



Kangaroo Mother Care: A review of mothers' experiences at Bwaila hospital and Zomba Central hospital (Malawi)



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ABSTRACT

Background: Kangaroo Mother Care is an intervention that can help reduce neonatal mortality rate in Malawi but it has not been rolled out to all health facilities. Understanding the mothers' experience would help strategise when scaling-up this intervention.

Objective: to review experiences of mothers Kangaroo Mother Care at two hospitals of Bwaila and Zomba.

Design: quantitative, descriptive using open interviews.

Setting: two central hospitals in Malawi.

Participants: 113 mothers that were in the Kangaroo Mother Care unit and those that had come for follow-up two weeks after discharge before the study took place.

Findings: mothers had high level of knowledge about the significant benefits of Kangaroo Mother Care but 84% were not aware of the services prior to their hospitalisation. 18.6% ($n=19$) were not counselled prior to KMC practice. Mothers preferred KMC to incubator care. There were factors affecting compliance and continuation of KMC, which were lack of support, culture, lack of assistance with skin-to-skin contact, multiple roles of the mother and stigma.

Key conclusions: mothers had a positive attitude towards KMC once fully aware of its benefits.

Implications for practice: there is need for awareness campaigns on KMC services, provision of counselling, support and assistance which can help motivate mothers and their families to comply with the guidelines of KMC services.

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Introduction

Globally, four million infants die in the first month of life and 27% of these deaths are directly attributed to low birth weight (LBW) and/or preterm birth (Lawn et al., 2005). In addition, preterm birth is a major risk factor for infants dying of other causes, especially infections. Keeping these infants warm, feeding them regularly, and preventing infections are key elements in improved survival rates, in conjunction with the timely recognition and management of complications such as respiratory distress syndrome, infections, and jaundice (Ministry of Health-Retrospective Evaluation Report, 2007).

Kangaroo Mother Care (KMC) is a well-known method of caring for infants, especially those that are preterm. It is a natural method for caring for LBW infants. It consists of continuous skin-to-skin contact between mother and infant (dressed only in nappy and hat), exclusive breast feeding, and an early hospital discharge with the continuation of the kangaroo position (Charpak et al., 2005). Infants weighing 2000 g or less at birth and unable to regulate their body temperature remain with their mothers who function as human incubators and provide a source of warmth, stimulation and feeding (Ruiz-Peláez et al., 2004).

It is a low-cost and feasible method of caring for LBW and preterm infants at all levels of care and in all settings. In view of the World Health Organization (WHO) proposal to expand utilisation of key evidence-based interventions, there was need to critically evaluate all interventions, including KMC. These interventions, if implemented appropriately, could greatly contribute to saving newborn lives of premature/LBW infants in low-income

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countries. It is not known how feasible and locally acceptable the recommended practices are, or which delivery strategies are best for use in Sub-Saharan Africa (SSA).

In Malawi, there are 15,000 neonatal deaths annually and 60–90% of these are secondary to LBW, frequently premature infants who could significantly benefit from KMC. Therefore, there was need to review mothers' KMC experiences and identify any problems related to utilisation of the method. Most current recommendations are based on studies conducted in Asia and South America and minimally on study results from sub-Saharan Africa. In Malawi, few studies have been conducted to review mothers' experiences of KMC and identify problems.

Ruiz-Peláez et al. (2004) found out that mothers were not comfortable with the kangaroo position and that the difficulties that arose from both health professionals and mother-families were often related to local cultural issues. Studies have shown a significant reduction of in-hospital mortality with KMC, including mortality rates in low-resource settings (Lincetto et al., 2000; Worku and Kassie, 2005; Pattinson et al., 2006). It has been proposed that the uptake of KMC in Malawi be increased to reduce the neonatal mortality rate, which is currently at 33% according to MICS report (2006).

Background

KMC originated in Columbia, South America, in 1979. The pioneers of this method were two neonatologists, Dr Hector Martinez and Dr Edgar Rey of Maternal Child Institute in Bogotá, Columbia. They developed this simple method to care for LBW infants to overcome the inadequacies of neonatal care in developing countries. They were concerned with problems arising from a shortage of incubators and from the impact of separating women from newborns in neonatal care units (Ruiz-Peláez et al., 2004). In developing countries, KMC is being used to complement conventional treatment when resources for caring for LBW are insufficient and scarce. Bergman and Jürisoo (1994) state that 96% of premature born infants worldwide do not have access to technology. They do however have access to the habitat they require for them to survive (the mother's body) – this makes up skin-to-skin contact (kangaroo), exclusive breast feeding from birth and support (care).

To promote KMC uptake, counselling of the mother becomes an important element. Thukral et al. (2008) state that the first few sessions are important and require extended interaction and the counsellor should demonstrate to the mother the KMC procedure in a caring, gentle manner with patience.

The implementation of KMC also focuses on the decision-making process, which depends not only on the mother's desire and willingness, but also on the support provided by the family network and empathetic health care teams. Although mothers realise the importance of KMC for their infants' recovery, personal and family problems may prevent them from taking active part in the programme (Toma, 2003). In Nepal, Female Community Health Volunteers were used to coach and support mothers to provide KMC to their infants at home and after 15 months the programme was evaluated. The results showed that there were positive perceptions and negative ones. The negative ones were that the warm weather made it difficult for the mothers to keep the infant in KMC position due to sweat; lack of support to keep infant in KMC position due to culture; work load and absence of mother-in-law made it difficult to sustain KMC; mother was too shy for KMC position; fathers not providing KMC; cord infection and fear of being soiled with stool and urine (The Cochrane Library, 2003).

Malawi is one of the developing countries in the Sub-Saharan African Region with scarce human and materials resources to care

for LBW/premature infants. In Malawi, 20% of all births have a birth weight of less than 2500 g (DHS, 2000, cited by WHO (2002)). This high prevalence rate of LBW/premature infants leads to congestion of hospital nurseries in Malawi and hence KMC adoption.

Reducing neonatal mortality rate is one of the priority issues for Malawi and hence there is a need to scale up KMC services considering the scarce resources in the health care settings. However, before this is done, it is important to find out the experiences of mothers using the strategy. The results will inform the scaling up. This is the major focus of this study.

Methods

This study was guided by an adapted model of Theory of Reasoned Action and used three major components of the theory to guide this study. The Theory of Reasoned Action was developed by Ajzen and Fishbein in 1975 to examine the complex set of explanations that address individual's behaviours and behaviour patterns (Clemen-Stone et al., 2002). The three components utilised for this study were attitude towards KMC, normative beliefs about KMC, and motivation to comply with KMC. In addition to these constructs, the researcher added one more construct: awareness and knowledge of the benefits of KMC. These constructs were used to formulate the objectives of the study.

According to Burns and Grove (2005), the design of a study is the end result of a series of decisions made by the researcher concerning how the study will be conducted. The design is closely associated with the framework of the study and guides planning for implementing the study. This study used a quantitative study design with an element of qualitative design to review mothers' KMC experiences. Quantitative research is a formal, objective, systematic process in which numerical data are used to obtain information about the world (Burns and Grove, 2005). The quantitative approach was used so as to examine discrete factors as concretely as possible. The participants were interviewed by the researcher using a pre-structured and pre-tested questionnaire in a private environment and the information collected was translated into numerical information and analysed using statistical procedures. The questionnaire had both open-ended and close-ended questions. The open-ended questions were included in the questionnaire to allow participants to identify variables not foreseen by the researcher.

Target population

A population is the total group of subjects that meets a designated set of criteria. Polit and Hungler (1999) state that target population includes all cases about which the researcher would like to make generalisations. The target population consisted of all mothers who had their preterm/LBW infants in the KMC unit at Bwaila Hospital in Lilongwe and Zomba Central Hospital in Zomba and those that had come for follow-up two weeks after hospital discharge before this study started.

Eligibility criteria

According to Polit and Beck (2006), eligibility criteria is the criteria used to designate the specific attributes of the target population, and by which people are selected for participation in a study. This included mothers that had their preterm/LBW infants in the KMC unit, and those that had been discharged before this study started but had to come for follow-up after two weeks.

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