Significantly more low-birthweight (LBW) infants are born in developing countries than in First-World countries; they are often born to women with serious antenatal risk factors and are delivered at hospitals with inadequate facilities. Due to limited neonatal intensive care facilities, these infants are predominantly managed in the special care nursery (SCN) and postnatal ward (PW). Readmission to hospital due to feeding difficulties and jaundice is common. Triage by midwives in labor ward to either the SCN or PW according to written guidelines is essential directly after birth:

- Group 1: infants with birthweight (BW) between 1,500 and 1,800 g are transferred by incubator to the SCN.
- Group 2: infants with BWs between 1,800 and 2,000 g are transferred to either the SCN by incubator (<34 weeks) or the PW in the kangaroo mother care (KMC) position (≥34 weeks).
- Group 3: infants >1,800 g with a gestation of ≥34 weeks or those >2,000 g are transferred in the KMC position to the PW.
- Group 4: infants who require admission to the NICU.

Preventing the separation of mother and infant as far as possible and initiating breastfeeding and KMC in labor ward in the infants who are to be transferred to the PW is a priority.

Infants with BWs between 1,500 and 1,800 g are nursed in an incubator and receive an intravenous 10% glucose-electrolyte solution on admission at a volume of 70 ml/kg per day. Breast milk, with its low risk of necrotizing enterocolitis can be advanced rapidly to increase enteral protein intake. Once a mother is stable, she is assisted in the technique of KMC, the technique of manually expressing colostrum and breast milk and the correct labeling of bottles and of refrigeration. Stable infants commence immediately with intermittent KMC, expressed breast milk (EBM) feeding and breastfeeding which progresses to continuous KMC. The HIV status of every mother must be known on admission of her baby to the ward. EBM of HIV+ mothers is pasteurized using the flash method.
of pasteurization. The use of breast pumps is not allowed as they may be shared and in so doing HIV, CMV, hepatitis B, etc. may be transmitted. Pasteurized donor EBM is generally only available for very-low-birth-weight infants. If mother’s own breast milk is unavailable due to maternal illness or death, formula is commenced. Parenteral nutrition is only available for LBW infants with feeding intolerance or bowel obstruction. Enteral iron, at a dosage of 2 mg/kg per day, is commenced at 2 weeks of age, while a multivitamin supplement, containing at least 400 IU vitamin D, is commenced once the infant is on full enteral feeding. Infants are discharged home when they reach a gestational age of at least 34 weeks, a weight of 1,600–1,800 g, are gaining adequate weight, are fully breastfed or bottle fed and the mother is confident to care for her baby at home.

LBW infants ≥34 weeks’ gestation and ≥1,800 g are managed with term babies in the PW. Establishing breastfeeding in LBW infants is a challenge due to their poor muscle strength, latching, suckling and swallowing. Formula should be prescribed according to strict criteria, including a mother who has died or is too ill to breastfeed, the HIV+ mother who chooses not to breastfeed, etc. Whether the mother-infant dyad is ready for discharge is determined on an individual basis. Discharge usually takes place after 48 h, mostly before the infant has regained his/her BW.

The clinics in the community function as an extension of the hospital management. The baby should be assessed and weighed and referred to the hospital if there is excessive weight loss, lethargy, jaundice, etc.

Optimal nutrition can be provided to LBW infants in resource-constrained environments by maintaining the mother-infant dyad in hospital and providing skilled breastfeeding support. The clinics in the community must provide postdischarge nutritional support.