



Kangaroo Mother Care Related to Breast Feeding, Social Support, its Belief and Birth Options

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KEYWORDS :

INTRODUCTION

Kangaroo mother care (KMC) implies placing the newborn baby in intimate skin-to-skin contact with the mother's chest and abdomen coupled with frequent and preferably exclusive breast-feeding.¹KMC has emerged as a non-conventional low cost method for newborn care that provides warmth, touch, and security to the newborn and is believed to confer significant survival benefit. An updated Cochrane review has reported that KMC benefits breastfeeding outcomes and cardio-respiratory stability in infants without negative effects.²

Kangaroo mother care is developmentally supportive type of new born care.

Benefits of KMC to infants are:

1. Faster weight gain
2. Improve thermal,cardiovascular ,respiratory regulation
3. Enhanced neurological development
4. Reduce frequency of infectinal illness
5. Improve baby and mother bonding.

Benefits of KMC to mother are:

1. Oxytocin release
2. Less breast feeding difficulty
3. Reduce postpartam psychosis.

AIM:

To identify expectant mothers knowledge about an attitude towards Kangaroo mother care.

HYPOTHESIS:

Despite benefits, kangaroo care use in the delivery room is low and infants are often separated from their mother at birth, evidencing a need for interventions such as Kangaroo care to reinstitute contact between mother and newborn.³

Based on previous research , we expect that

KMC attitudes and knowledge would correlate positively with attitudes towards breast feeding, SES own education level, income and spouse education level ,perceived social support ,perception of control over decisions related to pregnancy/labor and delivery, and interest in a more" natural" pregnancy and birth experience.

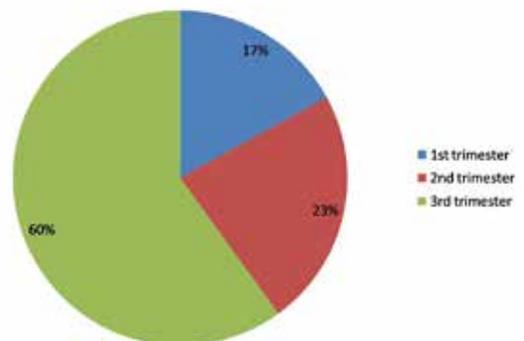
KMC attitudes and knowledge would correlate negatively with depression level.

METHOD:

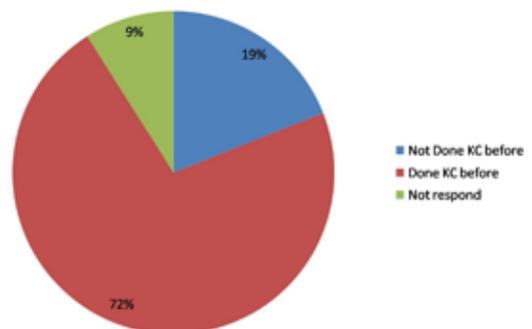
It is an observational study conducted in department of Obstetrics & Gynaecology, National Institute of Medical Sciences and Hospital and Primary health care centre Achrol, Jaipur. The period of study done was from July 2014 to July 2015. A . 100 antenatal women were recruited.

- Participant (N= 100 antenatal women)
- Mean age = 23.4 years
- 41% of women were pregnant for first time.

Participants by trimester



Percentage of mother who had done KC before



Measures

- IOWA Infant Feeding Attitude Scale(IIFAS; de la Mora, Fusell, Dungy, Losch & Dusdieker,1998)
- Beck Depression Inventory II(BDI;Beck et al 1961)
- Demographics Form
- Kangaroo Care Attitudes Inventory(KCAI).This inventory, developed for this study, consisted of 34 Likert type items assessing past exposure to KMC, interested in doing KMC at different time periods, perception of spouse/partner's support of KMC and willingness to do KMC, knowledge about KMC(e.g risks and benefits of KMC), and attitudes towards KMC(e.g privacy concerns).

Procedure

After obtaining informed consent , surveys were done in person in NIMS hospital and primary health care centers .The debriefing form contained information about prenatal depression and resources regarding prenatal /postpartum depressions and KMC.

Data Analysis

SPSS for windows was used for all analyses. Inventories were reverse coded such that higher scores indicated increased depression (BDI), more positive attitudes toward breast feeding (IIFAS), and increased knowledge and interest in KMC (KCAI).

Descriptive Statistics:

KCAI mean = 4.24 , SD= 0.45 (possible range = 1-5 on a Likert -type scale)

IIFAS mean = 4.29 ,SD= (possible range = 1-5 on a Likert- type scale)

BDI mean= 11.23 , SD= 8.69(possible range was 0-64; minimal depression=0-13 , mild14-19 moderate =20-28, severe=29-63)

Breast feeding:

Women with favorable attitudes toward breastfeeding (IIFAS) were more knowledgeable about and interested in KC (KCAI) , $r(100) = 0.629$, $p < .001$. They were also more interested in beginning KMC immediately after birth before the infant has been cleaned or assessed, $r(100) = .505$, $p < .001$, and continuing KMC after 6 weeks , $r(100) = .233$, $p < .05$. Intention to breast feed exclusively correlated positively with higher KCAI score $r(94) = .508$, $p < .001$.

Social support:

Having a spouse/partner who would be willing to do KMC at birth was highly correlated with higher maternal KCAI scores, $r(100) = .533$, $p < .001$, with interest in doing KMC immediately after birth , $r(100) = .630$, $p < .001$ and with interest in continuing KMC after 6 weeks, $r(100) = .345$, $p < .01$.

Having a spouse /partner support their decision to KMC slightly increased interest in doing KMC at birth , $r(96) = .293$, $p < .05$. More generalized social support during pregnancy did not have a significant effect.

Medical System Usage and Attitudes

Women who received prenatal care from a obstetricians scored higher on the KCAI than women receiving care from another source , $F = 6.652$, $df = 1$, $p < .05$. Women planning for hospital deliveries scored higher KCAI, $F = 5.365$, $df = 3$, $p < .01$ as shown by an ANOVA of the effect of place of planned delivery.

The higher women scored on the KCAI , the less interested they were in a C-section, $r(93) =$, $p < .01$, and they were more interested in a vaginal birth delivery $r(93) = .449$, $p < .001$.

The more control women felt they had over decisions related to their delivery , the higher they scored on the KCAI , $r(72) = .232$, $p < .05$.

No effect of depression, income, own/spouse's education level were found.

Conclusion :

Intention to breast feed exclusively correlated positively with higher kangaroo mother care score.

DISCUSSION

Strengths:

This study is showing variables that influence expectant mothers knowledge about attitudes toward KMC, and willingness to do KMC with their infant, which was previously missing from the literature.

In the sample the number of women were higher who opted for using obstetricians and had hospital deliveries which helped to uncover the differences between the women in compare to those using trained birth attendants /other sources and selecting home birth deliveries settings.

Some effects may have gone undetected, such as possible effects of income and education level knowledge about and attitudes towards KMC. This is possible because our sample included low- income women being cared for at a free clinic where trained birth attendants or other sources care was provided. KMC and deliveries in hospital and health care centres were encouraged.

Although KCAI was phrased as objectively as possible, potential social desirability effects cannot be ruled out. In this case , it is likely that individuals may have inferred that the researchers were supportive of KMC based on the fact that they were interested in women's perception of practice.

FUTURE DIRECTIONS

This study laid the groundwork for the development of the kangaroo Care attitudes Inventory. Further studies should narrow the item pool to increase variability and discriminate ability, and should employ longitudinal methods to determine to determine the predictive power of this tool.

RECOMMENDATIONS

Proper counseling and prenatal education is required for spouse/partners/family for the benefits of KMC.

Mother should be educated about the benefits of breast feeding and how KMC can help in enhancing the breast feeding experience and also helps in reducing the breast feeding difficulties.

Women using traditional birth attendants/ other sources care instead of trained birth attendants or obstetricians care , may be at a disadvantage for learning about KMC and would benefit from increased education about KMC.

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