

A ROOMING-IN PROGRAM FOR MOTHERS AND NEWBORNS^{1, 2}

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The hospital rooming-in program described below provides mothers with professional instruction and supervised practice in caring for their newborns. It thus helps to assure these infants' normal growth and development.

Introduction

Rooming-in represents an advance in care of the newborn, in that it permits establishment of a closer relationship between the mother, her newborn, and the health care team. This daily contact is very beneficial, especially for the newborn.

Rooming-in means that the mother is allowed to live with her child. This strengthens emotional bonds, fosters development of greater maternal sensitivity to the infant's priority needs, encourages breast-feeding, and increases the mother's willingness to accept advice about care of her child. Rooming-in also fosters better relations between the mother and the health care team through the mother's active involvement, and thus sets the scene for effective instruction and practical experience in child care. Furthermore, it establishes a firmer relationship between mother and pediatrician, so that the mother is encouraged to attend peripheral

health centers for periodic monitoring of the growth and development of her child; it enables the mother to care for the normal newborn from its first hours of life, thereby allowing the obstetrics team to devote more attention to newborns at risk; it reduces the possibility of cross-infections inherent in the confinement of many infants together in a single unit; and it allows the members of the health care team to improve their teaching skills through daily practice, and to gain a fuller understanding of community needs.

Objectives

The aims of the program are (a) to train the mother in the care of her child; (b) to encourage breast-feeding; (c) to increase the number of infants whose health is monitored at peripheral health centers; and (d) to reduce morbidity and mortality during the first year of life among the infants enrolled in the program. These objectives can only be fully realized if there is adequate coordination between the maternity hospitals and the peripheral maternal and child health centers to which the mothers and their infants are referred.

Resources

The physical plant, manpower, and material resources of Montevideo's Clinical Hospital (see Photo 1) are used to conduct the program. No additional assistance is required, and in fact the program achieves a more rational distribution of existing resources as well as active participa-

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PHOTO 1—The Clinical Hospital of the University of the Republic, Montevideo, Uruguay.

tion by the mothers in caring for their newborns.

Facilities. The rooming-in unit consists of an 80 m² area divided into 12 cubicles, each of which contains a bed, a bassinet (see Photo 2) and a washbowl. Adjoining the unit is a room for holding classes and mothers' meetings.

Material resources. The unit's equipment consists of 12 beds, 12 bassinets, a trolley with supplies for hygienic care of the newborn, a trolley for soiled diapers, a scale, a stethoscope, and a tape measure.

One trolley contains all the basic materials needed to tend the infant, which are the same as those the mother will later use in her own home: containers of boiled water, soapy water,

alcohol, and swabs of cotton and gauze. Attached to one end of the trolley is a disposable bag for soiled swabs (see Photo 3).

Human resources. On a day-by-day basis, the rooming-in program utilizes the personnel listed below for the number of hours shown:

Personnel	Hours per day
Obstetrician	2
Neonatologist	3
Nurse	4
Social worker	4
Auxiliary	24
General services personnel	2

Activities

Basic procedures. The newborns spend the

first six hours of their lives in the observation unit beside their mothers. Thereafter they are transferred by the nursing staff to the rooming-in unit (see Figure 1).

All newborn infants are included in the program, except those requiring special intermediate or intensive care. At the discretion of the obstetrician or neonatologist, infants whose mothers are suffering from dystocia or other conditions potentially detrimental to newborns may also be included in the program.

Each newborn infant has its own individual bassinet area. All newborn care is provided at the bassinet, with the mother's active participation and under supervision of the nursing staff. Before handling the infant, the mother washes her hands and forearms. Visiting is limited to fathers and grandparents; if the father wishes to hold his child, he too must wash his hands.

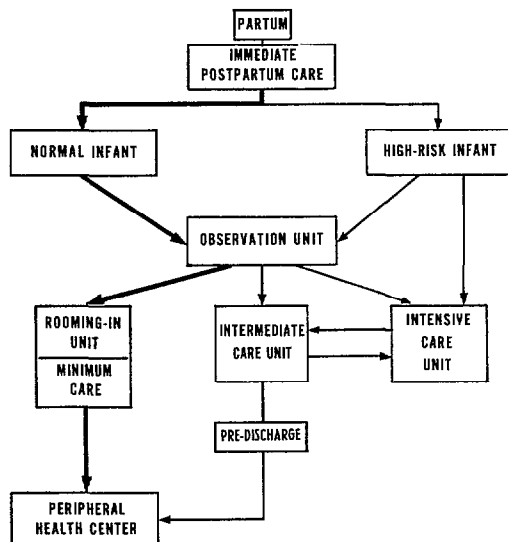
The technical team (obstetrician, neonatologist, and nurse) do a morning round of all mothers and infants, getting to know them, answering questions, and reducing anxieties. The team also makes a complete physical examination of each newborn between 24 and 48 hours old in the newborn's cubicle beside its mother. It is desirable that the father be present during this examination.

A second visit, for which the physician on duty is responsible, is made in the afternoon or evening to answer questions or solve any technical problems that may have arisen since the morning visit.

The duty team that conducts the morning visit is responsible for discharging the mother and her infant. At the time of discharge (after three days in the unit) each mother is personally interviewed, and with her help the peripheral health center nearest to her home is located on a map posted at the unit (see Photo 4); this is the clinic to which she will send her child for regular checkups. It is considered desirable to have the father present at this final interview.

The social worker is responsible for informing the appropriate health center of the discharge of the newborn and the date on which it is due to be brought in for a checkup.

FIGURE 1—Care delivery flow chart. The thick arrows show the path followed by most newborn infants; the other arrows show alternative paths available for infants with special problems.



The activities that this program carries out have been broken down and standardized by technical personnel, and have been incorporated into the General Procedures for Care of the Newborn recommended by the Latin American Center for Perinatology and Human Development.

Supervision. The technical team supervises the mothers as they care for their infants. On the morning shift, activities are supervised by the unit nurse, a nursing auxiliary, and the neonatologist; during the rest of the day this is done by a nursing auxiliary, who consults the head nurse on the floor and the duty neonatologist as needed.

Teaching. The rooming-in program has a strong instructional component, one considered essential by the technical team.

The nurses and nursing auxiliaries provide individual, continuous and systematic instruction to the mothers, supplemented with instructional slides selected by the technical team. The slides and accompanying group discussions serve several functions: they add an element of

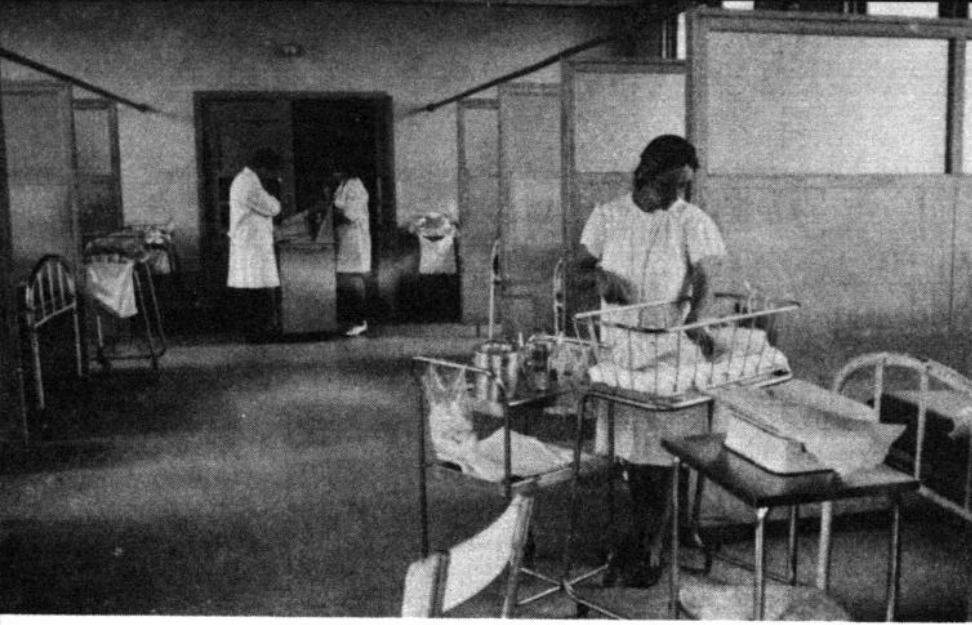


PHOTO 2—The rooming-in unit. A mother tends her infant beside their cubicle.

PHOTO 3—A mother washes her infant's umbilical stump under the supervision of a nurse in the rooming-in unit.

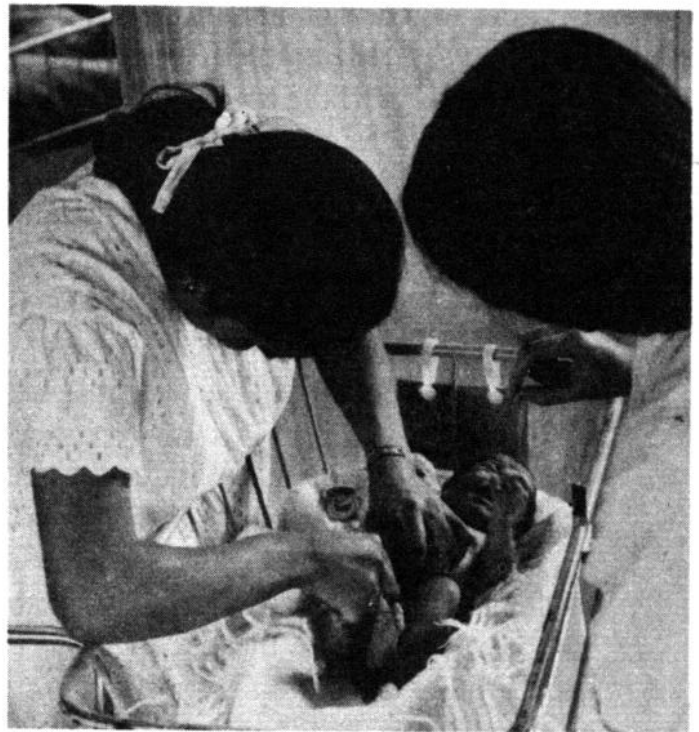


PHOTO 4—At her final interview, each mother locates the maternal and child health center nearest her home, where she will bring her child for periodic checkups.



uniformity to the health team's pool of knowledge and help set standards for the instruction given the mother during her three-day stay; they also emphasize points made during individual instruction and encourage further discussion of these points.

The instruction given to the mothers is directed at three fundamental matters: (a) the importance of breast-feeding; (b) the need for proper hygiene, with emphasis on prevention of digestive and respiratory infections in the newborn and on proper care of the umbilical stump; and (c) the importance of starting early to monitor the health of the newborn through checkups at a peripheral health center.

Individual instruction by the nursing staff, group discussions involving the full technical team (with projection of instructional slides), and the mother's active participation in caring for her infant make up main elements of the educational program at the rooming-in unit.

Program Evaluation

The program is evaluated on the basis of how well it is achieving its goals. To this end, data on mothers and newborns participating in the program are collected at the end of the infant's first month and first year of life.

Partial evaluation of the program is carried out every four months by studying the following data: (a) the age at which the newborn is brought to the peripheral health center; (b) the number of visits made to the center; (c) morbidity and hospitalizations; (d) mortality; (e) nutritional considerations; and (f) indications of the mother's ability to care for her child. This information is collected by the Social Welfare Department of the Clinical Hospital, and the medical and nursing personnel assigned to the program collaborate with the Department in making the subsequent evaluation.

SUMMARY

This report describes a rooming-in program based on allocation of resources to patients in accord with their health needs.

It outlines the advantages of having the healthy infant kept with the mother continually during the puerperium. This promotes easier psychological adaptation of mother and infant, reduces the incidence of cross-infections in the hospital, encourages breast-feeding, and paves the way for providing the newborn with regular checkups at peripheral health centers.

The report also points out the need to instill a strong instructional component into the

rooming-in program. The basic elements of the overall program are maternal training based on individual instruction, group discussion sessions accompanied with instructional slides, and participation by the mother in the care of her infant under supervision of the midwifery team.

The adoption of a program of this nature does not imply an increase in existing human and material resources, but rather a rationalization of the distribution of present resources and the added contribution of the mother's active participation in helping to care for her child.

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CORRIGENDUM

Concerning the article "Patterns of Infant and Early Childhood Mortality in the California Project of a Collaborative Inter-American Study" by Helen M. Wallace, *et al.*, published in the last issue of the *Bulletin*, we wish to advise our readers of the following changes:

- (1) The section entitled *Infant Mortality* on page 33 should read:

"Immaturity was found to be the most prominent cause of infant mortality in the California Project, playing a role as an associated cause of death in over half of the 784 cases. Congenital anomalies were the second most prominent, accounting for approximately one-sixth of the 2,137 underlying and associated causes of death cited. Anoxia, which ranked third, accounted for nearly one-sixth of the associated causes of death. In addition, sudden death was found to be a prominent cause of postneonatal mortality in the California study."

- (2) In Table 3, on page 36, the lines showing totals and subtotals should read:

Total	327	7.3	73	10.3	254	6.7
2,500g or less	280	6.3	69	9.7	211	5.6
2,501g and over	47	1.1	4	0.6	43	1.1