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Postprint

This is the accepted version of a paper published in *African Journal of Midwifery and Women's Health*. This paper has been peer-reviewed but does not include the final publisher proof-corrections or journal pagination.

Citation for the original published paper (version of record):

Söderbäck, M., Erlandsson, K. (2012)

Kangaroo Mother Care in a Mozambican Perinatal ward: A Clinical Case study.

African Journal of Midwifery and Women's Health, 6(1): 21-27

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Permanent link to this version:

<http://urn.kb.se/resolve?urn=urn:nbn:se:mdh:diva-12675>

Kangaroo Mother Care in a Mozambican Perinatal ward

A Clinical Case study

Maja Söderbäck, PhD, BSc, RNSC, RNT

Associate Professor, School of Health, Care and Social Welfare, Mälardalen University,
Sweden

Kerstin Erlandsson, Med Dr, RNM

Associate Professor, School of Health, Care and Social Welfare, Mälardalen University,
Sweden

Correspondance:

Maja Söderbäck,

School of Health, Care and Social Welfare,

Mälardalen University, Box 883, Västerås, Sweden

e-mail.maja.soderback@mdh.se

Abstract

Kangaroo Mother Care (KMC) was first introduced in Mozambique in 1984. The aim of this study was to describe Mozambican mothers' experiences of going through admission, passing from an intensive care ward to a nursery ward with their premature baby, undergoing KMC training before early discharge. A clinical case study was conducted, involving naturalistic observations and a face-to-face interview with 41 mothers participating to complete a questionnaire. Descriptive statistics and manifest content analysis were used. The result demonstrate mothers of low socio-economic standard who experienced they were limited informed. The hierarchical organization within the hospital setting as well as communalistic behaviours influenced the mothers' experiences of KMC, including information, communication, support and relationships with the doctors, nurses and assistant nurses. The conclusion is that the proposed clinical KMC guidelines seemed to have been neither fully implemented on the KMC nursing ward nor rooted in the Mozambican community.

Keywords: Kangaroo Mother Care, KMC, Mozambique, Mothers' experiences, Neonatal care, Neonatal nursing, Premature baby

Introduction

Kangaroo Mother Care (KMC) was developed in Columbia in 1978 as a strategy for dealing with overcrowding and scarcity of resources in hospitals caring for low birth weight (LBW) infants (Charpak et al. 2005; Hall and Kirsten, 2008). The essentials of KMC are to keep the infant in skin-to-skin contact between the mother's breasts as long as possible, exclusive or nearly exclusive breastfeeding and early discharge, regardless of weight or gestational age. For premature babies studies of skin-to-skin interventions have shown reduced infant mortality (Sachdev 2003 Review) and morbidity from severe illness and infections (Sachdev 2003 Review; Charpak et al. 1997; 2001; 2005). Skin-to-skin contact also improves physiological response with maintained or improved stability (Bergman et al. 2004). Also the number of feeds per day is increased and breastfeeding competence is improved. Investigation has also shown that the infants are more settled in the kangaroo position (Andersson et al. 2003; Charpak et al. 2006). In developing countries, KMC is used as a complement to conventional treatment when resources for caring for LBW infants are insufficient, when there are no neonatal facilities, or in hospitals with access to resources, but where demand exceeds supply (Charpak et al. 1996; Cattaneo et al. 1998; Kirsten et al. 2001). According to Bergman (1994) and Charpak et al. (2001) the use of KMC in developing countries supports the well being of mother and child and early discharge.

In Mozambique KMC was partially introduced as early as 1984, and was part of the national policy for care of LBW infants in all levels of health facility. A study by Mondlane et al. (1989) reported encouraging results on thermal control. But, according to Cipire (1992) and Gujral (1996), trust in the Mozambican health system is found to be traditionally low among many families. Dauanzo (1991) found that the mothers abandoned the wards. Their attitude and perceived care problems concerning their premature baby led them to believe that a baby that was premature and too small could not survive. The mothers were not always willing to

feed their baby because they felt the infant was not a stimulating child. Neither did the mothers have the necessary patience or encouragement to care. Conflicts in the family, concerning belief in traditional care contra medical care, and hard work at home and more children to care for, influenced the care problems (Dauanzo, 1991). However, Lincetto (2000) found, in a Mozambican rural hospital, that the survival rates were improved among infants with LBW using KMC. The KMC method was well accepted by health staff at all levels. They worked to improve their knowledge of premature babies and the best caring method for the baby's survival. Also the mothers and their families in this rural area were found to have accepted the method. The mothers' opinion was that KMC protected the baby and helped it to grow. The main difficulty mentioned was to assure continuity of proper care in the rural context, where health staff and material resources were very limited. The cultural problems, mentioned by Lincetto (2000), centred mainly on the hospital stay after birth and the maternal role in the home. These difficulties were partly resolved by involving other mothers in helping to find the best solution for the newly admitted mother and baby. This communalistic way of living together in a context, such as on a hospital ward, with mothers supporting and educating each other, has been earlier described as an African ethical value by Kaphagawini (1998) and Haegert (2000). However, more studies were needed to assess and understand routines on a perinatal ward and about mothers' experiences of the care of a premature baby, and training in KMC in the hospital before early discharge. The aim of this present study was to describe events at a Mozambican neonatal unit and mothers' experiences of going through admission passing from an intensive care ward to a nursery ward with their premature baby, and then undergoing KMC training before early discharge home. Prematurity is defined as birth before nine months of gestation and a weight of less than 2500 grams.

Method

Study design

This clinical case study was conducted at a perinatal unit at the Central Hospital in Maputo (HCM). The case study employed a descriptive ethnographic design (Stake, 1978; Denscombe, 1998; Sandelowski, 2011). The study was inductive and exploratory, focusing on the conditions, the caring process and relationships on the ward, by capturing the mothers' experiences. The collection of data involved naturalistic observation and a face-to-face interview using a questionnaire.

Setting

Permission for the study was given by the Department of Health Systems at the Ministry of Health in Mozambique and by the medical and nursing management at the Paediatric Clinic at the Central Hospital in Maputo. Births at the Central hospital numbered about 30 000 /year (HCM, Moçambique, 2002). Neo-natal care was conducted on two wards. New born children admitted to the intensive care unit suffered from a range of diseases and LBW, or were premature, and numbered about 5.000. When the baby's condition allowed, the baby was transferred together with the mother to the nursery ward for training in KMC. The year this study was conducted 1.854 newborn babies were transferred to this ward. All of them had LBW and most were also premature. The average number of premature babies admitted to the KMC nursery ward each month was estimated at 70. The overall mortality rate for the intensive care and KMC units combined was 30% (HCM, Moçambique, 2002). The KMC nursery ward had in total 28 beds. Each mother and her baby/ies had a bed with a blanket and sheets. Four nurses were employed to support them. Two of these nurses had a specialist education in paediatric care with skills to train the mothers in KMC. Two were assistant nurses (serventes) who assisted the nurses and the mothers on the ward. A paediatrician

conducted consultations every day, and decided on early discharge on weekly visits when the baby was weighed, and the mother received support.

KMC policy for the nursery ward was established twenty years ago (Mondlane et al., 1989).

The policy was stated 1991 (Dauanzo, 1991) It contained that a constant and physiological microclimate for a tiny baby, wrapped in a cotton cloth (so called capulana), with skin-to-skin body contact and an 'ecological niche' will reduce the risk of hospital infections. The statements by Dauanzo (from 1991) was based on that somatosensorial stimulation from the mother will receive incidence of apnoea, and that the suckling and swallowing ability of a tiny baby will improve if it is frequently exposed to stimulation from the breast. Daily temperature and weight controls of the baby together with training, advice and support for the mother from a nurse would increase the use of KMC. The ward policy also encourages collaboration and solidarity between mothers in support of the KMC method (Duanzo, 1991). This KMC policy was in force at the time of this study 2002.

Data collection and Sample

The collection of data involved naturalistic observation of events two days a week over a one month period in 2002 on the KMC nursery ward, and was conducted by the first author who participated and followed everyday events. This fieldwork included open observations as well as talks with the nurses and mothers. The observations concerned the mothers' acting towards their premature babies, their interactions with the nurses, doctors and assisted nurses (serventes) and other mothers. The talks consisted of questions according to their actions.

Detailed field notes were compiled. The interviews were conducted face to face with the mothers by using a questionnaire during the same period. These interviews were made by two Mozambican research assistants who were familiar with both Portuguese and the local language Shangana. A purposive sample of 41 mothers admitted with their premature baby/ies was invited. The inclusion criteria were that their baby was premature. If agreed and after

receiving information about the questionnaire, the research assistant asked what language the mother would like to use, Portuguese or the local language, Shangana. The questionnaire was the same Mozambican questionnaire on family involvement (MFQ) in paediatric care used in another study (Söderbäck & Christensson, 2008), but with some modifications. Questions were added to collect more demographic characteristics, as well as questions about the mothers' admission to hospital and the birth of the child. Open questions concerning experiences of KMC were also added. At last the mothers rated the behaviour of doctors, nurses and assistant nurses towards them. The level of perceived fulfilment was rated on a five point Likert Scale using the values 'very good', 'good', 'bad' and 'very bad'. The research assistant helped the mother, by reading the questions and explaining the alternative answers and responses, and marked the mother's selected answer in the questionnaire. The research assistant also asked the open questions and wrote down the mothers' answers as verbatim as possible, word for word, in Portuguese.

Data analysis

All relevant data from the questionnaire was transferred for descriptive statistical analysis using SPSS 16.0 for Windows. The frequencies in the socio-demographic distribution among family care-givers, details of admission to the intensive care unit as well as the KMC nursery ward, were identified. A manifest content analysis, according to Graneheim and Lundman (2003), was used by coding the answers of the open questions about the mothers' experiences of the neonatal intensive care and the KMC ward. This analysis was made step by steps from the transcribed text to codes and then counted in frequencies. In the statistic analysis of the mothers' experiences of the behaviour of doctors, nurses and assistant nurses mean and median were used for rating. The case study, demographic data of the mothers, the observations of events at the nursery wards and the mothers' experiences, is narrative presented in the results section according to Stakes (1978).

Results

The demographic characteristics of the mothers and their babies are shown at Table 1. The events during the birth of the child and the mothers' experiences of admission to the intensive neonatal ward and transfer to the KMC ward are presented at Table 2.

The mothers' experiences of intensive neonatal care

During the time when the babies were receiving intensive neonatal care, the mother was given a place in a so-called 'sleeping-room'. The mean of the babies stay on the intensive care unit were about five days. Twelve of the babies spent from 6 to 10 days in intensive care (Table 2), during which time the mothers were required to visit their babies for breast-feeding every three hours during the day, starting at 7 o'clock in the morning. When breast-feeding their babies the mothers sat in line in a passage outside the ward. One mother said: *"If we do not turn up to the ward we will create trouble for ourselves"*. Another said about the intensive care of her baby: *"I have no right to stay there, either to express myself about the breast milk"*.

Events on the KMC ward

After transfer to the nursery ward using KMC, which took place mainly in the middle of the day, each mother was given her own bed to share with her baby/ies. She was told the routine by someone, another mother, an assistant nurse or a paediatric nurse (Table 2). The individual consultations with the mothers and their babies were conducted during the morning between 9 and 12 o'clock. These consultations were conducted in a big ward room, where all other mothers sat waiting their turn, including the discharged mothers coming for weekly consultations. The mothers sat with their babies on chairs beside their beds, waiting for a call from the nurse. The nurses called each mother (as *senhoras*) forward to bathe her baby/ies. Firstly the nurse checked the baby's temperature and weight and watched how the mother

took care of her baby. The nurses monitored and instructed the mother how to hold the baby close to the body with just the cotton cloth (capulana). The nurses' communication towards the mothers was brief and postulating. A common phrase from the nurse was: *"I can see from the baby's temperature if you are holding your baby close to your body"*. After the nurses' consultations the mothers met the doctor, who examined the baby, watched how the baby behaved, talked and instructed the mother on caring for the child. The doctor also decided about further KMC training with the mother, either staying on the ward or being discharged and called forward for weekly consultations. The nurses also dealt with the mothers as a collective (Senhoras) while teaching and giving them lessons (palestras) on hygiene and breast-feeding. The nurses explained to the mothers that they have to follow their monitoring of the KMC method and listen to the advice given them. The nurses told the mothers that: *"Kangaroo Mother Care is important for the baby's survival"* and *"the only way of caring for a premature baby is by becoming 'a close mother' (A propria mae)"*. The nurses encouraged the mothers to breastfeed every second hour, or whenever the baby wanted, and to clean their hands after visiting the latrine. No mother was ever observed asking a question or querying what she had been told during this instruction. Sometimes a mother, especially the really young mothers, was given individual KMC support by the paediatric nurses.

During the afternoons and at night the mothers were left alone to rest, and feed and care for the baby. A visiting period of one hour was allowed for families.

The Mothers' experiences of the KMC ward

When the mothers arrived on the KMC nursery ward they experienced they were given information about the routines on the ward mostly by other mothers (15/41), or by the assistant nurses (17/41). Some other received the information from the paediatric nurses (9/41). The mothers all took it for sure that they were expected to, and they also wanted to give their baby basic care (such as breastfeeding, bathing, and comforting). None of the

mothers experienced they received any information before transfer to the nursery ward about what KMC involved. In the end 28/41 of the mothers said that they wanted to be given this information, and 13/41 said they did not want any prior information. Some of those who wanted information before the transfer of their baby commented thus: *“I would like to know how to care for a premature baby”*; *“It would have been easier when I eventually had to face reality”*; *Knowing what they expected of me when caring for my baby*; *“Knowing the conditions beforehand would have facilitated my care of the babies, as well as easing the nurses’ workload”*; *“I wanted to know what I had to do and how it would all end.”*. The kind of information and training the mothers wanted from the nurses during the consultations and lessons to prepare for discharge was about; *“being trained how to care for the little baby”*; *“about nutrition”*; *“how to continue with the KMC method”* and *“advice on how the baby could develop without becoming ill”*. However, the mothers said that the provision of training by nurses was dependent on the nurse own willingness, sympathy and kindness on admission. There was a consensus among the mothers that it was only the doctors and the nurses who were capable of reaching and taking decisions about the baby’s state of health. However, they divided on the issue of receiving information about the state of health of the baby. Seven mothers said they did not want any such information, six mothers said they wanted it sometimes, but 28 said that they would always want to have information about their baby’s state of health. None of the mothers experienced they needed any kind of religious/spiritual support when staying on the ward.

As regards participating and assisting in painful situations for the baby, such as injections, 18 of the 41 mothers said they would always want to take part. However, 12 mothers would have wanted to some times, and 11 mothers said they never wanted to be involved in that type of situation. But, when asked about their experiences of how the nurses wanted them to participate and assist in painful situations for the baby, 29 of the mothers said that the nurses

always wanted them to participate and assist the baby in any way if possible, while 12 mothers said that they experienced that the nurses wanted them to leave the baby.

The mothers' experiences of the behaviour of doctors, nurses and helpers

The mothers met the doctors for only a short time in the morning during the consultations.

While one paediatric nurse and one assistant nurse (servente) were on duty on the ward during the whole day. At night only an assistant nurse was on duty. How the mothers rated the behaviour for their attentiveness and communication, their ability to explain, their kindness, sympathy, positive attitude and how they experienced the relationship overall is shown in Table 3.

The mothers rated the doctors' ability to communicate lower than the others. The doctors were experienced as being "*difficult to understand*". However, the paediatric nurses' ability to communicate was experienced different. A comment was "*The nurses really try to explain the KMC method to us*". The assistant nurses (serventes) were described as being "*good at explaining the routines*". However, the assistant nurses were also described as being "*easier to relate to, but they also treat us as troublesome*".

The mothers' expectations of being discharged

Most of the mothers (33/41) did not know, or had never thought about how their family members might perceive the birth of a premature baby. The other mothers had ideas about why a baby might be premature in their families' beliefs, such as "*a baby will have a low birth weight if it does not get good nutrition during the pregnancy*", and "*if you are working too hard or carrying too much*".

Knowledge in the community in general, as well as within individual families, about using KMC for premature babies was seen as non-existent; Only six mothers (6/41) said that their families knew about this caring method. However, sixteen mothers (16/41) believed that their

families will understand the situation surrounding a premature baby when they arrive home, and that they would try to give them support. These mothers said that they expected that the baby's grandmother, a sister or a sister-in-law, would provide care support for the baby. One mother expected it to be easier to use KMC at home rather than on the nursery ward, because with twins she would get help from her sister-in-law when she had to breastfeed one at a time, as well as carry each baby close to her body. Other mothers (25/41) said they expected other kinds of difficulty after they had been discharged from hospital. One mother said "*They (the family) don't know what a mystery a premature baby is*". The most common concern was that it would be difficult to continue with KMC because of the work the mother had to do in the house: carrying water, going to the market, cooking and cleaning the house, as well as caring for other children in the family. "*It will be difficult to have to always carry the baby close to my body*". Other concerns included the problem of using KMC if one had twins; the baby not wanting to breastfeed or go to sleep, or getting sick and not surviving. Two mothers also explained that they would miss the guidance given to them by the nurses on the KMC nursery ward.

Discussion

This study contributes towards an understanding of KMC in an African setting. It highlights the complexity of adapting the KMC method on a hospital unit. The results demonstrate that the mothers experienced that they were not sufficiently trained in KMC by the nurses, who had limited skills to empower the mothers to manage KMC on their own after discharged home. The mothers confessed a lack of understanding in the nursery ward. Even if they felt welcome to participate in caring activities it was to be beneficial to the staff. However, to compare also with parents in neonatal intensive care in others countries as Japan and New Zealand they also dealt with uncertainty and lack of information from the staff (Ichima, Kirk

& Hornblow, 2011) as well as mothers did in Sweden (Erlandsson, 2005). The setting and vulnerable position being a parent to a premature baby is exacting.

From this present study several barriers in the Mozambican setting could be identified as inhibited these mothers' experiences. First, the mothers lived together for several days in the sleeping room with limited facilities during their babies' time in the intensive care unit. Their experiences of communality have to be trying. Their experiences of having to visit the baby only for breastfeeding without any more involvement in the care of the baby demonstrated a vulnerable position within the intensive care. Also the events on the nursery ward, as well as the mothers' experiences, demonstrated a lack of information and wanting training. Not knowing what will happen to them, or their babies, will probably made the mothers feel neglected.

It was found also in this present study that the behaviour of the health personnel was rated highly overall by the mothers, with a mean of 'good'. But the result further demonstrated that the assessment of behaviour varied between and within each group of health personnel (doctors, nurses and assistant nurses). The mothers rated their experiences of doctors' behaviour with the best value, 'very good' and 'good', followed by nurses, 'good', with the level of approval given to the assistant nurses being more spread. Among specific behaviours ranked by the mothers, the experiences of the doctors' sympathy, attentiveness and positive attitude were valued the highest, rated as 'very good' or 'good'. The doctors, who are well trained, also had the highest status and position of authority, while the untrained assistant nurses with their experience of everyday practical matters were ranked lowest.

In the ward policy it was stated that collaboration and solidarity between mothers should be encouraged as a support to the KMC method (Dauanzo, 1991). From this study the mothers demonstrated that they could relate better to others mothers as well as to the assistant nurses (serventes). These are commonly of the same social-economical group. While the mothers'

uncertainty in their relationships with the paediatric nurses can be understood as the Mozambican nurse education is ranked on a middle educational level and affords an authoritative status through the ability and skills to deliver nursing care (Söderbäck & Christensson, 2007). Also Aarts et al (2011) found in a recent study from Mozambique into the practice of and support for breastfeeding that the nurses knew the benefits and passed on the information verbally, but had insufficient counselling skills.

A culture of not passing on information and of disempowering might be related to the fact that the social structure in Mozambique is hierarchical, due to the prevalence of poverty and a low standard of education, as revealed by Cipire (1992). Haegert (2000) further describes how communalism, involving being a subject together with others, is projected into the hospital environment and institutionalised through expectations, communication and relationships among the members. Hence, the hierarchic relationships among all the participants, doctors, nurses and mothers, in the ward setting have to be understood in the cultural context of the African ethos of communalism (Kaphagawani, 1998; Haegert, 2000). In an earlier study into Mozambican nursing practice on the paediatric wards it was also found that this communal way of life was practiced collectively, with the doctors and nurses in the position of superiority (Söderbäck & Christensson, 2007). A future challenge for KMC wards in Mozambique will be to empower the mothers, by enforcing the existing KMC guidelines that have existed for many years (Dauanzo, 1991). The challenge will be both by the paediatric nurses' way of empowering as well as by using the solidarity and supporting communication among the mothers and assistant nurses (serventes). The mothers' experiences of difficulties to continue with the overall idea of KMC after discharge are understandable as their demographic data revealed a low socio-economic standard. This is the case for most of households in Mozambique, the country being one of the poorest countries in the world (Human Development Report, 2010). Without support by the family in their everyday life the

mothers will have a lot of responsibilities as to carry water, cook and take care of other family members. Thus family support is needed to be included in the KMC training during the admission.

Limitations

This present study was a limited clinical case study based on naturalistic observations of events and face-to-face completion of a questionnaire about mothers' adoption of KMC. The method was useful for exploration, understanding and description. It is unusual that all individuals in a sample agree to participate in a study, as was the case in this study. It may reflect a cultural characteristic. For example the household survey carried out in Mozambique in 2003 (The Demographic and Health Surveys, DHS) had a response rate of about 95%. The mothers all granted informed consent and the availability of the researchers could be assessed as good if the mothers had something to add, ask or did not want to participate in the study anymore. As the face to face interviews were made during the admission the mothers answers can have been influenced by that they were in powerful interdependent of the health personals. A threat to internal validity could occur if the mothers' answers were really focused on the phenomenon of KMC because of the language difficulties, illiteracy etc. The fact that the first author is a paediatric nurse who have knowledge about Mozambican culture while living there for several years and that the second author, who contributed to the analysis and the writing of the manuscript, is also experienced in KMC, can be seen as strengthening the validity of the study. There can be a generalization or transferability to a similar case, rather than to a population of cases according to Stake (1978). Despite the limited sample, the descriptions of these findings can lead to a better understanding of mothers' KMC training on a hospital ward.

Conclusion

In conclusion the clinical KMC guidelines seem to have been neither fully implemented on the KMC nursing wards nor rooted in the community. For the future it is necessary to highlight the importance of empowering mothers to be motivated and trained while still on the nursery ward. To implement KMC training successfully the basic requirements of early information, a supportive environment, adequately trained and motivated health professionals able to provide the needed information, support and guidance to mothers initiating it for the first time, as well as to give support to get the benefits to the whole family are necessary.

Support for families also seems to be important to ensure the long-lasting effects of KMC after discharge.

Key phrases

- Kangaroo Mother Care (KMC) in Mozambique was first introduced for mothers of premature babies in 1984. The policy for guidelines on a KMC nursery ward is still in force.
- The mothers demonstrated low socio-economic standard as well as a low level of education, demonstrating uncertainty in the hospital setting.
- The mothers experienced a lack of information from the health professionals at the neonatal unit, both at the intensive care unit and on the KMC nursery ward.
- The mothers felt welcome to participate in caring activities when it was beneficial to the nurses, but did not really understand the meaning of KMC.

Acknowledgements

We would like to extend our thanks to all at the paediatric clinic and on the KMC ward at the Central Hospital in Maputo for their support, and especially to all the mothers who willingly shared their experiences. We also want to thank the research assistants, Gloria Macitela and Patricia Buque, who conducted the face-to-face interviews.

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Table 1
Socio-Demographic data for the Mothers (n=41)

Demographics	Number	Mean	Median
<i>Age of the mother</i>		22,8	22
14 years old	2		
15-19 years old	12		
20-24 years old	14		
25-29 years old	8		
30-34 years old	2		
35-39 years old	3		
<i>Civil status</i>			
Single	11		
Married or equal	28		
Widow	2		
<i>Household members</i>			
2-4 members	13		
5-7 members	18		
8-10 members	3		
>10 members	7		
<i>Children in the household</i>			
The premature baby	20		
1 child more	10		
2 children more	5		
3 children more	4		
4 children more	1		
5 children more	1		
<i>Children who have died</i>			
1 child	8		
2 children	2		
<i>Education</i>			
Secondary school (10-12 years)	5		
Primary school (5-7 years)	27		
Primary school (< 5 years)	6		
No education	3		
<i>The mother's work</i>			
Housewife	34		
Own business at the market	3		
Maid	3		
Student	1		
<i>House</i>			
Stone house	25		
Hut	5		
Unsafe construction	6		
Wood house	2		
Other	3		
<i>Water</i>			
Tap	22		
Water pump	3		
Well	8		
Open well	8		
<i>Toilet</i>			
Water toilet	18		
Open latrin	23		

Table 2. The birth of the child and admission to premature care (n=41)

Variabel	Number
<i>Place of Birth</i>	
Central hospital (HCM)	15
Other health facilities	19
On the way	2
Home	5
<i>Birthweight</i>	
1000-1500 g	6
1500-2000g	30
2000-2500g	5
<i>Who told about the hospitalization of the premature baby</i>	
A medical doctor	3
A nurse at the delivery ward	29
A nurse at the Kangaroo ward	1
Other	4
No one	4
<i>Days of the baby's admission at the Intensive neo-natal care unit</i>	
< 24 hours	3
24-48 hours	3
3 days	10
4 days	4
5 days	4
6-10 days	12
Don't know	1
<i>Place for the mother</i>	
The mothers' room in a bed alone	8
The mothers' room in the same bed as more mothers	25
The mothers' room on the floor	1
At home	7
<i>Who informed about the routines at when you arrived to the Kangaroo ward</i>	
A nurse	9
A Helper	16
Other mothers	13

Table 3. Mothers' experiences of Doctors, Nurses and Helpers Behaviour. N=41

Scores from 1 – 5 (1 = Very good and 5 = Very bad)

Behaviour	Doctors	Nurses	Helpers
<i>Attentiveness</i>			
Mean (median)	1,66 (2)	2,07 (2)	2,24 (2)
Very good	15	9	5
Good	25	22	25
Neutral	1	8	7
Bad or Very bad	0	2	4
<i>Communication</i>			
Mean (median)	2,12 (2)	1,95 (2)	1,95 (2)
Very good	15	13	14
Good	13	21	19
Neutral	6	4	5
Bad or Very bad	7	2	2
<i>Explication</i>			
Mean (median)	1,83 (2)	1,90 (2)	1,93 (2)
Very good	13	10	14
Good	22	27	19
Neutral	6	2	6
Bad or Very bad	0	2	2
<i>Kindness</i>			
Mean (median)	1,88 (2)	1,93 (2)	2,29 (2)
Very good	9	10	5
Good	28	25	21
Neutral	4	5	13
Bad or Very bad	0	1	2
<i>Sympathy</i>			
Mean (median)	1,59 (2)	2,12 (2)	2,41 (2)
Very good	17	8	3
Good	24	24	24
Neutral	0	5	9
Bad or Very bad	0	4	5
<i>Positivism</i>			
Mean (median)	1,85 (2)	1,93 (2)	2,27 (2)
Very good	8	8	3
Good	31	28	26
Neutral	2	5	10
Bad or Very bad	0	0	2
<i>Relationship</i>			
Mean (median)	1,54 (1)	1,88 (2)	2,24 (2)
Very good	21	13	5
Good	18	22	24
Neutral	2	4	9
Bad or Very bad	0	2	3
Total Mean of Experiences of Doctors, Nurses and Helpers Behaviour	1,78	1,97	2,19