The Council of International Neonatal Nurses Position Statement on Kangaroo Mother Care

COINN advocates for kangaroo mother care to be implemented at a country-level; as a routine and vital component of newborn care.

COINN supports the use of kangaroo mother care in both high and low resource settings; initiated soon after birth in any setting (health facility or home), when safe to do so and with adequate follow-up.

COINN recognizes that kangaroo mother care includes skin-to-skin contact between the mother or a substitute, and the newborn; and is important not only to enhanced short and long-term health and developmental outcomes, but also to child survival.

Background

Kangaroo mother care (KMC) is one of the most promising ways to save preterm and low birth weight babies in high and low resource settings. KMC, kangaroo care (KC), and skin-to-skin (S2S) care are all terms that relate to the holding of an infant bare-chest to bare-chest, by the mother, father, or substitutes designated by the family. KMC was originally introduced in 1979 in Bogota, Colombia, in part in response to a lack of resources for the care of low birth weight infants[1] and a significant reduction in infection and mortality rates were found. These findings have been replicated in high quality studies[2].

KMC may be initiated in a health facility or in the community (if health facilities are not available). It may be practiced intermittently (in the NICU) or continuously and should continue post discharge (ambulatory) until the baby weighs 2500 g.[3].

Each year 20 million low birth weight (LBW) infants are born around the world, 96.5 % of them in developing countries [4]. Fifteen million preterm births occur globally with 60% of these in Africa and South Asia [4]. The reasons for being born LBW are either prematurity or small for gestational age. It is estimated that at least 1.1 million infants die annually, many on their first day of life due to complications of prematurity such as infection, hypothermia, or asphyxia [4,5]. Approximately 75% of these deaths being preventable with low cost interventions[4] KMC(skin-to-skin-S2S and additional support for breastfeeding) is one of these care interventions that can contribute to saving an estimated 450,000 infants born small each year[4].

Key principles:

1. Core concepts of KMC are warmth, exclusive breastfeeding, early discharge from hospital with adequate follow-up[6, 7] and prevention and management of infections and breathing difficulties, support for positioning, and feeding [3].

2. KMC significantly lowers the risk of severe illness, infections, hypothermia and death; increases weight and head circumference; strengthens maternal bond. Breastfeeding rates improve and maternal satisfaction is heightened[2].
3. KMC should be used in all countries as a total health care strategy offered 24 hours per day for managing premature babies. It may be manifested differently depending on available resources, cultural differences or other contextual factors.[8].
4. KMC may be intermittent. Barriers to intermittent or continuous KMC include a lack of organizational support, limitations in the physical environment, insufficient staff education, and lack of clear protocols[9].
5. KMC and Skin-to-skin (S2S) should be offered immediately after birth, irrespective of delivery location, once the infant is stable, to facilitate successful breastfeeding; nonetheless KMC can be started within hours, days or weeks after birth[10, 11].
6. Implementation of KMC, including the continuous mode, can be encouraged from birth also in high tech NICUs, and continue until no longer needed by the infant for thermoregulation, depending on parents' ability and willingness[12, 13].
7. Information about KMC should be offered to mothers and families early and families should be offered encouragement and support in using the method to the extent they are able and willing[14].
8. KMC sessions of 1-2 hours can be introduced also in extremely preterm infants, from the 1st week of life, provided they are stable enough to tolerate transfer between incubator and parent and adequately covered[15].
9. The frequency and duration of KMC sessions can be increased as tolerated for infants recovering from serious health problems[16].
10. KMC has been shown to promote cardio-respiratory stability[17, 18], temperature maintenance[19]; reduction in pain[20], infection[2], stress[21], weight loss[22] .
11. KMC care is recommended and supported by Professional Societies[23].

Achieving best practice

COINN acknowledges that current practices in some countries need to be changed in order to support KMC. For KMC to be successful, it should be promoted and supported within communities, amongst the general public, health professionals, hospital management and regional and national governments. In addition KMC should be supported with appropriate policies, procedures, resources and education at all levels.

This Position Statement represents the views of The Council of International Neonatal Nurses. This Statement was approved by the board of COINN on DD Month Year. This statement was coordinated by Dr Trudi Mannix with expert input from Dr. Kerstin Hedberg Nyqvist, RN, MNSc, PhD, Associated Professor Emerita, Department of Women's and Children's Health, Uppsala University, Uppsala, Sweden, and a member of the International Network for Kangaroo Mother Care, and Dr. Anne-Marie Bergh, PhD, Senior Researcher, MRC Unit for Maternal and Infant Health Care Strategies, University of Pretoria, South Africa.

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