METHODOLOGY

The training package contained interactive sessions using powerpoint, skill station using mannequins, visit to SNCU, clinical demonstrations and videos. A copy of training package was provided to each participant during the training program. There were 4 video sessions displayed during ToTs. These videos were meant to be shared with the mothers with detail facilitation through role play. The facilitation skills were demonstrated and role plays were arranged during the two days ToTs.

Table 3. Training content of FPC video sessions

<table>
<thead>
<tr>
<th>SESSION</th>
<th>THEME</th>
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</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>Sensitization to FCC and entry into nursery</td>
</tr>
<tr>
<td>Session 2</td>
<td>Developmentally supportive care and feeding</td>
</tr>
<tr>
<td>Session 3</td>
<td>Kangaroo Mother Care</td>
</tr>
<tr>
<td>Session 4</td>
<td>Preparation for discharge and care of the baby at home</td>
</tr>
</tbody>
</table>
STATE LEVEL TRAINING OF TRAINERS (ToTs)

The training duration was for two days and Vriddhi team provided technical support for conducting the same.

Participants
• All SNCUs of the state with due priority given to Aspirational Districts.
• One Medical Officer (MO)/specialist and two staff nurses from each SNCU of the state.

Facilitators
• Technical sessions were facilitated by national and state teams from Vriddhi projects
• Operational sessions were jointly facilitated by state health officials and Vriddhi state teams.

District Level Trainings
State level ToTs were followed by district level trainings. Vriddhi team supported FPC training in all the ADs. While in non-ADs, the states facilitated FPC trainings independently reflecting ownership of the government to implement FPC.

Participants: Medical officers/specialists and all staff nurses of SNCU other than those who participated in state ToTs.

Facilitators: Participants of state ToTs (Medical officer/specialists and staff nurses) and state and district level team of Vriddhi project.

All the district level trainings were completed within 2 weeks of state ToT. In Punjab, Haryana and Himachal Pradesh, the training completed by 2nd week of April. Jharkhand and Uttarakhand trainings were finished by 2nd week of June. Chhattisgarh trainings were completed by first week of September.

Table 4. Family Participatory Care State Level Training Summary Data

<table>
<thead>
<tr>
<th>STATE</th>
<th>Admin Post</th>
<th>Counselor</th>
<th>DAM</th>
<th>DDCH</th>
<th>DDMH</th>
<th>Dietician</th>
<th>Doctor</th>
<th>DPM</th>
<th>Nurse</th>
<th>Nutrition Counselor</th>
<th>Others</th>
<th>Grand Total</th>
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<tr>
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<td>0</td>
<td>0</td>
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<td>116</td>
<td>2</td>
<td>178</td>
<td>8</td>
<td>4</td>
<td>312</td>
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</table>
IMPLEMENTATION OF FPC
Implementation of FPC consisted of following activities-

Hand-holding Support
After FPC trainings its implementation started in SNCUs and to support the efforts of SNCU teams Vridhhi team conducted mentoring visits. The visiting team observed SNCU staff while conducting FPC sessions and provided need based support in terms of knowledge and skills. During mentoring visits documentation of FPC practices (Recording and reporting registers) were also reviewed which was followed by necessary suggestions for improvement.

Creation of Whatsapp Group
Project also facilitated creation of state level whatsapp groups, representatives (Specialists, MOs and Staff Nurses) of all SNCUs and selected NBSUs (Newborn Stabilization Unit) were added. Following activities were being executed in these groups on routine basis:
- Facilities were encouraged to share pictures of FPC implementation from their SNCU/NBSU.
- Sharing of technical document and answering technical questions.
- Follow up for monthly reporting.

Mothers capacity building session plan development
Planning of FPC sessions is primarily dependent on the ’need’ of available parents. Based on our experience of FPC implementation in 6 states and 30 SNCUs for more than a year, key lessons can be summarized as below:
- Sessions should be pre-planned and pre-informed. The session site should be prepared with adequate number of chairs and training resources (Audio, video equipment and mannequins)
- Each session should start with an introduction and rapport building followed by screening of the AV relevant to that session. The screening should be paused at the prescribed points, (which are marked as red indicators and serially numbered), to conduct discussions and convey key messages.
- Participation of parents should be ’voluntary’; hence no parent should be forced to participate in FPC sessions. Efforts should be made to involve parents of every newborn.
- Service providers should not discourage parents from attending FPC sessions.
- Facilitators should be able to identify the individual needs of parents. She/he may give more time to a needy parent, as FPC is based on Quality, Equity and Dignity approach.
- Even with only one admission in SNCU, FPC sessions should be conducted.
- Session 1(Sensitization to FPC and entry to nursery) should be conducted for parents of all admitted newborn before their entry in SNCU.
- Session 4 (Preparation for discharge and care of baby at home) should be done for all parents before discharge of baby.
• FPC video session 2 (Developmentally Supportive Care) and 3 (Kangaroo Mother Care) should be conducted for all eligible parents (based on the need of the newborn).

• Facilities are advised not to conduct more than 2 FPC video sessions per day unless exceptional situation requires. For instance, an SNCU decides to conduct; Session 1 (Infection prevention) and Session 2 (Developmentally supportive care) on a certain day. However, there is one child scheduled for discharge on the same day and her parent have not attended Session 4 (Preparing for discharge and care of baby at home) yet. In this situation, session 4 should be additionally conducted for the parents of this discharging newborn.

• Some parent(s) may want to attend more than 2 sessions a day or repeat a session. They should be encouraged, but first-time attending parents and those with need or schedule should be given priority.

• Since it is difficult to estimate FPC sessions in advance it may be better to plan the sessions on a daily basis. This will ensure adequate utilization of resources and need based planning of FPC sessions. The usual planning of FPC sessions are first and second session in morning and third–fourth session in the afternoon.

Documentation of FPC Practices
Recording and reporting registers were distributed and explained during FPC trainings. These formats captures process and output of FPC implementation related to babies, parents, service providers and FPC program itself as mentioned below;

Babies: Line listing, birth weight, date and time of admission, outcome and date of discharge from health facility,

Parents: Details of FPC video session attended (Type and number of sessions) by parents of each newborn

Service Provider: Name of SNCU staff who is supposed to conduct FPC session on given date and status of sessions held (Yes/No)

Program
• Session planning
• Admission and discharge of babies
• Admission and discharge of LBW (Low Birth Weight) babies (Less than 2 KG specifically)
• Attendance of parents in FPC video sessions
• Attendance of parents of LBW (Less than 2 KG specifically) babies in KMC sessions

IEC Material
Following tools are being used in implementation of FPC at facility level, details of some of these tools are given in Annexures;
• Operational Guidelines and Training Modules for facilitators and participants
• Posters; Total of 6 posters (Annexure 1)
• Brochure; Only 1(Annexure 2)
• FPC Videos; Total of 4 videos (Session handouts – Annexure 3)
• Documentation: Registers and reporting format; Total 2

Monitoring and Evaluation
At the end of each reporting month, designated staff nurses in SNCU collect data from FPC registers and prepare the monthly report. These monthly reports are shared with the unit in charge, facility in charge, district and state teams. Preparation of monthly report from FPC registers can be made in 10-12 minutes depending on the number of admissions.

Since SNCU in charge would review monthly report on regular basis, it is advisable to in-
volve SNCU in charge in the FPC implementation process from the beginning.

**Indicators to measure FPC implementation on monthly basis are:**
- Number of FPC sessions planned
- Number of FPC sessions held
- Total number of admissions in SNCU
- Total number of caregivers attended at least one FPC session
- Total number of newborns admitted with birth weight below 2 Kg
- Total number of parents/caregivers (Of babies with birth weight less 2 kg) attended KMC session

The Vriddhi team supports district and state teams in analysis of monthly data and sharing its findings with district and state health officials. Reporting status of facilities is also being tracked on a monthly basis to know how many facilities are actually reporting. During the COVID-19 pandemic Vriddhi team coordinated with states to issue direction to all SNCUs for social distancing during KMC among mothers and practice anti-infection measures to prevent COVID-19. Vriddhi project also developed two video clips on COVID-19 infection prevention practices to be shown during FPC sessions. One video was to be shown on day of admission and second video was made for the day of discharge. This was done in collaboration with Department of Pediatrics, PGI Chandigarh. Dr Praveen Kumar - Head of Department, PGI Pediatrics Department played a major role in the success of this video.

**Results and Outcomes**
Reporting from FPC in SNCUs of ADs started since April 2019 and gradually by September 2019, all 30 SNCUs were reporting on their monthly activities.

Till March 2020 a total of 17,041 admissions were made and 13,132 FPC sessions (out of 15,723 scheduled sessions) were reported. The average number of sessions planned by each SNCU was 55 while about 46 sessions were conducted. This means that SNCUs were able to conduct 84% of the scheduled sessions and 0.77 session held for every admitted newborn. A total of 12,850 caregivers attended 13,132 sessions. It also shows that average number of planned sessions was about 2 which is the preferred number of sessions as mentioned earlier in this document.

This data clearly reflects that session planning is adequate and enough number of sessions are being conducted in SNCUs.
During this period a total of 5,514 babies with birth weight less than 2 Kg were reported while KMC sessions were attended by 5,568 (102%) parents. As KMC is the integral part of FPC, strengthening of FPC in SNCUs will result in almost 100% coverage of parents in KMC video sessions. It is also observed that parents providing KMC in KMC Unit (Newborn not admitted in SNCU) also attended KMC sessions. It reflects that the scope of KMC session is beyond SNCU. Hence to reach more eligible/needy parents KMC video sessions should also be conducted for parents providing KMC in KMC units/postnatal Wards. This is an enormously effective strategy to target those LBW babies who are not admitted in SNCU but are at higher risk of death due to prematurity. Receiving KMC in KMC units/postnatal wards will give these babies an equal chance to survive and thrive.

**Challenges**

**People**
- Shortage of HR, especially staff nurses because in the existing set up staff nurses conduct FPC sessions in SNCU.
- Shortage of NHM consultants at state level makes follow up of FPC difficult.
- Some of the staff nurses feel that it would increase their workload
- Sometimes, parents do not volunteer for FPC because of their perceived fear that it may do harm to their babies or due to their hesitation to enter inside SNCU.
- Family members may not agree to send their daughter in law alone to SNCU.

**Places and Logistics**
- Space constraints in SNCUs and/or in KMC units. As FPC is a relatively new intervention,
it is likely that a place for FPC video sessions was not planned in initial SNCU designs.

- Unavailability/lack of essential things for FPC like; Lockers, grooming kit, mask, soap and sleepers
- Delays in procurement of other resources like lockers for parents
- Printing of recording registers, reported by few states

**Intervention**
- FPC seems to be a very simple intervention hence sometime staff do not recognize its value

**Program Management**
- Non availability of earmarked funds for FPC.
- Data collected for FPC is not part of routine MIS.
- Session planning due to frequent departmental deputation of staff nurses by administration

**Learnings**

**People**
- Acceptance by SNCU staff; all states showed high acceptance of this intervention.
- It resulted in better relationship and trust between medical staff and attendants; in general SNCU staff is happier about this new development.
- Improved communication between parents and medical staff relieves stress/anxiety/fear of parents.
- Less burden on staff nurses as mothers support SNCU staff in care of babies.
- Staff get more time for clinical work.
- Improved hand hygiene practices by parents, specially mothers
- Confidence among mothers is enhanced regarding care of newborn at home after discharge.
- Staff nurses being regularly involved in conducting sessions gets befitted by building their own knowledge on newborn care.

**Places and Logistics**
- With minimal changes, FPC can be organized in SNCUs/KMC units
- Incidence of cross infection is reduced
- With minimal effort, logistics (grooming kits etc.) can be arranged and other equipment (almirah, lockers for mothers, and slippers) can be procured from SNCU operational cost.

**Interventions**
- Availability of standard videos makes orientation of parents very easy for staff nurses in SNCU.
- Implementation of FPC has resulted in increased coverage of KMC services in SNCU, facilities also recording duration of KMC which is a quality indicator.
- Because of its simplicity, SNCU staff believes that it is do-able
- Better outcomes of babies

**Program Management**
- Increased follow up of babies.
Scale up and Sustainability

FPC Videos, Training Guidelines and Operational Guidelines are already approved by the Government of India; hence only funding through PIP is required. Similar to the pre-implementation phase, states were encouraged to make provision for future funding in their PIP which is essential for its sustainability. Follow ups using ICT (Information and Communications Technology) platforms are also being conducted according to the need of SNCUs.

Conclusion and Way Forward

Our experience shows that FPC as a concept is well on its way to becoming an established practice in SNCUs. Introducing family involvement in newborn care has strong evidence of positive outcomes. However, our goal in this implementation was not to focus at outcomes but to initialize and operationalize FPC in facilities in a systematic and structured way. While at national level support was provided for development of operational guidelines including quantum of financial resources and monitoring framework, state level implementation support of working with state governments and scientifically convincing health providers dispelling their apprehensions and capacity building yielded rich dividends. A future role of the SNCUs could be to examine newborn outcomes. Nevertheless, gains accrued from KMC, reduction in incidence of infection, improved hand hygiene of mothers will go a long way in reducing newborn mortality. With regard to operationalization, FPC is a simple and low cost model which is easy to implement. Challenges in logistics can be easily addressed as these do not involve high cost and can easily be replaced or replenished with available funds. In terms of shortage of human resource, it can be addressed by developing FPC nurse cadre. These staff nurses will be transferred to SNCU and NBSU only. They will be responsible for conducting FPC video sessions, supporting parents in providing DSC and in lactation management. The positive experience of SNCU staff and parents that has been observed helps in building trust which ultimately leads to increased access and utilization of public health facilities. Increased follow up of parents is already an indication of the increased trust in healthcare workers. Operationalization of FPC in all the SNCU and NBSU of the country will be a huge step in India’s mandate for improved newborn care. This is possible by integrating FPC as a part of capacity building package of SNCU in the FBNC (Facility Based Newborn Care) module. Funds for infrastructure and mentoring of FPC should be added under operational plan of SNCUs.
Annexures

Annexure 1 - FPC Posters
परिवार केंद्रित नवजात शिशु की देखभाल

नवजात शिशु में स्तनपान की विधि

प्रमुख बातें:

- नन्हे का दूध नवजात शिशु के लिए समस्त स्वाद आदर होता है।
- स्तनपान जन्म के बाद जन्म से तक एक पंडे के अंदर शुरू करना जरूरी है।
- नन्हे का पहला दूध (नूहदूध) निषेच्छा को दो सप्ताह बढ़ाने वाले के लिए लेना उपयुक्त होता है। बच्चे को फूलमा अगर घिराए।
- बच्चे का दूध शुष्क बनने पर बच्चे का दूध दिन में 6 से 8 बार पेंशन करें।
- पूरे समय पर दूध बच्चे के लिए का तृतीय में कम से कम 6 से 8 बार पूरा पिलाते हैं।
- कम बच्चे का दूध पिलाते हैं।
- समय से पहले जन्मे का 3 महीने से कम अपनी नन्हे की साती से दूध पूरी तरह नहीं पी पाते। उन्हें दूध पिलाने की कोशिश करें-समय से दूध पिलाए जाता है।
- बच्चे को नन्हे के सुदूर के अलग 6 महीने तक पूरा और ना में।

स्तनपान के फायदे:

- नन्हे के दूध में बच्चे के लिए सरी सरी लाभ होते हैं।
- इत्यादि से नन्हे का समस्त नूहदूध होता है।
- नन्हे का दूध आवश्यक तथा पूरा होता है।
- नन्हे के दूध की चाहत से रखा जाता है।

स्तनपान करने का सही तरीका

- नन्हे की कमतर
- नन्हे का दूध बच्चे की कमतर लेना।
- नन्हे का दूध बच्चे की कमतर पिलाना।
- स्तन का उपरी काना हिला दीवार। कानों के छोटे हिलते हैं।
- नन्हे का दूध पूरा काना हिलता नन्हे का दूध बच्चे का कान में काली हो जाते हैं।
- नन्हे का पूरा दूध बच्चे के कान में काली हो जाते हैं।
एक नहाना न अपनी समस्या का ध्यान दें।
• भीती, मूसी, शूल, अंधवैज्ञानिक उत्तर दें।
• शर्त की वाक्य को कोहिरी तक खोज लें।
• वीमार अवस्था में नर्सी में न जाएं।
• अपनी लम्बी उपार के नर्सी की बच्चन वाला।
• अपने शर्त को नॉले दिन ने रिकार्ड गई प्रक्रिया के अनुसार करें।

लाथ धोने की प्रक्रिया

1. ड्राइंग बैक के पानी
2. रसोई के पीछे
3. बूटी नमकक संग्रह के साथ
4. धोंगूं
5. संध्या की संख्या
6. बूटी नमकक संग्रह के साथ

नर्सी में राहने के दौरान कब-कब लाथ धोएँ?
• नर्सी में प्रवेश से पहले
• शिशु का क्षय से पहले तथा उसके पश्चात
• रात्रि के पत-पूर्व साफ करने के बाद

गाउन पहनकर नर्सी में प्रवेश
परिवार केन्द्रित नवजात शिशु की वेधभाल

नवजात शिशु की मूल भूत देखभाल संबंधी जानकारी बातें

छूटी होने पर इन बातों का ध्यान रखें

बच्चे से साथ समय विताना
- नया वाढ़ पर जाकर बच्चे के
  साथ समय प्यारी बातें
  करें, उनके साथ खेलें,
  उनसे चर्चा करें,
  इससे बच्चे का
  बनाएय अधिक नौकरी उठा होता है

शिशु में घटने के लक्षण की पहचान
इन लक्षण पर शिशु को तुरंत अस्पताल लेकर
जाएं:
- आंखों व नाकों से गहरा
  आना
- बच्चे ने रात में नींद लेना
  भूल पहनना, दूध के पीना
- बच्चे ने इलाज नहीं लिये
  तेजी से बढ़ते हुए
  बच्चे का
  दर्द बढ़ना

अनुमति कार्यक्रम
- छूटी होने के बाद कार्यक्रम गुलामी से किए
- इस कार्यक्रम में बच्चे की बल्लेबाजी,
  गोले, विकासवाद,
  मदद, लोकतंत्र समलैंगिक समस्याओं की
  समस्या से राहत होती है
- इस कार्यक्रम में छूटी होने के उपरान्त बच्चे को कम से
  कम 2 वर्ष तक अपने दादा को दिखाई दें

टिकाकरण
- जब तक शूल होकर 5 वर्ष तक बच्चे को नियमित
  टिकाकरण करें
- इससे बच्चे की भीषणताओं से पूर्व बच्चा होगा
Annexure 3 - FPC Session Handouts

Session 1

Handout Session 1
Preparation for Entry into Nursery & Handwashing

- Give your introduction and welcome the parents.
- Required Requirements
  1. Video on entry into nursery + TV
  2. Scrub station/washbasin
  3. Soap, wipes
- Gown (Disposable or Cotton gown)
- Name tag
- Mannequin
- Nail Cutter
- Keep the video ready on ‘play’ mode

Step 1 Sensitization to FCC (Play video till Step point 1)

Benefits of family participation in newborn care.
1. Less stress.
2. Enhance bonding with the baby.
3. Increase breast-milk output.

Step 2 Preparation for entry into the nursery (Play video till Step point 2)

- Before entering nursery:
  1. Remove rings etc.
  2. Tie hair in a bun.
  3. Fold the sleeves up to the elbow.
  4. Leave outside footwear at the door.
  5. Wash hands using proper technique.
  6. Put on your gown.

Maintain personal hygiene:
- Bathe regularly and wear clean clothes.
- Cut nails and remove nail polish.
- Ensure you don’t have any disease.

Step 3 Handwashing, wiping & grooming (Play video till Step point 3)

1. Explain why hand washing is important.
2. Explain when to do handwashing?
3. Demonstrate steps of hand-washing.
4. Demonstrate grooming.
5. Now let them practice and demonstrate hand-washing.

Step 4 Introduction to the environment of nursery (Play video till the end)

1. Do not touch equipment unnecessarily.
2. Introduce basic equipment one by one.

Step 5 Summarize the session and answer their queries and clear their doubts.

Thank parents!
Session 2

Handout Session 2
Developmentally Supportive Care & Feeding

1. Give your introduction and welcome parents.
2. Keep the video ready on ‘play’ mode.

**Step 1** Familiarization with the concept of DSC (Play video till Step point 1)
- Correct environment of nursery.
- Avoid excessive exposure to light.
- Avoid loud noise in the nursery like mobile phones and machine alarms.

**Step 2** Reducing stress, nesting, positioning, lifting & plugging (Play video till Step point 2)
1. How to calms a baby?
2. How to lift a baby?
3. Importance and technique of nesting?
4. Importance and technique of positioning the baby?
5. New demonstration by mother the technique of nesting & positioning?

**Step 3** Clearing the soiled baby (Play video till Step point 3)
1. Method of cleaning.
2. Disposal of soiled diaper remember to wash hands after cleaning.

**Step 4** Breastfeeding (Play video till Step point 4)
1. Importance of breastfeeding.
2. Demonstrate how to hold baby while breastfeeding using doll or mannequin.
3. Explain signs of proper attachment.
4. New demonstration by mother using doll or mannequin.

**Step 5** Expression of milk & feeding by Katori-Spoon/Paladai (Play video till Step point 5)
1. When to feed with Katori-Spoon or Paladai?
3. Correct method for holding the baby.
5. Storage of extracted milk New initiate practice by mothers.
Step 6: When to alert the provider

1. Any new development / change in routine noticed.
2. Dislodging of tube / probe.

Step 7: FAQs about breastfeeding

Step 8: Summarize the session and answer their queries and clear their doubts.

REINFORCE CHECKPOINTS WITH PARENTS

1. Demonstrate the steps in making nesting, positioning, lifting & placing.
2. Demonstrate the correct attachment to breast.
3. Demonstrate the correct technique of expression of breast milk.
4. Demonstrate the correct way of Paladai / Kamari-spoon
5. Enumerate signs new born

Thank parents!
Session 3

**Handout Session 3**

**Kangaroo Mother Care**

- Give your introduction and welcome the parents.
- Keep the video ready on ‘play’ mode
- Requirements
  1. Video on KMC+TV
  2. KMC Chair
- 3. Gown
- 4. Baby socks, cloth/disposable diaper and head cap
- 5. Premie Nailie including Care plus Wrap (optional) or a doll
- 6. Cloth for wrapping the baby

**Step 1** Familiarization with the concept, benefits of KMC *(Play video till Stop point 1)*

1. Maintains temperature of the baby.
2. Protects the baby from infections
3. Helps in faster growth.
4. Enhances bonding between parents and child.

**Step 2** Requirements of doing KMC *(Play video till Stop point 2)*

1. Which babies require KMC?
2. Who can give KMC?
3. Things required for KMC

**Step 3** Method of giving KMC *(Play video till the end)*

- Demonstrate method:
  - The mother should sit comfortably.
  - The baby should be put in between mother’s breast in a frog like position.
  - The baby’s face should be on one side so that mother can observe the baby.
  - Now wrap the baby with gown/dupatta.

- Signs to remember while providing KMC:
  1. Baby is breathing evenly
  2. Baby’s feet, palms and tummy are equally warm
  3. Baby’s heart beat can be felt.
  5. Baby is taking feed

**Step 4** Practice session

Now ask the mothers to start the practice. Already practicing mothers/attendants can share their experiences.
### Step 5
**Promote KMC with certain facts**

1. It is a low cost method inspired by nature.
2. It can be easily practiced at home.
3. Family members can also contribute.
4. It allows the mother freedom to undertake her routine tasks.

### Step 6
**Summarize the session and answer their queries and clear their doubts.**

**REINFORCE CHECKPOINTS WITH PARENTS**

1. Enumerate benefits of KMC.
2. Enumerate materials required for KMC.
3. What is the correct position of mother and baby for KMC?
4. What is the duration for which KMC is to be done daily?
5. What are the signs to be watched for while doing KMC?

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Thank parents!
**Session 4**

### Handout Session 4

**Preparation for discharge & care of the baby at home**

- **Give your introduction and welcome parents.**
- **Keep the video ready on 'play' mode.**

**Required:**
1. Video film + TV
2. Mannequin/doll

#### Step 1

**Familiarization with the concept (Play video till Step point 1)**

#### Step 2

**General care of baby at home**

**General hygiene measures (Play video till Step point 2)**

1. Mother should bathe daily, wear tidy clothes.
2. Wash hands after changing diapers and cleaning of soiled baby.
3. Dry hands using clean cloth.
4. **Bathing/Cleaning/dressing up the baby and environment (Play video till Step point 3)**
   
   1. How to clean a soiled baby?
   2. When to start bathing a baby?
   3. How to change diaper?
   4. Which type of clothes are suitable for the baby?
   5. How to maintain the temperature of the room where baby is placed?

**Feeding the baby (Play video till Step point 4)**

2. Technique of breast feeding.
3. What to feed and not to feed?
4. Burping
5. Technique of Katori-Spoon/Palada feeding.
6. When to play and talk to the baby?

**Step 3 Early Signs Of Sickness (Play video till Step point 5)**

1. Signs of a well-baby.
2. Early signs of sickness and when to seek medical help.

**Step 4 Advice on discharge and immunization (Play video from Step point 5 to till the end)**

1. Encourage compliance with follow-up advice on discharge.
2. Explain importance and schedule of immunization.
Step 5
Summarize the session and answer their queries and clear their doubts.

REINFORCE CHECKPOINTS WITH PARENTS

1. What steps will you take to prevent infection in your baby?
2. When are you going to bath your baby first, what are the precautions to be taken?
3. Appropriate clothing for the baby.
4. Tell importance of breastfeeding and what are the signs that baby is getting adequate feeds?
5. Enumerates the dangers signs.
6. Enumerates importance of immunization and when are they required to visit hospital again.

Thank parents!
Family Participatory Care: Implementation Model Development