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Hurdles and opportunities for newborn care in rural Uganda

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ABSTRACT

Introduction: a set of evidence-based delivery and neonatal practices have the potential to reduce neonatal mortality substantially. However, resistance to the acceptance and adoption of these practices may still be a problem and challenge in the rural community in Uganda.
Objectives: to explore the acceptability and feasibility of the newborn care practices at household and family level in the rural communities in different regions of Uganda with regards to birth asphyxia, thermo-protection and cord care.
Methods: a qualitative design using in-depth interviews and focus group discussions were used. Participants were purposively selected from rural communities in three districts. Six in-depth interviews targeting traditional birth attendants and nine focus group discussions composed of 10–15 participants among post childbirth mothers, elderly caregivers and partners or fathers of recently delivered mothers were conducted. All the mothers involved has had normal vaginal deliveries in the rural community with unskilled birth attendants. Latent content analysis was used.
Findings: two main themes emerged from the interviews: 'Barriers to change' and 'Windows of opportunities'. Some of the recommended newborn practices were deemed to conflict with traditional and cultural practices. Promotion of delayed bathing as a thermo-protection measure, dry cord care were unlikely to be accepted and spiritual beliefs were attached to use of local herbs for bathing or smearing of the baby's skin. However, several aspects of thermo-protection of the newborn, breast feeding, taking newborns for immunisation were in agreement with biomedical recommendations, and positive aspects of newborn care were noticed with the traditional birth attendants.
Conclusions: some of the evidence based practices may be accepted after modification. Behaviour change communication messages need to address the community norms in the country. The involvement of other newborn caregivers than the mother at the household and the community early during pregnancy may influence change of behaviour related to the adoption of the recommended newborn care practices.

Introduction

Newborn care has been a neglected area globally for a long period of time (Lawn et al., 2006). The Lancet neonatal survival series highlighted the gaps existing internationally, regionally and at country level in terms of policy, advocacy and implementation (Martines et al., 2005). The fourth Millennium Development Goal (MDG-4) targets the reduction of the under five childhood mortality (U5MR) by two-thirds by 2015. Thirty-eight per cent of this mortality is attributable to deaths arising during the neonatal period (Lawn et al., 2005; UN, 2008). Targeting the first seven days of life where the majority of neonatal deaths occur would significantly decrease the U5MR (Lawn et al., 2005). Up to three-quarters of the perinatal and newborn deaths could be prevented with an additional cost of less than U$1 per head with the use of low cost technology and observation of a set of evidence-based practices (Bhutta et al., 2005; Darmstadt et al.,

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2005; Knippenberg et al., 2005). A continuum of care through pregnancy and in the neonatal period has been proposed, which requires implementation of a set of evidence-based behaviours at home and in health facilities (Marsh et al., 2002). However, for these evidence-based practices and interventions to be well promoted and effective in the community, the local determinants affecting behavioural practices related to the desired practices need to be addressed (UNICEF, 2004; Winch et al., 2005; Kumar et al., 2008).

Maternal and child conditions in Uganda contribute to a high burden of disease with at least 45,000 newborn deaths yearly (MOH, 2008). Twenty-six per cent of the U5MR arises in the neonatal period (WHO, 2006). Although a decline of the U5MR has occurred over the years, the progression has been slow, from 167 in 1991 to the present 137 per 1000 live births representing an annual reduction of 1.1%. This rate is insufficient for Uganda to achieve the MDG-4 target of U5MR of 56/1000 per live births by 2015 (MOH, 2007, 2008; UNDP, 2007). Fifty-nine per cent of deliveries occur in the community with the assistance of unskilled birth attendants like traditional birth attendants, relatives or friends. Newborn morbidity and mortality is further compounded by health system bottlenecks due to low coverage of many priority interventions, poor coordination, weak infrastructure, shortage of trained motivated health workers, low uptake of available capacity, community local practices that place the newborn at risk and household resistance to the acceptance of recommended, evidence-based practices. (Okuonzi, 2004; Sheba et al., 2006; MOH, 2008; Waiswa et al., 2008)

Studies in Uganda undertaken in an urban health facility and one community setting on current and desired patterns of care (Byaruhanga et al., 2008; Waiswa et al., 2008) have demonstrated perceived difficulties in using recommended, evidence-based practices related to thermal protection, cord care and birth asphyxia. These constraints to change may be addressed both through appropriate behaviour change communication (BCC) and through modification of the recommended practices. As BCC messages are now being developed by the ministry of health to promote feasible and practical newborn practices in the community, it is important to explore the contextual situation in several geographic and cultural settings to obtain a deeper understanding of the community's choices without compromising the risk reduction usefulness of the promoted, 'compromise' practices.

This study was done to explore the acceptability and feasibility of the newborn care practices at household and family level in the rural communities in different regions of Uganda with regards to birth asphyxia, thermo-protection and cord care.

Methods

The study setting

The study was performed in three purposively selected rural communities in three districts in Uganda namely Kayunga, Soroti and Ntungamo. These represented different regions, with different language, cultural, socio-economic and demographic characteristics. The catchment population for the three districts combined was estimated at one million people. Kayunga, Ntungamo and Soroti districts are located in the central, south western and eastern part of the Uganda where childbirth by a skilled attendant is estimated at 51%, 32%, 41% and the perinatal mortality rate, weight specific at 22, 38, and 22 per 1000 total births, respectively (UBOS, 2006). The eastern and northern part of the country has one of the lowest wealth quintiles and in the past experienced episodes of political insurgence and famine.

Study design

An exploratory qualitative study using in-depth interviews (IDIs) and focus group discussions (FGDs) was performed during August 2008. The study was part of formative research on behaviour change communication (Nsungwa-Sabiiti et al., 2008).

Participants and sampling

Six IDIs and nine FGDs were conducted in the rural communities. The respondents for this study were purposively selected from different villages and parishes with the assistance of the district health visitor, community health workers and local community leaders in the area. They were selected from villages in the district with the poorest health indicators. The villages chosen differed from those in the other phases of the larger study (Nsungwa-Sabiiti et al., 2008)

All respondents selected resided in the local community. All the mothers involved has had normal vaginal deliveries in the rural community without the help of a skilled attendant and had live babies. The elderly caretakers had to have had experience caring for a mother and her infant, while the partners or husbands had to have a wife who had recently delivered.

The IDIs were performed with traditional birth attendants (TBA) so as to provide information regarding practices done immediately after birth. The FGDs were with post childbirth mothers, elderly caregivers (older women, mothers in law, grandmothers), partners or husbands of the recently delivered mothers so to explore and obtain the diverse experiences of the respondents on newborn born care. Each FGD was composed of 10–15 participants. Each of the participants gave verbal consent prior to the interviews.

Data collection

The IDIs were conducted at the homestead of the TBA, whereas the FGDs were done in selected secluded areas in the community to ensure privacy. The interviews were conducted in the local language by selected experienced research assistants who had undergone training for a week on newborn care and on the use of the interview guide seven days prior to the field work. Each district was allocated two research assistants. One of the research assistants acted as a moderator who guided the interviews, whereas the other took notes, did tape recording. Non-verbal communication of the participants was observed by both research assistants. Each IDI and FGD took between 60 and 90 minutes. A standardised interview guide covering specific thematic areas on newborn care practices at time of childbirth, the postpartum period on areas related to thermo-protection, birth asphyxia, cord care, was used (Dahlgren et al., 2004). Questions were raised and the respondent/respondents were encouraged to express their opinions openly about the issues with the moderator ensuring that all the women and men participated. A point of saturation was deemed to have been reached when no new information was being obtained during the interviews.

Data analysis

The tapes were transcribed in the local language and translated into English and were then analyzed using content analysis (Graneheim and Lundman, 2004). The analysis was done independently by the three authors R.N.B., J.K., and J.N.S. The transcripts were read several times. The text was read several times to identify the meaning units. Key words, phrases were underlined, condensed meaning units formed and the codes were