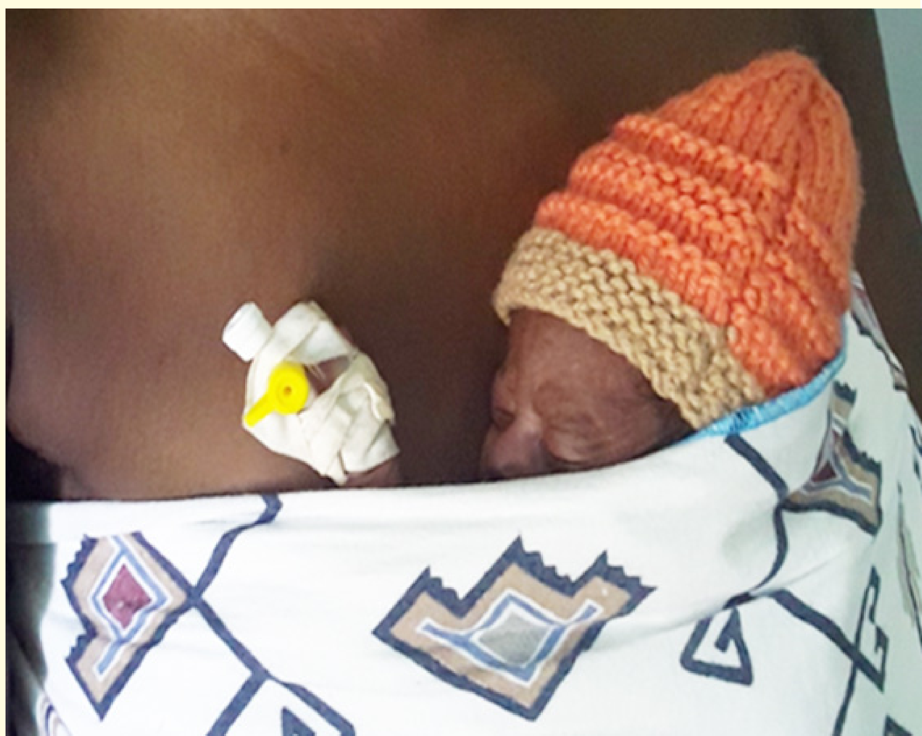
MAKERERE UNIVERSITY

East Africa
Preterm Birth Initiative
UCSF
University of California San Francisco

RESEARCH BRIEF

Improving Kangaroo Care for Small Babies: What is the Missing Link?



Understanding Kangaroo Care

Kangaroo Care improves wellbeing and survival of some preterm and low birth weight infants. It involves early, continuous and prolonged skin-to-skin contact between the mother (or other adult) and the baby; exclusive breastfeeding (ideally); is initiated in hospital and can be continued at home; small babies can be discharged early; and mothers should be provided with adequate support and follow-up.

It has been proven to reduce up to half of all neonatal deaths among stable preterm babies weighing less than 2,000g. Additionally, it advances development of the baby and increases love between the mother and baby as well as the mother's self-esteem since she takes part in caring for her baby. It has also been advocated for as affordable and easier to implement.

However, despite its benefits, there has been low use of KC globally and in Uganda. For instance, in 2012, an assessment of KC coverage in Uganda indicated low uptake, with KC only practiced in Kampala and four regions of the country, and in 17 health facilities in total.

This study set out to explore barriers and facilitators to KC uptake and adherence in the health facilities and communities in Busoga region, East central Uganda.

What did we do?

From December 2016 to July 2017, we conducted research across five districts in Busoga region.

We held key informant and in-depth interviews with mothers, support persons, health workers, Village Health Teams, Traditional Birth Attendants (TBAs), District Health Officers and local leaders.

Group discussions were held with mothers and support persons, and health facility assessments conducted in six major hospitals in the region.

What did we find?

In all the six hospitals, KC was being implemented. Health workers in the Special Care Unit (SCU) knew how to do KC and there was high acceptability among health workers and patients.

Most mothers were knowledgeable, although at times there were gaps in information, especially about the number of hours KC should be done, and when it should be terminated. There are also a few men actively engaged in KC. However, we identified challenges to its uptake and adherence that we highlight here

Health facility barriers

Human resources: Understaffing, over worked health workers in the Special Care Unit; limited KC knowledge among those not in the SCU; irregular training that has mostly been externally organized or on-the job training from those who were already taught.

Poor quality of care and infrastructure: Small and overcrowded KC rooms, lack of comfortable beds and chairs, shortage of Nasogastric (NG) tubes, cannulas, oxygen and other drugs. This is coupled with poor sanitation and hygiene facilities. All these affect the comfort of the mothers, and their ability to consistently practice KC while in the health facility.

No food provided in the hospitals: Mothers are not given food and so have to spend time either preparing it or money on buying it. This increases time spent away from KC, expenses, and stress.

Health worker attitudes: Some patients indicated lack of support with KC, with health workers seen as rude, harsh and uncaring.

Community barriers

Cultural and traditional practices: These include the use of charcoal stoves to warm babies, giving herbs to preterms, creating warmth by wrapping them in cotton wool, giving birth from the TBAs homes (who do not know about KC), the fact that in Uganda we usually carry babies on the back not chest, among others. These are more of a challenge when the mother is back home and no longer under the watchful eye of the health workers.

Competing domestic priorities: Activities like child care, washing, looking after animals and other house chores keep women occupied at home, especially in a rural setting. Mothers often cannot afford to hire extra help. Therefore, they reduce the time that they can dedicate to KC.

Gender roles: Women are often expected to perform multiple household chores, including taking care of the husband / partner, regardless of whether she or her child has a health related challenge. On the other hand, the men are often expected to go out to work, rather than help with KC. This leaves the woman too overwhelmed to do KC as required, and the man absent from home.

...But then if the mother tells you, "musawo [doctor] yesterday I did not eat", my husband is not coming, he doesn't have a phone or I am calling his phone and it is off, of course you know that she is tortured, has nothing to eat, she will tell you the other day it is the neighbour who gave me food, please discharge me and I go, of course you discharge her on request (Health worker, Iganga district) Mothers, especially those in rural areas, have a lot of work to do so most times they do not give much attention to their babies and this leads to suffocation since they do not always check on their babies ... (Caretaker, Bugiri district)

Barriers found in both the health facility and community

Financial issues: Due to the prolonged hospital stay, parents require more money for things like food, pampers, baby caps, soap and medicines. They also need money in order to return to the hospital for the follow up appointments and treatment. Furthermore, KC results in a loss of productivity and income on the part of the mother, who is often unable to engage in any economic activity she may have previously been doing. It is time consuming and the mother almost cannot do anything else.

Lack of community follow up of mothers doing KC: Mothers are not followed up into the community by health workers for assistance due to lack of resources. However, they get challenges when the baby falls sick and are unaware of what to do. More so, some mothers cannot afford transport to return for care, eventually dropping out or coming less regularly. This affects effectiveness of KC and endangers the baby's life.

Lack of support: Many mothers were not receiving support from their families, particularly the fathers of the children. This refers to both financial support, as well as physical help with doing KC, having attendants in hospital, getting food and performing other tasks. The situation was worse for mothers who had multiple births. This makes it harder for the woman to adhere to KC, and there are frequent requests for early discharge.

Psycho-social effects: Mothers face stress, depression and discouragement during KC. This is related to the already mentioned challenges, including financial barriers, lack of support, as well as the frustration of caring for preterms.

Physical effects: KC is painful to do, and is worse for mothers who have had caesarean sections. It causes backache, chest pain, and is tiresome

What can be done?

In the health facility...

- **Training** all health workers in KC as part of their school curriculum; refresher training, including those not in SCU and for health workers in HC III and IV; provision of guidelines and posters that are visible on the ward; mentorship by others already experienced in KC
- Increasing the **number** of health workers and having a special full time nurse in the SCU
- Provision of **food** for mothers in hospitals, as well as **drugs**, NG tubes, cannulas, oxygen and other supplies like baby caps, wraps and small pampers
- **Spacious KC rooms**, appropriate beds and chairs for mums to use; posters and guidelines of KC on the ward; as well as edutainment like TVs
- **Psycho-social support:** Increased counselling of mothers doing KC so they can cope better
- Improving **hygiene and sanitation** in the health facilities.

In the community...

- Support health workers and Community Health Workers with resources to **follow up the mothers** in the community after discharge and monitor the baby's progress
- Use of **peer-to-peer support** among mothers, where women who have successfully done KC teach and guide others who are struggling
- **Pregnant women should be sensitized** and prepared during antenatal care for the possibility of a preterm birth and use of KC
- **Sensitization** and counselling about KC and other preterm care should be given to mothers and their **families**, especially husbands / partners, as well as other community members. This could be through radios, televisions, community meetings, posters in local languages; integrating KC into community outreaches on family planning, and others. Local leaders should also be engaged to advocate for KC programs
- **Train TBAs** on KC because although they were banned in Uganda, they still actively deliver babies and handle preterms
- **Partner with other sectors** beyond health, for instance to encourage women to have income generation projects and have savings so they can plan for the birth of the baby.

Now just like you have invited us, we can also go out and teach other women who are not yet in the system (Mother, Bugiri district)

Study limitations

Among the methods for identifying mothers of preterms was the use of hospital records, which include phone numbers. However, we failed to get many of the respondents because sometimes the mother would register her own mothers phone number but on follow up would have already moved back to her own home, or the phones would be switched off.

This study was sponsored by The Preterm Birth Initiative East Africa (PTBi EA) through the Resource Allocation Program (RAP), University of California, San Francisco.

Districts where study was done:
Jinja, Iganga, Kamuli, Bugiri and Mayuge

Participating hospitals: Jinja Regional Referral Hospital, Iganga Hospital, Kamuli General Hospital, Kamuli Mission Hospital, Bugiri Hospital and St. Francis Buluba Hospital

Contact Us:
Ms Doris Kwesiga,
Study Principal Investigator
www. dknnkwesiga@gmail.com
www.mnh.musph.ac.ug