Fellow's Column: Letter to the Editor "A Delphi Survey – Enhancing Parents' Knowledge and Practice of Kangaroo Mother Care"

Dear Editor:

With great interest, I read "A Delphi Survey – Enhancing Parents' Knowledge and Practice of Kangaroo Mother Care" (Paulse, N. A Delphi Survey – Enhancing Parents' Knowledge and Practice of Kangaroo Mother Care. Neonatology Today. 2022;17(11):3-10). In this article, Paulse aims to establish guidelines for a teaching program to enhance parents' understanding and application of kangaroo mother care (KMC) for preterm infants. The Delphi Survey method assessed a panel of experts to determine the essential KMC practice directives to include in the teaching program. The authors encourage applying these created directives in practice and evaluating their effects on KMC coverage. We believe this teaching program could adequately address one of the most important barriers in KMC practice, patient education. Hopefully, improving patients' understanding of KMC will increase their engagement in KMC. As challenges associated arise, we believe it would be valuable to analyze and amend the program directives as needed.

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Since the introduction of KMC twenty-five years ago in Columbia (1), several meta-analyses and systematic reviews have shown the benefits of KMC (2). It is now widely accepted and practiced in multiple countries (3). While KMC is beneficial and popular, some barriers hinder its prevalence in practice and understanding. In "Kangaroo mother care: a systematic review of barriers and enablers," published in 2016, Chan et al. categorized barriers to kangaroo mother care practice into six categories: Buy-in and bonding, Social support, Time, Medical concerns, Access, and Context (4). In another study, Alenchery et al. split the barriers to skin-to-skin contact (SSC) into three main branches: system barriers, experiential barriers, and knowledge barriers (5). Both studies emphasize the importance of parents' knowledge and patient education as major barriers to KMC. Paulse's created directives hope to address this knowledge gap regarding KMC accordingly. While we believe it would be beneficial to address general patient education, other barriers to KMC application should be addressed to create a more comprehensive directive.

Additionally, directives addressing Covid-19 patient education regarding KMC should be added. At the beginning of the Covid-19 pandemic in 2020, the American Academy of Pediatrics (AAP) temporarily recommended separating newborns from mothers with Covid-19 due to a lack of knowledge about the virus (6). This initial guideline created detrimental separation practices and negatively impacted KMC practice (7). In July 2020, the AAP guideline was amended because direct breastfeeding and rooming-in were proven safe. After all, perinatal transmission of Covid-19 is unlikely if proper precaution is taken (8). A comparative risk analysis published by Minckas et al. found that the benefit of KMC outweighs the mortality risk of Covid-19 by 65-fold in preterm neonates in low- and middle-income countries, which further supports KMC practice during the Covid-19 pandemic (9). We believe updating parents about the most recent Covid-19 postnatal care guidelines is crucial to their newborns' care. Misinformation can cause parents to unnecessarily fear Covid-19 transmission, which may become a barrier to applying KMC. Additionally, many hospitals have strict and complicated visitor guidelines due to Covid-19, which could exasperate parents' fear of transmission to their newborns and negatively affect their willingness to practice KMC.

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Paulse and Venter focus on parents' vital role in KMC practice through their KMC directives. We agree with the importance of patient education and suggest expanding the guidelines to address the views of other associated parties, such as healthcare professionals and lawmakers. Per Minckas et al., these associated parties provide patients with the services and protection that encourage them to practice KMC. In a multi-site implementation research study by Mony et al., patients were more inclined to practice KMC due to support from government leadership, health workers' recommending KMC as the standard of care, and systematic changes in infrastructure and policy (10). To promote the frequency of KMC, Mony recommends creating policies that minimize mother and baby separation, allowing parents to care for their hospitalized children, and focusing on the needs of the mother and baby through integrated care. Policymakers must put these principles into practice while allowing for adaptation in the event of unique cases.

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In order to better understand potential barriers to KMC, various healthcare personnel who participate in KMC should be consulted. In an interview with a NICU nurse in Southern California, we learned that time and human resources have been limiting factors in providing KMC for patients. By combining general principles established by Paulse and Venter with individual opinions on barriers to care, the created directives could provide both the backbone and terminal bridges to enhance KMC practice from top-to-bottom and bottom-to-top directions for all those involved.

In conclusion, we sincerely appreciate the KMC directives created by Paulse and Venter.

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Sincerely,

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Dear Dr. to be Chen,

Thank you for a very cognitive review of this paper. KMC's simplicity causes much concern because of perceived risks to the care of the patients. There is also a knowledge gap between what parents, nurses, and physicians expect. The idea of skin-to-skin did not begin recently but is probably as old as our species and may extend back further. There are certainly animal analogies to KMC. The point is that there was never an instruction manual or a right or wrong way of engaging skin-to-skin parents with the baby. Prematurity does complicate the interaction, and there are individual issues that are care-related that may preclude KMC in certain instances, but this does not connotate an inability to engage or approach engagement at some later point.

"COVID-19 did present a conodrum. (1) We understood that this pathogen was capable of causing severe morbidity and mortality in adults and that several cases of vertical transmission had produced disease in neonates. Unique in this particular situation was the concern that COVID-19 would in some way affect staff and thereby cause staffing issues. "

COVID-19 did present a conodrum. (1) We understood that this pathogen was capable of causing severe morbidity and mortality in adults and that several cases of vertical transmission had produced disease in neonates. Unique in this particular situation was the concern that COVID-19 would in some way affect staff and thereby cause staffing issues. To the editor's knowledge, there is no documented COVID-19 passage from a neonate vertically to NICU staff. Strict visitation policies that precluded the presence of one or both of the parents for large epochs of the hospital stay were toxic to the presumption of routine KMC and any teaching regarding these practices. (2, 3)

As the pandemic progressed, it became apparent that the risks were different than initially thought. COVID-19 did not have to be a barrier to KMC and teaching. Moving forward, we must learn that programs involving parents' and babies' separation are not sustainable. However, with the next pandemic or health, scare come

new risks, and it is impossible to quantify how the health systems will react, especially if this threat involves increased risk to infants and staff members. (4)

The resource issue must be separated from the applying KMC. In theory, with parents who understand their role, neonates in KMC should be more stable and require less monitoring. These directives must focus on realistic expectations, maintenance of the infant-parent dyad, and further the benefits offered by KMC.

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NEONATOLOGY TODAY

Loma Linda Publishing Company

A Delaware "not for profit" 501(c) 3 Corporation.

c/o Mitchell Goldstein, MD

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Fellow's Column is published monthly.

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