Title: "Implementation of KMC in the Colombian Social Security in Bogotá "

L. Rosero, R.Martinez (Colombia)

It is a pleasure for us to present you our Colombian Kangaroo Mother Program. It is supported by the Colombian Social Security and the World-Laboratory, a Swiss non governamental organization who believe in the Kangaroo Technique and gave us the support in its evaluation since 1989.

These pleasure is increased because, as you know, the Kangaroo Technique was created by Dr Edgar Rey Sanabria in 1978, in Bogota, Colombia. It was developed and promoted by Dr. Hector Martìnez for 14 years in the same institution with the further help of Dr Luis Navarette Perez. This original program was never evaluated rigorousily and for this reason, received many national and international criticisms. Our Kangaroo Mother Program keeps the philosophy of the original colombian program but was established by a multidisciplinary team, modifying the original rules and supported it with scientific evaluations done in Colombia and abroad.

We will present you some of the difficulties we meet with the medical and nurse staff of the maternity in the implementation of our KMC program in his first year.

1. *At the begining we meet a neonatologist resistance from neonatologist against the change introduced by KMC in the medical and nurseries routine but this resistance disappeared quickly.The solution came alone when they understood that KMC represented less work and less overcrowded unit so they were able to work better.*
2. *At the same time we found a deep nurses distrust about mothers competence to look after their very small babies at home. We found resistance from nurses to accept to take the baby off the incubators and to give him to their mothers. This problem was resolved by short educational sesions about the program and the benefits it could give for babies, mothers and nurses too.*
3. *In a second step, the advantage of early discharge brought out a new problem. We had to resist a high pressure of the same pediatricians for early discharge, sometimes before the infant had cumplished the elegibility criteriae. We had to explain them that KMC is not a method to empty the Unit (remember that the CSPC has 15000 high risk deliveries per year and only 16 intensive care unit beds are available, 70 beds of intermediate and minimal care unit and 100 mother-and-child beds, so we have to understand them) and that early discharge without respect of kangaroo eligibility criteriae will only have one negative result: more early readmittions. To resolve this problem we present them outcomes of the first year research and clinic cases showing the danger of no elegibility criteria respect and when a baby was not fitting these criteriae we always used to returne him back to the unit. The solution was the creation of the intrahospitalary Kangaroo adaptation Unit where the mother and her baby are trained in breastfeeding her premature baby and in kangaroo position before discharge. Two trained nurses from the kangaroo mother program are working in this adaptation in coordination with the medical and nursing staff of the neonatology Unit and they decide together when the baby fit the eligibility criteriae.*
4. *In the ambulatory consultation , as you can see we have some problems with the space in the kangaroo little house where the ambulatory kangaroo program take place. The Program growth quickly and we hope that we will have a new little house for next year.*
5. *Another problem we meet in the first year of implementation of KMC was the emergency consultation of the kangaroo baby during the night because doctors were no prepared to*

attend this very small baby caring at home. They were afraid and we begin to have unjustified readmittions. This problem was solved by presentations in the clinic to all the medical and nurse staff.

6. *In the last two years, more and more infants with birth weight < 1000 grams and GA < 30 WGA are saved in the neonatal Unit of the San Pedro Clinic and too many of them are developping chronic lung disease. Since 2 years we are receiving kangaroo babies with ambulatory oxygen. We were obliged to write new eligibility criteria for these babies: the mother must be able to come daily at the consultation with the oxygen so she must have a familiar to help her. Also some buses don t accept them with the oxygen and the taxi is expensive, usually too expensive for these families. The medical staff have to respect the criteria of the social worker and the psychologist about the capacity of the mother and his family to be eligible for the ambulatory kangaroo program before the infant is discharged. In this case it is necessary to keep the baby at the hospital until he regulates temperature. Anyway, even without oxygen, when the mother or the family is not able to take care of her baby at home, we have to refuse the entry in the kangaroo ambulatory program and it is not well accepted even now.*
7. *It was not easy to convince the social security about the importance of high risk follow up until at least one year of corrected age and the need of more time for the consultation to include neurologic and psychomotor evaluation. We demonstrated them the importance to detect as soon as possible any problems like visual, auditive or delay in the neuro - psychomotor development for an earlier intervention to avoid sequels that can be more expensive for the institution and for the society.*
8. *We did not have problems with the customs or religions.*
9. *Nutritional problems were present when we began the KMC program. We have to insist in a better interhospitalary nutrition specially in babies with a long period of hospitalization. Many babies arrived at the ambulatory program with a high undernutrition and it is very difficult to recuperate a good nutritional status for these babies.We decided to give 30% of the daily needs with artificial milk for premature baby in case of inadecuate weight and height gain in the consultation (15 g per Kg per day for the weight and 0.7 cm per week for the height). We choose a 4 onzes´bottle of liquid milk and we used it like a complement of breast feeding. We divided the ration on 24 hours and the mothers are teached to give it by dropper before breast feed their baby. The amount is minimal, 5 to 10 cc each time and do not interfere with maternal feeding. Very often we can suspend it when the baby reachs 40 weeks of postconceptional age and to continue with exclusive breast feeding when posible. This supplement is not available in the market so the mother has not the possibility to give more than the prescription. It is our way to give more proteines and calcium to these small babies when they need it. Manipulations are minimum and we didn´t have had more gastro intestinal infectious problems.*

We hope to continue improving our program to offer the best alternative for all our small prematures and their families.