Abstract: Continuous KMC from birth in a Swedish Neonatal Unit 6th International Workshop of the International Network of Kangaroo Mother Care Cleveland, 11-15 October 2006

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Background and aim: In industrialized societies the KMC method is usually implemented as short periods (1-2 h) of skin-to-skin (STS) contact between infants and parents in neonatal units, not as a medical treatment model. Because of accumulating research evidence of benefits, the original KMC method should also be offered to parents in settings with optimal medical/health care resources. The aim is to present a policy for the Kangaroo Mother Care method, defined as continuous (or nearly continuous) skin-to-skin contact between infants/mothers and fathers in a Swedish NICU, and to describe a consecutive sample of infants with (nearly) uninterrupted STS during the initial phase of policy implementation.

Method and materia/: Description of a) a KMC policy for a high tech NICU and of b) a retrospective chart review of a consecutive sample of infants in the unit who received care according to this policy during the initial period of implementation 23 singletons (17 preterm and 6 full term), born at a median (range) GA of34,3 (31,4-41,0) weeks, 16 vaginal births and 7 cesarean sections, with weights ranging between 1,715 and 3,700 g.

Results*:* a) The aim ofthe policy is to support infant/parent STS 24 h/d or as much as possible also for infants with intensive care, uninterrupted from birth/after initial stabilization, or as soon as possible. Post-partum care to mothers in the NICU is provided by midwives in the maternity unit. The father provides STS in the NICU when the mother is unable, e.g. the first 2 days after a caesarean section. STS is planned during rounds and documented. Most nursing procedures can be carried out during STS. Privacy screens and co-care rooms render one/both parents' presence possible for 24 h. b) In addition to prematurity, diagnoses included respiratory problems, SGA, hypo glycemia, hyperbilirubinemia, infection, hypospadia, anal atresia. Four infants needed 1-2 days ofventilator/CPAP/oxygen treatment, 7 spent day 0 in an incubator, and 3 had access to a crib; 15 infants were treated with phototherapy and/or biliblanketlbilibed. Oxygen saturation was monitored in 21 infants for a median of 4 (1-13) days, and cardiorespiratory functions in 8 infants for 2,5 (1-9) days. Hypothermia «36.5°C) was noted in 6 infants and treated by STS. Data on STS and parents' admission to a co-care room were incomplete; at least 10 fathers provided the infant's care from day 0 and one from day 1, and 8 mothers from day 0 and one from day 1; 14 mother-father couples roomed in together with the infants. Most infants commenced breastfeeding on day 0-1, ITom a PMA of 31.6 weeks. 20 infants were sent home on early discharge at a median postmenstrual age of 35,5 (34,1-41,6) weeks, with a weight from 1,970 g. The majority, 18/20 infants with data, were breastfed exclusively at discharge and 2 partially. Full, demand breastfeeding was noted at a median of35,1 weeks, from 33.9 weeks. Formal discharge occurred ITom 34,7 weeks. Follow-up during home care was provided by the NICU policlinic.

Conclusions

Also in Sweden, a western industrialized country, mothers and fathers appear to accept the complete KMC method with early, continuous, prolonged STS, exclusive breastfeeding, early discharge and adequate follow-up. Continuous STS and transfer of infants' care to parents was introduced early. The documentation ofSTS was incomplete, possibly because nurses did not regard this method as medical treatment. Parents' perceptions of the method and infant outcome variables need to be further explored in prospective studies.