KANGAROO MOTHER CARE (KMC)

Let nature do the nurturing

The common problems of small babies – hypothermia, hypoglycaemia, and hypoxia - are alleviated, if not cured, by a common solution: kangaroo mother care (KMC)

ALL facilities with maternity services SHOULD implement KMC as ROUTINE practice

What is KMC?
Kangaroo mother care consists of skin-to-skin care of babies (usually low birth weight or very low birth weight). KMC also promotes early and exclusive breastfeeding, but may be used even when babies are formula fed.

What are the cornerstones of KMC?

1) Kangaroo Position
Dress the baby in a nappy and cap and place in an upright position against the mother’s bare chest, between her breasts and inside her blouse. One may use a special garment, or one can tuck the mother’s blouse under the baby or into her waistband. Cover both mother and baby with a blanket or jacket if it is cold. Many hospitals have designed their own wraps (for example, out of old theatre drapes), or have involved community based organisations in the making of wraps. You too can be innovative.

2) Kangaroo Nutrition
Babies who are unable to suckle should be fed expressed breast milk via a nasogastric tube or cup if they can swallow. Keep babies in the KMC position whilst being tube fed. Allow them to try to suckle during the tube feed. In the KMC position, babies will declare themselves ready to suckle, as their rooting and suckling reflexes become manifest. Once the baby is able to suckle, allow the baby to breast feed on demand but at least every three hours.

3) Kangaroo Support
It is very important to explain and demonstrate to the mother until she is motivated and confident to try the kangaroo position. In KwaZulu-Natal the word “Ukugona” (to hug or embrace) is used. Assist the mother with positioning and feeding, and give emotional support. The concept should be explained to other family members (especially the maternal grandmother), and they can also practise KMC (especially the father).

4) Kangaroo Discharge
Use the KMC score chart (Form Paed/26) to evaluate readiness for discharge. Discharge when the baby has a sustained weight gain and has a KMC score of 19 or more. Bring the baby back for follow up in the next few days to ensure that baby is well and growing. It is good practice to follow up KMC babies in a designated place near the KMC ward.

When do we start KMC?
Intermittent KMC can be practised while the baby is still in the nursery. It is possible even with babies on oxygen and IV therapy. Frequency is determined by how stable baby is. A common sense approach is best. Aim for a minimum of 3 times a day.

Continuous KMC can be instituted once the baby is stable, suckling well, preferably > 1500g (but at any weight if confidence and competence has been established) and needs no additional care. The baby can then be transferred to an adjoining KMC ward. Smaller babies may be able to go onto continuous KMC if they are stable and do not require oxygen.

Where do we do continuous KMC?
The KMC ward should be in close proximity to the Neonatal unit and under the supervision of the neonatal staff, with 24 hour nursing coverage. The ward should be comfortable, homely and warm but not heated. There should be no cribs.
What is the daily routine of a KMC Ward?

1) Monitoring
   - Babies should be weighed daily, and feeds adjusted according to weight gain. If not yet breastfeeding on demand, they should receive 175ml/kg/day, in 8 feeds 3 hourly.
   - Babies on oxygen should have their oxygen saturation monitored 3 hourly.
   - The Basic Neonatal Nursing Observation chart can be used.

2) Record Keeping
   - For babies who are "just growing", use only the KMC Daily Score (Form Paed/26) sheet. If babies have any other problems (like oxygen dependency) carry on using the normal continuation sheet.

3) Medication
   - From two weeks of age, use VIDAYLIN® 0.6ml/dose 24H and VITAMIN D 400U/dose 24H. Add FERRODROPS® 0.3ml/dose 24H at 6 weeks. All preterm babies should be on THEOPHYLLINE 1-2mg/kg/dose 12H until they weigh about 1800g.

4) Immunisation
   - Give the BCG and Polio vaccines when baby weighs 1800g, or at discharge, whichever comes first.

5) Complications
   - It is important to watch out for:
     a. Anaemia of immaturity
        Transfuse preterm babies if their Hb is less than 9g%.
     b. Patent Ductus Arteriosus (PDA)
        Bounding pulses are the hallmark of PDA’s in small babies. Check pulses daily, and if they are bounding, listen for a murmur. Refer to a regional hospital if a PDA is present, and reduce intake to 120ml/kg/day
     c. Sepsis Neonatorum
        Babies in KMC are less likely to acquire infections, but they are still at risk. At any sign of infection, fully and carefully assess baby, and manage according to the "Sepsis Neonatorum" guideline.

KMC discharge
   - Use the KMC scoring sheet to decide when to discharge.
   - Discharge on medications as above (usually it is appropriate to stop the vitamin D at discharge). Iron and multivitamins should be continued for the first year of life.
   - Try and develop the follow up clinic as part of the neonatal/nursery service. Don’t make KMC babies go and sit in an outpatient queue.
   - Do use the same scale to weigh them when they come for follow up.