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Mothers' Perspectives and Experiences of Kangaroo Mother Care in the Fezile Dabi Health District, South Africa: A Qualitative Study

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MOTHERS' PERSPECTIVES AND EXPERIENCES OF KANGAROO MOTHER CARE IN THE FEZILE DABI HEALTH DISTRICT, SOUTH AFRICA: A QUALITATIVE STUDY

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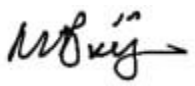
A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Public Health (Mother and Child).

Johannesburg, August 2025.

Declaration

I, Muellatt van Biljon, declare that this Research Report is my own, unaided work. It is being submitted for the Degree of Master in Public Health (Maternal and Child Health) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



(Signature of candidate)

On the 5th day of August 2025 in Welkom, Free State Province

Dedication

I dedicate this dissertation to my husband, Roelof, bereft of life, who inspired me to start my MPH journey and who believed in me so much. Your love and encouragement will always be treasured.

I also dedicate this dissertation to my beloved family, especially my sisters and children (especially Cillie), who made me believe I could manage and complete the MPH as I was a diligent worker and needed to believe in myself. Thank you for the many coffees and jokes.

Lastly, I dedicate this dissertation to God, Father of Heaven and Earth, who heard all my prayers when trying to find the strength to continue and for giving me clarity of mind throughout this journey.

Abstract

Kangaroo mother care (KMC) is a high-impact, cost-effective intervention to improve the health outcomes of preterm and low birth weight infants. This evidence-based method is safe, increases infant survival and has positive physiological, behavioural, neuroprotective, and psychosocial effects. The qualitative study reported here explored on mothers' perspectives and experiences of KMC in the Fezile Dabi District in South Africa.

In-depth interviews were conducted with five healthcare workers from the neonatal unit and 13 mothers practising KMC at the Boitumelo Regional Hospital or who had been in the KMC ward before discharge. A deductive analysis identified barriers and enablers to KMC practice, followed by an inductive analysis of participants' perspectives and experiences of KMC.

Most mothers had positive views of KMC, but reported minimal preparation during pregnancy for preterm birth or KMC. This led to initial mixed emotional reactions, including being shocked, worried, and happy that the baby was alive. Over time, mothers accepted the value of skin-to-skin care and exclusive breastfeeding. On discharge, they were counselled and all looked forward to taking their babies home. Healthcare workers highlighted their roles in supporting KMC and emphasised the importance of paternal involvement in caring for both the mother and the premature infant.

The findings from the barriers-enablers analysis yielded two themes: support for mothers and the health system. Support for mothers encompassed psychosocial and financial support, which e KMC. In the hospital, healthcare workers played a crucial role by providing emotional support, sharing KMC knowledge, and offering practical guidance on positioning the baby, thermal care, feeding, and hygiene. This support helped ease mothers' fears and boosted their confidence in continuing KMC at home. Most mothers received some family support eat home, although paternal involvement was limited if the father lived separately. Financially, the majority of mothers were unemployed and relied on family support and government grants.

The findings related to the health system theme are organised according to its key building blocks. Several barriers to optimal KMC services were identified, including a lack of leadership and management support to address the implementation of KMC policies, limited budgets for infrastructure improvements, a shortage of skilled healthcare workers, and inadequate supplies.

Service delivery remains inconsistent across provinces and districts in South Africa, affecting the quality of KMC. Strengthening the health system and increasing public awareness about preterm birth and the benefits of KMC could help improve public demand for and access to quality care for small and sick newborns.

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I would like to express my deepest gratitude to my supervisors, Prof Wiedaad Slemming and Dr Anne-Marie Bergh. This endeavour would not have been possible without your inspiration, guidance, and expertise in the field. Your dedication and commitment to guiding me through this process and encouraging me to continue, regardless of the difficult path, are greatly appreciated and respected. Your expertise in the field and the skills you so selflessly shared are commendable.

Lastly, I thank family and friends for continuous support and encouragement since I started in 2020. I am incredibly grateful to you all.

Abbreviations

24/7	24 hours a day, seven days a week
CA	Clinical associate
CHW	Community health worker
ENAP	Every Newborn Action Plan
KMC	Kangaroo mother care
LBW	Low birth weight
LIMCs	Low- and middle-income countries
NICU	Neonatal intensive care unit
POPD	Paediatric outpatient department
SDGs	Sustainable Development Goals
SGA	Small for gestational age
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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Glossary

Term	Definition
Gestational age (GA)	"The weeks of gestation completed at the time of delivery. Gestational age is defined as the number of weeks that have elapsed between the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery, irrespective of whether the gestation results in a live birth or a fetal death." (1)
Kangaroo mother care (KMC)	"The care of preterm or low-birth-weight infants in continuous and prolonged (i.e. 8–24 hours per day, for as many hours as possible) skin-to-skin contact initiated immediately after birth unless the newborn is critically sick, with support for exclusive breastfeeding or breast-milk feeding ... An additional feature of KMC, when initiated in health-care facilities, is timely discharge from the neonatal intensive or special care unit to a lower level of care within the facility or at home, with continued skin-to-skin contact and close monitoring ..." (2)
Low birth weight (LBW) - categories	"'Low birth weight' (LBW) has been defined as first weight recorded within hours of birth of <2500 g. Very low birth weight (VLBW) is accepted as <1500 g and extremely low birth weight (ELBW) is <1000 g …" (3)
Neonatal/Newborn mortality	"Death of a newborn in the first 28 days after birth. Reported as neonatal mortality rate (i.e. newborn deaths in the first 28 days after birth per 1000 live births)." (2)
Preterm infant	"Preterm is defined as babies born alive before 37 weeks of pregnancy are completed. There are sub-categories of preterm birth, based on gestational age: • extremely preterm (less than 28 weeks) • very preterm (28 to less than 32 weeks) • moderate to late preterm (32 to 37 weeks" (4)
Small for gestational age (SGA)	"Infant below the 10th percentile of birth weight for gestational age. A small for gestational age newborn may be preterm or full-term and can have low birth weight or normal birth weight …" (2)
Small/Vulnerable newborn	A live newborn "who [is] preterm (born before 37 completed weeks of gestation), [is] small for gestational age at birth (birthweight below the 10th centile of the recommended international, sex-specific birthweight for gestational age standard), [or has] low birthweight (LBW; <2500 g)." (5)

Term	Definition
Stillbirth	“A stillbirth is defined as a baby born with no signs of life after a given threshold, usually related to the gestational age or weight of the baby.“ (6)
Vulnerable newborn	See Small/Vulnerable newborn.

CHAPTER 1: BACKGROUND AND INTRODUCTION

Stillbirths, preterm birth and low birth weight (LBW)[1] are current priorities on the global newborn health agenda (6-9) as part of the achievement of the outcomes of the Every Newborn Action Plan (ENAP) (10) and the Sustainable Development Goals (SDGs) (11, 12). The target of the SDGs is to reduce neonatal deaths to 12 per 1,000 live births (12). Globally, there has been slow progress in newborn survival and even a slower decline in stillbirths, with the highest burden and slowest pace in the sub-Saharan and southern Asian regions (9). According to the ENAP, universal coverage of quality maternal and newborn care could save 3 million lives of mothers, newborns, and stillborn (10).

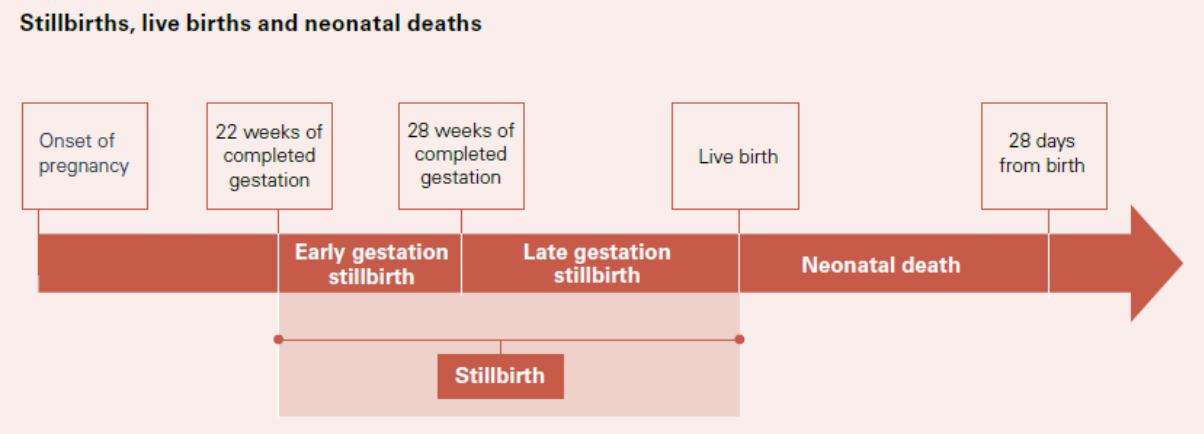
1.1. Magnitude of stillbirths and newborn deaths

The burden of stillbirths and neonatal deaths remains high in low- and middle-income countries (LMICs) (13, 14). In 2021, there were 1.9 million stillbirths, equivalent to 13.9 stillbirths per 1,000 total births (15). Of these, 74% were due to preterm birth (14).

Neonatal deaths occur in the first 28 days after birth, which is the most vulnerable time for the survival of the newborn (5), with the first week of life comprising about three-quarters of these deaths (16, 17). According to global estimates for 2022, the number of neonatal deaths amounted to 2.3 million, translated into 17.3 deaths per 1,000 live births (16). The risk of death for a newborn was 11 times higher in sub-Saharan Africa (27/1,000 live births) than in countries with the lowest death rate (16). South Africa's estimated neonatal mortality rate was 11 per 1,000 live births in 2022 (18). Figure 1 depicts the relation of the cut-off points between stillbirths, live births, and neonatal deaths.

Neonatal deaths are primarily caused by complications of prematurity, intrapartum-related complications (birth asphyxia/birth trauma), neonatal infections (sepsis, meningitis, pneumonia, and diarrhoea), and congenital disorders (7, 10, 16). Prematurity is currently the leading cause of newborn deaths (35%) and deaths in children under five (16%) (7, 10).

[1] For definitions of these and other terms relevant for this study, see the glossary preceding this chapter.



Source: *A neglected tragedy: the global burden of stillbirths* (6)

Figure 1. Relation between cut-off points of stillbirths, live births and neonatal deaths

Despite advances in the improvement of under-five survival, consideration has been given to possible strategies to accelerate achieving the SDG target of 12 neonatal deaths per 1,000 live births. A new conceptual framework under the umbrella term of small vulnerable newborns has recently been proposed to define the problem and better respond to it (5). Small vulnerable newborns comprise three distinct categories that cover all LBW infants: preterm newborns that are not small-for-gestational-age (SGA) (born too soon) (8.8%); term SGA newborns (born too small) (16.3%); and preterm SGA newborns (born too soon and too small) (1.1%) (14). This means that one in every four live births delivers a small vulnerable newborn.

1.2. Treatment of small vulnerable newborns

In the past few decades, there have been many advances in the treatment of small vulnerable newborns to prevent complications and to minimise the negative short- and long-term impact of being born too soon and/or too small. The last 15 years witnessed calls for action for committing to prioritising high-quality care at birth, with a special focus on the evidence for high-impact interventions that would improve the quality of care and the survival of preterm and LBW newborns. The following are seminal publications: Global Report on Preterm Birth and Stillbirth (2010) (19); the ENAP (2014) (10); the *Lancet* Every Newborn series (2014) (20); the Survive and Thrive document (2019) (7); the *Paediatrics* supplement on Evidence for Global Health Care Interventions for Preterm or Low Birth Weight Infants (2022) (21); and the *Lancet* Small Vulnerable Newborn series (2023) (5).

One intervention that appeared frequently as a high-impact, cost-effective intervention was (facility-based) kangaroo mother care (KMC) and feeding support for small newborns (21-23). The ENAP also suggests that indicators be developed for KMC and feeding support as part of the tracking for the coverage of complications and extra care of newborns (10). The World Health Organization (WHO) considers KMC as essential for all preterm and LBW infants and calls for its integration in all national health programmes covering maternal, newborn and child health (2).

Kangaroo mother care is the focus of this report, as will be clear from the problem statement, aim and objectives discussed below. KMC as an intervention is covered in more detail in Chapter 2.

1.3. Problem statement and rationale for the study

Globally, a substantial number of studies have reported on the KMC experiences and perceptions of mothers and caregivers (24-27). Seidman et al. (25), for example, conclude that context-specific factors need to be explored to understand their potential impact on a KMC programme – these include local circumstances, cultural attitudes and support for the mother. Barriers identified that would inform this study included the factors that could influence mothers' and their families' perceptions and experiences of KMC in the hospital and at home related to service delivery; health worker allocation and distribution; community and social context and norms; and caregiver capabilities (including KMC knowledge and skills).

Our study was conducted in the Fezile Dabi Health District in the Free State Province, South Africa. Boitumelo Regional Hospital is the only referral hospital in the district. All preterm and LBW infants from the district who need specialised care are admitted there. Health professionals working in the hospital referred to their difficulties in providing the continuum of care to these infants in need. The newborns received KMC during their hospital stay; however, there were issues around the quality and comprehensiveness of the in-hospital KMC service because of human resource challenges. There was also uncertainty about whether community health workers were conducting home visits after discharge from the hospital.

Health professionals indicated a need for more information on how mothers of LBW and preterm babies admitted to the Boitumelo Hospital perceived KMC and how they

experienced the practice of KMC in the hospital and at home. No research on KMC services and client experiences of KMC had been conducted in the Fezile Dabi District before. The rationale for this study was therefore to contribute to the understanding of KMC practice and experience in this district and how it was influenced by contextual factors. Although the Fezile Dabi District is similar to other districts in South Africa, comparing our findings to other district settings could yield useful insights.

1.4. Study aim and objectives

The aim of this study was to explore the perspectives and experiences of kangaroo mother care of mothers with a preterm or LBW infant admitted to the Boitumelo Hospital in the Fezile Dabi Health District, South Africa, between September 2023 and February 2024.

The following was the research question to be addressed:

> What are the perspectives and experiences of mothers of low birth weight and preterm infants admitted to the Boitumelo Hospital in the Fezile Dabi Health District with regard to KMC?

The objectives of the study were to:

1. Describe the experiences of mothers with low birth weight and preterm infants along the continuum of care from antenatal through to postnatal care.
2. Explore the views of healthcare workers on mothers' experiences of KMC, with special reference to barriers and enablers to successful KMC practice in hospital and at home.

1.5. Structure of the research report

This report has six chapters. The background and introduction chapter are followed by a literature review chapter on KMC. The third chapter covers the methodology, and the fourth chapter covers the findings. Then follows the discussion chapter, and the report ends with a conclusion chapter that also includes recommendations.

Chapter 1: Background and introduction

> In this chapter, we discussed the global magnitude of stillbirths and newborn deaths and the treatment of small, vulnerable newborns, followed by the problem statement and rationale, and the aim and objectives of the study.

Chapter 2: Literature review: kangaroo mother care

The literature review covers different definitions and modalities of KMC, the benefits of KMC, barriers and enablers impacting the implementation of KMC services, women's experiences of KMC, and KMC in South Africa.

Chapter 3: Methodology

This chapter describes the following: study design; research setting; study population and sampling; data collection, management and analysis; rigour; and study limitations.

Chapter 4: Findings

The findings are presented in four main sections: study participants; birth and infant characteristics; barriers and enablers to KMC practice; and mothers' experience of KMC.

Chapter 5: Discussion

This chapter interprets our findings against the results of other studies conducted on KMC. It covers health system barriers to and enablers of KMC, support for KMC, and mothers' experiences of KMC.

Chapter 6: Conclusion and recommendations

In this chapter, the gaps identified in providing KMC services and families' support needs to continue practising KMC after discharge from the hospital are discussed. This is followed by recommendations for health facilities and healthcare providers regarding improving the quality of KMC for preterm or LBW newborns and their mothers, and for policymakers and programme managers.

1.6. Conclusion

This chapter serves as an introduction to the study reported here. In the next chapter, an overview will be given of important aspects of kangaroo mother care reported in the literature.

CHAPTER 2: LITERATURE REVIEW

2.1. What is kangaroo mother care?

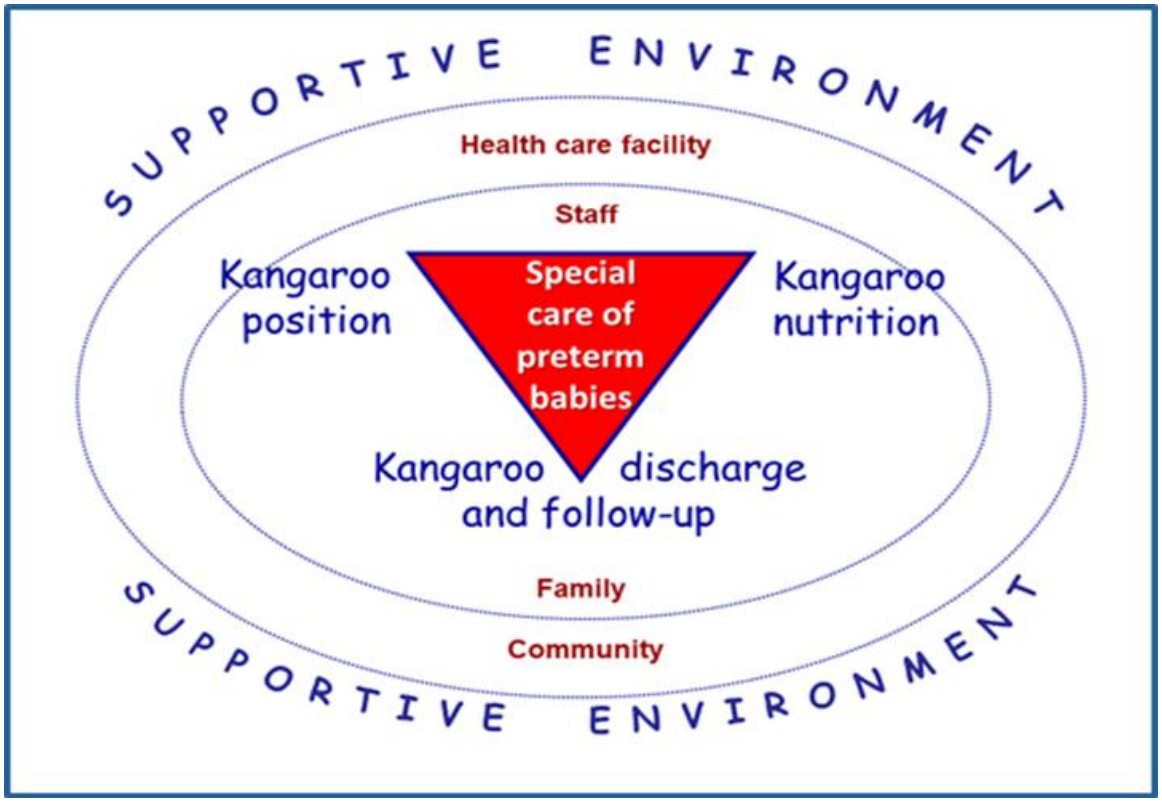
Kangaroo mother care (KMC) is an evidence-based intervention for reducing preterm mortality and morbidity and enhancing neurodevelopment (28-30). It was pioneered by Drs Edgar Rey and Hector Martinez in Bogota, Colombia, in 1978 to reduce the high rate of cross-infections caused by overcrowding in the neonatal ward at their hospital (28). The institutionalisation of KMC practice through appropriate KMC services is currently promoted for integration in all health systems at all levels where preterm and LBW infants are cared for (2). KMC is a notable intervention to achieve Sustainable Development Goal 3.2 of ending preventable neonatal deaths (32). The most current definition of KMC comes from the WHO's *Global Position Paper* on KMC as a transformative innovation in health care:

> "The care of preterm or low-birth-weight infants in continuous and prolonged (i.e. 8–24 hours per day, for as many hours as possible) skin-to-skin contact initiated immediately after birth unless the newborn is critically sick, with support for exclusive breastfeeding or breast milk feeding … An additional feature of KMC, when initiated in health-care facilities, is timely discharge from the neonatal intensive or special care unit to a lower level of care within the facility or at home, with continued skin-to-skin contact and close monitoring …" (2).

The kangaroo method is often described as having four components compatible with the definition above: KMC position; KMC nutrition; KMC discharge and follow-up; and KMC support. This description is compatible with the definition above. Figure 2 demonstrates the relationship between the different components of KMC (31).

2.2. Benefits of kangaroo mother care

Over the past four decades, studies have revealed the multiple benefits and positive effects of KMC, especially for preterm and LBW newborns. Numerous reviews focused on the effect on the survival of these vulnerable newborns in low-resource contexts (9, 28, 32). Different researchers have organised the benefits of KMC in different ways. Below is a synopsis of some of the most important findings.



Adapted from: *KMC implementation workbook* (31)

Figure 2. The main components of kangaroo mother care

In addition to the *reduction of neonatal mortality* in preterm and LBW infants, infants who receive skin-to-skin care and breastmilk feeding (the components of KMC) have better outcomes in terms of weight and length gain, head circumference, breastfeeding and length of hospital stay (32-34). The *physiological benefits* for these infants include improved physiological stability in terms of heart rate, respiration and a decreased risk of apnoea, oxygen saturation and temperature (32, 35). The closeness of the mother and her newborn after birth allows the newborn to take over the mother's protective microbiome, which lowers the risk of infection (36).

Further beneficial effects of KMC relate to *behavioural outcomes* (37). During KMC, infants' basic needs for non-separation and food are met. The infant's stress response is reduced, which is associated with the support of neurobehavioral and sensory development and the prevention of neurodevelopmental delays (37, 38). Small infants in the skin-to-skin position experience less pain when neonatal procedures are performed due to the lowered cortisol levels (39-41).

The physiological effects and behavioural outcomes of KMC not only enhance the short-term neurodevelopment of preterm infants, but the *neuroprotective effects* continue into adulthood (29). Long-term neuroprotection from KMC was also demonstrated through brain neuroimaging of young adults (30).

The findings of the *psychosocial effects* of KMC include maternal satisfaction with the method of infant care, maternal feelings of confidence and competence, improved measures of maternal-infant attachment, less maternal anxiety and more positive mother-newborn interactions for infants receiving skin-to-skin care (28, 37). Skin-to-skin contact and breastfeeding trigger the release of oxytocin in the mother, which has a calming effect on her and leads to a lower risk of maternal postpartum depressive symptoms and stress (42, 43).

Lastly, KMC also benefits *health facilities and the health system*. Small newborns receiving KMC tend to stay in hospital for a shorter period of time than infants receiving conventional care (28). This is not only convenient for parents but also contributes to lower hospital costs and a lower risk of overcrowding in the NICU, which can be the cause of nosocomial infections and neonatal deaths. The survival and lower morbidity of KMC infants furthermore reflect favourably on the performance of health facilities caring for small newborns.

2.3. Barriers and enablers to the implementation of kangaroo mother care services

Although KMC has been proven to be a safe and effective method of care, it has not yet been fully integrated into health systems worldwide. The quality of a KMC programme relies on a well-organised and coordinated response across all levels of the health system (44). The WHO *Global Position Paper* on KMC envisages that the operationalisation of the KMC concept “can serve as a strong foundation of highly efficient health systems that are rooted in the communities they serve and focus not only on preventing and treating illness but also on improving well-being and quality of life” (2).

Several reviews have systematically organised the barriers to implementing KMC services in health facilities. These barriers are often presented within the framework of the supply side of the health systems building blocks (45). Table 2.1 lists several barriers often mentioned in the literature (24, 25, 45-47).

Table 2.1. Supply-side barriers to the implementation of kangaroo mother care services

Building block	Barriers
Leadership and governance	• Absence of KMC policies, guidelines and strategies (45, 47) • Lack of creation or dissemination of service guidelines to implement and scale up KMC (45) • Lack of KMC awareness with leadership (45) • Limited collaboration between the obstetric and neonatal departments (45)
Health financing	• Funding limited or not available for implementation or scale-up of KMC (24, 45, 46) • Lack of KMC costing into plans/policies (45) • Limited budget for supplies (47)
Health workforce	• Lack of staffing, high workload, and poor distribution of competent and KMC-trained health workers (45-47) • Lack of training (45, 46) • Poor mentorship and supervision (45, 47) • Low level of knowledge and awareness (45, 46) • Poor attitudes (46, 47) • Lack of job descriptions (45)
Essential medical products and technology	• Scarcity or unavailability of resources and supplies to care appropriately for small and sick newborns (including KMC)) (24, 25, 45, 46) • Poor procurement and supply chain logistics for small and sick newborn care (including KMC) (45)
Health service delivery	• Lack of space (24, 25, 45, 46) • Logistical constraints related to support and monitoring of mothers/caregivers performing KMC (25) • Poor quality of care issues and lack of quality improvement related to KMC (45) • Lack of KMC follow-up after discharge (24) • Unavailability of services or disparities in delivering KMC (25, 46) • Lack of referral for KMC (transport and access) (24, 25, 45, 46)
Health information system	• Lack of information (45) • Poor or no data and records on KMC coverage (45) • Non-use of available data and results for improving quality of care (45) • Poor quality of information on LBW babies (45)

The flip side of a particular barrier often acts as a driver or enabler for implementing KMC services. Many issues listed above as barriers can also act as enablers in particular circumstances. Important enablers that often appear in the literature include good leadership and appropriate guidelines at all levels, the existence of good health metrics, sufficient KMC training for health workers with further supervision and mentorship, adequate follow-up systems for KMC babies and good facility-community links (25, 45, 46, 48-50).

The WHO *KMC Implementation Strategy* document sees KMC as the foundation of small and/or sick newborn care that would require the following to implement KMC at scale:

- System and structural changes to keep mothers and infants together and at the centre of care;

- Political commitment and programme leadership;
- A dedicated budget for KMC implementation; and
- A monitoring and evaluation framework to track progress (51).

2.4. Women's experiences of kangaroo mother care

There are also a variety of demand-side factors that influence women's ability or willingness to practise KMC, especially after discharge from the hospital. Table 2.2 summarises factors that have been reported to influence caregiver and community perceptions and acceptance of KMC positively or negatively (24, 25, 47-49, 52-58).

Table 2.2. Caregiver and community barriers to and enablers of kangaroo mother care

Factor	Barriers	Enablers
Health facility	• Difficulty accessing KMC services (48) • Unsupportive facility environment – lack of resources, lack of privacy, restrictive visitation policies (25, 54) • Unsupportive health workers – unassisted with KMC, breastfeeding, pain, fatigue, medical issues, postpartum depression (25) • Negative impressions of staff attitudes or interactions with staff: loud, uncaring (24, 25)	• Provision of KMC information and counselling (24, 25, 48, 52-55) • Male inclusion (24, 25, 52-55) • Access to staff and positive staff attitudes and respect for mothers (48, 52, 54) • Ability to stay with infant in health facility (54) • Baby's weight gain and earlier discharge as motivators (56, 57)
Social and cultural norms	• Community perceptions of preterm birth led to shame, stigma, fear or guilt of doing KMC in public (48, 52, 55) • Contradictions with traditional newborn care practices – infants carried on back and not on the front, bathing practices, nappies not used: mother is unclean (52) • Role definitions and gender roles – care of babies and KMC belong to females, disempowerment in decision making (24, 55)	• Belief that infant enjoys KMC (24, 54) • Societal acceptance of paternal involvement (24, 48, 52, 53, 55) • Multiple stakeholders involved (53)
Psycho-social factors	• Mother lonely and depressed in KMC ward – feelings of isolation (56) • Mother-infant attachment not well developed – perception that baby does not enjoy KMC (24) • Fear or anxiety of hurting the infant (24, 25, 54, 55)	Effects of KMC: • Promotes mother-infant bonding (24, 48, 52, 54) • Calming, relaxing, comforting, natural, instinctive, secure, logical, healing – speeds up emotional and physical recovery of mother (24, 48, 52, 54) • Caregiver confidence (24, 54) • Caregivers feel useful (24, 54)
Practical factors	• Poverty – cost associated with travel, food, lodging (24, 47) • Out-of-pocket expenses where health care is not free (24, 47) • Time – intensity of care of the preterm, other household or work responsibilities, commuting from home to health facility (24, 55) • Lack of transport and distance to facility (24, 47)	• Support of government or employers for parents, e.g. maternity leave, vouchers for transport (58)

Factor	Barriers	Enablers
Awareness and knowledge	• Low awareness of KMC benefits and newborn care among mothers, other caregivers and community (24, 25, 52, 55) • Information shared to men and women, families and communities only after the birth of the preterm and LBW baby (55) • Mother expected to perform KMC with little or no instruction (25)	• More likely to understand and respond well if KMC is well explained to mother (24, 25, 52, 55) • Awareness of KMC before birth (52, 55)
Family and community support	• General lack of buy-in/ low perceived value or community disapproving of KMC, especially mothers-in-law and grandmothers (24, 49, 52, 55) • Bad attitudes and pressure from peers (48, 55)	• Support from family, friends and other mothers, e.g. grandmothers, sisters, others helping with chores – also paternal support (24, 25, 48, 52-55) • Informal women's networks sharing information (52) • Community and religious leaders advocating KMC (52, 53)

2.5. Kangaroo mother care in South Africa

Studies published on KMC in South Africa can be divided into two broad themes: implementation and scale-up of KMC services, and mothers' experiences of the practice of KMC.

2.5.1. Implementation and scale-up of kangaroo mother care services in South Africa

Implementation of KMC started in South Africa in the 1990s at Groote Schuur Hospital in Cape Town (59) and at Kalafong Hospital, near Pretoria (60). This was followed between 2002 and 2006 by outreaches to scale up KMC services in hospitals in KwaZulu-Natal, Gauteng and Mpumalanga provinces to implement KMC (61-65). KMC was also included in other programmes to strengthen neonatal care services in hospitals (66, 67). In the first decade of the millennium, several studies were published about implementation at one specific hospital, focusing on infant health outcomes (68-70) and/or caregivers' and health providers' perspectives and attitudes towards KMC (57, 65). There were also several studies regarding the *health outcomes for small infants* receiving KMC (59, 68-71). As KMC became integrated into the neonatal healthcare system, KMC wards were also used for studying shorter and longer-term outcomes of preterm or LBW infants (72, 73).

Since 2012, the rollout of KMC became incorporated into official policy and guideline documents such as South Africa's *National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa* (CARMMA) (74) and the 2012-2016

Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition (75). The *Tshwane Declaration of Support for Breastfeeding in South Africa* mandated the implementation of KMC together with the Baby Friendly Health Initiative (BFHI) in the country (76).

As KMC became integrated into the neonatal healthcare system, KMC wards were also used for studying shorter and longer-term outcomes of preterm or LBW infants (81, 82).

2.5.2. Kangaroo mother care practice in South Africa – mothers' experiences

Despite the uneven implementation of KMC in the public healthcare sector and very little implementation in the private sector in South Africa (77), several (mostly qualitative) studies have been published on mothers' experiences and perceptions of KMC and healthcare providers' attitudes in various provinces in South Africa. These include three from Gauteng (78-80), one from KwaZulu-Natal (65), two from Limpopo (54, 81) and four from the Western Cape (56, 57, 82, 83). The study settings comprised only public hospitals, covering the whole spectrum from district hospitals (4 studies) (54, 81-83) to regional hospitals (1 study) (65) to tertiary hospitals (2 studies) (56, 57) to academic/central hospitals (3 studies) (56, 78-80). All studies included mothers of preterm or LBW infants, with one study focusing on adolescent mothers (82), and one on isiXhosa-speaking mothers in Cape Town who originated from the Eastern Cape Province (56). Two studies from the Western Cape included fathers (57, 82) and two studies covered nursing staff (81, 83). The number of participants ranged between 6 and 38 per study. The studies from Gauteng all reported the use of focus group interviews as data collection technique (78-80), the rest reported using individual interviews, sometimes further qualified with terms such as "face-to-face" (54, 65, 83), "in-depth" (54, 57, 82), "semi-structured" (56) and "unstructured" (81).

Mothers' experiences are discussed according to the four components of KMC explained in Section 2.1 of this chapter. The supportive (and non-supportive) environment is covered by the hospital environment and the support mothers have received from healthcare providers, other mothers, and families. Under the heading of KMC acceptance, the focus is largely on skin-to-skin care, which was new to many study mothers. This section ends with a review of breastfeeding experiences and planning for discharge.

The hospital environment

A prominent finding in many studies was the *unpreparedness of mothers*, fathers and families for preterm birth and what the course of events, including practising KMC, would entail. Leonard and Mayers (57) describe the unexpected early birth as accompanied by "intense disappointment and overwhelming fear". Mothers' emotions are also described in the literature by terms such as worried, confused, distressed, uncertain, scared and sad (56, 57, 65, 81, 82). Their concerns were about the physical well-being of their small babies (e.g. hypothermia; suffocating, hurting or dropping the baby) (56, 65, 81) and about their parenting (e.g. handling the baby and breastmilk production) (56). Some mothers also did not have prior knowledge about KMC (83). Mpongwana-Ncetani et al. (56) report that isiXhosa-speaking women found KMC a foreign, western concept in conflict with the Xhosa culture of not holding babies for long periods, but they also acknowledged that KMC was beneficial.

Two aspects of the hospital environment related to this unpreparedness were reported in the literature: the high-tech environment of the neonatal care intensive unit (NICU) and the neonatal high-care unit; and the environment in the continuous KMC unit or ward.

Very little data was found on the practice of KMC while preterm infants were still in the *NICU or high-care unit*. From a few study reports, it could be deduced that KMC was practised intermittently before starting with continuous KMC (57, 83). Leonard and Mayers (57) refer to the unfamiliar and intimidating environment of the NICU with high-tech equipment and incubators that hampered parent interaction. One academic hospital only allowed breastfeeding after a newborn had been transferred to the KMC unit (79). Mothers in this study found tube feeding stressful and had challenges with expressing breastmilk and maintaining milk supply for a long time.

Four studies provided information on how the *continuous KMC environment* influenced mothers' moods. The study by Ndou et al. (54) refers to the physical environment of the KMC ward with its limited basic amenities and lack of privacy. Mothers also had to supply their own detergents for washing their clothes and sometimes nappies for the baby. The other three studies describe the challenges for mothers having to stay with their babies in the KMC unit. Leonard and Mayers (57) call these the "living-in challenges" that included restricted support from and visiting hours for the family, the father's exclusion from KMC, and the mother's 24/7 care of the infant and sacrifice of own needs. Mpongwana-Ncetani et al. (56) identified a theme, "distress in the KMC ward", for the Xhosa women who found KMC

physically demanding. In the literature, other complaints that triggered a longing to go home were feelings of being disheartened, frustrated, bored, lonely, tired, sleep-deprived and having backache (54, 57, 80, 82). Xhosa mothers who missed the cultural custom of older women training the new mothers for motherhood indicated that the KMC ward mimicked the home environment in that nurses took on the role of these older women and that the KMC ward provided a safe space that protected the baby from illnesses and evil spirits (56).

The conditions in the KMC ward described above could impact the support for KMC mothers, especially from partners, spouses and other family members, and their relationships.

Support for mothers, interactions and relationships

Support and relationships in the KMC ward are described in different ways in the literature (65, 82). Mpongwana-Ncetani et al. (56), for example, describe the KMC ward environment as "the KMC village" consisting of mothers, doctors and nurses who define the interpersonal relations in the ward.

Support from and interactions with healthcare providers. Most studies referred to some form of support from healthcare providers for mothers of preterm babies receiving KMC. This entails practical support (65), emotional support (57, 65, 82, 83) and support for mothers in preparation for discharge (81). Providing regular information to mothers on the progress of the baby (57) and the availability of health workers to answer questions or clarify issues (54) are forms of informational support. Practical support refers to guidance on and assistance with providing skin-to-skin care and facilitating the early initiation of breastfeeding (54, 65, 82).

Studies report that the majority of mothers were generally satisfied with the support and treatment they received from nurses and the interactions they had with them. Vulnerable groups to receive additional or better support are first-time mothers (80), adolescent mothers (82) and mothers from specific cultural backgrounds (56, 81). Adolescent and Xhosa mothers perceived their interactions with doctors in a more positive light than their interactions with nurses (56, 82). The literature also alludes to mothers' requests for more client-centred care (83).

Support from and interactions with other mothers in the KMC ward. Five studies refer to the positive interactions between mothers in a KMC unit that resulted in mutual trust and friendships (56, 57, 65, 82, 83). Support came about by other mothers being good listeners

and mutually sharing “feelings, fears and emotions" (57) and encouragement (65). They also shared or discussed information received from health professionals (56), such as the importance of KMC, how to comfort a baby, and proper KMC positioning (83). They even shared food and toiletries (56).

Support from family members and relationships with them. Generally, mothers were emotionally supported by their spouses, partners and other family members (57, 65, 82) through frequent visits and comforting words (54). Xhosa women missed the support they would have received from their extended family at home (56). The long period of separation – which could even be longer than 4-6 weeks – when mothers were away from their families could create tensions with husbands/partners and affect the care of other children negatively (57, 82, 83).

Acceptance of KMC

Initial apprehension and hesitation about KMC made way for acceptance of KMC as mothers became familiar with the method and gained confidence in caring for their small babies with the support of the healthcare workers (56, 65, 80). This was especially noticeable when a baby was moved from the neonatal unit with incubator care to a continuous KMC ward, which meant spending more time with the baby in the skin-to-skin position (56, 80, 82). Closeness to their babies was perceived as a major factor in mothers’ feeling a special bond with their babies (56, 57, 65, 80). This closeness also enabled parents to get to know their babies (57, 80), monitor their well-being (54, 80), and respond to their cues and cries (56, 80). Growth and weight gain were the ‘proof’ that KMC was working (65, 80) and the measure of the successful care of a small newborn (57).

Breastfeeding

Several South African KMC studies refer to breastfeeding as one of the components of KMC in their background section and/or in specific quotes from mothers. Leonard and Mayers (57) link their findings to two main roles of mothers of preterm infants: providing breastmilk and warmth through skin-to-skin care, which enhances lactation. In addition to literature with very general statements about breastfeeding (65, 81, 82), Rodriguez et al. (70) describe that 87 exclusively breastfed infants treated on KMC had a good growth pattern, which could be ascribed to exclusive breastfeeding.

There are scant mentions in the literature relating to individual mothers' specific positive experiences regarding breastfeeding. Robertson and Crowley (82) cite one adolescent mother who said that feeding at the breast made her realise, "I am now a mother". Ndou et al. (54) quote a mother saying, "I constantly observe my baby ... how she sucks from the breast. All the time when she cries, I am closer to her."

Reports of negative experiences were more from the time in the neonatal unit when mothers had to express breastmilk for tube and/or cup feeding, before they moved with their babies to a continuous KMC unit. Three mothers in the study by Solomons and Rosant (83) indicated that they would have wanted assistance with breastmilk expression. Randa et al. (80) mention first-time mothers' perceptions of poor nursing support for breastfeeding, which caused stress and worry about insufficient milk production. Some participants in Mpongwana-Ncetani et al.'s study (56) felt overwhelmed by the two-hour feeding schedule of the preterm infants and were stressed about whether the feeding tubes were working properly, as they perceived nurses were not checking them regularly.

Two publications discuss in more detail the feeding experiences and intentions of mothers in a KMC unit in a tertiary hospital. The 2021 paper by Madiba and Sengane (79) mentions general feeding difficulties were mothers' constant worry about milk supply and babies' inadequate sucking ability. Mothers experienced milk expression as difficult, stressful and painful and lacked confidence and skill to administer the breastmilk via tube. The transition from tube feeding to feeding at the breast had other challenges, such as the baby's latching on the breast and a mother's worry that the baby would lose weight. There were, however, also positive experiences associated with establishing breastfeeding, such as the baby's improved sucking reflexes and the mother-infant bonding. The 2023 study by Madiba et al. (78) reports on mothers' initial difficulties with breastfeeding, their positive attitudes expressed while in the KMC unit, and their intentions to continue breastfeeding after discharge. The authors also allude to the counselling, training and support nurses gave to mothers, which positively influenced their breastfeeding intentions after discharge.

Discharge planning

No information could be found on South African mothers' KMC experiences after hospital discharge. Gooding et al. (84) surveyed mothers in a KMC unit on their readiness for discharge; 88% reported a high level of discharge readiness. The discharge-readiness tool contained item categories related to feeding, infant care, infant health and medications, and

practising KMC. Mahwasane et al. (81) interviewed a sample of midwives in a district in Limpopo Province on the post-discharge needs of mothers of preterm infants. Still, the study did not involve mothers or their experiences. The 2003 KMC policy and guidelines for the Western Cape Province discuss planning discharge with the parents, discharge criteria regarding weight gain, and follow-up procedures (85). A chart completed daily to assess readiness for discharge was used in KwaZulu-Natal Province through observing the baby's weight gain and feeding ability and the mother's confidence in infant care, home support for her and the baby, and compliance with continuous KMC (86).

Three studies from the Western Cape refer to discharge. Leonard and Mayers (57) indicate that "weight gain symbolises a step closer to discharge and to life as a family outside the hospital". Mpongwana-Ncetani et al. (56) refer to mothers' preoccupation with weight gain and sufficient milk supply to enable discharge home. Robertson and Crowley (82) describe the information and support nurses and social workers provided to adolescent mothers before discharge.

2.6. Conclusion

This chapter provided an overview of the development of the kangaroo intervention over more than 40 years, internationally and in South Africa. The definition of KMC and its benefits, as well as the barriers and enablers regarding the uptake of KMC, were discussed. The last section of the chapter describes mothers' experiences of KMC in South Africa. The next chapter gives an overview of the methodology followed in executing the study reported here.

CHAPTER 3: METHODOLOGY

This chapter discusses the study design, the research setting, the study population, data collection, data management and analysis, and applications of rigour.

3.1. Study design

As no research on KMC services and client experiences of KMC had been conducted in the Fezile Dabi District before, an exploratory qualitative research design was considered the most appropriate for this study. Little information was available on the important issues that mothers and their families experienced as barriers or enablers to the practice of KMC in hospitals and at home. A better understanding of these experiences and other factors that influenced service provision and the involvement of mothers and healthcare workers in caring for small newborns was needed. Conducting semi-structured interviews was considered the most appropriate technique to elicit rich information. This approach is also in line with the proposal of Seidman et al. (25) about the need for qualitative and ethnographic research focusing on KMC mothers, healthcare providers and community members. The design of this study would also be a first for the Free State Province, as it differed from that of the other two Free State KMC studies reported in the literature (69, 70).

3.2. Research setting

The setting for this study was the Boitumelo Regional Hospital and the Fezile Dabi District. Fezile Dabi is one of the five districts in the Free State Province of South Africa and has a population of 509,912 in 2022 (87). Boitumelo Hospital in Kroonstad is the district's only public regional (level 2) hospital. Kroonstad is part of the Moqhaka Municipality with a population of 155,410 in 2022 (88). As there is no district hospital in this municipality, Boitumelo also functions as a district hospital for level 1 care. Of the available 312 inpatient beds, 15 are maternity beds and 12 neonatal beds, of which 4 are allocated for intensive and high care and 8 for KMC (personal communication, Dr Refilwe Mofokeng, 23 January 2025).

Study participants were recruited in the neonatal unit (including the KMC ward) and the postnatal follow-up clinic at the paediatric outpatient department (POPD) at the Boitumelo Hospital.

3.3. Study population and sample

The study population included mothers admitted to the Boitumelo Regional Hospital in Kroonstad who were providing or who had provided KMC for their preterm and LBW infants. Health professionals and other health workers caring for these mother-infant dyads were also included.

Table 3.1 summarises the different groups of study participants, sampling strategies, inclusion criteria and the intended versus the realised sample in this study. The planned sample sizes for this study were based on the need to ensure a diverse range of perspectives across key participant categories. Purposive sampling was used to target mothers with direct experience of KMC in both hospital and community settings. The initial sample size estimates were guided by the information provided by the head of the neonatal unit during initial visits and were determined by the potential number of participants that would be available in the KMC unit and at the POPD during the data collection period.

Mothers with infants born >2500g were excluded. A further exclusion criterion was potential informants who were unwilling or unable to participate. None of the approached informants refused to participate in the study.

Table 3.1. Summary of sampling and data collection methods

Data collection method	Participants	Sampling strategy	Inclusion criteria	Number planned	Number obtained
Key informant interviews	Head: paediatric unit	Purposive	• Intimate involvement in the care of preterm and LBW infants • Willing and available to participate	1	1
	Nursing manager: paediatric unit	Purposive		1	1
Individual interviews	Other relevant health professionals	Snowball	• Referred by other participants as an important source of information • Willing and available to participate	Not specified	3
Individual interviews	Mothers in the neonatal unit (incl. KMC ward)	Convenience	• Mothers of LBW and preterm infants practising KMC in hospital or at home • ≥18 years of age • Willing and available to participate	8	6
	Mothers at the POPD clinic	Convenience		5	7

Data collection method	Participants	Sampling strategy	Inclusion criteria	Number planned	Number obtained
Focus group discussions (1 for each group)	CAs	Total population	• Working in the coverage area of the Boitumelo Hospital • Willing and available to participate	4	0
	CHWs	Convenience		6-8	4

Abbreviations: LBW, low birth weight; KMC, kangaroo mother care; POPD, paediatric outpatient department; CA, clinical associate; CHW, community health worker

3.4. Data collection

Data collection for the study was conducted with available participants over two consecutive weeks in February 2024. Although fewer mothers than planned were available in the KMC unit for interviews and more mothers at the POPD, data saturation was reached, and no further issues or insights emerged in the last interviews conducted.

Table 3.1 served as the original plan for data collection. All types of interviews with all the main informant groups were conducted, except the focus group interview with clinical associates. As there were no clinical associates attached to the hospital at the time of data collection, this group had to be excluded.

Key informant interviews were conducted with the paediatrician in charge of the neonatal unit and the nursing manager. Other potential information-rich health workers identified for individual interviews were one professional nurse and two enrolled nursing assistants. Individual interviews were conducted with six mothers of preterm and LBW infants in the neonatal and KMC units and with seven mothers bringing their infants back for follow-up at the POPD of the hospital. Only four community health workers (CHWs) could be recruited at the primary healthcare facility (clinic) closest to the Boitumelo Hospital for a focus group discussion. These participants were considered the link between the hospital and the community.

All interviews were face-to-face and took place in private spaces. They were audio-recorded with the participants' permission and lasted between 30 and 45 minutes. The interviews were conducted with the aid of semi-structured interview guides with open-ended questions, which were available in English, Sesotho and Afrikaans (see Appendices G to I).

Interviews with mothers and the focus group with CHWs were conducted in the participants' language of choice, which were English and/or Sesotho. No participant requested an interview in Afrikaans. A retired Sesotho-speaking nurse experienced in interviewing assisted with the five interviews conducted in Sesotho. She was also familiar with the district but did not work for the Free State Department of Health. Interviews in Sesotho included the focus group with the CHWs, two with mothers in the KMC ward, and two at the POPD. The researcher and the assistant interviewed healthcare providers and the rest of the mothers in English.

3.5. Data management and analysis

All interviews were audio-recorded with participants' permission, and field notes were made during interviews at the hospital. Field notes were typed, and audio-recordings were transcribed verbatim. The Sesotho interviews were transcribed, and each transcript was then translated into English by two separate translators to enhance the quality of the interpretation.

The field notes of each data-collection event and each interview transcript received a unique identifier in their file name. The researcher kept a reflexive journal for documenting research processes and her own impressions, experiences and possible biases. As part of the audit trail, an MS Excel spreadsheet was kept of all field notes, audio-recordings, and their transcripts.

It is acknowledged that data collection, analysis and report writing in qualitative studies often overlap. The description below clarifies how the analysis was done systematically. Data analysis was done separately for three different groups in the following order: mothers in the neonatal/KMC unit; mothers at the POPD; and health professionals in the neonatal unit. The transcript of the CHW focus group discussion was excluded from the data analysis. CHWs were supposed to have been linked to KMC mother-infant dyads at discharge in order to support them at home, encourage follow-up visits and refer in the case of danger signs. This appeared not to have happened, and they were unable to answer the interview questions in a meaningful way.

The transcripts were copied into Excel MS templates to facilitate manual analysis. The interviews followed the questions in the interview guides fairly closely, and the questions were copied in the first column. A separate column was created for each participant's verbatim answers. Participants' answers to the same question could then be analysed by reading through the answers in horizontal rows. At the end of each row, separate columns

were created for the inductive coding by the researcher and a second analyst, and for facilitators and barriers.

Each group's data was deductively analysed according to the barriers and enablers described in Tables 2.1 and 2.2 in Chapter 2. Thereafter, the same data sets were analysed inductively to contextualise the findings. For this, Braun and Clarke's six-phase thematic analysis approach was followed (89). After further familiarising myself with the data (step 1), a process of general initial coding (step 2) was followed, looking for categories and themes (step 3), and reviewing the themes, accompanied by constant comparison between transcripts (step 4). The next step was the comparison of categories and themes that emerged from the analysis of the data collected from mothers and health professionals, with further refining of the themes (step 5) to construct an interpretation framework to use for writing the report (step 6).

A second independent data analyst reviewed the data, categories and themes that emerged from the analysis at various intervals during the analysis process to verify the feasibility of the interpretation. The researcher made notes in a column in the Excel database sheets, with the second analyst making her notes in a separate column. These notations formed part of Braun and Clarke's step 2, and could be considered as the development of a type of code book. The codes were then further explored iteratively throughout steps 3, 4 and 5 in multiple discussions between the researcher and the second analyst until consensus was reached on themes, sub-themes and categories.

3.6. Ethical considerations

The study protocol received ethical approval from the following institutions: the University of Witwatersrand, Johannesburg, Human Research Ethics Committee (Medical) (clearance certificate no M230711 MED23-05-032); the University of the Free State Health Sciences Research Ethics Committee (ethical clearance number: UFS-HSD2022/1513/2504-0006); and the Free State Department of Health (no reference number). Permission letters for conducting the study are included as Appendices A, B and C.

Participant information letters were prepared in English, Sesotho and Afrikaans and explained the purpose and scope of the study and their rights as participants (see Appendices D to F). Participants received further verbal explanations of the content and had time to ask questions before signing consent to participate in an interview and to have the interview

audio-recorded. Because mothers with sick and small babies are considered a vulnerable group, a distress protocol was in place in case a maternal participant needed counselling and support as a result of participating in the study (Appendix J).

3.7. Rigour

The trustworthiness of the study is demonstrated by various measures put in place from the inception of the study until report writing. We used the trustworthiness criteria as described by Lincoln and Guba, namely credibility, transferability, dependability and confirmability (90). Table 3.2 summarises how the trustworthiness criteria were applied.

Member checking could not be done because of the wide area in which the mothers lived, and communication barriers and time constraints made this difficult. However, at various points

Table 3.2. Trustworthiness criteria for the study

Criterion	Techniques applied in this study
Credibility (truth value)	• Content validity of data collection tools was ensured and evaluated by experts in the field • Interviews with mothers continued until data saturation was reached (content validity) • A second researcher reviewed the data, categories, themes and interpretation • Verbatim quotes from participants are included in the findings chapter
Transferability (acceptability)	• Study participants were identified and described • Interviews elicited basic demographic and other contextual information from participants • Districts with similar populations may identify with some of the findings
Dependability (consistency)	• Audit trail • Reflexive journal documented the research process and decisions • Triangulation of data sources (key informant interviews with health professionals and individual in-depth interviews with mothers)
Confirmability (neutrality)	• Self-reflection on the researcher's positionality is provided in Section 3.7.1. • A statement on the researcher's background in public health that may have influenced influence the presentation of findings is included in the study limitations in Section 5.4. • Reflexive journal kept documenting own experiences, impressions and potential biases

during the interviews, the researcher confirmed her understanding by giving a summary of the information back to the interviewee. To overcome this limitation with regard to the Sesotho transcriptions, a second translator did independent translations of the transcripts to ensure a more accurate interpretation of the mothers' views.

3.7.1. Researcher positionality

Aspects that could have influenced how the study was conducted are my position as a white, middle-aged woman with a professional background in nutrition and employed as the manager of a school-based HIV- and gender-based violence prevention programme. It was easy to relate to the health professionals involved in the study, as we all had similar understandings of our professional responsibility of caring for vulnerable people.

Despite growing up on a farm in the apartheid era, I was raised to respect life, treat people with dignity and embrace all human beings. I was aware having received better formal education, coming from a privileged background, and not being able to speak the mother tongue of the maternal study participants placed me in a position of power. It was thus important to create a situation where they would participate voluntarily and not because they felt obliged to do so.

Having a research assistant fluent in the first language of most of the participants assisted in bridging some of these gaps. The two of us shared our findings, emotions, and experiences of the day while driving back from Kroonstad to home every day. The next morning, we would discuss our internalisation of the data collected the previous day.

My fears of being unable to do justice to the study participants' expectations were further allayed during recruitment and the interviews. Both the research assistant and I were cognisant that we entered the space where the mothers had been living or lodging for the past month or more as outsiders. By allowing the interviewees to set the pace of the interview, they appeared to feel at ease expressing and voicing their experiences and perceptions freely. During the interviews, I was touched by the mothers' fears and anxieties about their preterm and LBW babies and their socioeconomic circumstances facing poverty, and even more so by those of the younger, inexperienced mothers.

As a healthcare manager, I knew I had to listen with the ear of a researcher, trying to stay neutral, leaving my own experiences, values, and beliefs aside during the engagements with the participants and the interviewing process. However, minimising subjectivity was easier

said than done. During the first few interviews, I had to constantly check myself to not respond with expressions of appreciation or agreement. In one or two of the interviews, I also found myself ending the interview by counselling a participant on breastfeeding, one of my areas of expertise.

3.8. Conclusion

This chapter provided an overview demonstrating the systematic processes followed in collecting and analysing the data. The findings emanating from the analysis are discussed in the next chapter.

CHAPTER 4: FINDINGS

The findings are presented in four main sections: study participants; birth and infant characteristics; barriers and enablers to KMC practice; and mothers' experience of KMC. The explanation for the codes for direct quotations is the following:

- M1W#: mothers interviewed in the neonatal and KMC ward; # refers to the unique participant number;
- MPN#: mothers interviewed in the POPD; # refers to the unique participant number; and
- PS#: health professionals interviewed; # refers to the unique participant number.

4.1. Study participants

The interview transcripts of 18 participants were included in the analysis. Participants comprised six mothers in the KMC or neonatal ward, seven mothers returning for follow-up at the paediatric outpatient department (POPD), and five healthcare workers. Table 4.1 provides detailed demographic information of all participating mothers and Table 4.2 contains information on the participating health workers.

A total of 13 mothers were interviewed, six in the KMC and neonatal ward and seven at the POPD at a follow-up visit after discharge from the hospital. Their ages ranged between 19 and 35 years. The participants from the KMC/neonatal ward were slightly younger (range of 19 -27 years) than the mothers interviewed at the POPD (range of 23-35 years). Ten mothers had Sesotho as their home language, whereas two were Xhosa-speaking and one spoke English. All mothers in the KMC/neonatal ward were non-local residents, referred from other health facilities in the Fezile Dabi District during pregnancy or after birth. Regarding the others who visited the OPD, only two were living further away, and the remaining five were local residents living in and around Kroonstad. The travel distance for mothers living elsewhere was between 59 km and 122 km.

All participants had at least a Grade-9 level of education, with one having a post-school qualification. Five had completed Grade 12, with four having achieved Grade 11. Unemployment was high: eight participants were without any work, three had part-time employment or 'piece jobs', and one was employed full-time.

Table 4.1. Characteristics of maternal study participants (n=13)

Characteristics	Mothers in KMC and neonatal wards (n=6)						Mothers at POPD follow-up visit (n=7)						
	M1W1	**M1W2**	**M1W3**	**M1W4**	**M1W5**	**M1W6**	**MPN1**	**MPN2**	**MPN3**	**MPN4**	**MPN5**	**MPN6**	**MPN7**
Age	27	18	22	19	26	26	27	23	40	30	34	35	28
Highest education level													
Grade 9	X	X											
Grade 10												X	
Grade 11			X	X			X			X			
Grade 12					X	X		X	X		X		
Post-school education													X
Home language													
Sesotho	X	X	X		X	X		X		X	X	X	X
isiXhosa				X					X				
English							X						
Employment:													
Unemployed	X	X	X	X			X	X		X		X	
Piece jobs/Part-time					X						X		X
Fixed position						X			X				
Residence:													
Kroonstad area								X		X	X	X	X
Further away	X	X	X	X	X	X	X		X				

Characteristics	Mothers in KMC and neonatal wards (n=6)						Mothers at POPD follow-up visit (n=7)						
	M1W1	M1W2	M1W3	M1W4	M1W5	M1W6	MPN1	MPN2	MPN3	MPN4	MPN5	MPN6	MPN7
Relationship with father:													
Married / Living together	X										X		
Boyfriend (not living together)			?	X	X	X	X	X				X	X
Single		X							X	X			
Sources of family income:													
Child grant for current baby											X	X	X
Child grant for previous child			X				X					X	
Pension or social grant[¥]		X	X	X	X					X			
Own salary/wage						X			X				
Partner/husband income	X												
Other*				X	X	X	X	X		X	X		X
Sources of support at home:													
Husband/partner	X										X		
Own mother (=baby's grandmother)		X	X	X	X		X	X		X			
Own grandmother						X				X			
Other relatives (sister, uncle, cousin)		X	X	X	X		X				X	X	X
No support						X			X				

[¥] Pension or grant of participant's mother or grandmother

* Mostly family members for whom the type of income is unspecified

Abbreviations: KMC, kangaroo mother care; POPD, paediatric outpatient department

A total of five healthcare workers were interviewed, including one paediatrician, two professional nurses (KMC/neonatal ward) and two enrolled nursing assistants (Table 4.2). All staff interviewed had more than five years of professional experience. Qualifications were appropriate for their designations. The two professional nurses also had an advanced midwifery qualification in addition to their general nursing diploma. The paediatrician had a certificate in child nutrition.

Table 4.2. Background of participating healthcare providers (n=5)

Background	PS1	PS2	PS3	PS4	PS5
Designation	NICU Manager (PN)	Enrolled nursing assistant	Paediatrician	Professional nurse	Enrolled nursing assistant
Years in career	11	5	8	14 (total) 8 as PN	13 (>5 years in neonatal unit)
Years at Boitumelo Hospital	2½	5	5	32	
Qualifications	General nursing with midwifery (diploma)	In-hospital training	MBChB; MMed (Paeds)	Assistant nurse General nursing with midwifery	In-hospital training
Additional qualifications	Advanced midwifery		Certificate in Child Nutrition	Advanced midwifery	

Abbreviations: MBChB, Bachelor of Medicine and Surgery; MMed (Paeds), Master of Medicine (Paediatrics); NICU, neonatal intensive care unit; PN, professional nurse

4.2. Birth and infant characteristics

Table 4.3 provides more information on the infants of the mothers in the study. Ten mothers reported a first pregnancy, and three already had at least one child. Six mothers had a normal vaginal delivery, and seven infants were delivered by caesarean section. There were two sets of twins among the mothers in the KMC/neonatal ward and one among mothers visiting the POPD. Birth weights and gestational age were, unfortunately, not systematically probed from all mothers. For those with a reported gestational age, it ranged between 28 and 38 weeks. Only 9 mothers reported the birthweight: two infants were between 500-999g, four infants had a weight range of 1000-1499g, and three infants were between 1500-2499g. One mother reported that her twins were “underweighted” (M1W1).

Table 4.3. Birth and infant characteristics

Characteristic	Mothers in KMC and neonatal wards (n=6)						Mothers at POPD follow-up visit (n=7)						
	M1W1	M1W2	M1W3	M1W4	M1W5	M1W6	MPN1	MPN2	MPN3	MPN4	MPN5	MPN6	MPN7
Parity													
Primigravida		X		X	X	X		X	X	X	X	X	X
Multigravida	X		X				X						
Delivery mode													
Vagina	X		X	X			X	X				X	
Caesarean		X			X	X			X	X	X		X
Multiple birth (twins)	X				X			X					
Gestational age		28 weeks	38 weeks	28 weeks	29 weeks	32 weeks	31 weeks	7 months	30 weeks	7 months	6 months	34 weeks	36 weeks
Birth weight													
500-999gr									X		X		
1000-1499g				X	XX					X			
1500-2499g							X					X	X
Low birthweight/SGA	X												

Abbreviations: KMC, kangaroo mother care; POPD, Paediatric outpatient department; SGA, small for gestational age

4.3. Barriers and enablers to kangaroo mother care practice

The barriers and enablers to KMC practice are organised around two main themes: support (or lack of it); and the health system.

4.3.1. Theme 1: Support for mothers

Figure 3 provides a graphic representation of the further division of the overarching theme of support into psychosocial and financial support.

Subthemes for psychosocial support include support from healthcare providers and support from the family. Financial support is divided between government support and family support. All subthemes are divided into the categories of barriers and enablers.

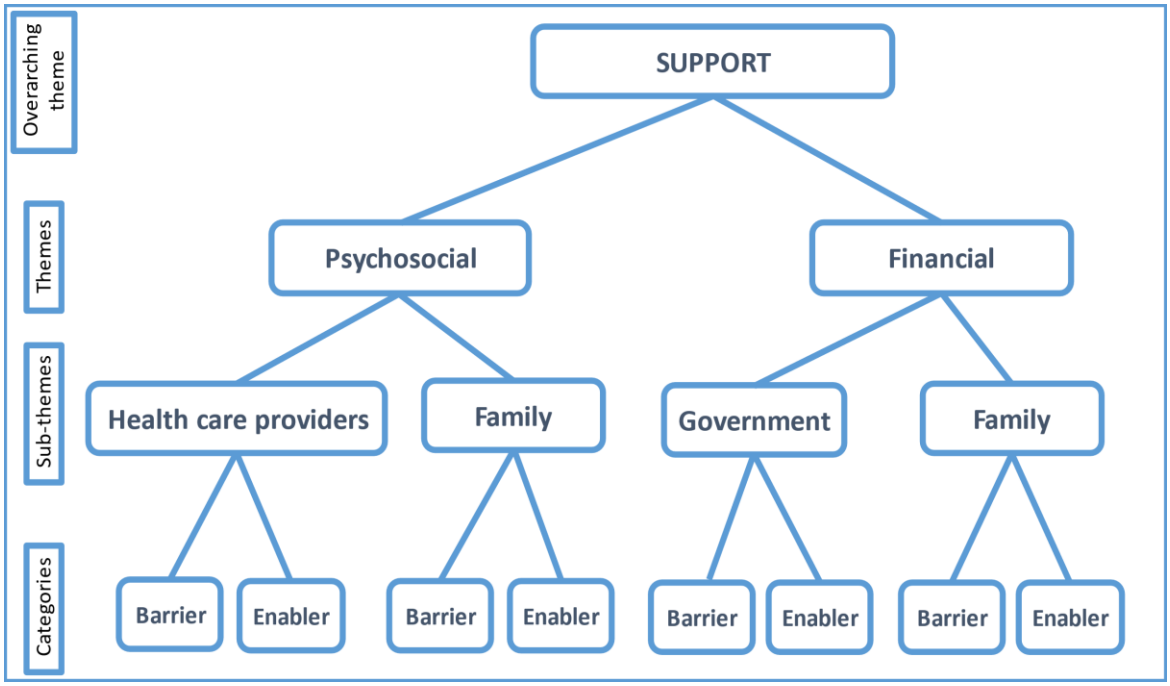


Figure 3. Graphic depiction of the themes, subthemes and categories of support

Psychosocial support

In our analysis, we interpreted psychosocial support as actions that addressed the emotional and social needs of mothers of preterm or LBW infants, contributing to their feelings of well-being and confidence to care for their infants. These included actions related to educating and supporting mothers on how to care for their infants.

Family support. During labour and while in the hospital, most mothers received some form of psychosocial support from family members, but especially from healthcare workers. It was unclear how much support mothers received from the infants' fathers, as some worked far away. One mother indicated: *"He just came to assist"* (M1W6). A participant with twins indicated that *"the father of the babies will help me [at home]; he always visits us at the hospital"* (M1W1). From Table 4.1, it appears as if most mothers experienced a general lack of paternal support from the infants' fathers because of their living arrangements. Three participants lived on their own, whereas eight lived with other relatives but not with the father. Only two lived with their husband or partner. Family support at home varied between support from the infant's grandmother, and the mother's grandmother, sisters, cousins or uncles.

Healthcare worker support. Overall, mothers experienced the support and treatment they received from healthcare workers during antenatal care and their hospital stay as positive – *"very caring"*; *"very patient"*; *"gave me some respect"*; *"just kind"*; *"nice"*; *"friendly"*; *"fair"*; and *"fine"*. One mother referred to the empathy she received from staff: *"I think they understood what I was going through"* (M1W6). The health workers were also described as *"helpful" – "They show me and help me"* (MPN6). This is what one mother visiting the POPD said about the support she received with the care of her infant:

> *"The nurse will come and help you hold the baby so that you don't drop the baby, and when you wake up, they will help you breastfeed, and then if you didn't know how to breastfeed, they would show you how to breastfeed and what to do and hold the baby."* (MPN1)

There were also a few comments referring to less desirable treatment from some of the healthcare workers, although not all:

> *"They treated me well [in antenatal care], but there are some of those that are irritating at times and like to shout at people. But overall, they treated me well."* (M1W1)

The same mother remarked that the healthcare workers in the KMC ward were *"nice, but others like to be harsh to mothers sometimes."* (M1W1). Other mothers had similar mixed reactions about the treatment they received:

"Well, they're okay. … I would say is that everyone is different. You get those that are willing to assist, that are friendly towards you. … They understand that this is your first experience. And then there are just those that like, so, I think 80% are quite good at what they do and they understand. And then the other 20 is just …". (M1W6)

A major form of support related to mothers' psychosocial needs, was the education, guidance and reassurance they received from the healthcare workers. This kind of support entailed factual education, demonstrations of correct practices, posters and pictures. We argue that providing factual information and guidance could give mothers confidence in handling their infants and indirectly influenced how mothers experienced KMC and the support they received – *"They talked to me. If I asked something I could talk to them"* (MPN7) and *"How they told me about how my baby is. ... They always tell me how she is feeling, everything"* (M1W4).

"They are always there for us … and if we make mistakes, they're always there to tell us, 'This is this thing you're doing is wrong. You have to do this.' Yeah, they always being very supportive." (M1W3)

This is how one of the healthcare workers explained their involvement in providing information to mothers:

"First health talk. The importance of breastfeeding. Mothers must know their babies. If they know their babies, they can be able to see if the colour of the baby changes, then they will report." (PS2)

It appears as if *"good hygiene"* and *"cleanliness"* (M1W3) around the preterm baby were emphasised in the hospital, from *"surroundings must always be clean"* (MPN4) to handling and feeding the baby – *"I realised that hygiene is very important, you know, to prevent the baby from getting infected"* (M1W6) and *"That we should always wash our hands to avoid them getting any diseases"* (MPN4).

"I was not familiar with it [hygiene], or you can be familiar, but practising is difficult. I was even to be like to do whatever it takes when I am around the baby. Washing your hands and the space around your baby." (MPN7)

"Like we must keep the germs away from the baby and that's what I know that when we arrive there, we wash our hands. Other mothers they're not supposed to change their babies' nappies, while we are still feeding." (M1W5)

Other topics and caring tasks mentioned in antenatal care and during the hospital stay are summarised in Table 4.4.

Table 4.4. Topics and care tasks mentioned in antenatal care and hospital

Topic/task	Quotation
At antenatal care:	
Safe sexual practices	"*About they are talking about using protection. So that the baby must not be affected of many things.*" (M1W5)
Wearing tight clothing	"*You shouldn't wear too many clothes to suffocate yourself.*" (MPN1)
In hospital:	
Holding position	*"They taught me how to pick her up and I must not position her on another side because she will bleed, so I had to be careful when holding her."* (MPN3)
Breastfeeding	*"…. when you wake up they will help you breastfeed, and then if you didn't know how to breastfeed, they would show you how to breastfeed and what to do and hold the baby."* (MPN1)
Baby's developmental milestones	*"… then it was teaching us about how is your baby growing? And then at this month, the baby will be this old, … the baby will be doing this and then"* (M1W5)
Caring for the baby	• *"It was important to us to learn how KMC is, and we must take care of our babies."* (MPN2) • *"Feeding the baby, clean the baby's face with a wipe, change the nappy and washing of hands."* (M1W4) • *"They taught me a lot from how to hold and handle the baby, how you give the baby medication, how you sleep with baby, be there was a lot."* (MPN4) • *"First, when you are done with the nappy, you have to go and wash through the nappy before feeding the baby and wash your hands. Then come feed your baby and you always have to wash your baby's cup before feeding, yeah."* (M1W3)

Some mothers, however, did not perceive that they received the necessary informational support from healthcare workers during antenatal care – *"They only gave me information about HIV with pregnancy, they did not say much "*(M1W2).

> *"They did not tell me much. I am sure they could have helped me with the pains. They do not tell me anything. They did not check that much."* (MPN5)

Most mothers were positive about the educational support they received from healthcare workers in the KMC and neonatal wards, although one indicated, *"I didn't get any information"* (M1W2). The three messages that appeared to have been reinforced the most were how to handle the baby and the importance of KMC and breastfeeding. This is how one mother with a 900-gram newborn explained the handling of her *"too small"* baby:

"They taught me how to pick her up and I must not position her on another side because she will bleed, so I had to be careful when holding her. … In her legs I mustn't pull her up because she will bleed so I have to be careful how I handle her." (MPN3)

The quotations below illustrate the importance given to KMC and breastfeeding – *"They encourage me to feed the baby, always doing skin to skin"* (MPN5).

"They told me to carry on with KMC because if the baby is having pain, it becomes less when you are doing KMC and the baby feels warm when on the mother's lap." (MPN3)

"*Ah, it was well, because they gave me all the information how to put down my baby in there to do the skin to skin*." (M1W3)

"The other sister came to us in the morning. That side she was showing us the picture of the how to breastfeed the child. She was saying, I don't know what is this thing, the nipple: 'So even if you don't have the nipple, the nipple doesn't feed the baby. The baby must be holding to this place [pointing at areola], not the nipple. If you, we always say we have a problem, for example, I don't have any nipple, so my baby cannot eat and stuff. No, the baby can eat. You must just know how to hold your breast for the baby to eat.' She came with the picture and showed us the picture of a good and bad breastfeeding." (M1W5)

Financial support

Financial support as a barrier or enabler for mothers and infants is divided between government and family support (Figure 3). Most participants reported a mixture of government and family support in terms of financial provision.

The majority of mothers depended on child grants, pensions and other social grants received by other family members (Table 4.1) – *"We are not working; we live with the grant money"* (MPN6). Only two participants earned a salary or wage and one participant reported an income from the husband. Five participants indicated that a family member – either the mother's mother or grandmother – received a pension or disability grant: "*My grandmother gets her pension grant, and my mother works as a domestic worker"* (MPN4). The grant income is often supplemented by a wage or salary earned by one or more of the family members: "*Well, my mom is earning an income; my granny as well, pension though; my uncle, everyone, granny's brother"* (M1W1).

Three mothers in the POPD visit group already received a child grant for their last baby, whereas two mothers received a grant for an older child. One mother in the hospital group received a grant for a previous child. Two mothers referred to using the *"grant money"* to buy food – "*Sometimes I buy [food] when I get R350 from the government, but mostly it's my sister and mom they buy groceries*" (MPN1).

4.3.2. Theme 2: The health system

We categorised the barriers and enablers in the health system according to the WHO's six health-system building blocks, namely the health workforce, service delivery, health system leadership and governance, financing, medical products and technologies, and health information systems (97). Some building blocks are more prominent in the participants' perceptions as barriers or enablers than others, notably the health workforce and service delivery.

In the interviews with healthcare workers, it was apparent that the functioning of the health system could provide or neglect to provide sufficient support to KMC mothers, which could influence the quality of care for small and sick newborns. The provider participants' descriptions of their impressions of the quality of neonatal care services in the hospital ranged from *"good"* (PS4) to *"fairly well"* (PS1) to *"we are not doing great; we are not doing bad"* (PS3). Some of the participants gave the improvement in neonatal mortality rates as *"a positive indicator"* (PS1) for their judgement:

> *"I think we're more in the middle because our, I think our neonatal mortality rate, we're still having a high neonatal mortality rate, but our late neonatal mortality rate is low. … after the babies get over the seven- or 10-days period, then they do fairly well."* (PS3)

One participant who described the services as "*for myself it is bad"* (PS5) gave the service delivery, especially infrastructure, discussed below as the rationale.

The health workforce

The support that mothers reported they received from healthcare workers has already been discussed in the previous section. Issues around the needs of the health workforce and healthcare workers included staff shortages and workload, the absence of a multidisciplinary team, limited knowledge of KMC, and a need for capacity building. Staff shortages – "*We must have enough staff"* (PS4) – and a high workload were the most frequently reported

challenges for health workers to provide good care and effectively implement KMC – *"We are working through in neonatal, sometimes we admit 18 to 20 babies … being two on duty"* (PS4).

> *"Mainly staff, so we have a really severe shortage of nursing staff and things like we would like to send more smaller babies for KMC, but that's the main challenge … and in order for us to send even more stable babies to KMC, we are restricted in such a way that we know that there is not enough nursing staff to supervise the moms for the smaller babies*." (PS3)

Healthcare workers also expressed the wish for the availability of a multidisciplinary healthcare team, as well as more family-participatory care:

> *"If we could have a multidisciplinary team, social workers involved, psychologists as well and involve family participation, involve the husband, the father, the mother."* (PS1)

A longing to work with a broader team to support mothers with KMC positioning and the feeding of premature and LBW infants was also shared:

> *"We don't have facilities like having an OT [occupational therapist], … to come and show them, you know, proper positionings, teach them and the dietician to teach them about the care of their babies and the benefits of breastfeeding all the time. They [the mothers] just know that they have to breastfeed, but they do not know the benefits of breast."* (PS3)

Furthermore, staff allocations determined how much knowledge the nursing staff had about KMC and the *"different levels of knowledge regarding KMC"* (PS3) among the healthcare workers was a concern.

> *"I found out that our nurses mostly that are working in KMC, they were just put in KMC because of the shortage of staff but they were not knowledgeable as to the why, the importance of KMC."* (PS1)

> *"The nursing staff, I find that the professional nurses that are midwife trained they know… some about the benefits of KMC, but the ones that have no midwifery actually do not have, you know, any knowledge. I also always have to teach them about the benefits of KMC and the lower staff like your staff nurses or your auxiliary nurses, they*

really have no idea about the benefits of KMC … There is quite a vast difference." (PS3)

One professional nurse related her KMC training experience in 2012 as follows:

"It was years back when they started this thing of KMC units when they came. KMC units were about to start. We went and we did a, I will … call it a crash course. I was still in [name of hospital] by then, but we went for KMC training." (PS1)

Medical interns also came with little knowledge of KMC – *"I find that the interns from medical school, they really do not know much about the benefits of KMC"* (PS3).

Knowledge and skills around KMC were mainly acquired on the job and with in-service training sessions with the paediatrician and the nurse with KMC training:

"Though they [nurses and assistants] are not certified, but at least with what I have taught them, the importance of KMC, now at least they are on par with us, they practice. We talk one language now." (PS1)

A further suggestion was for more KMC training for staff caring for newborns in the hospital.

"Our staff … should be skilled on the knowledge of KMC because none of our staff members have gone for KMC training. I would love to see that happen. At least KMC training for the people that are working with the unit specifically." (PS1)

Service delivery

The availability of sufficiently skilled staff members impacts service delivery. In addition, the researcher's observations on the existing infrastructure and equipment, such as the limited space and lack of privacy in the neonatal and KMC wards, and worn-out beds in the KMC ward, were also confirmed by the healthcare worker participants. This is how participants explained the overcrowding of a *"not … conducive neonatal unit as according to the guidelines is said half a metre spacing in between the beds"* (PS1):

"It is … this space. This is too little and sometimes you find we are having 12 points for oxygen, so which means I think we have to admit 12 babies. But we are admitting, like now we are having 14 babies, and the other side here doesn't have the point of oxygen. We have to struggle." (PS5)

Overcrowding in the neonatal ward increased the risk of neonatal infections:

"*So, we are challenged in that sense and that actually now makes a challenge of we're having a whole lot of nosocomial sepsis. Sepsis is due to overcrowding in the neonatal unit, so that is one of our, you know, the biggest hiccups."* (PS3)

"Most of our deaths are because of the infection in the unit. We had to do. what we call terminal cleaning and then we have to find out the cause and try to mitigate the situation because we had the spike of infection rate but mostly caused by … the overcrowding in the unit." (PS1)

Overcrowding was also experienced in the KMC ward:

"*Secondly, the KMC took six babies. They have to be six, but sometimes you find them being eight in the ward and then again there must be a ventilation [of air]. And it's wrong again; [it is] good for the babies to be in a good environment. Then the mothers are sleeping there, the babies are there, the food, everything in there is so stuffed from my side, even in the ward."* (PS5)

One healthcare worker reflected on the lack of privacy in the KMC ward:

"To pray whatsoever and the mum cannot somewhere some of them, they are not comfortable to like. Let me make an example if I'm taking some kind of medication somewhere, somehow, I cannot be comfortable to take that medication in front of the people. Secondly, sometimes others cannot breastfeed in front of the people. If there are enough space it will be fine." (PS5)

Healthcare workers also made suggestions on how to improve the conditions for KMC:

" To make a KMC like home-friendly; would like to believe the KMC unit should be a home away from home. That's why, as I say in the neonatal unit is just here for weight gain and we want to see her grow. But in the meantime, let's not neglect the mother. They can be here three to four months. They miss the family too much especially over the festive season. Let's make KMC a home from home. Let's accommodate them and their own personal … Let's focus on their side as well." (PS1)

The paediatrician reflected on the strengths in the neonatal unit that influence the quality of care:

"Our serious strength is that we are very good at breastfeeding, so we get to breastfeeding quite quickly in our unit. So that is one of the strengths and you know, I

think we have a good protocol as well. So that the doctors, even if I'm not here, they know what to do. You know, there's basic things that they follow regarding those kinds of things as well. And we have very good antibiotics stewardship programme as well we don't just give anybody, you know, antibiotics. And yeah, and I think also the KMC integrated also very early as well. The babies might not have gone into the KMC unit, but when the mummies do come and visit, they do KMC the babies intermittently as well in their unit as well, once they are stable, yes." (PS3)

Finances, leadership and governance

One participant touched upon the importance of leadership and governance and the need for support from different management levels, especially financial support, given the challenges with space and staff:

"I think the management needs to get a lot involved regarding the care of these babies and in my opinion, … they actually think [for] KMC and the babies, you need very little budget, but we actually need a big budget because it's actually a big thing. If we are going to say reduce under-five mortality … but they don't, you know, I think they don't realise that that's how important it is so that we can start tackling it down. It needs involvement of the management …" (PS3)

Upgrading of the lodger mothers' facility and the KMC ward, which would have budget implications, was also recommended:

"I think the facilities could also be improved quite a lot for the moms. But the facilities where the moms are staying, I think because they stay here long could be, you know, very much improved for their comfort. The beds that they stay on are not the most comfortable." (PS3)

One healthcare worker referred to having a 'thinking big' approach to the renovations needed for the neonatal and KMC wards:

"Usually, this hospital, but now these hospitals are now under, they are doing renovations and everything. I think in the future they must consider the neonatal ward, it has to be big, and it has to have the full equipment, like when we have to wash the hands, we don't have to use one basin. I think in this space, maybe there must be enough basins enough towels of everything you see. I think they must consider when they when they are doing their things, neonatal must be in their mind it has to be big.

And KMC also if they want to do continuous KMC, they have to consider that it is big to accommodate people." (PS5)

Medical products and supplies

The interviews with healthcare providers yielded fewer perspectives on medical products and supplies, except for one participant referring to challenges related to *"equipment" and "medical consumables"* (PS1). Another participant referred to the absence of KMC wraps for tying infants to their mothers' chests: *"They are always just using sheets to cover the baby; is not your normal KMC wraps*" (PS3). Dilapidated beds were also raised as a suggestion for improvement: *"The beds are old and not comfortable to sleep on. … I think they should consider purchasing the new ones for the mothers"* (PS2).

Health information system

Elements of the health information system to generate data for action to improve practices were not probed systematically either. One participant did, however, refer to the causes of neonatal deaths as a result of infections due to overcrowding but added that *"together with the … paediatric team and the nursing team through the support of our doctor we did manage to bring the deaths down"* (PS1).

Healthcare professionals utilised KMC tick sheets to record all vitals, temperature, weight, expressed breastmilk, methods of milk administration, time, et cetera. Participants also mentioned the Road to Health Book all mothers received. In this booklet, growth, immunisations, feeding and illnesses are documented and it is also used to track the infant between the PHC facility (clinic) and hospital.

4.3.3. Summary

In conclusion, this is how one healthcare worker summarised the situation in terms of the health system needs of the hospital:

"As I've told you earlier, we are the only referral hospital in the district, and we are receiving babies from all over. When I say all over, I'm saying the whole district is referring to us ... So, what I'd like you to take back is to [the authorities] the expansion of our facility … The neonatal unit and KMC expand and then when you expand, of course, you're going to need human resources as well. You're going to need more

equipment, some of which I think for us to produce quality, you need to provide. We are one team. You cannot expect quality, but you don't give me the tools of trade." (PS1)

From the description above, different configurations of barriers and enablers to KMC practice applied to individual mothers. Barriers and enablers are often two sides of the same coin – enablers assist with access to an appropriate level of hospital care that will enable KMC practice and quality care for the baby. In contrast, barriers make life for the mother and baby more difficult. Tables 4.4 and 4.5 provide summaries of possible barriers and enablers identified in the analysis of participant responses.

Table 4.5. Summary of barriers and enablers to KMC practice for mothers and families

Barriers for mothers and families	**Enablers for mothers and families**
Mothers' readiness for dealing with preterm birth and practising KMC • Mother's unfamiliarity with KMC prior to hospitalisation • Inadequate knowledge of the benefits of KMC • Lack of emotional readiness (discomforts and fear of practising KMC)	General healthcare worker supportive supervision and assistance: • Information and education on all aspects of newborn care, including KMC • Guidance and support for practising skin-to-skin care and breastfeeding • Availability of educational material (e.g. booklet, posters and pictures)
	Effect of KMC on mothers' sense of empowerment and increased confidence
	Good breastfeeding practices
Little paternal support for most mothers	Psychosocial and financial support from family
	Government support grants

Table 4.6. Summary of health system barriers and enablers to KMC practice

Health system barriers hampering optimal KMC for mothers	**Health system enablers for KMC practice**
Service provision	
Delays in ambulance services	Access to a healthcare facility
Inadequate facilities in the neonatal ward	Access to transport – ambulance services
Facilities from mothers not comfortable – lack of privacy	Ability to lodge in before delivery and while the baby is in hospital
	Access to follow-up services at the POPD
	Availability of the Western Cape KMC guidelines (2001) and standardised criteria for discharge
	Integration of KMC in neonatal services
	Good breastfeeding practices
	Protocol followed

Health system barriers hampering optimal KMC for mothers	Health system enablers for KMC practice
	Integration of KMC early in the care of small and sick newborns
Health workforce	
Little training or refreshers on the latest guidelines for KMC practice	Skilled staff and a constant availability of the doctor
Staffing shortages and workload	Good teamwork between doctors and nurses
	Staff enthusiasm and acceptance of KMC – understanding KMC benefits
	Acting as mentors and sharing KMC knowledge
Leadership and governance	
KMC and newborn care not considered important by managements	Healthcare workers' advocacy for KMC
Financing	
KMC not prioritised in budget planning	
Medical products and supplies	
Shortage of equipment	Good antibiotic stewardship
Shortage of medical consumables	

4.4. Mothers' experiences of kangaroo mother care

Mothers' experience of KMC or the 'absence' of KMC started during antenatal care and with the birth of a preterm or LBW baby. In preparation for the birth, a process was started to get transport to deliver at the hospital. Some mothers were brought in by ambulance from towns further away from Kroonstad. For two participants in this study, the ambulance did not arrive in time, and the infants were born at home – *"They were born at home because the ambulance arrived late"* (M1W1.) This is how this mother (with twins) explained her experience of getting to hospital:

> *"Yes, I did well in the first and second trimester. Everything was well until the third trimester – I had high blood. When I was like, what, 32 weeks? Towards 32 weeks, I was told that I also have an ulcer. I was transported here [Boitumelo Hospital]. I went to the clinic in Viljoenskroon for my usual checkups, and then when I got the high blood, was very high building [up], I got transported here." (M1W1)*

Mothers living in the Kroonstad area did not all stay in the KMC unit with their infants due to the limited beds available. They commuted daily between their homes and the hospital and practised KMC intermittently in the neonatal unit during the day. This practical arrangement

explains why the study mothers in the KMC unit were from further afield. This is in contrast with the participant mothers who came for follow-up at the POPD, who were mostly from the immediate area. It could be argued that for the mothers living further away, returning for follow-up visits may be more of a challenge, or they were followed up nearer to home.

Mothers' experiences related to the early birth of their babies and the practice of KMC are discussed under the following headings: preparation for and knowledge of preterm birth and KMC; mothers' emotional reactions; mothers' experience of caring for small infants in hospital; discharge readiness; follow-up; and healthcare worker perceptions of their roles and responsibilities in KMC. This section concludes with the advice and recommendations that our study mothers would give to other mothers with preterm and LBW babies.

4.4.1. Preparation for and knowledge of preterm birth and KMC

Mothers had very little preparation for preterm birth and KMC during **pregnancy**, also because they *" did not expect it [labour] to come earlier"* (MPN6). One mother did elaborate on how she was counselled to deal with danger signs in pregnancy:

> *"If there's anything wrong with you during the week, you should come to us, and then if it's serious, we will transfer you to the hospital during the week, but then when it's weekends, you should go straight to the hospital."* (MPN1)

Another mother described how her work life was turned upside down with the early arrival of her baby:

> *" I had already taken maternity leave from the first of March. So having to deliver the baby early [6 Feb] had problems because at work they were pestering me as you know, you have to submit your leave, and I thought that I would be home to deliver the baby where my family [is]. God decided otherwise."* (M1W6)

The majority of mothers in our study did not have any prior knowledge of KMC and first heard about it in hospital – "*I only heard about it here at the hospital by the sister in the ward"* (M1W3) – and through observing *"other mothers practising it"* (MPN3). Three mothers knew about KMC:

- Through word of mouth: *"I hear about it at college. This other lady told me about KMC"* (MPN7).

- Through "*Social media and from home"*: *"… before I came here, but I just thought it is not necessary"* (M1W6).
- Previous experience of KMC – as illustrated by the quotation below:

> *"I heard about Kangaroo in like first time I was having my first pregnancy, and I was on 2015 … at Sasolburg Hospital. I even did it like they were telling us that we must connect with our baby, putting them in like inside."* (M1W5)

4.4.2. Mothers' emotional reactions

At birth, mothers had mixed emotions regarding their preterm delivery. Ten of the 13 mothers in this study were primigravidae and had no previous experience of childbirth and childcare. In addition to the challenge of getting to know how to care for a baby, the early birth was unexpected. Mothers described their feelings of being "*scared"* (MPN7) with expressions like *"I was surprised, and I was shocked."* (MPN1) and *"It was something touchy; I went through a lot"* (M1W6).

> *"I was a bit distressed really, because I wanted to be closer to home. But I had to accept it because it was a risk, yeah, considering my condition [pre-eclampsia], yeah."* (M1W6)

Mothers also had happy feelings that the baby was alive: *"Emotionally, I was scared; scared and happy."* (MPN2).

In addition to the shock of preterm birth, mothers also experienced anxiety about the well-being of their vulnerable newborns, some of whom were "*still in an incubator"* (M1W6) – *"It was depressing. She had syphilis and her spleen and lung are big"* (M1W4). The baby's growth and weight gain seem to have been one of the biggest sources of stress as mothers wanted to go home:

> *"I was not ready because of I knew that they were like, tiny, very small. So I was, not happy at all that they [twins] came earlier because of now I'm struggling here in the hospital with their weight so that they must grow."* (M1W5).

In addition, breastfeeding was also experienced as overwhelming by this mother of twins:

> *"Like my experience since I was here, like being taught about breastfeeding the child. Me, I think on my own, it's a little bit too much. Why am I saying that?*
>
> *Like for me was my first time doing the expressing the milk and stuff. I think then*

like the way they're giving us the meals [breastmilk] to feed the babies and that's how you don't have like enough milk. You end up having stress that my babies are not eating and then they will not gain weight. And then I'll be not going home soon, that's the stress that I'll be having because of me I'm feeding two kids. Like sometimes I can't express the meal that they want. So sometimes I feel like if maybe not possible.

I like feeding the babies on my own. It won't go through the drip thing [gastric tube], so sometimes I come back like, go to my room, feeding them like small, small meals.

So that thing is giving me stress, meaning I didn't feed them well. Tomorrow is the scale day and if they are not gaining the weight, I'm not going home. That's what's stressing me a lot." (M1W5)

4.4.3. Mothers' experience of caring for small babies in hospital

One of the big challenges for mothers was to adapt to caring for a small baby while in hospital – *"we have to take care of our babies so that they can grow"* (MPN4). This included the general care of the baby as well as breastfeeding and practising skin-to-skin care. The support, treatment, guidance and education the mothers received from the healthcare providers have been described above.

"They support me well and given some I some good advice to me, so I must learn how to do things, and I must be patient for my kid." (MPN2)

"Just to take care of my baby usually. Keep her warm, it will help her to grow, I will know if she is sick or what. I must always know my baby's weight." (MPN5)

The study participants were not familiar with carrying their baby skin-to-skin but their journey progressed from reluctance to acceptance of KMC – *"I was not used to it [KMC], but I am now used to it "* (M1W1). One mother described it as *"a painful journey that you have to be patient with"* (MPN1). Another mother who knew about KMC beforehand and thought it was not necessary said, *"I actually got excited that I'll be bonding with the child and then it helps with the growing of the child"* (M1W6).

"They encouraged us to practice KMC and I can see that it is working. They advise and encourage you so you can raise the child and I saw that the kangaroo helps the child to grow faster [than] when they are in the incubator." (M1W1)

> *"Keeping my baby warm. The KMC helped a lot. I was supposed to leave the hospital in January but I had the patience, I left the hospital on 27 December on the weight of 1.7 kg."* (MPN5)

From the observation of one of the nurses KMC appeared to be well accepted by mothers and promoted social interaction with other mothers:

> *"Whether they are lying down, they'll be sitting there with their phones. They'll be chatting to another. They will be putting their babies, whether they are sitting on a chair, they will be putting their babies here [on the chest]. Yes. They only take the babies out and put them down, maybe it's going to the bathroom, and then going for a walk. Maybe when they have visitors they accompany their visitors outside the ward, then when they come back, they're putting the babies on here [on the chest]."* (PS1)

Mothers received *"mouth-to-mouth info"* (MPN5) from healthcare workers – *"They just talked to us"* (M1W2). They also referred to the posters and pictures in the KMC ward: *"I saw all the message[s] of the kangaroo and I read them"* (PNM6). One participant visiting the POPD remembered: *"We must do KMC all the time; must not put the baby in bed"* (MPN2).

The *"keep breastfeeding"* (MPN5) message from healthcare workers was one of the messages most cited by mothers. Despite anxiety about breastfeeding and having sufficient milk, *"The most important one [information] for me was breastfeeding and bonding with the baby"* (MPN4). One mother found it helpful *"that you have to get used to be waking up every two hours, to know that it's time to breastfeed the child"* (MPN1). Other snippets of "*they told me to …"* information shared by participants are the following: *"… hold her [the baby] in a position so that she can breathe to prevent her from choking"* (MPN3) and *"… feed the baby well so that the blood sugar does not drop"* (M1W2).

4.4.4. Discharge readiness

Discharge readiness was, amongst others, determined by the criteria listed in a discharge scoring sheet.

> *"What we do have is a KMC score sheet that we score the babies daily. The score is up until 20. Then it says: Is the baby feeding well? Has the baby gained weight? … You score the baby daily, so it will tell you the score … at the bottom. If the baby doesn't*

meet [the criteria] or is below 17 or 19, the baby is not eligible yet for discharge. That's how we know our babies are doing well by doing the daily score sheet." (PS1)

One participant coming for a follow-up consultation said the staff *"did not prepare me"* (MPN5) for discharge. Two mothers just referred to the discharge events: *"After feeding the baby, the doctor told me I am discharged. They give me medication and how to take care of her."* (MPN6) ". The rest of the mothers visiting the POPD recalled a variety of information provided during discharge counselling. Three referred to KMC – *"carry on with KMC ... buy a baby wrapper ... and hold her so that she does not fall"* (MPN1); *"I can do KMC"* (MPN2); and *"how to do KMC on my own"* (MPN7). Two mothers referred to hygienic practices such *"my space should be always clean for the baby"* (MPN7) and "*always wash my hands before I handle the baby"* (MPN4). One mother referred to washing her baby: *"I should be able ... to bath the baby because we did not wash the baby at KMC; they told me exactly how to wash the baby"* (MPN7).

One of the discharge criteria was sufficient weight gain. One mother on a postnatal visit referred to the discharge criterion of 1.8 kg and said her baby's *"weight was 1,810 kg when she was discharged"* (MPN3). Weight gain while in hospital has already been discussed as an emotional stressor for some mothers – "*if they are not gaining the weight, I'm not going home"* (M1W5).

All mothers still in hospital looked forward to going home with their babies, and most indicated that the family at home was *"very ready"* (M1W1):

" I'm very much prepared because I have always been looking forward to receiving the baby. Even my family is okay." (M1W6)

One mother was hesitant about her own readiness to cope at home:

" I don't know. My mother and grandmother know what to do and I will also practise what was said at the hospital." (M1W2)

Another was concerned about the general hygiene conditions at home:

"The only thing I'm thinking about is if she will get an infection and stuff. Because at home, it's not that safe." (M1W3)

The same mother also referred to having a flat nipple on one breast and how she was going to deal with it:

"No, I have a problem with my one breast, yeah. So I just I wanted to go with the cup so that this one I can to express it and this one. I can breastfeed. I can just do them both." (M1W3)

The main messages for going home were "*to continue with KMC"* (MPN4) and *"I will continue with breastfeeding"* (M1W1).

4.4.5. Follow-up

Mothers did not share much of their experiences on follow-up during the interviews. One mother did receive a visit from a community health worker after discharge. One of the healthcare providers estimated that *"5 out of 10"* (PS5) mothers continued practising KMC at home.

A professional nurse described the arrangements for following up babies after discharge as follows:

"And then we also do have a POPD after our babies have been discharged from KMC, then discharged home, they were given a follow update to come to paediatric clinic. They are also seen by the very same team. They do make a follow-up in the POPD." (PS1)

Another nurse described the return of mothers and babies for follow-up:

"The best when you see the baby come out alive, when you see your babies are growing… and they are going home and then they come back for clinic." (PS4)

Mothers or caregivers had *"different stories"* (PS5) for not bringing their babies back to the hospital or defaulting follow-up visits. These included transportation issues (finances), small baby referred to the regional hospital from an area far away (distance), relocation to another area (mobility), and no caregiver to look after other children (child care). One health worker participant referred to *"carelessness"* –" When *they come back, the baby will be sick and the baby will be admitted in paediatric ward"* (PS5).

Healthcare workers felt that there was good acceptance of KMC in the community, based on what they observed during follow-up visits:

"I think … the acceptance of KMC [is good]. … From the interviews of the outpatients, from the other patients as well, you'll find that you know the patients that you've seen, you know, continue came seeing the baby as well, to say even the father came here and

KMC. You find that the fathers are also, now they're at home, are also doing it [KMC] as well, or the grandmother is doing it. So there is quite acceptance I think in our community of KMC. So, because sometimes that we advocate that the fathers when they come for visiting hours here at our hospital that they be led to KMC the baby." (PS3)

4.4.6. Healthcare worker perceptions of their roles and responsibilities in KMC

All five healthcare worker participants supported the implementation and facilitation of KMC and felt it was important *"to ensure that the mothers adhere to KMC and understand it; giving them health education every day"* (PS2):

"Don't leave the baby unattended You keep the baby inside you so that you can be able to hear its breathing. Your heartbeat must beat the same, your baby must feel it." (PS4)

The provider participants referred to the involvement of the mothers and also the fathers, if available, in the care of their small newborns:

"They [staff] also counsel their mothers as well, because we must also do involvement of the family as well. Yes. We also involve the mother. If there is a father, also involve the father, then we teach them about the importance of KMC as well." (PS1)

In addition to completing the daily score sheet, healthcare providers also used the KMC guidelines from the Western Cape government – *"They use the neonatal guideline booklet used by the … University of the Western Cape (sic) in Cape Town"* (PS3). One of the participants described her care responsibilities as follows:

"Our responsibility and mainly in the unit is to make sure that our premature grow and then we fight off infection because we know our neonates need. Then most their immune system is low, so they are more prone to have infections. So it is to try and stop the spread of infection and we must make sure the babies they grow to the optimal weight …" (PS1)

Other caretaking responsibilities mentioned by the nursing participants included the following:

"My main responsibility is to ensure that they are well fed. They are dry, the atmosphere, the room in which they are is warm and if they need a peripheral line or an infusion line and make sure that the doctors put the line immediately." (PS4)

We are doing everything. We admit the babies. We issue out the medication but under the supervision and then sometimes because of shortage of staff, it can happen that you find yourself being alone in the ward and you do everything in the ward. … We are working under supervision and then we are working under scope of your practice." (PS5)

A participating enrolled nursing assistant listed in more detail what her care responsibilities entailed:

"My responsibility is to weigh the babies; to do observations to the babies; to check if they can eat properly[sucking]. Also to do the observations to the mothers for chronic illnesses; to report to my seniors about any abnormalities; to give oral medication under supervision." (PS2)

4.4.7. In conclusion … "Always be clean – Love your child"

Towards the end of the interview, maternal participants were asked what advice they would give to a new mother with a preterm or LBW baby. A powerful message was that a mother should not compare her baby and her situation with those of others:

"You should never compare yourself to the next person you know. Babies are different and the motive behind us being or the babies being in our incubator are different. What might be happening to you might not be happening to the next person, so you just need to stay focused. Don't let things get to you because you will be in a very emotional state, so try by all means to mind your own business, never really pay attention to what the next person says to you about you or about your baby. Remember the reason why you're here. Yeah, you're not here to make friends. You're just here for your baby and stay strong. Continue praying. Yes, I think that is the best advice." (M1W6)

Other messages are summarised in Table 4.7.

Table 4.7. Advice from maternal participants to new mothers

Message	Quotation
Listen to your healthcare provider	*"They should always listen to the doctors and the nurses because they know what's best for us."* (M1W3) *"Listen to the healthcare, follow every instruction given to her."* (MPN5)
Ask for help	*"To always ask for help from anyone."* (M1W4)

Message	Quotation
Breastfeeding promotes growth	*"I would advise the mother to get the child in the incubator and feed them properly so the child can grow."* (M1W1)
KMC works	*"I will encourage her to practice KMC because it is working. I saw mine when she was in [the] neonatal unit; she was not growing like when we were in KMC."* (MPN3)
Be patient	*"The baby needs some care. She needs some patience and need some time to take care of the baby and here [at the hospital] they will teach her to take care of them and they will grow nicely."* (MPN2)

The KMC experiences of each mother-baby pair were unique and barriers and enablers affected them in unique ways.

CHAPTER 5: DISCUSSION

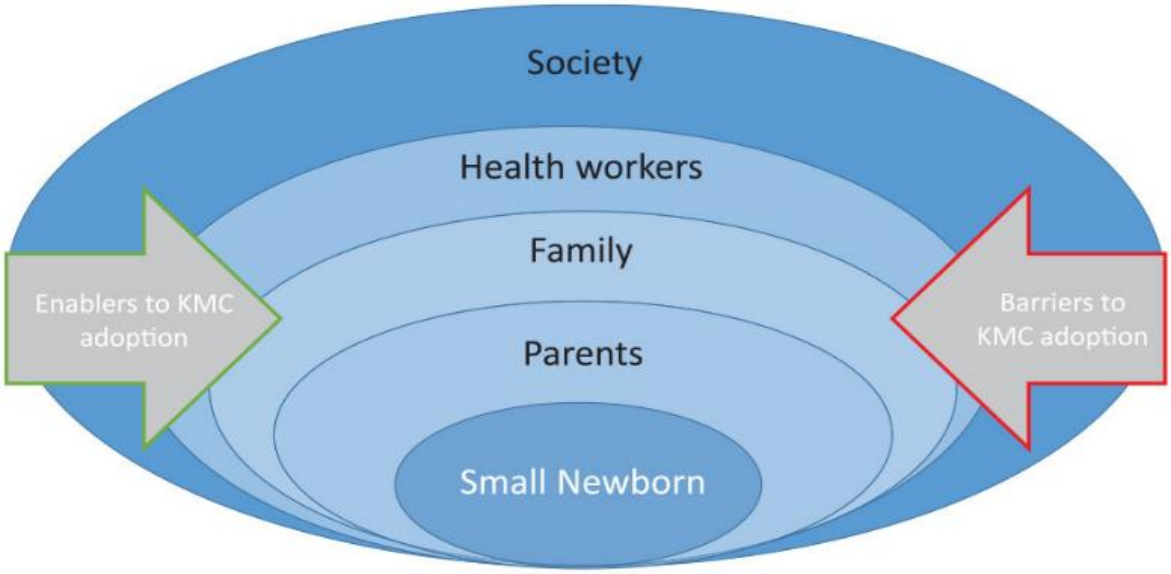
This study reports on experiences and perceptions of KMC elicited from mothers in the neonatal unit and KMC ward at a regional referral hospital in the Free State Province, South Africa and from mothers bringing their preterm and LBW babies for a follow-up visit to the paediatric outpatient department (POPD) of the hospital. Healthcare worker perspectives regarding mothers' KMC experience and practice were also probed.

A key finding from our study revolves around health system level barriers that may impede the optimal delivery of neonatal services and KMC practices. These include inadequate infrastructure leading to overcrowding and lack of privacy in the neonatal and KMC wards. The health workforce was characterised by staff shortages, a lack of training in KMC, and the absence of allied healthcare workers in the KMC team. Key enablers of KMC were the psychosocial support mothers received from staff and family members, and available financial support. A prominent finding was the staff's psychological, emotional and counselling support that ensured appropriate guidance and motivation for building mothers' confidence and promoting breastfeeding.

The rest of this chapter focuses on the following: factors in the health system acting as barriers and enablers for KMC service provision, such as the health workforce, infrastructure, and policy, leadership and governance; the influence of different types of support for the mother; and mothers' experiences of KMC.

Findings of our study were framed as barriers and facilitators to KMC practice, and the experiences of mothers and healthcare providers of KMC. Our findings have similarities with the conceptual framework presented in Chan et al.'s systematic review on barriers and enablers to KMC, which is depicted in Figure 4 (91). Data collection focused on mothers (and indirectly on parents and family) and health workers, with less attention to broader societal factors.

Chan et al. describe barriers and enablers according to three levels of stakeholders/role players: (a) mothers, fathers, and families; (b) healthcare workers; and (c) facilities (health system) (91). Studies by South African authors allude to factors that can facilitate successful KMC implementation, for example, a multitude of resources, dedicated space in the



Source: Chan et al. *Kangaroo mother care: a systematic review of barriers and enablers* (91)

Figure 4. Conceptual framework for interpreting barriers to and enablers of KMC

healthcare facilities, skilled healthcare workers, supervision, and buy-in from local and national healthcare authorities and stakeholders (61, 62, 92).

5.1. Health system barriers to and enablers of kangaroo mother care

Health system level barriers mentioned in Chapter 2 include, but are not limited to, inadequate space in the neonatal and KMC unit, lack of budget, shortage of staff, and lack of guidelines and supportive supervision. At the healthcare provider level, increased workload and lack of KMC knowledge were perceived as barriers to KMC practice. Lastly, at the mother and family level, mothers required support from health workers while practising KMC in the hospital and from their families and peers after discharge (25, 52). Vesel et al. (45) state that successful KMC implementation – in the face of poor communication and the absence of exchange of best practices – depends on the collaboration and agreement between health policymakers, senior management in healthcare facilities, front-line nurses and other health workers, and mothers and families.

Our study uncovered numerous aspects of care provision related to the **health workforce**. Healthcare workers in our study alluded to inadequate services influencing the quality of KMC for preterm and LBW infants and the challenge of providing sufficient support to KMC

mothers because of staff shortages. The literature reports that *inadequate staffing and work overload* are major contributing factors to the non-optimal implementation of KMC. Staff shortages and workload are among the top five on the list of nursing barriers to quality KMC (25, 45). Limited staffing levels and high workloads can preclude KMC provision for both stable and unstable newborns (93) and can result in errors in service provision (50). In one South African tertiary neonatal unit, staff shortages limited KMC to the practice of intermittent KMC only (67). Staff and workload barriers also hampered scaling up KMC in low- and middle-income countries (LMICs) settings, especially in Africa and Asia (25, 45, 47, 50, 94). Furthermore, other staffing factors that can negatively impact the quality and sustainability of KMC implementation are staff turnovers, policies on staff rotations, and the lack of orientation of new staff (62).

Despite the many barriers to and challenges in providing quality KMC with a limited health workforce, we found the *positive attitude of healthcare staff* towards KMC and its benefits for mother and baby to be similar to the findings of other studies conducted in Cape Town, South Africa (57, 83). Systematic reviews published by Kinsella et al. (47), Mathias et al. (48) and Chan et al. (91) all confirm that health professionals who believed in the benefit of KMC and used their vast experience, motivation and willingness to implement KMC facilitated successful implementation.

One of the barriers identified in our study was the absence of a *multidisciplinary team* to improve the care of small and sick newborns. A report from Tshwane Health District in Gauteng Province, South Africa on a KMC quality improvement initiative emphasises that successful KMC implementation requires partnerships between neonatal and obstetric care workers, family physicians and primary healthcare nurses. This illustrates the importance of a multidisciplinary team approach to effect change, with team members from different disciplines complementing each other (95). This is in line with the WHO's KMC context-adaptable implementation strategy for scale-up that refers to the multidisciplinary team consisting of paediatricians, neonatologists, obstetrician-gynaecologists, general practitioners, nurses and midwives who should lead by example by demonstrating a change in practice (51). These professional staff can lead by sharing KMC evidence and providing ongoing KMC training sessions to motivate and encourage healthcare staff to work effectively as a team (51). Although KMC could be described as "primarily a nursing intervention with medical support" which points to the leadership role of the neonatal nurse in the support for KMC in a multidisciplinary team (31, 96), allied health professionals such as dieticians,

occupational therapists, speech-language therapist and social workers also play important roles in providing comprehensive care as part of the KMC services (95).

In our study, concern was expressed about the different *levels of knowledge* regarding KMC among the nursing staff and medical interns. Knowledge and skills around KMC were mainly acquired on the job and with in-service training sessions with the paediatrician and the nurse with KMC training. The limits and variance in KMC knowledge were also reported in other South African studies. A study from the Western Cape reported that two-thirds of the staff lacked knowledge of KMC (83). A study from Limpopo found that poor knowledge among healthcare professionals negatively influenced the successful implementation of skin-to-skin contact (97). Nurses need continued training to improve their knowledge and skills to better support mothers with KMC (80).

The *lack of training* for healthcare providers in our study is consistent with Solomons and Rosant's finding that 60% of the nursing staff did not have any KMC training and that access to adequate and consistent training presented a barrier for healthcare providers to implement KMC (83). The WHO document on an implementation strategy for the scale-up of KMC refers to the need for KMC to be incorporated into all newborn-care pre-service and in-service curricula (51). More so, a contributing factor to the provision of quality KMC in the hospital and at home are healthcare professionals who educate and train other staff, parents and family members (96).

Infrastructural constraints such as *limited space* in the neonatal and KMC units leading to *lack of privacy and overcrowding* were some of the barriers mentioned by healthcare staff in their interviews. This appears to be a common barrier globally and in South Africa (45, 71, 86). It is also confirmed in a systematic review by Cai et al. (98) that facility conditions with limited space are an important aspect that influenced the operational implementation of KMC. Lack of privacy created an uncomfortable environment for mother and baby, and identifying and creating private areas was recommended in some publications (91, 99).

Overcrowding because of the lack of space in the neonatal and KMC units, which led to nosocomial infections, was another barrier identified in our study. Cho et al. (93) came to the same conclusion in a study conducted in the Gambia where the hospital had limited capacity in the neonatal unit for premature and LBW newborns.

The importance of **leadership and governance** and the need for support from different management levels, especially financial support, given the challenges with space and staff,

were key aspects of our findings. Leadership is an essential requirement for the successful rollout of best practices, as viewed by healthcare professionals cited in several studies. Ten Ham et al. found that there was a perceived lack of leadership on several levels (individual, management and provincial) in the roll-out of KMC in South Africa (100). The Gambian study on barriers and facilitators to KMC before infant stability highlighted the importance of leadership and management in supporting KMC implementation at all health system levels to facilitate successful KMC implementation (93).

At the Boitumelo Hospital, the availability of a KMC protocol and the Western Cape's KMC *guidelines* (101) was a facilitating factor for KMC implementation. Dippenaar et al. (69) provided suggestions for the safe implementation of KMC in district hospitals and primary healthcare maternity units in the Free State Province in South Africa. Various other South African studies alluded to the importance of accessible *KMC policy documents* and that policy alignment through protocols and guidelines was key in the implementation process of KMC at different management levels (62, 95, 100). The Gambian study mentioned that accessible protocols with supportive supervision were a key aspect in the quality of KMC practices (93), whereas a lack of clear guidelines has been highlighted in systematic reviews as a key barrier for nurses in the LMICs (25).

5.2. Support for kangaroo mother care

We framed our interpretation of KMC mothers' support needs around the constructs of financial support and psychosocial support. Mahwasane et al. (81) use a framework of support needs of mothers assisting them to understand their baby's health condition through continuous sharing of information to be confident in KMC care practices and continuation at home. This framework is divided between informational support needs, instrumental support needs through direct supervision, and psycho-cultural and emotional support needs.

There was little information in the literature linking KMC to *financial support*. A study in Zambia mentioned that less than half of the study mothers received some kind of financial assistance from families, with more than half never receiving such support (52). In our study, financial support was related to the ability of a mother to return for follow-up visits at the hospital. Most of our study mothers were reliant on social support grants as their primary source of funding. Kwesiga et al. (102) highlighted the lack of finances as a key barrier for mothers not returning for follow-up visits in Uganda.

Our study findings regarding *psychosocial support* correspond well with those of studies that highlighted parents' recognition of the hospital as a supportive environment with healthcare workers and other mothers providing encouragement and support (29, 47, 50, 91, 103, 104). In addition to the support of the hospital and healthcare workers, mothers and parents also require assistance from family members to practise KMC successfully. The valuable role of healthcare providers and families as KMC enablers is also highlighted in the literature (25, 29, 110).

Support related to mothers' psychosocial needs in the form of *education, guidance and reassurance* from the healthcare workers was a major finding in our study. In a study in a tertiary hospital in the Western Cape Province, Xhosa mothers mostly viewed healthcare workers as supportive and representing the older women in communities who taught and offered physical support (56). Leonard and Mayers (57) found that other mothers in a Cape Town KMC ward provided encouragement and were good listeners when they had bad days. A mixed-methods systematic review of healthcare providers' perceptions and experiences of KMC concludes that mothers required the healthcare worker's support to fulfil their needs through guidance, structured schedules for holding the baby, and a comfortable, quiet environment (105). A Zambian study on the acceptance of KMC recommended that healthcare workers share information and support mothers to increase the latter's knowledge and understanding of KMC and to ensure improvement in KMC implementation (52).

In our study, not all mothers were happy with all the healthcare providers' treatment and attitude. The study among Xhosa women noted that, despite the positive feedback from mothers, the KMC ward was understaffed and healthcare workers had a poor work ethic or were unapproachable and disrespectful (56). One systematic review mentions mothers' negative impressions of staff attitudes and interactions (25), whereas, in another, parents reported healthcare workers to be occasionally loud and not caring (24). Lomotey et al. (106) reported that others experienced the behaviour of healthcare workers as unfriendly and uncordial, leaving them with the impression that nurses did not care about their well-being.

Healthcare worker education and information sharing of KMC practices and benefits with mothers not only improve mothers' knowledge of KMC but increase their ability to understand and execute specific caring tasks and routines of KMC. Our study findings revealed that information on the following topics and caring tasks were perceived to be

important for mothers: first health talk; breastfeeding; hygiene; clean surroundings; changing of nappies; KMC holding position; milestones of the baby; and general care of the baby.

KMC *training of the mother and supportive supervision* were enabling factors for its implementation in Northeast Ethiopia (107). Rahmatika et al. (50) describe one of the roles of healthcare workers in a KMC unit in Indonesia as being an educator because the low level of knowledge or lack of knowledge of mothers and the age of young mothers could be barriers to acceptance of or adherence to KMC. In our study, the majority of mothers did not know about KMC until hospital admission and relied on healthcare workers to help them understand KMC benefits and practice. A Zambian study indicated that mothers accepted KMC after receiving well-communicated information (52). The systematic review by Smith et al. (24) confirms that mothers were less likely to accept KMC if healthcare workers could not clearly explain the benefits of KMC. The presence of skilled healthcare workers trained to facilitate KMC implementation reduced the hesitation of mothers to practise KMC and take care of their babies (24). In Malawi, Ghana and India, using KMC pictures or dolls, pictorial presentations and photographs/posters of mothers practising KMC and return demonstration of KMC dolls eased understanding of KMC practice and motivated mothers to practice KMC (55).

5.3. Mothers' experiences of kangaroo mother care

Mothers' experiences related to the early birth of their babies and the practice of KMC are discussed below under the following topics: preparedness and emotions; support for breastfeeding; acceptance of KMC; and discharge and follow-up.

The experiences of mothers in the Boitumelo KMC unit started with an *unprepared and unplanned delivery* of a preterm or LBW baby. The unexpected delivery took them by surprise and evoked mixed emotions. Most mothers in our study had *no prior knowledge of KMC* and first heard about it in the hospital. This is in line with the findings of two Cape Town studies that generally mothers had not heard about KMC before the birth of their infants (56, 83). The study by Solomons and Rosant reports that 83% of the postnatal mothers still lacked knowledge of KMC at a follow-up visit, although they were pleased with the weight progress of their preterm babies.

Some of the systematic reviews on KMC confirm that many mothers did not know about KMC before delivery. Kinsella et al. (47) refer to an Indian study that found that one-third of

mothers had heard about KMC, whereas a Nigerian study cites that nearly 68% of mothers had heard of KMC before (24, 25). A Zambian study suggests low knowledge levels of KMC among mothers of LBW infants, with a limited understanding of the benefits of skin-to-skin contact (108). A Ghana study argues that the reason mothers did not perform KMC was that they had never heard of KMC (106).

Mothers' *mixed emotions* regarding their preterm delivery and their lack of awareness of KMC, as described in the literature, are similar to our findings. Mothers' thoughts during delivery through to the admission of their babies to a mother-baby unit in Ghana influenced the fluctuation between negative and positive emotions (106). Various other authors refer to the experience of positive and negative feelings around the care of a preterm infant. According to Robertson and Crowley (82), adolescent mothers found KMC practice challenging, but most of the young mothers felt happy and excited when they could be with their infants 24 hours per day, practising continuous KMC. Leonard and Mayers (57) report that after parents had realised their baby was alive, the shock and anxieties subsided. Parents wanted to hold their tiny babies but found it difficult to connect with their infants in the unfamiliar neonatal unit – they were scared that they would hurt or drop them.

Mixed emotions are a result of the stress mothers and parents experience with the birth of a premature, LBW or sick baby. Our findings compare well to those of the study by Lomotey et al. (106), which concludes that the unexpected birth of a baby was very stressful for the parents. The parents' role had changed when the mother and baby were separated immediately after birth, and the baby would receive breastmilk through a tube. These unfamiliar practices further contributed to anxiety and stress (106).

Support for breastfeeding is considered very important for the care of all newborns. According to Campbell-Yeo et al. (109), healthcare providers should start to inform and encourage mothers of the benefits of KMC and breastfeeding and support them as early as possible. A systematic review by Almutairi et al. (105) found the lack of sufficient support for breastfeeding preterm babies to be a key barrier in hospital settings. This is in contrast to our study setting, where many mothers referred to the encouragement they got for breastfeeding. Some mothers were, however, uncertain if their babies were receiving sufficient volumes of milk, which is similar to a finding by Madiba et al. (78) in a tertiary hospital in South Africa. Mothers in the latter study talked about how painful the initiation of breastfeeding was, and that breastfeeding hurt and caused discomfort – these were not in the

foreground in our interviews. Lomotey et al. (106) refer to the feeding difficulties expressed by mothers, including the initial pain when they started to express breastmilk and the inability of the baby to suck well. They confirm that a two-hour feeding schedule was challenging for mothers, but on the other hand, it allowed mothers to spend time with their babies (106). Two-hourly feeding was also mentioned by some of our study participants, but they did not complain about it.

The *joy of bonding* as a result of KMC was frequently expressed in our study. Breastfeeding – one of the components of KMC – contributes to mother-infant bonding and attachment (78). Despite feeding schedules and other challenges, mothers continue breastfeeding as it enhances the bonding and interaction time between mother and baby (106).

According to the literature, just as in our study, there appears to be a *general acceptance of KMC* by mothers and their families. The Zambian study refers to mothers who agreed to place their babies in an upright position skin-to-skin continuously for 20 hours, sleep with the baby on the chest, and keep doing KMC at home (52). A study in a tertiary hospital in India found that mothers were very comfortable practising KMC (110). A systematic review by Smith et al. (24) on caregivers' perspectives of barriers and enablers of health system adoption of KMC reports that the positive perception of mothers and families about the benefits of KMC promoted KMC uptake. According to a scoping review by Mathias et al. (48), maternal love and confidence, coupled with health-seeking behaviour, prompted parents of LBW infants to practise KMC regardless of the circumstances, as this brought an individual sense of mother-infant bonding and promoted KMC practice.

At Boitumelo Hospital, health workers did a daily assessment of mothers' and babies' *discharge readiness* with a discharge scoring sheet, which is similar to the tool used in KwaZulu-Natal Province (86). The sheet captures a number of observations, such as the mother's confidence in caring for her baby, available home support for the mother and baby, and compliance with continuous KMC. Upon discharge, mothers were given an appointment for the first follow-up visit at the hospital. Our findings also correspond with those of a Limpopo study that reported that healthcare professionals provided mothers with some discharge information about the practice of KMC and made appointments for follow-up visits (54). These authors remarked that although some mothers did not feel ready for discharge to care for the baby at home, quality discharge preparation in the KMC unit empowered mothers with the skills needed to safely care for infants at home. This is concurred by Madiba et al.

(78) regarding the preparation for breastfeeding at home. The WHO document on the scale-up of KMC in different country contexts also includes recommendations for discharge (51).

Concerning *follow-up*, our study did not probe mothers' experiences of follow-up visits, but the healthcare worker participants felt that from their observations of mothers coming for follow-up accompanied by fathers or grandmothers, KMC's acceptance in the community was good. We could also not find any literature referring specifically to KMC mothers' experiences of follow-up.

Several barriers mentioned by the study participants to the follow-up of their preterm and LBW babies and to the continuation of KMC at home were also found in the literature. Lack of follow-up plans and lack of support by healthcare workers to link the mother to a primary care facility (111, 112) were different in our study because mothers and babies returned to the hospital for follow-up according to specific dates given to them on discharge. In our study, only one mother had contact with a community healthcare worker, similar to other studies that found that community healthcare workers (CHWs) were not supporting and visiting the mothers and babies (102, 112). Kwesiga et al. (107) also found that CHWs did not do follow-ups of mothers and babies at home due to a lack of an effective community-based follow-up system. Some mothers in our study mentioned a lack of transport and distance from home to the follow-up hospital (86, 102, 112) as a barrier, especially due to financial difficulties in returning for follow-up. Davidge reported that in KwaZulu-Natal Province in South Africa, most of the KMC mothers from rural communities had poor public transport access and little medical care access (86). It appears as if the lack of preparedness for the continuation of KMC and breastfeeding at home (78) was less prominent in our study findings. Our findings pointed towards positive attitudes of mothers to continue KMC and exclusive breastfeeding at home. Similar to the study by Madiba et al. (78), healthcare workers provided information and education on KMC and breastfeeding, which contributed to the mothers' perception that they could provide care and safety to their babies after discharge.

5.4. Strengths and limitations of the study

The researcher's background in nutrition and public health may have influenced the study. Her qualifications and experiences in the prevention of mother-to-child transmission of HIV and the importance of exclusive breastfeeding for the first six months of life may have resulted in a greater focus on the breastfeeding component of KMC. On the other hand, exposure to working in hospitals with LBW and preterm infants sensitised her to the other

care routines and interventions for these infants. This enhanced her observations during data collection and analysis, not only on breastfeeding patterns but also on skin-to-skin care, mother and infant behaviour, and matters related to discharge and follow-up.

Conducting interviews within the health facility may have introduced positive response bias, as participants, particularly mothers, may not have wanted to share negative experiences about the care they received. Participants could have perceived the research team as part of the hospital, feeling obliged to give favourable answers. The researcher had to continuously be mindful of her own experiences, values, and beliefs and how they should be set aside during the interviews. Measures to further enhance the validity of the findings included having a Sesotho-speaking research assistant not connected to the hospital who also shared her observations concerning the mothers' state of mind. Other measures included allowing participants to feel at ease in a private room where the interviews took place and letting them set the pace and direction of the interviews.

This study was a qualitative investigation focusing on the perspectives and experiences of mothers with LBW and premature infants in the hospital. We did not collect aggregated hospital data for quality improvement purposes, for example, the length of hospital stay of preterm and LBW babies who did not receive continuous KMC in the hospital, compared to those who resided in the KMC unit.

At the time of the data collection, clinical associates no longer worked at the hospital and could not be included in a focus group interview as described in the research proposal. The community health workers were interviewed as planned, but could not provide any information relevant to the study's aim and objectives.

Some of the interviews with mothers were conducted by a research assistant in Sesotho, as the researcher was not proficient in the home languages of the participants. The assistant also coordinated participant recruitment in collaboration with healthcare staff, scheduled her interviews, took detailed field notes, and ensured that informed consent procedures were followed. The researcher conducted her interviews with mothers in English. All of them had at least 10 years of schooling. However, their level of English proficiency may have influenced the depth of the collected information.

Our cross-sectional study was limited to one hospital setting. The findings may therefore not be generalisable to other settings. However, the main themes identified in our study resonate with the findings of other international and South African studies.

5.5. Conclusion

The study of mothers' experiences of KMC in the Fezile Dabi District in the Free State did not yield any new findings but confirmed that the experiences of mothers are universal and were similar to those reported in other studies across different countries and in systematic and scoping reviews. Health professionals in the district expected there would be unique context-specific insights. Without doing the study, it would not have been possible to confirm the similarities with the findings of other studies. Health workers could actually learn from these similar findings. The barriers to and facilitators of optimal KMC practice and service implementation could also serve as pointers for developing programmes to improve KMC services and enhance mothers' and families' experience of KMC at the facility level and post-discharge.

Healthcare providers, other mothers, partners/fathers and families are key role players in the health and well-being of mothers and babies from conception to the first 1000 days of the infant's life.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

In South Africa, neonatal mortality and morbidity continue to be a major challenge. The global and local evidence for the positive outcomes for preterm and LBW newborns who receive KMC is overwhelming. South Africa has, over the last few decades, succeeded in rolling out KMC services to most public district, regional and tertiary hospitals, albeit very unevenly (77).

Our study took place at Boitumelo Regional Hospital in the Fezile Dabi District in the Free State Province. It explored mothers' experiences of caring for preterm and LBW babies both in the KMC unit and after discharge. The analysis focused on the support they received and health system factors that could shape their experiences and perceptions.

Mothers received valuable psychosocial support from healthcare providers, who were described as empathetic and helpful with baby care and breastfeeding. Support from partners was limited, often due to living separately. Other family members played an important supportive role, especially grandmothers, sisters, cousins and uncles.

Mothers' experiences started with being unprepared for a preterm birth when they were admitted to the hospital. Antenatal care did not prepare them for a possible early birth and KMC. Their initial emotional reactions ranged between fear, anxiety, uncertainty and confusion. The unfamiliar hospital environment and doubts about KMC added to their distress. However, education, practical guidance and emotional support from the healthcare workers encouraged them to adopt KMC. Over time, mothers gained confidence as they bonded with their babies and saw positive growth. At discharge, they received the following key messages: continue KMC at home; breastfeed exclusively; and monitor for and report danger signs in the baby immediately.

Healthcare workers understood their roles in prioritising the care of mothers and babies in the KMC unit. However, health system challenges throughout the continuum of care affected service quality and the adequacy of support to KMC mothers. Key barriers included hospital staff shortages, the resultant high workload, and limited refresher training in KMC. Other

observations were: overcrowding in the neonatal unit; inadequate infrastructure and facilities for the KMC mothers; and limited equipment, supplies and commodities.

Furthermore, our study identified health system factors that facilitated mothers' acceptance of KMC. Integrating KMC into neonatal services and following KMC protocols and guidelines ensured a continuum of hospital care for small and sick newborns. Enthusiastic and skilled healthcare professionals shared the benefits and practices of KMC with mothers. They also acted as mentors and demonstrated good teamwork, and a medical doctor was available around the clock. Additional enablers included access to the health facility through transport and ambulance services, lodging facilities before and after delivery, and post-discharge services.

6.1. Recommendations

Several recommendations emanated from this study. They are summarised below as recommendations for KMC services and practice, for managers and policymakers, and for further research.

6.1.1. For KMC services and practice

The first set of recommendations pertains to improving KMC services and practice at the grassroots level. Any healthcare facility can use it to reflect on and evaluate the state of KMC in the institution.

Visible and concrete messaging about the benefits and practice of KMC in hospitals and clinics is an essential step in sensitising the public and families on the importance of KMC in caring for small and sick newborns. Learning materials on preterm birth for mothers and families during pregnancy should be available during hospital stay and in the KMC unit. Mothers should also be prepared adequately during antenatal care for a premature delivery and a possible longer hospital stay that would include special care and KMC. According to Chan et al., there is a need for clear communication with parents and families about KMC and education platforms and materials that could enhance the understanding of KMC practices (91). Printed educational materials and videos to play in the KMC unit are recommended, as well as identifying online learning modalities. A list of available websites with messages for preterm mothers could be compiled. Messages should be included in telehealth programmes (e.g. MomConnect), and mothers should be connected to organisations supporting mothers of premature babies (e.g. Preemie Connect).

Family-centred care in the hospital should be prioritised by *involving fathers* (and other family members) in the care activities in the KMC unit to ensure support for the mother at home and continuation of KMC. Parents and families experience high levels of stress and anxiety with preterm births. This influences the acceptance of KMC, which is caused mainly by a lack of knowledge about KMC (91). An Indian study found that adherence to KMC after discharge was better if the husband or other family members assisted in skin-to-skin contact. Fathers' knowledge of the benefits of KMC also increased from 48% at the baby's admission to KMC in the hospital to 80% two weeks post-discharge (112).

Preparation for the discharge of the mother and baby from the hospital should be a priority in the hospital, with measures in place to ensure that all mothers receive adequate counselling, e.g., by using a discharge checklist. This preparation should include counselling for the mother-infant dyad, the father, and other family members, as well as education on danger signs (91). A family meeting before the baby is discharged is important to address the family's social, economic, and other challenges they may face. This is especially important for ensuring the safety of babies of adolescent mothers.

Access for KMC mothers to a multidisciplinary team (e.g., dieticians, occupational therapists, physiotherapists, speech therapists, psychologists, and social workers) was not optimal in the study hospital. Having these different professionals available could assist with optimising care for small newborns during the KMC period in the hospital and after discharge. This support could lead to better long-term health outcomes as described in Chapter 2. The WHO also emphasises the educational role of a multidisciplinary team at the facility level in supporting mothers with continued education on KMC and practical application, and providing refresher courses for other healthcare workers (51).

Mechanisms for sufficient support for continuing KMC after discharge should be devised by the hospital and surrounding clinics. The WHO recommends regular follow-up on progress through telehealth, phone calls, home visits, and community health programmes to be in place (51). Support groups for mothers of preterm and LBW babies could also be created, similar to the HIV mothers2mothers initiative in South Africa (113), involving retired nurses, social workers, and mothers with preterm birth and KMC experience.

6.1.2. For managers and policymakers

Financing and service delivery are key barriers to successful KMC within health systems and hospitals (91). Financial commitment for KMC should be prioritised in newborn care budgets to provide sufficient resources and infrastructure improvements to enhance the overall quality of newborn care (51, 93). Limited space in KMC wards causes mothers discomfort in practising KMC effectively (98). Budgets for KMC should include means to create safe, private spaces with appropriate beds and chairs, quality pillows, and sufficient KMC wraps. Such arrangements would enhance mothers' sleep quality and could play a vital role in their physical and mental health when they provide KMC for prolonged periods (91, 93).

The study hospital used the Western Cape KMC guidelines. Nationally and provincially, newborn care *policies and guidelines* that include KMC should be distributed to all relevant healthcare facilities and staff members as they become available, emphasising the importance of following KMC policies and guidelines developed by the National Department of Health. According to the WHO's KMC implementation strategy for scale-up, governments should include KMC in maternal newborn policies and all training curricula for healthcare providers at national and district levels (51). The WHO also recommends the training and development of all healthcare providers responsible for caring for mothers with preterm and LBW babies in KMC through pre-service and in-service training, as well as supportive supervision (51). Cho et al. (93) observed that the education of healthcare workers on KMC was a key factor in KMC implementation. The education should be supported by relevant protocols and guidelines, effective supervision, knowledge sharing between professionals, and hospital and primary healthcare networks (93).

Primary healthcare clinics and community health workers could be better utilised in the follow-up with mothers and vulnerable babies after discharge from the hospital, especially where specialised follow-up cannot be provided regularly or is unavailable. Follow-up of preterm and LBW babies should be integrated into the current primary healthcare programmes with functional communication between the different levels of care. Systems should be devised to perform the necessary monitoring and evaluation, streamline reporting lines, and ensure accountability regarding the outcome and impact of the quality of KMC practices (91).

The greater involvement of primary care facility staff implies the *upskilling* of healthcare providers to enable them to address gaps identified concerning the support of pregnant

women and the appropriate support of mothers with preterm babies. There should be sufficient coverage of KMC in the district's in-service training plans on caring for and managing small and sick newborns. Also for consideration is the training of community health workers or ward-based outreach teams on how to do follow-up visits of KMC babies at home and identify danger signs in babies that should be referred for care in a health facility (98).

6.1.3. For further research

Our study covered only one of the 52 health districts and only focused on its regional health facility. The data collected reflected the experiences and perceptions of mothers with preterm and LBW infants in KMC at the health facility level, as in most other studies. This confirms that more research is needed on *community-level KMC.*

KMC practices and implementation vary among different provinces and districts in South Africa. Further research is also needed nationally and in other districts and provinces on systems that enhance the *sustainability of KMC implementation*.

Our study focused on one hospital that was the focal referral point of the district. There is a dire need for more information on and an understanding of *district referral networks between different levels of health facilities.* Although community healthcare workers participated in this study, virtually no information was obtained regarding KMC-supportive home visits to mothers with a premature or LBW infant discharged from the hospital. The workers had limited knowledge about KMC, and no link could be identified between the hospital and primary care health facilities in following up on these special mother-infant dyads.

Other areas to investigate are the following: how district hospitals care for small and sick newborns and how they practice KMC; similarities and differences in experiences and perspectives of health professionals and mothers of KMC in district hospitals; and the functionality of the referral systems.

6.2. In conclusion

Healthcare service delivery in South Africa is still unbalanced regarding quality in KMC in healthcare facilities between provinces and districts (77). There are also differences in the number and level of competent healthcare workers, the level of adequate resources, and the ability to provide the required KMC services. Improved advocacy for and sensitisation of

preterm birth and KMC as one of the effective interventions to care for small vulnerable newborns can also go a long way in getting the public to demand the best possible small and sick newborn care services, including KMC.

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APPENDICES

Appendix A: Ethics approval from the University of the Witwatersrand

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Mrs Muellatt Van Biljon M230711 MED23-05-032

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M230711 MED23-05-032

NAME: (Principal Investigator)	Mrs Muellatt Van Biljon
STUDENT/STAFF NO:	2373163
DEGREE:	MPH (Maternal and Child Health)
DEPARTMENT:	Faculty of Health Sciences School of Public Health Boitumelo Regional Hospital, Fezile Dabi District, Free State
PROJECT TITLE:	Mothers' perspectives and experiences of kangaroo mother care in the Fezile Dabi Health District, South Africa: A Qualitative Study
DATE CONSIDERED:	11/08/2023
DECISION:	Approved unconditionally
CONDITIONS:	(Resubmission M220666 MED22-05-072)
SUPERVISOR:	Dr W Slemming and Dr A Bergh
APPROVED BY:	Mrs M van Niekerk, Co-Chair, HREC (Medical)
DATE OF APPROVAL:	24/11/2023 **EXPIRY DATE:** 24/11/2028

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report** in July each year until study is closed. Failure to submit annual report will result in ethics clearance certificate suspension. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in July and will therefore be due in the month of July each year. Unreported changes to the application invalidate the clearance given by the HREC (Medical). Email signed copy of this ethics clearance certificate prior to commencing with the study hrec-medical.researchoffice@wits.ac.za

M230711n Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix B: Ethics approval and extension from the University of the Free State

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

20-Apr-2023

Dear **Mrs Muellatt van Biljon**

Ethics Clearance: **Mothers' perspectives and experiences of kangaroo mother care in the Fezile Dabi Health District South Africa: a qualitative study**

Principal Investigator: **Mrs Muellatt van Biljon**

Department: **External Affiliation**

Submission Page

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is:**UFS-HSD2022/1513**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

Research conducted in any Department of Health facility: Researchers are required to sign and return the HSREC approval letters to the provincial Department of Health where they applied. It is also a requirement for researchers to submit electronic copies of their final research findings, and/or make a presentation of their findings and recommendations at departmental research days when and where indicated.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2020); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; International Council for Harmonisation (ICH) Harmonised Guideline, Integrated Addendum to ICH E6(R1), Guideline for Good Clinical Practice (GCP) E6(R2), 2016, SAHPRA Guidelines as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

The Principal Investigator (PI) bears final responsibility for the RTMS application. In the event of any misconduct or improper activities perpetuated by a third party, the PI will be held vicariously liable. The HSREC will bear no responsibility or liability for any actions of a PI and/or third party or breach of confidentiality caused by the PI and/or third party.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Prof. A. Sherriff
Chairperson: Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 E: ethicsfhs@ufs.ac.za
IRB 00011992; REC 230408-011; IORG 0010896; FWA 00027947

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

21-May-2024

Dear **Mrs Muellatt van Biljon**

Ethics Number: UFS-HSD2022/1513/2504-0006

Ethics Clearance: **Mothers' perspectives and experiences of kangaroo mother care in the Fezile Dabi Health District South Africa: a qualitative study**

Principal Investigator: **Mrs Muellatt van Biljon**

Department: **External Affiliation**

Submission Page

SUBSEQUENT SUBMISSION APPROVED

With reference to your recent submission for ethical clearance from the Health Sciences Research Ethics Committee. I am pleased to inform you on behalf of the HSREC that you have been granted ethical clearance for your request as stipulated below:

- Continuation report approved until May 2025.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2020); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; International Council for Harmonisation (ICH) Harmonised Guideline, Integrated Addendum to ICH E6(R1), Guideline for Good Clinical Practice (GCP) E6(R2), 2016, SAHPRA Guidelines as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

The Principal Investigator (PI) bears final responsibility for the RIMS application. In the event of any misconduct or improper activities perpetuated by a third party, the PI will be held vicariously liable. The HSREC will bear no responsibility or liability for any actions of a PI and/or third party or breach of confidentiality caused by the PI and/or third party.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4012650/9860 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this request for ethical clearance and we wish you continued success with your research.

Yours Sincerely

Dr. C. Armour (Barrett)
Chairperson : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
T: +27 (0)51 401 2650/9860 E: ethicsfhs@ufs.ac.za
IRB 00011992; REC 230408-011; IORG 0010096; FWA 00027947
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www.ufs.ac.za

Appendix C: Permission from the Free State Department of Health

health
Department of Health
FREE STATE PROVINCE

04 April 2023

Mrs M van Biljon
External Affiliation
WITS

Dear Mrs M van Biljon

Subject: Mothers' Perspectives and Experiences of Kangaroo Mother Care in The Fezile Dabi Health District, South Africa: A Qualitative Study.

- Please ensure that you read the whole document, permission is hereby granted for the above-mentioned research on the following conditions:
- Participation in the study must be voluntary.
- Consent must be obtained from each participant.
- Serious adverse events to be reported to the Free State Department of Health and/ or termination of the study.
- Ascertain that your data collection exercise neither interferes with the day-to-day running of the **Boitumelo Hospital** nor the performance of duties by the respondents or health care workers.
- The Free State Department of Health expects that the researcher will be the responsible data manager according to the POPI Act. The responsibility thus lies with the researcher to ensure that the processing of all participants' personal information and research data is lawful according to the stipulations of the POPI Act (Protection of Personal Information Act 4 of 2013).
- Confidentiality of information will be ensured and please do not obtain information regarding the identity of the participants.
- Department of Health to be fully indemnified from any contravention of the POPI Act as you conduct this study.
- **Research results and a complete report should be made available to the Free State Department of Health upon completion of the study (a hard copy plus a soft copy).**
- Progress report must be presented not later than one year after approval of the project to the Ethics Committee of the University of Free State and the Free State Department of Health.
- Any amendments, extensions or other modifications to the protocol or investigators must be submitted to the Ethics Committee of the University of Free State and the Free State Department of Health.
- **Conditions stated in your Ethical Approval letter should be adhered to and a final copy of the Ethics Clearance Certificate should be submitted to Sebeelats@fshealth.gov.za/Gwantshuws@fshealth.gov.za before you commence with the study.**
- No financial liability will be placed on the Free State Department of Health.
- **Please discuss your study with the Institution Manager on commencement for logistical arrangements.**
- Department of Health is to be fully indemnified from any harm that participants and staff experience in the study.
- As part of the feedback, you will be required to present your study findings/results at the Free State Provincial Health Research Day.

Trust you find the above in order.

Kind Regards

MR. MNG MAHLATSI
HEAD: FREE STATE DEPARTMENT OF HEALTH

Date: 11/04/2023

Head: Free State Department of Health
PO Box 227, Bloemfontein, 9300
4th Floor, Executive Suite, Bophelo House, cnr Maitland and, Harvey Road, Bloemfontein
Tel: (051) 408 1646 Fax: (051) 408 1556 e-mail chikobvup@fshealth.gov.za
www.fs.gov.za

Appendix D: Information letter and consent (mothers)

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

APPENDIX D(1)

PARTICIPANT INFORMATION SHEET
MOTHERS

Study title:
Mothers' perspectives and experiences of kangaroo mother care in the Fezile Dabi Health District, South Africa

Introduction
Good day,
My name is Muellatt van Biljon. I am a master's student in public health at the University of the Witwatersrand with a special interest in maternal and child health. As part of my studies, I have to do a research project that will provide new knowledge. Dr Wiedaad Slemming is my supervisor. In my study we want to learn how mothers with a preterm or low birth weight baby admitted to the Boitumelo Hospital perceive and experience kangaroo mother care.

Invitation to participate
This project includes interviews with mothers of small babies and health care workers. As part of the project, I would like to invite you to take part in an interview. I will ask you a number of questions about your pregnancy, the birth of your baby, how you experienced kangaroo mother care (KMC), caring for the baby at home, and challenges with having a preterm or low birth weight baby.

The interview will take about 45-60 minutes. With your permission, I would also like to audio record the interview using a small tape recorder. These recording and written documents will be stored securely in a lockable cabinet and only the researcher and the supervisor will have access to it. It will be destroyed after 6 years.

Ethical approval
This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg (protocol M220666) and the Health Sciences Research Ethics Committee of the University of the Free State (UFS-HSD2022/1513). A principal function of this Committee is to safeguard the rights and dignity of all people who agree to participate in a research project. We also have the permission of the Free State Health Department and Boitumelo Hospital to do this study.

Participation is voluntary

Your participation in this study is entirely voluntary. You can refuse to participate or withdraw at any time during the interview without giving any reason. There will be no disadvantages or penalties for you and your care and the care of your baby will not be affected in any way.

Benefits of being in the study

There will be no direct benefits to you participating in the study. However, your honest and open feedback will help us to gather trustworthy information on mothers' experience of kangaroo mother care.

Possible discomforts

If you feel uncomfortable with any of the questions we ask, you don't need to answer and don't need to give a reason. If you experience distress or feel very upset at any point in this process, we will stop the interview and the health worker assisting me with the interview will offer you counselling assistance in the language of your choice. If you feel okay and are willing, we will continue with the interview. If you do not feel okay, we will – with your consent – refer you to the doctor or sister in charge of the neonatal unit for further counselling. They will also be able to refer you for further psychological support should you wish so.

Costs and compensation

If you participate in the interview, there will be no personal costs to you, except your time. You will also not receive any compensation.

Confidentiality

The interview will be completely confidential and your name will not be disclosed to anyone else. The information you give to me will not be linked to your name in any study report. I will be using a coding system to represent your participation in my final research report. The results of the study will be written up as a research report that will be available online through the University library website.

Contact persons

If you have any questions during or afterwards about this study, feel free to contact me on the details listed below.

Principal investigator: Muellatt van Biljon: 071 501 3562; email: 2373163@students.wits.ac.za

Supervisor: Dr. Wiedaad Slemming: 011 717 2292/82; email: Wiedaad.Slemming@wits.ac.za

If you have any concerns or complaints regarding the ethical procedures of this study or the way in which this study is conducted, please contact one of the following committees:

Human Research Ethics Committee (Medical), University of the Witwatersrand
Chairperson: Professor Clement Penny
Tel: 011 717 2301; email: Clement.Penny@wits.ac.za
Committee secretariat:
Tel: 011 717 2700/1234; email: Zanele.Ndlovu@wits.ac.za or
Rhulani.Mukansi@wits.ac.za

Health Sciences Research Ethics Committee, University of the Free State
Chairperson: Professor A Sheriff
Head of administration: Mrs MGE Marais
Tel: 051 401 7794/7387; email: ethicsfhs@ufs.ac.za

Date: October 2022

PARTICIPANT CONSENT SHEET

Project title: Mothers' perspectives and experiences of kangaroo mother care in the Fezile Dabi Health District, South Africa: a qualitative study

1. I received a Study Information Document that explains the nature and processes involved in this study, which is attached hereto.
2. I was given time to read it, or had it read to me, in the language I best understand.
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory.
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be.
5. I understand that there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment. Conversely, participation will not cost me anything but my time.
6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons. Should I withdraw, any data collected about me for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained.
7. I am aware that the information obtained in the study, including personal details, will be anonymously processed and presented in the reporting of results.
8. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

9. I am participating willingly.
10. I have received a signed copy of this informed consent agreement.

Name of Participant: _____ (Please print)

Date: _____ Place: _____

Signature or mark: _____

Witnessed by: Name of Witness: _____ (Please print)

Signature: _____ Date: _____

CONSENT FORM FOR AUDIO RECORDING OF STUDY PARTICIPATION

I hereby consent to audio recording of the interview.

I understand that:

- The recording will be stored in a secure location (a locked cupboard or password protected computer) with restricted access to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed.
- The recordings will be erased within either (a) two (2) years of the publication of the research findings, or (b) six (6) years, if no publications arise from this research.
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg.
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Name of Participant: _____ (Please print)

Date: _____ Place: _____

Signature or mark: _____

Witnessed by: Name of Witness: _____ (Please print)

Signature: _____ Date: _____

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

APPENDIX D(2)

TLHOKOMEDISO EA HO BONTSHA
BATHO BA BANG

Sehlooho sa ho ithuta:
Bo-mme maikutlo le boiphihlelo ba tlhokomelo ea bo-mme ba kangaroo seterekeng sa Fezile Dabi Health, Afrika Boroa

Selelekela
Dumela,
Lebitso la ka ke Muellatt van Biljon. Ke seithuti se hloahloa bophelong ba sechaba Univesithing ea Witwatersrand se nang le thahasello e khethehileng bophelong ba bo-mme le ba bana. E le karolo ya dithuto tsa ka, ke tlameha ho etsa projeke ya dipatlisiso e tla fana ka tsebo e ncha. Ngaka Wiedaad Slemming ke mookamedi wa ka. Phuputsong ya ka re batla ho ithuta hore na bo-mme ba nang le lesea la pele kapa le tlase la tswalo ba amohetswe sepetlele sa Boitumelo ba lemoha le ho ba le tlhokomelo ea bo-mme ba kangaroo.

Memo ya ho nka karolo
Morero ona o kenyelletsa dipuisano le bo-mme ba masea a manyane le basebetsi ba tlhokomelo ya bophelo bo botle. E le karolo ya morero, ke kopa ho o mema hore o nke karolo puisanong. Ke tla o botsa dipotso tse mmalwa mabapi le boimana ba hao, tswalo ya ngwana wa hao, hore na o bile le tlhokomelo ya' m'a oa kangaroo (KMC), ho hlokomela ngwana lapeng, le mathata a ho ba le ngwana wa pele le karolo ya tshehetso ya hao.

Puisano e tla nka metsotso e ka bang 45-60. Ka tumello ya hao, ke kopa hape ho hatisa puisano ka ho sebelisa rekoto e nyane ya theipi. Ditokomane tsena tsa ho rekota le tse ngotsweng di tla bolokwa di sireletsehile ka hara khabinete e notlelletsweng mme ke mofuputsi feela mme mookamedi a tla e fumana. E tla fediswa kamora dilemo tse 6.

Tumello ea boitšoaro
Boithuto bona bo amohetsoe ke Komiti ea Boitshwaro ba Batho ya Dipatlisiso tsa Batho (Medical) ya Univesithi ya Witwatersrand, Johannesburg (protocol M220666) le ea Komiti ea Boitšoaro ba Lipatlisiso tsa Saense ea Bophelo ea Univesithi ea Free State (UFS-HSD2022/1513). Mosebetsi o ka sehloohong wa Komiti ena ke ho sireletsa ditokelo le seriti sa batho bohle ba dumelang ho nka karolo morerong wa dipatlisiso. Ronahape o na le tumello ho tsoa Lefapheng la Bophelo la Foreisetata le ho tsoa Boitumelo Sepetlele ho etsa phuputso ena.

Ho nka karolo ke ho ithaopa
Ho nka karolo ha hao thutong ena ke ka boithatelo. O ka hana ho nka karolo kapa ho itokolla neng kapa neng nakong ya dipuisano ntle le ho fana ka lebaka. Ha ho na ho ba le dikotsi kapa dikotlo bakeng sa hao le tlhokomelo ya hao mme tlhokomelo ya ngwana wa hao e ke ke ya ameha ka tsela efe kapa efe.

Melemo ya ho ba thutong
Ha ho na melemo e tobileng ho wena e nkang karolo thutong. Leha ho le jwalo, karabo ya hao e tshepahalang le e bulehileng e tla re thusa ho bokella tlhahiso-leseding e tshepahalang ho bo-mme ba boiphihlelo ba tlhokomelo ya bo mme ba kangaroo.

Ho ka ba le mathata a ho ba teng
Haeba o ikutloa o sa phutholoha ka dipotso leha e le dife tseo re di botsang, ha ho hlokahale hore o di arabe mme ha ho hlokahale hore o fane ka lebaka. Haeba o ba le khatello ya maikutlo kapa u ikutloa u hloname haholo ka nako efe kapa efe tshebetsong ena, re tla emisa puisano mme mosebeletsi wa bophelo bo botle a nthusa ka puisano o tla o fa thuso ya tlhabollo ka puo eo o e khethileng. Haeba o ikutloa o lokile mme o ikemiselditse, re tla tswelapele ka puisano. Haeba o sa utloe ho lokile, re tla, ka tumello ya hao re o ise ho ngaka kapa khaitsedi e ikarabellang bakeng sa yuniti ya neonatal bakeng sa tlhabollo e eketsehileng. Ba tla khona ho o fetisetsa bakeng sa tshehetso e eketsehileng ea kelello haeba o lakatsa jwalo.

Ditshenyehelo le matshediso
Haeba o nka karolo puisanong, ho ke ke ha ba le ditshenyehelo tsa hao ho wena, ntle le nako ya hao. Hape ha o na ho fumana matshediso, empa ho tla fanwa ka ntlafatso e nyane nakong ya dipuisano.

Lekunutu
Puisano e tla ba lekunutu ka botlalo mme lebitso la hao le ke ke la tsebiswa mang kapa mang. Tlhahiso-leseding eo o mohileng yona e ke ke ya hokahana le lebitso la hao tlalehong efe kapa efe ya ho ithuta. Ke tla be ke sebelisa sistimi ya ho ngola dikhoutu ho emela ho nka karolo ha hao tlalehong ya ka ya ho qetela ya dipatlisiso. Diphetho tsa thuto di tla ngolwa e le tlaleho ya dipatlisiso e tla fumaneha inthaneteng ka webosaete ya laeborari ya Univesithi.

Batho ba ikopanyang
Haeba o na le dipotso nakong ya thuto ena kapa kamora moo, ikutlwe u lokolohile ho ikopanya le nna ka dintlha tse thathamisitsweng ka tlase.
Mofuputsi ya ka sehloohong: Muellatt van Biljon: 071 501 3562; lengolo-tsoibila: 2373163@student.wits.ac.za
Mookameli: Dr. Wiedaad Slemming: 011 717 2292/82; lengolo-tsoibila: Wiedaad.Slemming@wits.ac.za

Haeba o na le dingongoreho dife kapa dife kapa ditletlebo mabapi le ditsamaiso tsa boitshwaro tsa phuputso, kapa tsela eo phuputso e entsweng ka yona, ka kopo ikopanye le Human Research Ethics Committee (Medical) ya Univesithi ya Witwatersrand kapa Komiti ea Boitšoaro ea Lipatlisiso tsa Saense ea Bophelo ea Univesithi ea Forelsetata.

Univesithi ya Witwatersrand
Modulasetulo: Moprofesa Clement Penny
Mohala: 011 717 2301; lengolo-tsoibila: Clement.Penny@wits.ac.za

Tsamaiso ea bongoli ba Komiti:
Mohala: 011 717 2700/1234; lengolo-tsoibila: Zanele.Ndlovu@wits.ac.za kapa Rhulani.Mukansi@wits.ac.za

Univesithi ea Foreisetata.
Molula-setulo: Moprofesa A Sheriff
Hlooho ea tsamaiso: Mofumahali MGE Marais
Mohala: 051 401 7794/7387; lengolo-tsoibila: ethicsfhs@ufs.ac.za

Letsatsi: 1 Phuptjane - 30 Pulungoana

MOTSAMAI TUMELO LEKUTANE

Sehlooho sa morero: Bo mme maikutlo le boiphihlelo ba tlhokomelo ya bo mme ba kangaroo seterekeng sa Pezile Dabi Health, Afrika Boroa: thuto e tshwanelehang

1. Ke fumane Tokomane ya Tlhahiso leseling ya Bothuto e hlalosang mofuta le litshebetso tse amehang thutong ena, e hoketsoeng mona.
2. Ke ile ka fuwa nako ya ho e bala, kapa e ile ya mpalla, ka puo eo ke e utlwisisang hantle.
3. Ke ile ka fuwa nako ya ho botsa dipotso leha e le dife tseo ke neng ke batla ho di fumana mme ka fumana dikarabo leha e le dife tseo ke di fuweng hore di be le kahlolo e molemo ebile di khotsofatse.
4. Ke dumela hore ke utlwisisa ka botlalo hore na hobaneng thuto e ntse e etswa le hore na sephetho se rerilweng e tla ba eng.
5. Kea utlwisisa hore ha ho na ho ba le molemo hang hang ho nna, ha nka dumela ho nka karolo, kapa hona ke ke ke ka fumana tefo. Ka lehlakoreng le leng, ho nka karolo ho ke ke na ntefella letho haese nako ya ka.
6. Kea utlwisisa hore, le haeba qalong ke dumela ho nka karolo thutong, nka tlona ka nako efe kapa efe mme ke ne nke ke ka tlameha ho fana ka mabaka. Ha nka tlohela, data efe kapa efe e bokelletsweng ka nna ka sepheo sa thuto e ne e tla fediswa hang hang, ntle le haeba ke fana ka tumello ya hore e bolokwe.
7. Kea tseba hore tlhahiso-leseding e fumanweng thutong, ho kenyelletsa dintlha tsa motho ka mong, e tla sebetswa ntle le lebitso mme e hlahiswe tlalehong ea sephetho.
8. Ke fuwe dintlha tse fapaneng tsa ho ikopanya, tse thathamisitsweng ka tlase. Haeba ke hloka tlhahiso-leseding e eketsehileng kapa ke amehile ka karolo efe kapa efe ya thuto ena, ke lokolohile ho bua le mang kapa mang wa mabitso ana.
9. Ke nka karolo ka boithatelo.
10. Ke amohetse kopi e saenneng ea tumellano ena ya tumello e nang le tsebo.

Lebitso la Motho ya nkang karolo: _____

Letsatsi: _____ Sebaka: _____

Signature kapa letshwao: _____

E pakilwe ke: Lebitso la Paki: _____

Signature: _____Letsatsi: _____

FOROMO EA TUMELO BAKENG SA REKHOTO EA MORUO EA HO KENYA MOSEBETSI OA THUTO

Ka hona ke lumela ho rekota molumo wa puisano.

Kea utlwisisa hore:

- Ho rekota ho tla bolokwa sebakeng se sireletsehileng (khabote e notletsweng kapa khomphutha e sireleditsweng ya password) e nang le phihlello e lekanyeditsweng ho mofuputsi le mookamedi wa dipatlisiso.
- Ho rekota ho tla hatiswa mme tlhahiso-leseding efe kapa efe e ka ntlhahang e tla tloswa.
- Direkoto di tla hlakoloa kahare ho (a) tse pedi (2) dilemo tsa phatlalatso ya dipatlisiso, kapa (b) tse tsheletseng (6) dilemo, haeba ho se na lingoliloeng tse tsoang dipatlisisong tsena.
- Mang kapa mang ea lakatsang ho fumana tlhahiso-leseding ena nakong e tlang o tla tlameha ho fumana tumello ya Komiti ya Boitsthwaro ba Batho yaa Dipatlisiso tsa Batho (Medical) ya Univesithi ea Witwatersrand, Johannesburg.
- Ho qotsitswe ka kotloloho puisanong ya ka, ntle le tlhahiso-leseding e ka ntlhahang, ho ka pontshwa tlalehong ya dipatlisiso kapa dingoloa tse ling tsa dipatlisiso.

Lebitso la Motho ya nkang karolo: _____

Letsatsi: _____ Sebaka: _____

Signature kapa letshwao: _____

E pakilwe ke: Lebitso la Paki: _____

Signature: _____Letsatsi: _____

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

APPENDIX D(3)

INLIGTINGSBLAD VIR DEELNEMERS
MOEDERS

Studietitel:
Moeders se perspektiewe en ervarings van die kangaroe-moedersorg in die Fezile Dabi gesondheidsdistrik, Suid-Afrika

Inleiding
Goeie dag. My naam is Muellatt van Biljon. Ek is 'n meestersgraadstudent in openbare gesondheid aan die Universiteit van die Witwatersrand met 'n spesiale belangstelling in die gesondheid van moeder en kind. Ek moet 'n navorsingsprojek doen as deel van my studies om nuwe inligting te bekom. Dr Wiedaad Slemming is my toesighouer. In my studie wil ons leer hoe moeders met 'n premature of lae geboortegewig-baba, kangaroe-moedersorg by die Boitumelo Hospitaal belewe.

Uitnodiging om deel te neem
Hierdie projek sluit onderhoude met moeders met klein babas en gesondheidwerkers in. Ek wil u nooi om deel te neem aan die onderhoud as deel van die projek. Ek gaan u 'n aantal vrae vra oor u swangerskap, die geboorte van u baba, hoe u die kangaroe-moedersorg ervaar het, en watter uitdagings u by die huis ondervind met 'n premature of lae geboortegewig-baba.

Die onderhoud sal ongeveer 45 tot 60 minute duur. Met u toestemming sal ek graag ook 'n klankopname met 'n klein klankopnemer maak. Hierdie opname en geskrewe dokumente sal veilig in 'n sluitbare kabinet gestoor word en net die navorser en toesighouer sal toegang daartoe hê. Dit sal na 6 jaar vernietig word.

Etiese goedkeuring
Hierdie studie is goedgekeur deur die Menslike Navorsingsetiekkomitee (Medies) van die Universiteit van die Witwatersrand, Johannesburg (protokol M220666) en die Gesondheidswetenskappe Navorsingsetiekkomitee van die Universiteit van die Vrystaat (UFS-HSD2022/1513). 'n Hooffunksie van die komitees is om die regte en waardigheid van al die persone wat toestem tot deelname aan die navorsingsprojek te beskerm. Ons het ook toestemming van die Vrystaatse Gesondheidsdepartement en van Boitumelo Hospitaal om hierdie studie onderneem.

Deelname is vrywillig
U deelname aan die studie is heeltemal vrywillig. U kan weier om deel te neem of enige tyd in die onderhoud onttrek sonder om 'n rede te gee. Daar sal geen nadele of straf vir uself en u sorg wees nie, en die sorg van u baba sal glad nie geaffekteer word nie.

Voordele om deel te wees van die studie
Daar sal geen direkte voordele wees as u aan die studie deelneem nie, maar u eerlike en oop terugvoering sal ons help om betroubare inligting in te samel oor moeders se ervarings van kangaroe-moedersorg.

Moontlike ongemak
As u ongemaklik voel met enige vraag wat gevra word, hoef u nie te antwoord of 'n rede te gee nie. As u enigsins angs ervaar of ontsteld voel op enige stadium in die onderhoud, sal ons die onderhoud stop en die gesondheidswerker wat my bystaan sal beradingsbystand bied in die taal van u keuse. As u beter voel en gewillig is, sal ons aangaan met die onderhoud. As u nie beter voel nie, sal ons u – met u toestemming – na die dokter of suster in beheer van die neonatale eenheid verwys vir verdere berading. Hulle sal u ook kan verwys na verdere sielkundige ondersteuning sou u dit verlang.

Koste en vergoeding
Daar is geen persoonlike koste as u aan die onderhoud deelneem nie, behalwe u tyd. U sal ook geen vergoeding ontvang nie, maar 'n klein verversing sal bedien word gedurende die onderhoud.

Vertroulikheid
Die onderhoud is heeltemal vertroulik en u naam sal nie bekend gemaak word aan enige iemand anders nie. Die inligting wat u gee sal nie in enige studieverslag aan u naam gekoppel word nie. Ek gaan 'n kodestelsel gebruik om u deelname in my finale navorsingsverslag te verteenwoordig. Die resultate van die studie sal opgeskryf word as 'n navorsingsprojek wat aanlyn beskikbaar sal wees deur die Universiteit se biblioteekwebtuiste.

Kontak persone
As u enige vrae tydens of na die studie het, kan u my kontak op die besonderhede wat hieronder gegee word.

Hoofondersoeker: Muellatt van Biljon: 071 501 3562; e pos:
2373163@students.wits.ac.za
Toesighouer: Dr. Wiedaad Slemming: 011 717 2292/82; e-pos:
Wiedaad.Slemming@wits.ac.za

As u enige bekommernisse of klagtes het oor die etiese prosedures van die studie, of die manier hoe hierdie studie uitgevoer is, kontak asseblief een van die volgende komitees:

Menslike Navorsingsetiekkomitee (Medies), Universiteit van die Witwatersrand
Voorsitter: Professor Clement Penny
Tel: 011 717 2301; e-pos: Clement.Penny@wits.ac.za
Komiteesekretariaat:
Tel: 011 717 2700/1234; e-pos: Zanele.Ndlovu@wits.ac.za or Rhulani.Mukansi@wits.ac.za

Gesondheidswetenskappe Navorsingsetiekkomitee, Universiteit van die Vrystaat
Voorsitter: Professor A Sheriff
Hoof administrasie: Mev MGE Marais
Tel: 051 401 7794/7387; e-pos: ethicsfhs@ufs.ac.za

Datum: Oktober 2022

DEELNEMER SE TOESTEMMINGSBLAD

Projektitel: Moeders se perspektiewe en ervarings van die kangaroe-moedersorg in die Fezile Dabi gesondheidsdistrik, Suid Afrika: 'n kwalitatiewe studie

1. Ek het die Inligtingsblad vir Deelnemers ontvang wat die aard van die studie en die studieprosesse beskryf, wat hierby aangeheg is.
2. Ek is tyd gegee om die dokument deur te lees, of het dit vir my laat lees, in die taal wat ek die beste verstaan.
3. Ek is tyd gegun om enige vrae te vra wat ek wou en die antwoorde aan my was redelik en bevredigend.
4. Ek glo ek verstaan ten volle hoekom die studie gedoen word en wat die beoogde uitkomste is.
5. Ek verstaan dat daar geen onmiddellike voordeel vir my sal wees as ek instem om deel te neem nie, en ek sal ook geen betaling ontvang nie. Omgekeerd, my deelname sal niks kos behalwe my tyd nie.
6. Ek verstaan dat, selfs al gee ek toestemming om aan die studie deel te neem, ek te enige tyd later kan onttrek en daar sal nie van my verwag word om enige redes te verskaf nie. Sou ek onttrek, sal enige data wat oor my ingesamel is vir die doeleindes van die studie onmiddellik vernietig word, tensy ek toestemming gee dat dit behou mag word.
7. Ek is bewus daarvan dat die inligting wat in die studie verkry is, insluitend persoonlike besonderhede, anoniem verwerk en in verslae oor resultate aangebied sal word.
8. Ek het 'n aantal kontakbesonderhede ontvang wat hierbo gelys is. Indien ek verdere inligting verlang of bekommerd word oor enige aspek van hierdie studie, staan dit my vry om met enige van hierdie kontakpersone te praat.
9. Ek neem vrywillig deel.
10. Ek het 'n getekende afskrif van hierdie toestemmingsooreenkoms ontvang.

Naam van deelnemer: _____ (Drukskrif asb.)

Datum: _____Plek:_____

Handtekening of merk: _____

Waargeneem deur: Naam van getuie: _____ (Drukskrif asb.)

Handtekening:_____Datum:_____

TOESTEMMINGSVORM VIR KLANKOPNAME VAN STUDIEDEELNAME

Ek stem hiermee toe tot die klankopname van die onderhoud.

Ek verstaan dat:

- Die opname op 'n veilige plek gestoor sal word ('n geslote kas of wagwoordbeskermde rekenaar) met beperkte toegang slegs vir die navorser en die studieleier.
- Die opname getranskribeer sal word en enige inligting wat my kan identifiseer, sal verwyder word.
- Die opnames uitgevee sal word binne of (a) twee (2) jaar na die publikasie van die navorsingsbevindinge, of (b) ses (6) jaar indien geen publikasies uit hierdie navorsing voortspruit nie.
- Enigiemand wat in die toekoms toegang tot hierdie inligting wil verkry, sal eers die goedkeuring van die Menslike Navorsingsetiekkomitee (Medies) van die Universiteit van die Witwatersrand, Johannesburg moet verkry.
- Direkte aanhalings uit my onderhoud, sonder enige inligting wat my kan identifiseer, mag in die navorsingsverslag of ander navorsingskrywes aangehaal word.

Naam van deelnemer: _____ (Drukskrif asb.)

Datum: _____Plek:_____

Handtekening of merk: _____

Waargeneem deur: Naam van getuie: _____ (Drukskrif asb.)

Handtekening:_____Datum:_____

Appendix E: Information letter and consent (professionals)

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

APPENDIX E(1)

PARTICIPANT INFORMATION SHEET
HEALTHCARE PROFESSIONALS

Study title:
Mothers' perspectives and experiences of kangaroo mother care in the Fezile Dabi Health District, South Africa

Introduction
Good day,
My name is Muellatt van Biljon. I am a master's student in public health at the University of the Witwatersrand with a special interest in maternal and child health. As part of my studies, I have to do a research project. Dr Wiedaad Slemming is my supervisor. The aim of my study is to explore how mothers with a preterm or low birth weight baby admitted to the Boitumelo Hospital perceive and experience kangaroo mother care.

Invitation to participate
This project includes interviews with mothers with small infants practising kangaroo mother care, as well as key newborn-care healthcare professionals at the Boitumelo Hospital. As part of the project, I would like to invite you to take part in an interview. I will ask you a number of questions about your main responsibilities with regard to newborn care, how Boitumelo Hospital is performing with regard to small and sick newborn care, about kangaroo mother care at the hospital, the follow-up of the premature and low birth weight babies after discharge and the priority areas for improvement of KMC.

The interview will take about 45 to 60 minutes. With your permission, I would also like to audio record the interview using a small tape recorder. These recording and written documents will be stored securely in a lockable cabinet and only the researcher and the supervisor will have access to it. It will be destroyed after 6 years.

Ethical approval
This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg (protocol M220666) and the Health Sciences Research Ethics Committee of the University of the Free State (UFS-HSD2022/1513). A principal function of this Committee is to safeguard the rights and dignity of all

people who agree to participate in a research project. We also have the permission of the Free State Health Department and Boitumelo Hospital to do this study.

Participation is voluntary

Your participation in this study is entirely voluntary. You can refuse to participate or withdraw at any time during the interview without giving any reason. There will be no disadvantages or penalties for you.

Benefits of being in the study

There will be no direct benefits to you participating in the study. However, your honest and open feedback will help us to gather trustworthy information on mothers' experience of kangaroo mother care.

Possible discomforts

If you feel uncomfortable with any of the questions we ask, you don't need to answer and don't need to give a reason. If you experience any discomfort or have to attend to an emergency care situation at any point in this process, we will stop the interview or resume at another time.

Costs and compensation

If you participate in the interview, there will be no personal costs to you, except your time. You will also not receive any compensation.

Confidentiality

The interview will be completely confidential and your name will not be disclosed to anyone else. The information you give to me will not be linked to your name in any study report. I will be using a coding system to represent your participation in my final research report. The results of the study will be written up as a research report that will be available online through the University library website.

Contact persons

If you have any questions during or afterwards about this study, feel free to contact me on the details listed below.

Principal investigator: Muellatt van Biljon: 071 501 3562; email: 2373163@students.wits.ac.za

Supervisor: Dr. Wiedaad Slemming: 011 717 2292/82; email: Wiedaad.Slemming@wits.ac.za

If you have any concerns or complaints regarding the ethical procedures of this study or the way in which this study is conducted, please contact one of the following committees:

Human Research Ethics Committee (Medical), University of the Witwatersrand
Chairperson: Professor Clement Penny
Tel: 011 717 2301; email: Clement.Penny@wits.ac.za
Committee secretariat:
Tel: 011 717 2700/1234; email: Zanele.Ndlovu@wits.ac.za or
Rhulani.Mukansi@wits.ac.za

Health Sciences Research Ethics Committee, University of the Free State
Chairperson: Professor A Sheriff
Head of administration: Mrs MGE Marais
Tel: 051 401 7794/7387; email: ethicsfhs@ufs.ac.za

Date: October 2022

PARTICIPANT CONSENT SHEET

Project title: Mothers' perspectives and experiences of kangaroo mother care in the Fezile Dabi Health District, South Africa: a qualitative study

1. I received a Study Information Document that explains the nature and processes involved in this study, which is attached hereto.
2. I was given time to read it, or had it read to me, in the language I best understand.
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory.
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be.
5. I understand that there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment. Conversely, participation will not cost me anything but my time.
6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons. Should I withdraw, any data collected about me for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained.
7. I am aware that the information obtained in the study, including personal details, will be anonymously processed and presented in the reporting of results.
8. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.
9. I am participating willingly.

10. I have received a signed copy of this informed consent agreement.

Name of Participant: _____ (Please print)

Date: _____ Place: _____

Signature or mark: _____

Witnessed by: Name of Witness: _____ (Please print)

Signature: _____ Date: _____

CONSENT FORM FOR AUDIO RECORDING OF STUDY PARTICIPATION

I hereby consent to audio recording of the interview.

I understand that:

- The recording will be stored in a secure location (a locked cupboard or password protected computer) with restricted access to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed.
- The recordings will be erased within either (a) two (2) years of the publication of the research findings, or (b) six (6) years, if no publications arise from this research.
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg.
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Name of Participant: _____ (Please print)

Date: _____ Place: _____

Signature or mark: _____

Witnessed by: Name of Witness: _____ (Please print)

Signature: _____ Date: _____

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

APPENDIX E(2)

TLHOKOMEDISO EA HO BONTSHA

LEQEPHE LA DITSEBISO YA DITSELISO TSA TSEBELETSO YA BOPHELO

Sehlooho sa ho ithuta:

Maikutlo a bomme le boiphihlelo ba tlhokomelo ya bo mme ba kangaroo mother care seterekeng sa Fezile Dabi Health, Afrika Borwa

Selelekela

Dumela,

Lebitso la ka ke Muellatt van Biljon. Ke seithuti se hloahloa bophelong ba sechaba Univesithing ya Witwatersrand se nang le thahasello e khethehileng bophelong ba bo mme le ba bana. E le karolo ya dithuto tsa ka, ke tlameha ho etsa projeke ya dipatlisiso. Ngaka Wiedaad Slemming ke mookameli ya ka. Morero ya thuto ya ka ke ho hlahloba hore na bo mme ba nang le lesea la pele kapa le tlase la tswalo ba amohetse sepetlele sa Boitumelo ba lemoha le kangaroo mother care.

Memo ya ho nka karolo

Morero ona o kenyelletsa dipuisano le bo mme ba nang le masea a manyane a sebedisang tlhokomelo ya kangaroo mother care, ha mmoho le bohlokwa ba basea batjha - litsebi tsa tlhokomelo ea bophelo bo botle sepetleleng sa Boitumelo. E le karolo ya morero, ke kopa ho o mema hore o nke karolo puisanong. Ke tla o botsa dipotso tse malwa mabapi le boikarabello ba hao ba mantlha mabapi le tlhokomelo ya masea a sa tswa hlaha, hore na Sepetlele sa Boitumelo se sebetsa jwang mabapi le tlhokomelo e nyane le e kulang ya masea, mabapi le kangaroo mother care sepetlele, ba latelang morao ho fihlela masea a pele le a tlase a tswalo kabmora ho tswa le dibaka tse tlang pele bakeng sa ntlafatso ea KMC.

Puisano e tla nka metsotso e ka bang 45 ho isa ho e 60. Ka tumello ya hao, ke kopa hape ho hatisa puisano ka ho sebelisa rekoto e nyane ya theipi. Ditokomane tsena tsa ho rekota le tse ngotsweng di tla bolokoa di sireletsehile ka hara khabinete e notleditsweng mme ke mofuputsi feela mme mookameli o tla e fumana. E tla felisoa kamora dilemo tse 6.

Tumello ya boitswaro

Boithuto bona bo amohetswe ke Komiti ya Boitswaro ba Batho ya Dipatlisiso tsa Batho (Medical) ya Univesithi ya Witwatersrand, Johannesburg (protocol M220666) le ea Komiti ea Boitšoaro ba Lipatlisiso tsa Saense ea Bophelo ea Univesithi ea Free State (UFS-HSD2022/1513). Mosebetsi o ka sehloohong wa Komiti ena ke ho sireletsa ditokelo le seriti sa batho bohle ba dumelang ho nka karolo morerong wa dipatlisiso. Ronahape o na le tumello ho tsoa Lefapheng la Bophelo la Foreisetata le ho tsoa Boitumelo Sepetlele ho etsa phuputso ena.

Ho nka karolo ke ho ithaopa

Ho nka karolo ha hao thutong ena ke ka boithatelo. O ka hana ho nka karolo kapa ho itokolla neng kapa neng nakong ya dipuisano ntle le ho fana ka lebaka. Ha ho na ho ba le dikotsi kapa

dikotlo bakeng sa haulo.

Melemo ya ho ba thutong
Ha ho na melemo e tobileng ho wena e nkang karolo thutong. Leha ho le jwalo, karabo wa hao e tsepahalang le e bulehileng e tla re thusa ho bokella tlhaiso leseling e tsepahalang ho bo mme ba boiphihlelo ba kangaroo mother care.

Ho ka ba le mathata a ho ba teng
Haeba o ikutlwa o sa phutholoha ka dipotso leha e le dife tseo re di botsang, ha ho hlokahale hore o di arabe me ha ho hlokahale hore o fane ka lebaka. Haeba o na le mathata kapa o tlameha ho ya maemong a tlhokomelo ya tsohanyetso ka nako efe kapa efe tsebetsong ena, re tla emisa puisano kapa re qale hape ka nako engwe.

Ditsenyehelo le matsediso
Haeba o nka karolo puisanong, ho ke ke ha ba le litsenyehelo tsa hao ho wena, ntle le nako ya hao. Hape ha o na ho fumana matsediso.

Lekunutu
Puisano e tla ba lekunutu ka botlalo mme lebitso la hao le ke ke la tsebiswa mang kapa mang. Tlhahiso leseding eo o mphileng yona e ke ke ya hokahana le lebitso la hao tlalehong efe kapa efe ya ho ithuta. Ke tla be ke sebelisa sistimi ya ho ngola dikhoutu ho emela ho nka karolo ha hao tlalehong ya ka ya ho qetela ya dipatlisiso. Diphetho tsa thuto di tla ngolwa e le tlaleho ya dipatlisiso e tla fumaneha inthaneteng ka webosaete ya laeborari ya Univesithi.

Batho ba ikopanyang
Haeba o na le dipotso nakong ya thuto ena kapa kamora moo, ikutlwe o lokolohile ho ikopanya le nna ka dintlha tse thathamisitsoeng ka tlase.
Mofuputsi ya ka sehloohong: Muellatt van Biljon: 071 501 3562; lengolo-tsoibila: 2373163@student.wits.ac.za
Mookameli: Dr. Wiedaad Slemming: 011 717 2292/82; lengolo-tsoibila: Wiedaad.Slemming@wits.ac.za

Haeba o na le dingongoreho dife kapa dife kapa ditletlebo mabapi le ditsamaiso tsa boitshwaro tsa phuputso, kapa tsela eo phuputso e entsweng ka yona, ka kopo ikopanye le Human Research Ethics Committee (Medical) ya Univesithi ya Witwatersrand kapa Komiti ea Boitšoaro ea Lipatlisiso tsa Saense ea Bophelo ea Univesithi ea Foreisetata.

Modulasetulo: Moprofesa Clement Penny
Mohala: 011 717 2301; lengolo-tsoibila: Clement.Penny@wits.ac.za
Tsamaiso ea bongoli ba Komiti:
Mohala: 011 717 2700/1234; lengolo-tsoibila: Zanele.Ndlovu@wits.ac.za kapa Rhulani.Mukanni@wits.ac.za

Univesithi ea Foreisetata.
Molula-setulo: Moprofesa A Sheriff

Hlooho ea tsamaiso: Mofumahali MGE Marais
Mohala: 051 401 7794/7387; lengolo-tsoibila: ethicsfhs@ufs.ac.za

Letsatsi: 1 Phuptjane -30 Pulungoana 2023

MOTSAMAI TUMELO LEKUTANE

Sehlooho sa morero: Maikutlo le boiphihlelo a bo mme ba kangaroo mother care seterekeng sa Fezile Dabi Health, Afrika Boroa: thuto e tswanelehang

1. Ke fumane Tokomane ya Tlhahiso leseding ya Boithuto e hlalosang mofuta le ditsebetso tse amehang thutong ena, e hoketsoeng mona.
2. Ke ile ka fuwa nako ya ho e bala, kapa e ile ya mpalla, ka puo eo ke e utloisisang hantle.
3. Ke ile ka fuwa nako ea ho botsa dipotso leha e le dife tseo ke neng ke batla ho di fumana le ho fumana dikarabo tse fanweng nna ho ba le kahlolo e molemo le e khotsofatsang.
4. Ke dumela hore ke utlwisisa ka botlalo hore na hobaneng thuto e ntse e etswa le hore na morero o ne o reretsoe eng sephetho e tla ba.
5. Kea utlwisisa hore ha ho na ho ba le molemo hang-hang ho nna, haeba nka dumela ho nka karolo, kapa hona ke ke ke ka fumana tefo. Ka lehlakoreng le leng, ho nka karolo ho ke ke ha bitsa nna eng kapa eng haese nako ya ka.
6. Kea utlisisa hore, le haeba qalong ke dumela ho nka karolo thutong, nka khona kamora nako e itseng a ikhula ka nako efe kapa efe mme a ke ke a tlameha ho fana ka mabaka. Ha nka tlohela, data efe kapa efe e bokelletsoeng ka nna ka sepheo sa thuto e ne e tla feliswa hanghang, ntle le haeba ke fana ka tumello emma hore e bolokwe.
7. Kea tseba hore tlhaiso-leseding e fumanweng thutong, ho kenyelletsa dintlha tsa motho ka mong, e tla sebetswa ntle le lebitso mme e hlahiswe tlalehong ya sephetho.
8. Ke fuwe dintlha tse fapaneng tsa ho ikopanya, tse thathamisitsweng ka tlase. Haeba ke hloka tlhaiso leseling e eketsehileng kapa ke amehile ka karo o efe kapa efe ya thuto ena, ke lokolohile ho bua le mang kapa mang ya mabitso ana.
9. Ke nka karolo ka boithatelo.
10. Ke amohetse kopi e saenneng ea tumellano ena ya tumello e nang le tsebo.

Lebitso la Motho ya nkang karolo: _____

Letsatsi: _____ Sebaka: _____

Signature kapa letshwao: _____

E pakiwe ke: Lebitso la Paki: _____

Signature: _____Letsatsi: _____

FOROMO EA TUMELO BAKENG SA REKHOTO EA MORUO EA HO KENYA MOSEBETSI OA THUTO

Ka hona ke lumela ho rekota molumo oa puisano.

Kea utlwisisa hore:

- Ho rekota ho tla bolokwa sebakeng se sireletsehileng (khabote e notlelitsweng kapa password khomphutha e sirelelitsoeng) e nang le phihello e lekanyelitsoeng ho mofuputsi le dipatlisiso mookamedi.
- Ho rekota ho tla hatiswa mme tlhahiso leseding efe kapa efe e ka ntlhahang e tla ba tloswa.
- Direkoto ditla hlakolwa kahare ho (a) tse peli (2) dilemo tsa phatlalatso ya dipatlisiso tsa dipatlisiso, kapa (b) dilemo tse tseletseng (6), haeba ho se na dingolilweng tse tswang lipatlisisong tsena.
- Mang kapa mang ya lakatsang ho fumana tlhaiso leseding ena nakong e tlang o tla tlameha ho fumana tumello ya Komiti ya Boitswaro ba Batho ya Dipatlisiso tsa Batho (Medical) ea Univesithi ya Witwatersrand, Johannesburg.
- Ho qotsitswe ka kotlolloho puisanong ya ka, ntle le tlhahiso leseding efe kapa efe e ka ntlhahang, e kanna ea bontsoa tlalehong ya dipatlisiso kapa ho ngola tse ding tsa dipatlisiso.

Lebitso la Motho ya nkang karolo: _____

Letsatsi: _____ Sebaka: _____

Signature kapa letshwao: _____

E pakiwe ke: Lebitso la Paki: _____

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

APPENDIX E(3)

INLIGTINGSBLAD VIR DEELNEMERS
PROFESSIONELE GESONDHEIDSORGPERSONEEL

Studietitel:
Moeders se perspektiewe en ervarings van kangaroe-moedersorg in die Fezile Dabi gesondheidsdistrik, Suid-Afrika

Inleiding
Goeie dag. My naam is Muellatt van Biljon. Ek is 'n meestersgraadstudent in openbare gesondheid aan die Universiteit van die Witwatersrand met 'n spesiale belangstelling in die gesondheid van moeder en kind. Ek moet 'n navorsingsprojek doen as deel van my studies om nuwe inligting te bekom. Dr Wiedaad Slemming is my toesighouer. Die doel van my studie is om te ondersoek hoe moeders met 'n premature of lae geboortegewig-baba wat in die Boitumelo Hospitaal opgeneem word kangaroe-moedersorg beskou en belewe.

Uitnodiging om deel te neem
Hierdie projek sluit in onderhoude met moeders met klein babas wat kangaroe-moedersorg beoefen, sowel as belangrike professionele personeel betrokke by pasgeborenesorg by Boitumelo Hospitaal. As deel van die projek nooi ek u uit om aan 'n onderhoud deel te neem. Ek gaan 'n aantal vrae vra oor u hoofverantwoordelikhede ten opsigte van pasgeborenesorg, hoe Boitumelo Hospitaal presteer ten opsigte van die sorg van klein en siek pasgeborenes, oor kangaroe-moedersorg by die hospitaal, die opvolg van premature en lae geboortegewig-babas na ontslag en die prioriteitsareas vir die verbetering van kangaroe-moedersorg.

Die onderhoud sal ongeveer 45 tot 60 minute duur. Met u toestemming wil ek graag ook 'n klankopname met 'n klein bandopnemer maak. Hierdie opname en geskrewe dokumente sal veilig in 'n sluitbare kas gestoor word en slegs die navorser en toesighouer sal toegang daartoe hê. Dit sal na 6 jaar vernietig word.

Etiese goedkeuring
Hierdie studie is goedgekeur deur die Menslike Navorsingsetiekkomitee (Medies) van die Universiteit van die Witwatersrand, Johannesburg (protokol M220666) en die Gesondheidswetenskappe Navorsingsetiekkomitee van die Universiteit van die Vrystaat (UFS-HSD2022/1513). 'n Hooffunksie van die komitees is om die regte en waardigheid van al die persone wat toestem tot deelname aan die navorsingsprojek te beskerm. Ons het ook toestemming van die Vrystaatse Gesondheidsdepartement en van Boitumelo Hospitaal om hierdie studie te onderneem.

Deelname is vrywillig
U deelname aan die studie is heeltemal vrywillig. U kan weier om deel te neem of enige tyd tydens die onderhoud onttrek sonder om 'n rede te gee. Daar sal geen nadele of straf vir u wees nie.

Voordele om deel te wees van die studie
Daar sal geen direkte voordele wees vir deelname aan die studie nie, maar u eerlike en oop terugvoering sal ons help om betroubare inligting in te samel oor moeders se ervarings van kangaroe-moedersorg.

Moontlike ongemak
As u ongemaklik voel met enige vraag wat gestel word, hoef u nie te antwoord of 'n rede vir u besluit te gee nie. As u enigsins ongemak ervaar of aandag moet gee aan 'n noodsorgsituasie op enige tydstip, sal ons die onderhoud beëindig of op 'n ander tyd hervat.

Koste en vergoeding
Daar is geen persoonlike koste vir u deelname aan die onderhoud nie, behalwe u tyd. U sal ook geen vergoeding ontvang nie.

Vertroulikheid
Die onderhoud is heeltemal vertroulik en u naam sal nie bekend gemaak word aan enige iemand anders nie. Die inligting wat u voorsien sal nie in enige studieverslag aan u naam gekoppel word nie. Ek gaan 'n kodestelsel gebruik om u deelname in my finale navorsingsverslag te verteenwoordig. Die resultate van die studie sal opgeskryf word as 'n navorsingsprojek wat aanlyn beskikbaar sal wees deur die Universiteit se biblioteekwebtuiste.

Kontak persone
As u enige vrae tydens of na die studie het, kan u my kontak by die besonderhede wat hieronder gegee word.

Hoofondersoeker: Muellatt van Biljon: 071 501 3562; e-pos:
2373163@students.wits.ac.za
Toesighouer: Dr. Wiedaad Slemming: 011 717 2292/82; e-pos:
Wiedaad.Slemming@wits.ac.za

As u enige bekommernisse of klagtes het oor die etiese prosedures van die studie, of die manier hoe hierdie studie uitgevoer is, kontak asseblief een van die volgende komitees:

Menslike Navorsingsetiekkomitee (Medies), Universiteit van die Witwatersrand
Voorsitter: Professor Clement Penny
Tel: 011 717 2301; e-pos: Clement.Penny@wits.ac.za

Komiteesekretariaat:
Tel: 011 717 2700/1234; e-pos: Zanele.Ndlovu@wits.ac.za of Rhulani.Mukansi@wits.ac.za

Gesondheidswetenskappe Navorsingsetiekkomitee, Universiteit van die Vrystaat
Voorsitter: Professor A Sheriff
Hoof administrasie: Mev MGE Marais
Tel: 051 401 7794/7387; e-pos: ethicsfhs@ufs.ac.za

Datum: Oktober 2022

DEELNEMER SE TOESTEMMINGSBLAD

Projektitel: Moeders se perspektiewe en ervarings van kangaroe-moedersorg in die Fezile Dabi gesondheidsdistrik, Suid-Afrika: 'n kwalitatiewe studie

1. Ek het die Inligtingsblad vir Deelnemers ontvang wat die aard van die studie en die studieprosesse beskryf, wat hierby aangeheg is.
2. Ek is tyd gegee om die dokument deur te lees, of het dit vir my laat lees, in die taal wat ek die beste verstaan.
3. Ek is tyd gegun om enige vrae te vra wat ek wou en die antwoorde was redelik en bevredigend.
4. Ek glo ek verstaan ten volle hoekom die studie gedoen word en wat die beoogde uitkomste is.
5. Ek verstaan dat daar geen onmiddellike voordeel vir my sal wees as ek instem om deel te neem nie, en ek sal ook geen betaling ontvang nie. Omgekeerd, my deelname sal niks kos behalwe my tyd nie.
6. Ek verstaan dat, selfs al gee ek toestemming om aan die studie deel te neem, ek te enige tyd later kan onttrek en daar sal nie van my verwag word om enige redes te verskaf nie. Sou ek onttrek, sal enige data wat oor my ingesamel is vir die doeleindes van die studie onmiddellik vernietig word, tensy ek toestemming gee dat dit behou mag word.
7. Ek is bewus daarvan dat die inligting wat in die studie verkry is, insluitend persoonlike besonderhede, anoniem verwerk en in verslae oor die resultate aangebied sal word.
8. Ek het 'n aantal kontakbesonderhede ontvang wat hierbo gelys is. Indien ek verdere inligting verlang of bekommerd word oor enige aspek van hierdie studie, staan dit my vry om met enige van hierdie kontakpersone te praat.
9. Ek neem vrywillig deel.
10. Ek het 'n getekende afskrif van hierdie toestemmingsooreenkoms ontvang.

Naam van deelnemer: _____ (Drukskrif asb.)

Datum: _____Plek:_____

Handtekening of merk: _____

Waargeneem deur: Naam van getuie: _____ (Drukskrif asb.)

Handtekening:_____Datum:_____

TOESTEMMINGSVORM VIR KLANKOPNAME VAN STUDIEDEELNAME

Ek stem hiermee toe tot die klankopname van die onderhoud.

Ek verstaan dat:

- Die opname op 'n veilige plek gestoor sal word ('n geslote kas of wagwoordbeskermde rekenaar) met beperkte toegang slegs vir die navorser en die studieleier.
- Die opname getranskribeer sal word en enige inligting wat my kan identifiseer, sal verwyder word.
- Die opnames uitgevee sal word binne of (a) twee (2) jaar na die publikasie van die navorsingsbevindinge, of (b) ses (6) jaar indien geen publikasies uit hierdie navorsing voortspruit nie.
- Enigiemand wat in die toekoms toegang tot hierdie inligting wil verkry, sal eers die goedkeuring van die Menslike Navorsingsetiekkomitee (Medies) van die Universiteit van die Witwatersrand, Johannesburg moet verkry.
- Direkte aanhalings uit my onderhoud, sonder enige inligting wat my kan identifiseer, mag in die navorsingsverslag of ander navorsingskrywes aangehaal word.

Naam van deelnemer: _____ (Drukskrif asb.)

Datum:_____Plek:_____

Handtekening of merk: _____

Waargeneem deur: Naam van getuie: _____ (Drukskrif asb.)

Handtekening:_____Datum:_____

Appendix F: Information letter and consent (clinical associates and community health workers)

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

APPENDIX F(1)

PARTICIPANT INFORMATION SHEET
CLINICAL ASSOCIATES AND COMMUNITY HEALTHCARE WORKERS

Study title:
Mothers' perspectives and experiences of kangaroo mother care in the Fezile Dabi Health District, South Africa

Introduction
Good day,
My name is Muellatt van Biljon. I am a master's student in public health at the University of the Witwatersrand with a special interest in maternal and child health. As part of my studies, I have to do a research project that will provide new knowledge. Dr Wiedaad Slemming is my supervisor. In my study we want to learn how mothers with a preterm or low birth weight baby admitted to the Boitumelo Hospital perceive and experience kangaroo mother care.

Invitation to participate
This project includes interviews with mothers of small babies and health professionals in the neonatal unit, as well as one focus group discussion each with clinical associates and community healthcare workers, respectively. As part of the project, I would like to invite you to take part in one of these discussions. The discussion will include topics such as your main responsibilities with regard to newborn care, the care of small babies in Boitumelo Hospital, the main challenges for mothers and their families to care for these babies, and what support role you can play.

The discussion will take about 45 to 60 minutes. With your permission, I would also like to audio record the focus group discussions using a small tape recorder. These recording and written documents will be stored securely in a lockable cabinet and only the researcher and the supervisor will have access to it. It will be destroyed after 6 years.

Ethical approval
This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg (protocol M220666) and the Health Sciences Research Ethics Committee of the University of the Free State (UFS-HSD2022/1513). A principal function of this Committee is to safeguard the rights and dignity of all people who agree to participate in a research project. We also have the permission of the Free State Health Department and Boitumelo Hospital to do this study.

Participation is voluntary

Your participation in this study is entirely voluntary. You can refuse to participate or withdraw at any time during the focus group discussions without giving any reason. There will be no disadvantages or penalties for you.

Benefits of being in the study

There will be no direct benefits to you participating in the study. However, your honest and open feedback will help us to gather trustworthy information on mothers' experience of kangaroo mother care.

Possible discomforts

If you feel uncomfortable with any of the questions we ask, you don't need to answer and don't need to give a reason. If you experience any distress or discomfort you may leave the focus group discussion at any point without giving any reason or we will stop the discussion or resume at another time.

Costs and compensation

If you participate in the interview, there will be no personal costs to you, except your time. You will also not receive any compensation. The transport costs of community health workers will be refunded if they have to travel to the venue of the focus group discussion. Clinical associates are already at the venue and will not incur additional travel expenses.

Confidentiality

Although we request participants in a focus group discussion to treat the information shared by others confidentially, this cannot always be guaranteed. The research team will not disclose your name to anyone else and the information you give to me will not be linked to your name in any study report. I will be using a coding system to represent your participation in my final research report. The results of the study will be written up as a research report that will be available online through the University library website.

Contact persons

If you have any questions during or afterwards about this study, feel free to contact me on the details listed below.

Principal investigator: Muellatt van Biljon: 071 501 3562; email: 2373163@students.wits.ac.za

Supervisor: Dr. Wiedaad Slemming: 011 717 2292/82; email: Wiedaad.Slemming@wits.ac.za

If you have any concerns or complaints regarding the ethical procedures of this study or the way in which this study is conducted, please contact one of the following committees:

Human Research Ethics Committee (Medical), University of the Witwatersrand
Chairperson: Professor Clement Penny
Tel: 011 717 2301; email: Clement.Penny@wits.ac.za
Committee secretariat:
Tel: 011 717 2700/1234; email: Zanele.Ndlovu@wits.ac.za or Rhulani.Mukansi@wits.ac.za

Health Sciences Research Ethics Committee, University of the Free State
Chairperson: Professor A Sheriff
Head of administration: Mrs MGE Marais
Tel: 051 401 7794/7387; email: ethicsfhs@ufs.ac.za

Date: October 2022

PARTICIPANT CONSENT SHEET

Project title: Mothers' perspectives and experiences of kangaroo mother care in the Fezile Dabi Health District, South Africa: a qualitative study

1. I received a Study Information Document that explains the nature and processes involved in this study, which is attached hereto.
2. I was given time to read it, or had it read to me, in the language I best understand.
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory.
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be.
5. I understand that there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment. Conversely, participation will not cost me anything but my time.
6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons. Should I withdraw, any data collected about me for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained.
7. I am aware that the information obtained in the study, including personal details, will be anonymously processed and presented in the reporting of results.
8. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.
9. I am participating willingly.
10. I have received a signed copy of this informed consent agreement.

Name of Participant: _____ (Please print)

Date: _____ Place: _____

Signature or mark: _____

Witnessed by: Name of Witness: _____ (Please print)

Signature: _____ Date: _____

CONSENT FORM FOR AUDIO RECORDING OF STUDY PARTICIPATION

I hereby consent to audio recording of the focus group discussion.

I understand that:

- The recording will be stored in a secure location (a locked cupboard or password protected computer) with restricted access to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed.
- The recordings will be erased within either (a) two (2) years of the publication of the research findings, or (b) six (6) years, if no publications arise from this research.
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg.
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Name of Participant: _____ (Please print)

Date: _____ Place: _____

Signature or mark: _____

Witnessed by: Name of Witness: _____ (Please print)

Signature: _____ Date: _____

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

APPENDIX F(2)

TLHOKOMEDISO EA HO BONTSHA
BATHO BA KLINIKA LE BASEBETSI BA BOPHELO BA SETJHABA

Sehlooho sa ho ithuta:
Bo mme maikutlo le boiphihlelo ba tlhokomelo ya bo mme ba kangaroo seterekeng sa Fezile Dabi tsa bophelo bo botle, Afrika Borwa

Selelekela
Dumela,
Lebitso la ka ke Muellatt van Biljon. Ke seithuti se hlwahlwa bophelong ba setjhaba Univesithing ya Witwatersrand se nang le thahasello e khethehileng bophelong ba bo mme le ba bana. E le karolo ya dithuto tsa ka, ke tlameha ho etsa projeke ya dipatlisiso e tla fana ka tsebo e ntjha. Ngaka Wiedaad Slemming ke mookamedi ya ka. Phuputsong ya ka re batla ho ithuta hore na bo mme ba nang le lesea la pele kapa le tlase la tswalo ba amohetse sepetlele sa Boitumelo ba lemoha le ho ba le tlhokomelo ya bo mme ba kangaroo.

Memo ya ho nka karolo
Morero ona o kenyelletsa dipuisano le bo mme ba masea a manyane le ditsebi tsa bophelo bo botle setsing sa neonatal, hammoho le puisano e lengwe ya sehlopha se shebaneng le balekane ba bongaka le basebetsi ba tlhokomelo ya bophelo ba setjhaba, ka ho latellana. E le karolo ya morero, ke kopa ho o mema hore o nke karolo ho e ngwe ea dipuisano tsena. Puisano e tla kenyelletsa dihlooho tse kang boikarabello ba hao ba mantlha mabapi le tlhokomelo ya masea a sa tswa hlaha, tlhokomelo ya masea a manyane Sepetlele sa Boitumelo, diphephetso tse kholo bakeng sa bo mme le malapa a bona ho hlokomela masea ana, le karolo efe eo o ka e bapalang. Puisano e tla nka metsotso e ka bang 45 ho isa ho e 60. Ka tumello ya hao, ke kopa hape ho hatisa dipuisano tsa sehlopha sa tsepamiso ke sebelisa rekoto e nyane ya theipi. Ditokomane tsena tsa ho rekota le tse ngotsweng di tla bolokwa di sireletsehile ka hara khabinete e notlelitsweng mme ke mofuputsi feela mme mookameli o tla e fumana. E tla feliswa kamora dilemo tse 6.

Tumello ya boitshwaro
Boithuto bona bo amohetswe ke Komiti ya Boitšoaro ba Batho ya Dipatlisiso tsa Batho (Medical) ya Univesithi ya Witwatersrand, Johannesburg (protocol M220666) le ea Komiti ea Boitšoaro ba Lipatlisiso tsa Saense ea Bophelo ea Univesithi ea Free State (UFS-HSD2022/1513). Mosebetsi o ka sehloohong wa Komiti ena ke ho sireletsa ditokelo le seriti sa batho bohle ba dumellanang nka karolo morerong wa ho etsa dipatlisiso. Ronahape o na le tumello ho tsoa Lefapheng la Bophelo la Foreisetata le ho tsoa Boitumelo Sepetlele ho etsa phuputso ena.

Ho nka karolo ke ho ithaopa
Ho nka karolo ha hao thutong ena ke ka boithatelo. O ka hana ho nka karolo kapa ho itokolla neng kapa neng nakong ya dipuisano tsa sehlopha sa tsepamiso ntle le ho fana ka lebaka. Ha ho

na ho ba le dikotsi kapa dikotlo bakeng sa hao.

Melemo ya ho ba thutong
Ha ho na melemo e tobileng ho yena e nkang karolo thutong. Leha ho le jwalo, karabo ya hao e tsepahalang le e bolehileng e tla re thusa ho bokella tlhaiso-leseding e tsepahalang ho bo mme ba boiphihelo ba tlhokomelo ya bo mme ba kangaroo.

Ho ka ba le mathata a ho ba teng
Haeba o ikutlwa o sa phutholoha ka dipotso leha e le dife tseo re di botsang, ha ho hlokahale hore o di arabe me ha ho hlokahale hore o fane ka lebaka. Haeba o na le khatello ya maikutlo kapa ho hloka botsitso o ka tlohela puisano ya sehlopha sa tsepamiso ka nako efe kapa efe ntle le ho fana ka lebaka kapa re tla emisa puisano kapa re qale hape ka nako engwe.

Ditsenyehelo le matseliso
Haeba o nka karolo puisanong, ho ke ke ha ba le ditsenyehelo tsa hao ho yena, ntle le nako ya hao. Hape ha ona ho fumana matsediso. Ditsenyehelo tsa Dipalangoang tsa basebetsi ba bophelo bo botle ba setjhaba di tla buseletswa haeba ba tlameha ho ya sebakeng sa puisano ya sehlopha se shebaneng. Metswalle ya bongaka e se e le sebakeng seo me e ke ke ya kenya ditsenyehelo tse eketsehileng tsa maeto.

Lekunutu
Leha re kopa barupeluwa puisanong ya sehlopha sa tsepamiso ho phekola tlhaiso-leseding e arolelanwang ke ba bang ka lekunutu, sena se ke ke sa tlisoa kamehla. Sehlopha sa dipatlisiso se ke ke sa tsebisa mang kapa mang lebitso la hao mme tlhahiso leseding eo o mohileng yona e ke ke ya hokahanngoa le lebitso la hao tlalehong efe kapa efe ya ho ithuta. Ke tla be ke sebelisa sistimi ya ho ngola dikhoutu ho emela ho nka karolo ha hao tlalehong ya ka ya ho qetela ya dipatlisiso. Diphetho tsa thuto di tla ngolwa e le tlaleho ya dipatlisiso e tla fumaneha inthaneteng ka webosaete ya laeborari ya Univesithi.

Batho ba **ikopanyang**
Haeba o na le dipotso nakong ya thuto ena kapa kamora moo, ikutlwe o lokolohile ho ikopanya le nna ka dintlha tse thathamisitsoeng ka tlase.

Mofuputsi ya ka sehloohong: Muellatt van Biljon: 071 501 3562; lengolo-tsoibila: 2373163@student.wits.ac.za
Mookameli: Dr. Wiedaad Slemming: 011 717 2292/82; lengolo-tsoibila: Wiedaad.Slemming@wits.ac.za

Ebang o na le dingongoreho dife kapa dife kapa ditletlebo mabapi le mekgwa ya boitshwaro ya phuputso, kapa tsela eo phuputso e etswang ka yona, ka kopo ikopanye le Human Research Ethics Committee ya Yunivesithi ya Witwatersrand kapa Komiti ea Boitšoaro ea Lipatlisiso tsa Saense ea Bophelo ea Univesithi ea Foreisetata.

Univesithi ea Witwatersrand
Modulasetulo: Moprofesa Clement Penny

Mohala: 011 717 2301; lengolo-tsoibila: Clement.Penny@wits.ac.za Tsamaiso ea bongoli ba Komiti:
Mohala: 011 717 2700/1234; lengolo-tsoibila: Zanele.Ndlovu@wits.ac.za kapa Rhulani.Mukanni@wits.ac.za

Univesithi ea Foreisetata.
Molula-setulo: Moprofesa A Sheriff
Hlooho ea tsamaiso: Mofumahali MGE Marais
Mohala: 051 401 7794/7387; lengolo-tsoibila: ethicsfhs@ufs.ac.za

Letsatsi: 1 Phuptjane – 30 Pulungoana 2023

MOTSAMAI TUMELO LEKUTANE

Sehlooho sa morero: Bomme maikutlo le boiphihlelo ba thokomelo ya bo mme ba kangaroo seterekeng sa Fezile Dabi Health, Afrika Boroa: thuto e tswanelehang.

1. Ke fumane Tokomane ya Tlhahiso leseling ya Bothuto e hlalosang mofuta le litshebetso tse amehang thutong ena, e hoketsoeng mona.
2. Ke ile ka fuwa nako ya ho e bala, kapa e ile ya mpalla, ka puo eo ke e utlwisisang hantle.
3. Ke ile ka fuwa nako ya ho botsa dipotso leha e le dife tseo ke neng ke batla ho di fumana mme ka fumana dikarabo leha e le dife tseo ke di fuweng hore di be le kahlolo e molemo ebile di khotsofatse.
4. Ke dumela hore ke utlwisisa ka botlalo hore na hobaneng thuto e ntse e etswa le hore na sephetho se rerilweng e tla ba eng.
5. Kea utlwisisa hore ha ho na ho ba le molemo hang hang ho nna, ha nka dumela ho nka karolo, kapa hona ke ke ke ka fumana tefo. Ka lehlakoreng le leng, ho nka karolo ho ke ke na ntefella letho haese nako ya ka.
6. Kea utlwisisa hore, le haeba qalong ke dumela ho nka karolo thutong, nka tlohela ka nako efe kapa efe mme ke ne nke ke ka tlameha ho fana ka mabaka. Ha nka tlohela, data efe kapa efe e bokelletsweng ka nna ka sepheo sa thuto e ne e tla fediswa hang hang, ntle le haeba ke fana ka tumello ya hore e bolokwe.
7. Kea tseba hore tlhahiso-leseding e fumanweng thutong, ho kenyelletsa dintlha tsa motho ka mong, e tla sebetswa ntle le lebitso mme e hlahiswe tlalehong ea sephetho.
8. Ke fuwe dintlha tse fapaneng tsa ho ikopanya, tse thathamisitsweng ka tlase. Haeba ke hloka tlhahiso-leseding e eketsehileng kapa ke amehile ka karolo efe kapa efe ya thuto ena, ke lokolohile ho bua le mang kapa mang wa mabitso ana.
9. Ke nka karolo ka boithatelo.
10. Ke amohetse kopi e saenneng ea tumellano ena ya tumello e nang le tsebo.

Lebitso la Motho ya nkang karolo: _____

Letsatsi: _____ Sebaka: _____

Signature kapa letshwao: _____

E pakilwe ke: Lebitso la Paki: _____

Signature: _____Letsatsi: _____

FOROMO EA TUMELO BAKENG SA REKHOTO EA MORUO EA HO KENYA MOSEBETSI OA THUTO

Ka hona ke dumela ho rekota molumo wa dipuisano tsa sehlopha se shebaneng.

Kea utloisisa hore:

- Ho rekota ho tla bolokwa sebakeng se sireletsehileng (khabote e notletsweng kapa khomphutha e sireleditsweng ya password) e nang le phihlello e lekanyeditsweng ho mofuputsi le mookameli wa dipatlisiso.
- Ho rekota ho tla hatiswa mme tlhahiso-leseding efe kapa efe e ka nthahang e tla tloswa.
- Direkoto di tla hlakoloa kahare ho (a) tse pedi (2) dilemo tsa phatlalatso ya dipatlisiso, kapa (b) tse tsheletseng (6) dilemo, haeba ho se na lingoliloeng tse tsoang dipatlisisong tsena.
- Mang kapa mang ea lakatsang ho fumana tlhahiso-leseding ena nakong e tlang o tla tlameha ho fumana tumello ya Komiti ya Boitsthwaro ba Batho yaa Dipatlisiso tsa Batho (Medical) ya Univesithi ea Witwatersrand, Johannesburg.
- Ho qotsitswe ka kotloloho puisanong ya ka, ntle le tlhahiso-leseding e ka nthahang, ho ka bontshwa tlalehong ya dipatlisiso kapa dingoloa tse ling tsa dipatlisiso.

Lebitso la Motho ya nkang karolo: _____

Letsatsi: _____ Sebaka:_____

Signature kapa letshwao: _____

E pakilwe ke: Lebitso la Paki: _____

Signature: _____Letsatsi: _____

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

APPENDIX F(3)

INLIGTINGSBLAD VIR DEELNEMERS

KLINIESE MEDEWERKERS EN GEMEENSKAPSGESONDHEIDSORGWERKERS

Studietitel:

Moeders se perspektiewe en ervarings van die kangaroe-moedersorg in die Fezile Dabi gesondheidsdistrik, Suid-Afrika

Inleiding

Goeie dag. My naam is Muellatt van Biljon. Ek is 'n meestersgraadstudent in openbare gesondheid aan die Universiteit van die Witwatersrand met 'n spesiale belangstelling in die gesondheid van moeder en kind. Ek moet 'n navorsingsprojek doen as deel van my studies om nuwe inligting te bekom. Dr Wiedaad Slemming is my toesighouer. Die doel van my studie is om te ondersoek hoe moeders met 'n premature of lae geboortegewig-baba wat in die Boitumelo Hospitaal opgeneem is kangaroe-moedersorg beskou en belewe.

Uitnodiging om deel te neem

Hierdie projek sluit onderhoude met moeders van klein babas en gesondheidsorgwerkers in die neonatale eenheid in, asook een fokusgroepbespreking elk met kliniese medewerkers en gemeenskapsgesondheidsorgwerkers onderskeidelik. As deel van die projek wil ek u nooi om deel te neem aan een van hierdie besprekings. Die bespreking sal onderwerpe insluit soos u hoofverantwoordelikhede met betrekking tot pasgeborenesorg, die versorging van klein babas in die Boitumelo Hospitaal, die belangrikste uitdagings vir moeders en hul gesinne om hierdie babas te versorg, en watter ondersteuningsrol u kan speel.

Die onderhoud sal ongeveer 45 tot 60 minute duur. Met u toestemming wil ek graag ook 'n klankopname met 'n klein bandopnemer maak. Hierdie opname en geskrewe dokumente sal veilig in 'n sluitbare kas gestoor word en slegs die navorser en toesighouer sal toegang daartoe hê. Dit sal na 6 jaar vernietig word.

Etiese goedkeuring

Hierdie studie is goedgekeur deur die Menslike Navorsingsetiekkomitee (Medies) van die Universiteit van die Witwatersrand, Johannesburg (protokol M220666) en die Gesondheidswetenskappe Navorsingsetiekkomitee van die Universiteit van die Vrystaat (UFS-HSD2022/1513). 'n Hooffunksie van die komitees is om die regte en waardigheid van al die persone wat toestem tot deelname aan die navorsingsprojek te beskerm. Ons het ook toestemming van die Vrystaatse Gesondheidsdepartement en van Boitumelo Hospitaal om hierdie studie onderneem.

Deelname is vrywillig
U deelname aan die studie is heeltemal vrywillig. U kan weier om deel te neem of enige tyd tydens die onderhoud onttrek sonder om 'n rede te gee. Daar sal geen nadele of straf vir u wees nie.

Voordele om deel te wees van die studie
Daar sal geen direkte voordele wees as u aan die studie deelneem nie, maar u eerlike en oop terugvoering sal ons help om betroubare inligting in te samel oor moeders se ervarings van kangaroe-moedersorg.

Moontlike ongemak
As u ongemaklik voel met enige vraag wat gestel word, hoef u nie te antwoord of 'n rede vir u besluit te gee nie. As u enigsins ongemak of angs ervaar mag u die fokusgroepbespreking op enige stadium verlaat sonder om 'n rede te gee. Ons staak die bespreking of hervat dit op 'n ander tyd.

Koste en vergoeding
Daar is geen persoonlike koste wees as u deelneem aan die onderhoud nie, behalwe u tyd. U sal ook geen vergoeding ontvang nie. Gemeenskapsgesondheidswerkers se vervoerkoste sal terugbetaal word indien hulle na die lokaal van die fokusgroepbespreking moet reis. Kliniese medewerkers is reeds by die lokaal en sal nie bogenoemde reiskoste ontvang nie.

Vertroulikheid
Alhoewel ons versoek dat deelnemers aan 'n fokusgroepbespreking inligting vertroulik behandel, kan dit nie altyd gewaarborg word nie. Die navorsingspan sal nie u naam aan iemand anders bekend maak nie en die inligting wat u gee sal nie in enige studieverslag aan u naam gekoppel word nie. Ek gaan 'n kodestelsel gebruik om u deelname in my finale navorsingsverslag te verteenwoordig. Die resultate van die studie sal opgeskryf word as 'n navorsingsprojek wat aanlyn beskikbaar sal wees deur die Universiteit se biblioteek-webtuiste.

Kontak persone
As u enige vrae tydens of na die studie het, kan u my kontak by die besonderhede wat hieronder gegee word.

Hoofondersoeker: Muellatt van Biljon: 071 501 3562; e-pos: 2373163@students.wits.ac.za
Toesighouer: Dr. Wiedaad Slemming: 011 717 2292/82; e-pos:
Wiedaad.Slemming@wits.ac.za

As u enige bekommernisse of klagtes het oor die etiese prosedures van die studie, of die manier hoe hierdie studie uitgevoer is, kontak asseblief die een van die volgende komitees:

Menslike Navorsingsetiekkomitee (Medies), Universiteit van die Witwatersrand
Voorsitter: Professor Clement Penny
Tel: 011 717 2301; e-pos: Clement.Penny@wits.ac.za
Komitee sekretariaat:
Tel: 011 717 2700/1234; e-pos: Zanele.Ndlovu@wits.ac.za or Rhulani.Mukansi@wits.ac.za

Gesondheidswetenskappe Navorsingsetiekkomitee, Universiteit van die Vrystaat
Voorsitter: Professor A Sheriff
Hoof administrasie: Mev MGE Marais
Tel: 051 401 7794/7387; e-pos: ethicsfhs@ufs.ac.za

Datum: Oktober 2022

DEELNEMER SE TOESTEMMINGSBLAD

Projektitel: Moeders se perspektiewe en ervarings van die kangaroe-moedersorg in die Fezile Dabi gesondheidsdistrik, Suid-Afrika: 'n kwalitatiewe studie

1. Ek het die Inligtingsblad vir Deelnemers ontvang wat die aard van die studie en die studieprosesse beskryf, wat hierby aangeheg is.
2. Ek is tyd gegee om die dokument deur te lees, of het dit vir my laat lees, in die taal wat ek die beste verstaan.
3. Ek is tyd gegun om enige vrae te vra wat ek wou en die antwoorde was redelik en bevredigend.
4. Ek glo ek verstaan ten volle hoekom die studie gedoen word en wat die beoogde uitkomste is.
5. Ek verstaan dat daar geen onmiddellike voordeel vir my sal wees as ek instem om deel te neem nie, en ek sal ook geen betaling ontvang nie. Omgekeerd, my deelname sal niks kos behalwe my tyd nie.
6. Ek verstaan dat, selfs al gee ek toestemming om aan die studie deel te neem, ek te enige tyd later kan onttrek en daar sal nie van my verwag word om enige redes te verskaf nie. Sou ek onttrek, sal enige data wat oor my ingesamel is vir die doeleindes van die studie onmiddellik vernietig word, tensy ek toestemming gee dat dit behou mag word.
7. Ek is bewus daarvan dat die inligting wat in die studie verkry is, insluitend persoonlike besonderhede, anoniem verwerk en in verslae oor die resultate aangebied sal word.
8. Ek het 'n aantal kontakbesonderhede ontvang wat hierbo gelys is. Indien ek verdere inligting verlang of bekommerd word oor enige aspek van hierdie studie, staan dit my vry om met enige van hierdie kontakpersone te praat.
9. Ek neem vrywillig deel.
10. Ek het 'n getekende afskrif van hierdie toestemmingsooreenkoms ontvang.

Naam van deelnemer: _____ (Drukskrif asb.)

Datum: _____Plek:_____

Handtekening of merk: _____

Getuig deur: Naam van getuie: _____ (Drukskrif asb.)

Handtekening:_____Datum:_____

TOESTEMMINGSVORM VIR KLANKOPNAME VAN STUDIEDEELNAME

Ek stem hiermee toe tot die klankopname van die onderhoud.

Ek verstaan dat:

- Die opname op 'n veilige plek gestoor sal word ('n geslote kas of wagwoordbeskermende rekenaar) met beperkte toegang slegs vir die navorser en die studieleier.
- Die opname getranskribeer sal word en enige inligting wat my kan identifiseer, sal verwyder word.
- Die opnames uitgevee sal word binne of (a) twee (2) jaar na die publikasie van die navorsingsbevindinge, of (b) ses (6) jaar indien geen publikasies uit hierdie navorsing voortspruit nie.
- Enigiemand wat in die toekoms toegang tot hierdie inligting wil verkry, sal eers die goedkeuring van die Menslike Navorsingsetiekkomitee (Medies) van die Universiteit van die Witwatersrand, Johannesburg moet verkry.
- Direkte aanhalings uit my onderhoud, sonder enige inligting wat my kan identifiseer, mag in die navorsingsverslag of ander navorsingskrywes van navorsing aangehaal word.

Naam van deelnemer: _____ (Drukskrif asb.)

Datum:_____Plek:_____

Handtekening of merk: _____

Getuig deur: Naam van getuie: _____ (Drukskrif asb.)

Handtekening:_____Datum:_____

Appendix G: Interview schedule (mothers)

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

APPENDIX G(1)

INTERVIEW SCHEDULE

(Mothers at neonatal unit and outpatients department)

Reminders:

- Discuss information leaflet (emphasise confidentiality)
- Any questions?
- Consent form signed or verbal consent audio-recorded (telephone interview)

[The interviewer will be flexible with regard to the order of questions and probes below and the way they are phrased. Although only mothers with at least a basic command of English or Afrikaans will be interviewed, an assistant fluent in Sesotho will be present to assist if a mother does not understand a specific question]

Questions 1-4:	All participants
Question 5:	Mothers currently in the KMC unit
Questions 6 and 7:	Mothers at OPD
Question 8-10:	All participants

For all participants

1. Do you mind if I ask you a few questions about yourself? [In the form of a conversation, questions not necessarily in the same order as below]
   - 1.1. Is this your first baby?
   - 1.2. A boy or a girl? [Sex]
   - 1.3. How old is your baby now? (days/weeks) [Age of baby]
   - 1.4. How old are you? [Age of mother]
   - 1.5. Is Sesotho your first language?
     If No, probe further.
   - 1.6. What grade did you complete at school?
     If Grade 12, probe for after school studies
   - 1.7. With whom are you living? [Household]
     Probe for father of baby and relationship with father if not mentioned spontaneously
   - 1.8. Which of your household/family members have an income?
     Probe for grants if not mentioned spontaneously
   - 1.9. Who provides the food?
   - 1.10. How far do you live from this hospital? [Distance]
     Probe further on town/community/village/farm and transport

2. Your baby was born early/small. Tell me more about your pregnancy. [Participant first talks freely]

Probes:

2.1. Did you have any problems in your pregnancy?

2.2. How many times did you visit the clinic while you were pregnant?

2.3. What information did the sisters at the clinic give you?

2.4. Did you get information from other people as well?

If Yes, probe if not forthcoming: doctor; family members; friends; TV/radio; social media

2.5. How did the health care workers / the sisters at the clinic treat you?

Probe further if needed: Were they nice to you? Did they say something that worried you? Did they give you enough information?

2.6. Did you have a birth plan for what to do when the baby was coming?

2.7. Was you baby born here in Boitumelo Hospital? [Inborn/Outborn]

Probe further if born elsewhere: where, how, who helped her, etc.

2.8. How did you get to the hospital when you were in labour? [Transport to hospital]

Probes: Did someone come with you to the hospital? If a taxi or private transport: How much did it cost?

2.9. [Add additional probes as needed with subsequent interviews]

3. Can you tell me more about the birth of your baby? [Participant first talks freely]

Probes:

3.1. How far was the pregnancy when the baby was born? [Gestational age]

3.2. Was it a normal delivery or a caesarean section? [Mode of delivery]

3.3. How did you feel about the baby coming early?

3.4. After the birth, did your baby first go to an incubator before you started with KMC?

If Yes without elaboration: probe on care routines while baby was in the neonatal unit, feeding and expressing breastmilk, when did skin-to-skin care start

3.5. How did the staff treat you while your baby was in the neonatal unit?

Probes: How well did the staff support you? What could they have done differently?

3.6. When did you hear about KMC for the first time?

3.7. What information did the staff give you while your baby was in the neonatal unit?

Probe: Did they use picture or brochures [If a brochure/s, ask mother is she can show it to you. Ask the staff for a copy to take along]

3.8. What do you think was the most helpful information and other support that you got from the staff while your baby was in the neonatal unit?

3.9. [Add additional probes as needed with subsequent interviews]

4. You are now in the KMC unit. [For OPD participants: From the neonatal unit you went to the KMC ward with your baby.] Can you tell me what it is/was like to stay here/in the KMC ward with your baby? [Participant first talks freely]

Probes:

4.1. How many days after the birth of your baby were you and the baby transferred to the KMC ward?

4.2. How is/was it for you to do KMC in hospital? [Feelings/Experience of KMC]
Probes: What did you like about KMC? What did you not like about KMC?

4.3. Can you describe the support you get/got from staff here in the KMC unit?
Probes: What could the staff have done differently? What other kinds of support would you have liked?

4.4. What are the caring tasks that you have to do/did for the baby?
Probes: feeding, changing nappies, wash baby (top-and-tail), cleaning the cord, giving medicines Did the staff demonstrate the care tasks to you?

4.5. What other information did the staff give to you during your stay in the KMC unit?
Probe: Did they use picture or brochures [If a brochure/s, ask mother is she can show it to you. Ask the staff for a copy to take along]

4.6. What do you think was the most helpful information and support that you got from the staff in the KMC unit?

For mothers in KMC unit, go to Question 5
For mothers at the OPD, go to Questions 6 and 7

Question 5: For mothers in the KMC unit

5. What do you expect will happen when you get home the small baby? [Participant first talks freely]

Probes:

5.1. How prepared is everyone for receiving the small baby at home?

5.2. When you go home, are you going to continue carrying the baby in KMC position?
If Yes, Why are you saying so? If No, what will make it difficult to continue with KMC?

5.3. How are you going to feed your baby at home?

5.4. Who will help you when you go home with your baby?
Probes: What kind of support will they give you? Will any of the men around give you any support?

5.5. What are other challenges that will face you when you and the baby get home?
If not mentioned under 5.2: caring tasks, time, feeding, other children, back to work or school, space

5.6. [Add additional probes as needed with subsequent interviews]

For mothers in KMC unit, go to Question 8

Questions 6 and 7: For mothers at OPD

6. I would first like to hear more about what happened at the hospital when you and your baby were discharged from the KMC unit. [Participant first talks freely]

Probes:

6.1. How did the staff prepare you for discharge?

6.2. Did they give you (and your family) special counselling?
If Yes, what did they talk about? (Can probe further on general care of the baby, danger signs, coming back for follow-up)
6.3. Did the staff put you in touch with a community health worker?
If Yes without elaboration: Tell me a bit more about how this happened
6.4. Did a community health workers visit you at home?
If Yes, what did s/he talk about? (health topics discussed, reminder for follow-up, etc)
6.5. What other contact did you have with the community health worker?
Probes: phone call, messages, etc.
6.6. Did any other health worker visit you at home?
If Yes without elaboration: Tell me a bit more about it
6.7. Who supported you when you went home with your small baby?
Probes: What kind of support did they give you? Did any of the men around give you any support?
6.8. What was difficult for you when you took your small baby home? [Challenges]
Probes: caring tasks, time, feeding, other children, back to work or school, space
6.9. [Add additional probes as needed with subsequent interviews]

7. You have brought your baby back to the hospital for a follow-up visit. Is this your first follow-up visit at the hospital? *If No, probe further.*

Probes:

7.1. How difficult is it for you to come for the follow-up visit?
Probe further on distance, type of transport, cost of transport, time, etc.
7.2. What plans did you make to overcome the difficulties?
Pick up on previous answers
7.3. Why is it important to come for the follow-up?
7.4. Did you also go to your local clinic for the staff to check on you baby?
If Yes without elaboration: Can you tell me a bit more?
7.5. [Add additional probes as needed with subsequent interviews]

For all mothers

8. If you think back about our interview, what do you think the health staff or you and your family could have done differently to make your life with the small baby easier?

9. What advice will you give to a new mother that has a preterm or low birth weight baby?

10. We have come to the end of the questions. Is there anything else that you think I should know that can help me to better understand mothers' experiences of KMC?

Thank participant.

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

APPENDIX G(2)

INTERVIEW SCHEDULE

(Bomme lefapheng la neonatal le lefapha la kantle ho naha)

Dikhopotso:

- Buisa leqephe la tlhaiso-leseding (hatisa lekunutu)
- Dipotso leha e le dife?
- Foromo ya tumello e saenneng kapa e ngotsweng ka mantswe e tlalehilweng (puisano ya mohala)

[Motho ya buisanang le dipotso o tla fetoha le maemo mabapi le tatellano ya dipotso le dipatlisiso ka tlase le tsela eo di hlalosoang ka wona. Leha bo mme feela ba nang le bonyane taelo ya mantlha ya Senyesemane kapa Seafrika ba tla botswa dipotso, mothusi ya sebetsang hantle Sesotho o tla ba teng ho thusa haeba mme a sa utloisise potso e itseng]

Dipotso 1 - 4: Barupeluoa bohle
Potso ya 5: Bo mme hajwale ba le setsing sa KMC
Dipotso tsa 6 le 7: Bo mme ho OPD
Potso 8 - 10: Barupeluoa bohle

Bakeng sa bohle ba nkang karolo

1. Na o na le taba ya hore na ke o botsa dipotso tse tsamailanang le wena? [Ka mokgwa wa moqoqo, dipotso ha di hlile ha di jwalo ka tatellano e tswanang le e ka tlase ho]
   1.1. Na ke ngwana wa hao wa pele?
   1.2. Moshanyana kapa ngwanana? [Bong]
   1.3. Ngwana ya hao o dilemo di kae jwale? (Matsatsi / Dibeke) [Age ya lesea]
   1.4. O dilemo di kae? [Age ya mme]
   1.5. Ana Sesotho ke puo ya hao ya lapeng/hlaho? *Haeba tjhe, ke efe ya lapeng?*
   1.6. O qetile sekolong ka sehlopha sefe?
   Haeba kereiti yo 12, etso dipatlisiso tsa dithuto tsa sekolo komora sekolo
   1.7. O dula le mang? [Ntlo ya ntlo]
   Puo ya ntate wa ngwana le kamano le ntate haeba e sa bolelwe ka boithatelo
   1.8. Ke ditho dife tsa lelapa la hao / lelapa tse nang le chelete? *Puo wa dithuso haeba e sa bolelwe ka boithatelo*
   1.9. Ke mang ya fanang ka dijo?
   1.10. O phela ha kae le sepetlele? [Ho thibela]
   Pou ho ya toropong / setjhhabeng / motseng/ polasi le dipolangwang

2. Ngwana ya hao o hlahile kapele / o monyane. Kopa o mpolelle ho eketsehileng ka moimana wa hao. [Dipuisano tsa pele tse nkang karolo ka bolokolohi] *Mekhwa:*
   2.1. Ana o bile le mathata a ho ima wa hao?
   2.2. O etetse tleliniking ka makgetlo ama kae ha ontse o imme?
   2.3. Ke tlhahisoleseding efe eo bo manese ba tleliniking ba ofileng wena?

2.4. Ana le wena o fumane lesedi ho tswa ho batho ba bang?
Haeba ho jwalo, hlakisa haeba e sa tle: ngaka; ditho tsa lelapa; metswalle; TV / radio; metjha ya ditaba ya setjhaba.

2.5. Basebetsi ba tlhokomelo ya bophelo bo botle / dikhaitseli tsa tleliniking ba o tshwaretse jwang?
Hlakisa ho ya pele haeba ho hlokahala: Na ba ne ba le monate ho yena? Na ba buile ho hong ho o tswenyang? A entse ba o ofa lesedi le lekaneng?

2.6. Ana o ne o nale leano le moralo ya tsoalo bakeng sa seo o lokelang ho se etsa ha ngoana a tla?

2.7. Ana o sa le ngwana ya hlahetseng sepetlele sa Boitumelo? [O hlahile / O sa tswa ho hlaha]
Hlakisa ho ya pele haeba a hlohetse kae kae: kae, jwang , ke mang ya mo thusitseng, jwalo jwalo.

2.8. O fihlile sepetlele jwang ha o ne o otlo pepa? [Sepalangwang ya sepetlele]
Mohlomong: Na ho na le motho ya tlileng le wena sepetlele? Haeba tekesi kapa dipalangwang tsa poraefete: Tekesi e entse bokae e theko?

2.9. [Kenya ditlhakiso tse ding ha ho hlokahala ka dipuisano tse latelang]

3. O ka mpolella ho eketsehileng ka tswalo ya ngwana wa hao? [Dipuisano tsa pele tse nkang karolo ka bolokolohi] *Mekhwa:*

3.1. Kemaro e ne e le hole hakae ha ngwana a hlaha? [dilemo tsa boikoetliso]

3.2. Ana e ne e le tswalo e tlwaelehileng kapa karolo ya caesarean? [Mokhwa ya ho tsamaisa]

3.3. O ile ya ikutlwa jwang ka ngwana ya tlang pele ho nako?

3.4. Kamora ho hlaha, na ngwana hao wa ile a qala ho ya incubator pele o qala ka KMC? *Haeba ho jwalo ntle le tlhaiso-leseding: Hlakisa ka mekhwa ya tlhokomelo ha ngwana a le setswetsing sa neonatal, ho fepa le ho fepa le ho nyanisa letswele, ebe ho ka qalwang ka ho etsa letlalo letlalong le ngwana.*

3.5. Basebetsi ba o tswaretse jwang ha ngwana wa hao a le setsing sa neonatal?
Mohlomong: Basebetsi ba o tsehelitse hantle hakae? Ba ka be ba entse eng ka tsela e fapaneng?

3.6. O utlwileng neng ka KMC ka lekhetlo la pele?

3.7. Basebetsi ba o file lesedi lefe ha ngwana wa hao a le setsing sa neonatal?
Mohlomong: Na ba sebedisitse ditswantso kapa dibukana [Haeba bukana / boisa mme hore a ka o bontsa yona. Kopa basebetsi hore ba nke kopi ya ho tsamaya]

3.8. O nahana hore ke tlhahiso leseding e thusang ka ho fetisisa le tsehetso engwe eo oe fumaneng ho tswa ho basebetsi ha ngwana wa hao a le setsing sa neonatal?

3.9. [Kenya di hlaiso tse ling ha ho hlokahala ka dipuisano tse latelang]

4. Wena ha jwale o ka hara KMC unit. [Keya barupeluwa ba OPD: Ho tswa ho neonatal o ile ho lebatowa KMC le ngwana hao] O ka kgona ho njwetsa hore keng/ho nole jwang ho dula moo/ ka hara lebalowa ka KMC le ngwana hao? [Dipuisano tsa pele tse nkang karolo ka bolokolohi] *Mekhwa:*

4.1. Ke matsatsi a makae kamora ho hlaha ha ngwana wa hao mme ngwana o ile a fetisetswa lebatoweng la KMC?

4.2. Ho ne ho le jwang hore o etse KMC sepetlele? [Ho ikutlwa / ho hloka tsebo ha KMC] *Ho tswella pele: O ratile eng ka KMC? O ne o sa rate eng ka KMC?*

4.3. A na o ka hlalosa tsehetso eo o e fumanang / ho tswa ho basebetsi mona lebatoweng sa KMC?
Ho tswella pele: Basebetsi ba ka be ba entse eng ka tsela e fapaneng? O ka ba le mefuta e meng ya tsehetso eo o ka bang le eona ratilwe?

4.4. Mesebetsi e tsotellang eo o tlamehang ho e etsa / e e etselitse ngwana ke efe?
Ho tswella pele: ho fepa, ho fetola maleri, ho hlatsoa lesea (holimo le mohatla), ho hloekisa thapo, ho fana ka meriana. Na basebetsi ba o bontsitse mesebetsi ya tlhokomelo?

4.5. Ke tlhahiso leseding efe engwe eo basebetsi ba o fileng eona nakong ya ha o dula lebaloweng sa KMC?

Ho tswella pele: Na ba sebelisitse ditswantso kapa dibukana [Haeba bukana / botsa mme hore o ka u bontsa eona. Kapa basebetsi hore ba nke kopi ya ho tsamaya le yona.]

4.6. O nahana hore ke tlhahiso leseding e thusang ka ho fetisisa le tsehetso eo o e fumaneng ho basebetsi ba mahlakoreng a KMC?

Bakeng sa bo mme ba mahlokoreng ea KMC, e ea Potso ea 5 Bakeng sa bo mme ho OPD, eya ho Dipotso 6 le 7

Potso ya 5: Bakeng sa bo mme mahlakoreng ya KMC

5. O lebelletse hore ho tla etsahala eng ha o fihla hae ngwana e monyane? [Dipuisano tsa pele tse nkang karolo ka bolokolohi] *Ho tshwella pele:*
   5.1. Motho e mong le e mong o itokisitse hakae bakeng sa ho amohela ngwana e monyane lapeng?
   5.2. Ha o ya hae, na o tla tsoela pele ho jara ngwana maemong a KMC?
   Haeba ho jwalo, ke hobaneng ha o bua jwalo? Haeba ho jwalo, ho tla etsa hore ho be thata ho tswela pele ka KMC?
   5.3. O tla fepa ngolwana wa hao jwang lapeng?
   5.4. Ke mang ya tla o thusa ha o ya hae le ngwana wa hao?
   Mohlomong: Ba tla o tsehetsa ka mofuta ofe? Na ho na le banna ba haufi ba tla o fa letho tsehetso?
   5.5. Mathata a mang a tla tobana le wena ha wena le ngwana le fihla hae?
   Haeba ho sa boleloe tlasa 5.2: mesebetsi ya ho tsotella, nako, ho fepa, bana ba bang, ho khutlela mosebetsing kapa sekolong, sebaka
   5.6. [Kenya hlakiselso tse ding ha ho hlokahala ka dipuisano tse latelang]

Bakeng sa bo mme ba hlakoreng ya KMC, e ya Potso ya 8

Dipotso 6 le 7: Bakeng sa bo mme ho OPD

6. Ke kopa pele ho utlwa ho eketsehileng ka se etsahetseng sepetlele ha wena le ngwana wa hao le lokollwa lebatoweng la KMC. [Dipuisano tsa pele tse nkang karolo ka bolokolohi] *Mekhwa:*
   6.1. Basebetsi ba o lokiseditse jwang hore o hlakolwe?
   6.2. Na ba o file (le ba lelapa la hao) tlhabollo e khethehileng?
   Haeba ho jwalo, ba buile ka eng? (E ka etsa dipatlisiso ho feta tlhokomelo e akaretsang ya ngwana, matswao a kotsi, ho khutla bakeng sa ho latella)
   6.3. Ana basebetsi ba o kopanetse le mosebeletsi wa bophelo bo botle ba setjhaba? *Haeba ho jwalo ntle le tlhaisonleseding: Ako mpolelle ho eketsehileng ka hore na sena se etsahetse jwang*
   6.4. Ana basebetsi ba bophelo bo botle ba setjhaba ba o etetse hae?
   Haeba ho jwalo, o buile ka eng? (Dihlooho tsa bophelo bo botle di ile tsa tsohlwa, khopotso ya ho latella, jwalo jwalo)
   6.5. O bile le puisano efe le mosebeletsi wa bophelo bo botle wa setjhabeng? *Mekhwa: Mohala wa mohala, meiaetsa, jwalo jwalo.*
   6.6. Na ho na le mosebeletsi e mong wa bophelo bo botle ya o etetseng hae?
   Haeba ho jwalo ntle le tlhaiso leseding: Ako mpolelle ho eketsehileng ka hona
   6.7. Ke mang ya u tsehediteng ha o ya hae le ngwana wa hao e monyane?
   Mohlomong: Ba o file tsehetso ya mofuta ofe? Na ho na le banna ba neng ba le haufi ba o fileng tsehetso?

6.8. Ho ne ho le thata ho yena ha o ne o nka ngwana wa hao e monyane hae? [Diphephetso]
Mekhwa: mesebetsi ya ho tsotella, nako, ho fepa, bana ba bang, ho khutlela mosebetsing kapa sekolong, sebaka

6.9. [Kenya mekhwa emeng ding ha ho hlokahala ka dipuisano tse latelang]

7. O khutlisitse ngwana wa hao sepetlele bakeng sa ketelo e latelang ya.Na ke ena ya hao ya pele ketelo ya sepetlele? *Haeba tjhe, hlalosa ho ya pele.*
Mekhwa:

7.1. Ho thata hakae hore o tle ho latela ketelo?
Hlalosa hoya pele, mofuta wa dipalangoang, ditsenyehelo tsa dipalangoang, nako, jwalo jwalo.

7.2. O entse merero efe ya ho hlola mathata? *Nka dikarabo ho potso tse fetileng.*

7.3. Hobaneng ho le bohlokwa ho tla bakeng sa ho latela?

7.4. Na o bile tleliniking ya hao ya lehae hore basebetsi ba o hlahlobe? *Haeba ho jwalo ntle le tlhaiso leseding: O ka mpolella ho feta?*

7.5. [Kenya dihlakiso tse ding ha ho hlokahala ka dipuisano tse latelang]

Bakeng sa bo mme bohle

8. Haeba o nahana ka puisano ya rona, o nahana hore basebetsi ba bophelo bo botle kapa wena le ba lelapa la hao ba ka be ba entse ka tsela e fapaneng ho etsa hore bophelo ba hao le ngwana e monyane bo be bonolo?

9. O tla fana ka dikeletso dife ho mme e motjha ya nang le ngwana tswetsweng pele ho nako kapa ya tlase boima ba hae?

10. Re fihlile qetellong ya dipotso. Na ho na le letho le leng leo o nahanang hore ke lokela ho tseba seo na nka nthusa ho utlwisisa ha molemo bo mme ba diphihlelo tsa KMC?

Ke leboha karolo.

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APPENDIX G(3)

ONDERHOUDSKEDULE

(Moeders by die neonatale eenheid en buitepasiënteafdeling)

Onthounotas:

- Bespreek inligtingsblad (beklemtoon vertroulikheid)
- Enige vrae?
- Toestemmingsvorm onderteken of oudio-opname met mondelinge toestemming (telefoon-onderhoud)

[Die onderhoudvoerder sal buigsaam wees met betrekking tot die volgorde van vrae en die uitsteek van verdere voelers hieronder en die manier waarop hulle bewoord word. Afrikaanssprekende deelnemers sal 'n keuse hê om die onderhoud in Afrikaans of in 'n mengsel van Afrikaans en Engels te doen.]

Vraag 1-4:	Alle deelnemers
Vraag 5:	Moeders tans in die kangaroemoedersorg-eenheid (KMS-eenheid)
Vraag 6 en 7:	Moeders by Buitepasiënte
Vraag 8-10:	Alle deelnemers

Vir alle deelnemers

1. Gee jy om as ek jou 'n paar vrae vra oor jouself? [In die vorm van 'n gesprek; vrae is nie noodwendig in dieselfde volgorde as hieronder nie]
   1.1. Is hierdie jou eerste baba?
   1.2. 'n Seun of 'n meisie [Geslag]
   1.3. Hoe oud is jou baba nou? (dae/weke) [Ouderdom van baba]
   1.4. Hoe oud is jy? [Ouderdom van moeder]
   1.5. Is Afrikaans jou eerste taal?
   Indien Nee, vra verder uit
   1.6. Watter graad het jy voltooi op skool?
   As Graad 12, steek voelers uit oor verdere studies
   1.7. Saam wie bly jy? [Huishouding]
   Vind uit oor die pa van die baba en die verhouding met die pa as dit nie spontaan gegee word nie
   1.8. Watter van jou huishouding/familielede het 'n inkomste?
   Vind uit oor toelaes as dit nie spontaan genoem word nie
   1.9. Wie verskaf die kos?
   1.10. Hoe ver bly jy van die hospitaal af? [Afstand]
   Vra verder uit oor dorp/gemeenskap/dorpie/plaas en vervoer

2. Jou baba is vroeg/klein gebore. Vertel my meer oor jou swangerskap. [Deelnemer praat eers vryelik]
   Vind verder uit:
   2.1. Het jy enige probleme met jou swangerskap gehad?
   2.2. Hoeveel keer was jy by die kliniek gedurende jou swangerskap?
   2.3. Watter inligting het die susters by die kliniek vir jou gegee?
   2.4. Het jy ook inligting van ander mense ontvang?
   Indien Ja, vra verder uit as nie toegelig nie: dokter; familielede; vriende; TV/radio; sosiale media
   2.5. Hoe het die gesondheidsorgwerkers / susters jou by die kliniek behandel?
   Vra verder uit indien nodig: Was hulle gaaf met jou? Het hulle iets gesê wat jou bekommerd laat voel het? Het hulle genoeg inligting vir jou gegee?
   2.6. Het jy 'n geboorteplan gehad vir wat om te doen as die baba kom?
   2.7. Is jou baba hier in die Boitumelo Hospitaal gebore? [Binnegeborene/Buitegeborene]
   Vra verder uit as die baba op 'n ander plek gebore is: waar, hoe en wie het haar gehelp
   2.8. Hoe het jy by die hospitaal gekom toe jy in kraam was? [Vervoer hospitaal toe]
   Vind verder uit: Het iemand saam met jou hospitaal toe gekom? Indien met 'n taxi of private vervoer: Hoeveel het dit gekos?
   2.9. [Steek verdere voelers uit soos nodig met daaropvolgende onderhoude]

3. Kan jy my meer vertel oor die geboorte van jou baba? [Deelnemer praat eers vryelik]
   Vind verder uit:
   3.1. Hoe ver was die swangerskap toe jou baba gebore is [Swangerskapouderdom]
   3.2. Was dit 'n normale geboorte of 'n keisersnit? [Wyse van geboorte]
   3.3. Hoe het jy gevoel oor die baba wat vroeg kom?
   3.4. Na die geboorte, het jou baba eers na 'n broeikas toe gegaan voordat jy begin het met KMS?
   Indien Ja sonder toeligting: vra uit oor versorgingsroetines terwyl die baba in die neonatale eenheid was, voeding en uitpomp van borsmelk, wanneer vel-tot-vel-sorg begin het
   3.5. Hoe het die personeel jou behandel terwyl jou baba in die neonatale eenheid was?
   Vind verder uit: Hoe goed het die personeel jou ondersteun? Wat kon hulle anders gedoen het?
   3.6. Wanneer het jy vir die eerste keer gehoor van KMS?
   3.7. Watter inligting het die personeel vir jou gegee terwyl jou baba in die neonatale eenheid was?
   Vind verder uit: Het hulle prente of brosjures gebruik? [As 'n brosjure gebruik is, vra of die ma dit vir jou kan wys, vra vir die personeel vir 'n kopie om saam te neem]
   3.8. Watter inligting en ondersteuning wat jy by die personeel ontvang het, het jou die meeste gehelp terwyl jou baba in die neonatale eenheid was?
   3.9. [Steek verdere voelers uit soos nodig met daaropvolgende onderhoude]

4. Jy is nou in die KMS-eenheid. [Vir buitepasiënte-deelnemers: Van die neonatale eenheid het jy saam met jou baba na die KMS-eenheid gegaan] Kan jy my vertel hoe dit is/was om hier/in die KMS-eenheid te bly saam jou baba? [Deelnemer praat eers vryelik]
   Vind verder uit:
   4.1. Hoeveel dae na die geboorte van jou baba is jy en jou baba oorgeplaas na die KMS-eenheid toe?
   4.2. Hoe is/was dit vir jou om KMS te doen in die hospitaal? [Gevoelens/Ervarings van KMS]
   Vind verder uit: Waarvan het jy gehou met KMS? Waarvan het jy nie gehou met KMS nie?

4.3. Kan jy die ondersteuning beskryf wat jy kry/gekry het in die KMS-eenheid?
Vind verder uit: Wat kon die personeel anders gedoen het? Watter ander ondersteuning sou jy graag wou hê?

4.4. Watter die versorgingstake doen jy / het jy vir jou baba gedoen?
Vind verder uit: voeding, doeke omruil, baba was (bo en onder), naelstring skoonmaak, medisyne gee. Het die personeel vir jou gewys hoe om die versorgingstake te doen?

4.5. Watter ander inligting het die personeel vir jou gegee tydens jou verblyf in die KMS-eenheid?
Vind verder uit: Het hulle prentjies of brosjure/s gebruik? [As 'n brosjure/s vra die ma of sy dit vir jou kan wys. Vra die personeel vir 'n afskrif om saam te neem].

4.6. Wat dink jy was die nuttigste inligting en ondersteuning wat jy by die personeel in die KMS-eenheid gekry het?

Vir moeders in die KMS-eenheid, gaan na Vraag 5
Vir moeders by Buitepasiënte, gaan na Vraag 6 en 7

Vraag 5: Vir moeders in die KMS-eenheid

5. Wat verwag jy sal gebeur as jy en jou klein baba huis toe gaan? [Deelnemer praat eers vryelik]
Vind verder uit:

5.1. Hoe voorbereid is almal om die klein baba by die huis te ontvang?

5.2. Wanneer jy huis toe gaan, gaan jy aanhou om die baba in die KMS-posisie te dra?
Indien Ja, hoekom sê jy so? Indien Nee, wat sal dit moeilik maak om met KMS voort te gaan?

5.3. Hoe gaan jy jou baba by die huis voed/voer?

5.4. Wie gaan jou met jou baba help as jy huis toe gaan?
Vind verder uit: Watter soort ondersteuning gaan hulle vir jou gee? Sal enige van die mans jou ondersteun?

5.5. Wat is ander uitdagings wat vir jou wag wanneer jy en jou baba huis toe gaan?
Indien nie onder 5.2. genoem nie: versorgingstake, tyd, voeding, ander kinders, terug werk of skool toe, spasie.

5.6. [Steek verdere voelers uit soos nodig met daaropvolgende onderhoude]

Vir moeders in die KMS-eenheid, gaan na Vraag 8

Vraag 6 en 7: Vir moeders by Buitepasiënte

6. Ek wil eers meer uitvind oor wat by die hospitaal gebeur het toe jy en jou baba uit die KMS-eenheid ontslaan is. [Deelnemer praat eers vryelik]
Vind verder uit:

6.1. Hoe het die personeel jou voorberei vir ontslag?

6.2. Het hulle vir jou (en jou gesin) spesiale berading gegee?
Indien ja, waaroor het hulle gepraat? (Kan verder uitvra oor algemene versorging van die baba, gevaartekens, terugkom vir opvolg)

6.3. Het die personeel jou in kontak gebring met 'n gemeenskapsgesondheidswerker?
Indien ja sonder uitbreiding: Vertel my 'n bietjie meer oor hoe dit gebeur het.

6.4. Het 'n gemeenskapsgesondheidswerker jou by die huis besoek?
Indien ja, waaroor het hy/sy gepraat? (gesondheidsonderwerpe bespreek, herinnering vir opvolg, ens.).

6.5. Watter ander kontak het jy met die gemeenskapsgesondheidswerker gehad?
Vind verder uit: Telefoonoproepe, boodskappe, ens.

6.6. Het enige ander gesondheidswerker jou by die huis besoek?
Indien Ja sonder toeligting: Vertel my 'n bietjie meer daaroor

6.7. Wie het jou ondersteun toe jy met jou klein baba huis toe gegaan het?
Vind verder uit: Watter soort ondersteuning het hulle vir jou gegee? Het enige van die mans rondom jou vir jou ondersteun?

6.8. Wat was vir jou moeilik toe jy jou klein baba huis toe geneem het? [Uitdagings]
Vind verder uit: Versorgingstake, tyd, voeding, ander kinders, terug werk of skool toe, ruimte.

6.9. [Steek verdere voelers uit soos nodig met daaropvolgende onderhoude]

7. Jy het jou baba teruggebring na die hospitaal vir 'n opvolgbesoek. Is dit jou eerste opvolgbesoek by die hospitaal? *Indien Nee, vra verder uit.*
Vind verder uit:

7.1. Hoe moeilik is dit vir jou om vir 'n opvolgbesoek te kom?
Vra verder uit oor afstand, tipe vervoer, koste van vervoer, tyd, ens.

7.2. Watter planne het jy gemaak om die probleme te oorkom?
Neem vorige antwoorde in ag.

7.3. Hoekom is dit belangrik om te kom vir die opvolgbesoek?

7.4. Het jy ook na jou plaaslike kliniek toe gegaan sodat die personeel na jou baba kan kyk?
Indien Ja sonder toeligting: Kan jy my 'n bietjie meer vertel?

7.5. [Steek verdere voelers uit soos nodig met daaropvolgende onderhoude]

Vir alle moeders

8. As jy terugdink oor ons onderhoud, wat dink jy kon die gesondheidspersoneel, jou gesin of jy anders gedoen het om jou lewe met 'n klein baba makliker te maak?

9. Watter raad sal jy vir 'n nuwe ma met 'n premature of lae geboortegewig-baba gee?

10. Ons het aan die einde van die vrae gekom. Is daar nog iets wat jy dink ek moet weet wat my kan help om moeders se ervarings van KMS beter te verstaan?

Bedank die deelnemer.

Appendix H: Interview schedule (professionals)

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APPENDIX H(1)

INTERVIEW SCHEDULE

(Head of paediatric unit, nursing manager and other health professionals)

Reminders:

- Discuss information leaflet (emphasise confidentiality)
- Any questions?
- Consent form signed or verbal consent audio-recorded (telephone interview)

[The interviewer will be flexible with regard to the order of questions and probes below and the way they are phrased]

1. What are your main responsibilities with regard to newborn care in the Boitumelo Hospital? [Participant first speaks freely]
   Probes:
   1.1. Premature and low birth weight (LBW) babies
   1.2. Kangaroo mother care (KMC)
   1.3. Do you have specific guidelines with regard to the care of small and sick newborns? (provincial / national)
   Further probes:
   - If yes, how are these guidelines used?
   - Are babies still **transported** in the skin-to-skin position in the Fezile Dabi District? [Ask to elaborate if not enough information (e.g. If some, which ones? Some districts or sub-districts better adherence than others? Documentation about transport? Someone else who could give more information?)]

   1.4. [Add additional probes as needed with subsequent interviews]

2. How would you say Boitumelo Hospital is faring with regard to the care of small and sick newborns in particular? [Participant first speaks freely]
   Probes:
   2.1. What neonatal services are available?
   *Further probes: **strengths and challenges**; ask for **examples** if appropriate*
   2.2. How would you describe the quality of neonatal care in the hospital?
   *Further probes: **strengths and challenges**; **knowledge and skills** of doctors and nurses in the care of small and sick newborns; ask for **examples** if appropriate*
   2.3. What do you think are the priority areas for improvement in newborn care?
   2.4. [Add additional probes as needed with subsequent interviews]

3. Can you tell more about how kangaroo mother care is practised in the hospital? [Participant first speaks freely]
   Probes:
   3.1. What are your views on the knowledge and skills in KMC among different of health care workers
   *Further probes: (a) **doctors**; (b) **nurses** working in hospitals, community health centres and primary health care clinics; (c) **clinical associates**; (d) **community health workers**); **training** they had received*

3.2. What are your views on the acceptance of KMC by various stakeholders? [Participant first speaks freely]
*Further probes: (a) health **professionals**; (b) **families** with a preterm or low birth weight baby; (c) the **community** at large* [also probe on **traditional** community **views** on babies born prematurely, e.g. causes]

3.3. What happens with KMC after discharge?
*Further probes: What happens **at discharge** (e.g. counselling and information; are mothers put in touch with a community health worker)? Do mothers **continue with KMC at home**? What **percentage** do you think? What do they tell you are the **challenges** with continuing with KMC at home? What is the influence of the **extended family** (mothers, mothers-in-law, aunts) on baby care practices and KMC in particular? What role do **fathers** play in KMC?*

3.4. [Pick up on additional points mentioned that seem worthwhile to further explore]

4. Can you tell me more about the follow-up of the premature and low birth weight babies after discharge? [Participant first speaks freely]
Probes:
4.1. Is there a specific follow-up schedule?
4.2. What happens during a follow-up visit at the hospital?
4.3. How do you record and track follow-up visits?
4.4. What are the linkages between the hospital and primary health care clinics with regard to preterm and low birth weight babies?
4.5. What percentage of preterm and low birth weight babies come back for their follow-up visits at the hospital?
*Further probe: Do you have a **tracking system** to get in touch with mothers who do not come for follow-up / **default** on follow-up?* [If Yes only, ask for further elaboration]
4.6. Why do some mothers or caregivers not bring their babies back to the hospital for follow-up? / What are the reasons for mothers defaulting on follow-up visits? [Participant first speaks freely]
Further probes: distance; transport; cost; influence of significant others/community views; attitudes of mothers and community
4.7. [Pick up on additional points mentioned that seem worthwhile to further explore]

5. From our discussion about the care of newborns and small babies, what would you say are the priority areas for improvement of KMC? [Participant first speaks freely]
Probes:
5.1. How do you think the priority areas you mentioned could be improved? [Pick out what the informant mentions and focus on those]
5.2. What can be done to make sure preterm and low birth weight babies have access to the specialised follow-up they need at a hospital after discharge?
*Further probes: How can the **Province** help? How can the **District** help? How can the **hospital** help?*
5.3. [Add additional probes as needed with subsequent interviews]

6. Thinking back on our discussion, are there any other important points that stood out for you?

7. Is there anything else that you would like to add that would be important for me to have a better understanding of the context of Boitumelo Hospital or Fezile Dabe District?

Thank participant

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APPENDIX H(2)

INTERVIEW SCHEDULE (Sesotho)

(Head of paediatric unit, nursing manager and other health professionals)

Dikhopotso:

- Buisa leqephe la tlhaiso-leseding (hatisa lekunutu)
- Dipotso leha e le life?
- Foromo ya tumello e saenneng kapa e ngotsoeng ka mantswe audio audio e tlalehiloeng (puisano ya mohala)

[Motho ya buisanang le dipotso o tla fetoha le maemo mabapi le tatellano ya dipotso le dipatlisiso ka tlase le tsela eo di hlalosoang ka wena]

1. Boikarabello ba hao bo ka sehloohong ke bofe mabapi le tlhokomelo e sa tswa hlaha sepetleleng sa Boitumelo? [Motho ya nkang karolo o qala ho bua ka bohloko login] *Mekhwa:*
   1.1. Pele ho nako le boima ba mmele ba ho tswala bo tlase (LLBW) masea
   1.2. Tlhokomelo ya bomme ba Kangaroo (KMC)
   1.3. Na u na le ditataiso tse tobileng mabapi le tlhokomelo ya masea a manyane le a kulang? (provense / naha)
   Mekhoa emeng hape:
   - Haeba ho jwalo, ditataiso tsee di sebedisoa joang?
   - Na masea a ntse a tsamaiswa letlalong ho boemo ba letlalo seterekeng sa Fezile Dabi? [Botsa ho hlakisa haeba ho se na tlhahisoleseding e lekaneng (k.k. haeba tse ding, ke dife? Ditereke tse ding kapa ditereke tse tlase tsa di latela melao e metle ho feta tse ding? Ditokomane mabapi le dipalangwang? Motho e mong ya ka fanang ka tlhaisoleseding e eketsehileng?)
   1.4. [Kenya di-probes tse ding ha ho hlokahala ka dipuisano tse latelang]

2. O ka re Sepetlele sa Boitumelo se ntse se tswela pele jwang mabapi le tlhokomelo ea masea a manyane le a kulang haholo? [Motho ya nkang karolo o qala ho bua ka bolokolohi] *Mekhwa:*
   2.1. Ke ditsebeletso dife tsa neonatal tse fumanehang?
   Mekhwa e meng hae: matla le diphephetso; kopa mehlala haeba ho loketse.
   2.2. O ka hlalosa boleng ba tlhokomelo elya neonatal sepetlele jwang?
   Mekhwa e meng hope: matla le diphephetso; tsebo le boiphihlelo ba dingaka le baoki tlhokomelong ya masea a manyane le a kulang; kopa mehlala haeba ho loketse
   2.3. O nahana hore dibaka tsa pele tsa ntlafatso ya tlhokomelo ya masea ke dife?
   2.4. [Kenya di-probes tse ding ha ho hlokahala ka dipuisano tse latelang]

3. A na o ka tseba ho eketsehileng ka hore na tlhokomelo eya bomme ya kangaroo e etswa sepetlele jwang? [Motho ya nkang karolo o qala ho bua ka bolokolohi] *Mekhwa:*
   3.1. Maikutlo a hao ke afeng ka tsebo le bokhoni ho KMC hara basebetsi ba tlhokomelo ya bophelo bo botle ?

Mekhwa e meng hape: (a) dingaka; (b) baoki ba sebetsang dipetlele, ditsi tsa bophelo bo botle ba sechaba le ditleliniki tsa tlhokomelo ya bophelo bo botle; (c) metswalle ya bongaka; (d) basebeletsi ba bophelo bo botle ba sechaba); koetliso eo ba e fumaneng

3.2. Maikutlo a hao ke afe mabapi le kamohelo ya KMC ke ba amehang ba fapaneng? [Motho ya nkang karolo o qala ho bua ka bolokolohi]
Mekhwa e meng hape: (a) Ditsebi tsa bophelo bo botle; (b) malapa a nang le lesea la pele kapa le tlase; (c) sechaba ka kakaretso [hape le probe mabapi le maikutlo a setso a sechaba ho masea a hlahileng pele ho nako, k.k. disosa]

3.3. Ho etsahalang ka KMC kamora ho akheha?
Mekhwa e meng hape: Ho etsahalang ka ho lahla (k.k. tlhabollo le tlhaiso-leseding; na bomme ba kopantswe le mosebeletsi wa bophelo bo botle ba sechaba)? Ekaba bomme ba ntse ba tswela pele le KMC lapeng? O nahana ka diperesente dife? Ba o jwetsa eng mathata a ho tswela pele le KMC lapeng? Tsosometso ya lelapa le atolositsweng (bomme, bo mme ba molao, bo-nkhono) ditlwaelong tsa tlhokomelo ya masea le KMC ka ho khetheha? Bo ntate ba bapala karolo efe ho KMC?

3.4. [Fumana dintlha tse ding tse boletsoeng tse shebahalang di le bohlokwa ho tswela pele ho hlahloba]

4. O ka mpolella ho eketsehileng ka ho latela ho fihlela masea a pele le a tlase a tswalo kamora ho tswa? [Motho ya nkang karolo o qala ho bua ka bolokolohi] *Mekhwa:*
   4.1. Na ho nale kemiso e khethehileng?
   4.2. Ho etsahalang nakong ya ketelo e latelang ya sepetlele?
   4.3. O hatiseletsa le ho latela ho latela maeto?
   4.4. Khokahano dipakeng tsa sepetlele le di tliniki tsa tlhokomelo eya bophelo bo botle mabapi le pele le masea a tlase a tswalo?
   4.5. Ke diperesente dife tsa masea a pele le a tlase a tswalo a kgutlang bakeng sa ho latela maeto a bona sepetlele?
   Tlhahlobo engwe: Na o na le mokhwa wa ho latela ho ikopanya le bo mme ba sa tlang ho latela holimo / kamehla ho latela? [Haeba ho jwalo feela, kopa tlhaiso-leseding e eketsehileng]
   4.6. Hobaneng bo mme kapa bahlokomeli ba sa khutlisetse masea a bona sepetlele bakeng sa ho latela? / E kaba na mabaka a bo mme ba sa sebetseng ho latela maeto a latelang a l? [Motho ya nkang karolo o qala ho bua ka bolokolohi]
   Mekhwa e meng hape: sebaka; dipalangwang; litsenyehelo; tsusumetso ya maikutlo a *bohlokoa a batho ba bang / setjhaba; maikutlo a bo mme le setjhaba*
   4.7. [Fumana dintlha tse ding tse boletsoeng tse shebahalang di le bohlokoa ho tswela pele ho hlahloba]

5. Ho tswa puisanong ya rona mabapi le tlhokomelo ya masea a sa tswa tswalwa le masea a manyane, o ka re ke dibaka tsa pele tsa ntlafatso ya KMC? [Motho ya nkang karolo o qala ho bua ka bolokolohi] *Mekhwa:*
   5.1. O nahana hore dibaka tse tlang pele tseo o di boletseng di ka ntlafatsoa jwang? [Kgetha seo monga ditaba a setjholong ebe o tsepamisa maikutlo ho sona]
   5.2. Ho ka etswa eng ho etsa bonnete ba hore masea a pele le a tlase a tswalo a na le monyetla wa ho fumana tse ikhethang, latela ba hloka sepetlele kamora ho tswa?
   Mekhwa e meng hape: Profinse e ka thusa jwang? Setereke se ka thusa joang? Sepetlele se ka thusa jwang?
   5.3. [Kenya di-probes tse ding ha ho hlokahala ka dipuisano tse latelang]

6. Ha re nahana ka puisano ya rona, na ho na le dintlha tse ding tsa bohlokwa tse o emelang?

7. Na ho na le ho hong hape hoo o ka ratang ho ho eketsa ho ka bang bohlokoa ho nna ho ba le kutloisiso e ntle ya maemo a Sepetlele sa Boitumelo kapa Setereke sa Fezile Dabe?

Ke leboha morupelwoa.

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APPENDIX H(3)

ONDERHOUDSKEDULE

(Hoof van die pediatriese eenheid, verpleegbestuurder en ander gesondheidswerkers)

Onthou notas:

- Bespreek inligtingsblad (beklemtoon vertroulikheid)
- Enige vrae?
- Toestemmingsvorm onderteken of oudio-opname met mondelinge toestemming (telefoon-onderhoud)

[Die onderhoudvoerder sal buigsaam wees met die betrekking tot die volgorde van die vrae en die uitsteek van verdere voelers hieronder, en die manier waarop hulle bewoord word]

1. Wat is u hoof verantwoordelikhede met betrekking tot pasgeborene-sorg in Boitumelo Hospitaal?? [Deelnemer praat eers vryelik]
   Vind verder uit:
   1.1. Premature en lae geboortegewig-babas
   1.2. Kangaroemoedersorg (KMS)
   1.3. Het u spesifieke riglyne met betrekking tot die versorging van klein en siek pasgeborenes? (provinsiaal / nasionaal)
   Verdere voelers:
   - Indien wel, hoe word hierdie riglyne gebruik?
   - Word babas steeds in die vel-tot-vel-posisie in die Felize Dabi-Distrik **vervoer**? [Vra om uit te brei indien nie genoeg inligting gegee nie (bv. indien "Sommige", watter? Beter nakoming in sommige distrikte of sub-distrikte as ander? Dokumentasie oor vervoer? Is daar iemand anders wat meer inligting kan verskaf?)]

   1.4. [Steek verdere voelers uit soos nodig met daaropvolgende onderhoude]

2. Hoe sou u sê vaar Boitumelo Hospitaal met betrekking tot die versorging van klein en siek pasgeborenes? [Deelnemer praat eers vryelik]
   Vind verder uit:
   2.1. Watter neonatale dienste is beskikbaar?
   *Verdere voelers: **sterk punte en uitdagings**; vra vir **voorbeelde** indien toepaslik.*
   2.2. Hoe sal u die kwaliteit van die neonatale sorg in die hospitaal beskryf?
   *Verdere voelers: **sterk punte en uitdagings**; **kennis en vaardighede** van dokters en verpleegsters in die sorg van klein en siek pasgeborenes; vra vir **voorbeelde** indien toepaslik.*
   2.3. Wat dink u is die prioriteitsareas vir die verbetering van pasgeborene-sorg?
   2.4. [Steek verdere voelers uit soos nodig met daaropvolgende onderhoude]

3. Kan u my meer vertel oor hoe kangaroemoedersorg in die hospitaal beoefen word? [Deelnemer praat eers vryelik]
   Vind verder uit:
   3.1. Wat is u mening oor die kennis en vaardighede in KMS onder verskillende gesondheidsorgwerkers?
   *Verdere voelers: (a) **dokters**; (b) **verpleegsters** wat in die hospitaol werk, gemeenskapsgesondheid-sentrums en primêre gesondheidsorgklinieke; (c) **kliniese medewerkers**; (d) **gemeenskapsgesond-heidswerkers**; **opleiding** wat hulle ontvang het.*

3.2. Wat is u mening oor die onderskeie belanghebbendes se aanvaarding van KMS? [Deelnemer praat eers vryelik]
Verdere voelers: (a) ***gesondheidswerkers****; (b)* ***gesinne*** *met 'n lae geboortegewig-baba; (c) die* ***gemeenskap*** *oor die algemeen* [vra ook na tradisionele gemeenskapsbeskouings oor babas wat vroeg gebore word, bv. oorsake].

3.3. Wat gebeur met KMS na ontslag uit die hospitaal?
Verdere voelers: Wat gebeur by ***ontslag*** *(bv. berading en inligting; word moeders in aanraking gebring met 'n gemeenskapsgesondheidswerker)? Gaan moeders voort met die* ***KMS by die huis****? Watter* ***persentasie*** *dink u hou aan met KMS? Wat sê hulle is die* ***uitdagings*** *om met KMS by die huis voort te gaan? Wat is die invloed van die* ***uitgebreide gesin*** *(ma's, skoonma's, tannies) op babasorgpraktyke en KMS? Watter rol speel* ***vaders*** *in KMS?*

3.4. [Wees op die uitkyk vir addisionele punte wat die moeite werd lyk om verder te ondersoek]

4. Kan u my meer vertel oor die opvolg van premature en lae geboortegewig-babas na ontslag? [Deelnemer praat eers vryelik]
Vind verder uit:

4.1. Is daar 'n spesifieke opvolgskedule?

4.2. Wat gebeur tydens 'n opvolgbesoek by die hospitaal?

4.3. Hoe teken julle opvolgbesoeke aan en hou tred daarmee?

4.4. Wat is die skakels tussen die hospitaal en primêre gesondheidsorgklinieke met betrekking tot premature en lae geboortegewig-babas?

4.5. Watter persentasie van die premature en lae geboortegewig babas kom terug vir hul opvolgbesoeke by die hospitaal?
Verdere voeler: Het u 'n ***opsporingstelsel*** *om met ma's in kontak te kom wat nie vir 'n opvolg kom nie /* ***versuim*** *om opvolg by te woon.* [Indien Ja, vra vir verdere toeligting]

4.6. Waarom bring sommige moeders of versorgers nie hul babas terug na die hospitaal vir opvolg nie? / Wat is die redes waarom moeders versuim om opvolgbesoeke by te woon? [Deelnemer praat eers vryelik]
Verdere voelers: afstand; vervoer; koste; invloed van betekenisvolle ander / gemeenskapbeskouings; houdings van moeders en die gemeenskap.

4.7. [Wees op die uitkyk vir bykomende punte wat die moeite werd lyk om verder te verken]

5. Uit ons bespreking oor die versorging van pasgeborenes en klein babas, wat sou u sê is die prioriteitsareas vir die verbetering van KMS? [Deelnemer praat eers vryelik]
Vind verder uit:

5.1. Hoe dink u kan die prioriteitsareas wat u genoem het, verbeter word? [Kies wat die informant noem en fokus daarop]

5.2. Wat kan gedoen word om seker te maak premature en lae geboortegewig-babas het, ná ontslag, toegang tot die gespesialiseerde opvolg wat hulle by 'n hospitaal nodig het?
Verdere voelers: Hoe kan die ***Provinsie*** *help? Hoe kan die* ***Distrik*** *help? Hoe kan die* ***hospitaal*** *help?*

5.3. [Steek verdere voelers uit soos nodig met daaropvolgende onderhoude]

6. As u terugdink aan ons bespreking, is daar enige ander belangrike punte wat vir u uitgestaan het?

7. Is daar nog iets wat u wil byvoeg wat vir my belangrik sal wees om 'n beter begrip te kry van die konteks van die Boitumelo Hospitaal in die Fezile Dabi Distrik?

Bedank die deelnemer

Appendix I: Interview schedule (clinical associates and community health workers)



APPENDIX I(1)

Focus group discussion schedule
(Clinical associates; community health workers)

Reminders:

- Discuss information leaflet (emphasise confidentiality)
- Any questions?
- Consent form signed

[The moderator will be flexible with regard to the order of questions and probes below and the way they are phrased. Although community health workers have a fair command of English, the second moderator/assistant will be fluent in Sesotho and will assist if a participant/s does not understand a specific question. The questions are also available in Sesotho and will be used in the focus group discussions.]

1. What are your main work responsibilities? [Participants first talk freely]
   Probes:
   1.1. What is your involvement with the care of newborn babies in the community? [Participants first talk freely]
   Further probes if home visits are mentioned: How many babies do you visit per month? What do you do at a home visit? [Ask for examples, where appropriate]
   1.2. What do you do when a baby is premature or low birth weight/born very small? [Ask for examples, where appropriate]
   1.3. What training did you have to look after newborn babies?
   If they had training, probe further for training to look after preterm and low birth weight babies
   1.4. When did you first hear about kangaroo mother care?
   Further probe: Do you help mothers with kangaroo mother care? If Yes, can you explain a bit more? If No, is there a reason for this? [Ask for examples, where appropriate]
   1.5. How do you link up with Boitumelo Hospital?
   Further probes: Are you present when a mother of a small baby is discharged from hospital? If Yes: Can you tell me how it works? Do you have anything to do with the follow-up of babies at the hospital after discharge? [Ask for examples, where appropriate]

2. What do mothers and other community members tell you about the care of the small babies in Boitumelo Hospital? [Participants first talk freely]
   Probes:
   2.1. How satisfied are they with the treatment? [Ask for examples, where appropriate]
   2.2. How do mothers react if they hear they have to stay in hospital with their baby for quite a while? [Ask for examples, where appropriate]
   2.3. What challenges does the hospital have in caring for the small and sick newborns?
   Probe on KMC if not mentioned spontaneously
   2.4. How do you think newborn care and KMC can be improved in the hospital?

3. What would you say are the main challenges for mothers and their families in the care of their babies after discharge from hospital? [Participants first talk freely]
   Probes:
   3.1. Care of baby
      Further probes: caring tasks, feeding, time, space
   3.2. Household
      Further probes: care for other children, household chores
   3.3. Going back to work or school
   3.4. Follow-up visits to the hospital
      Probe further on distance, type of transport, cost of transport, time, etc.

4. If we get back to the care of babies after discharge from hospital. What could you as clinical associates/community health workers do more to support these mothers and families? [Participants first talk freely]
   Probe: What are your own support needs to be able to give a better service to families with premature or low birth weight babies?

5. Thinking back on our discussion, what are the most important points that we should take up further?

6. Is there anything else that you would like to add that would be important for me to have a better understanding of the context of Boitumelo Hospital or Fezile Dabe District?

Thank participants

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APPENDIX I(2)

SCHEDULE FOR FOCUS GROUP DISCUSSIONS (Sesotho)

(Clinical associates; community health workers)

Dikhopotso:

- Puisano ya leqephe la tlhaiso-leseling (hatisa lekunutu)
- Dipotso leha e le dife?
- Foromo ya tumello e saennoe

[Modisa o tla fetoha le maemo mabapi le tatellano ya dipotso le dipatlisiso ka tlase le tsela eo di hlalosoang ka eona. Leha basebetsi ba bophelo bo botle ba sechaba ba na le taelo e nepahetseng ya Senyesemane, mookamedi wa bobedi / mothusi o tla bua Sesotho mme o tla thusa haeba motho ya nkang karolo / a sa utlwisise potso e itseng.]

1. Boikarabello ba hao ba mantlha ba mosebetsi ke bofe? [Ba-Nka karolo ba qala ho bua ka bolokolohi]

   Mekhwa:

   1.1. Ho nka karolo ha hao ke eng ka tlhokomelo ya masea a sa tswa hlaha sechabeng? [Ba-Nka karolo ba qala ho bua ka bolokolohi]

   Ho boetse ho buuwa ka menyetla e meng haeba ho buuwa ka maeto a lapeng: O etela masea a makae ka khwedi? Eng o etela lapeng? [Botsa mehlala, moo ho loketseng]

   1.2. O etsa eng ha ngwana a le pele ho nako kapa a le tlase a hlaha / a le monyane haholo? [Botsa bakeng sa mehlala, moo ho loketseng]

   1.3. O ne o tlameha ho hlokomela masea a sa tswa hlaha?

   Haeba bo ne bo ikwetliso, etsa dipatlisiso tse ding bakeng sa kwetliso yo ho hlokomela masea a pele le a tlase a tswalo

   1.4. O qalile ho utlwa neng ka tlhokomelo ya kangaroo?

   Phuputso e nngwe hape: Na o thusa bo mme ka tlhokomelo ya bo mme ba kangaroo? Haeba ho jwalo, na o ka hlalosa hanyane ho feta?

   Haeba Che, na ho na le lebaka lo see? [Botsa mehlala, moo ho loketseng]

   1.5. O hokahana jwang le Sepetlele sa Boitumelo?

   Mekhwa e meng hape: Na o teng ha mme wa ngwana e monyane a lokoliwa sepetlele? Haeba ho jwalo: O ka mpolella hore na e sebetsa jwang? Na ho na le seo o lokelang ho se etsa ka ho latela ho fihlela moseo sepetlele kamora ho tswa? [Botsa mehlala, moo ho loketseng]

2. Bo mme le ditho tse ding tsa sechaba ba o jwetsa eng ka tlhokomelo ya masea a manyane sepetlele sa Boitumelo? [Ba-Nka karolo ba qala ho bua ka bolokolohi]

   Mekhwa:

   2.1. Ba khotsofetse hakae ka kalafo? [Botsa mehlala, moo ho loketseng]

   2.2. Bo mme ba arabela jwang haeba ba utlwa ba tlameha ho dula sepetlele le ngwana wa bona bakeng sa ngwana wa bonaha? [Botsa mehlala, moo ho loketseng]

2.3. Sepetlele se na le mathata afe a ho hlokomela masea a manyane le a kulang?
Phuputso ho KMC haeba e sa bolelwe ka boithatelo

2.4. O nahana hore tlhokomelo ya masea a sa tswa hlaha le KMC li ka ntlafatsoa jwang sepetlele?

3. O ka re mathata a mantlha a bo mme le ba malapa a bona tlhokomelong ya masea a bona kamora ho tswa sepetlele? [Ba-Nka Karolo ba qala ho bua ka bolokolohi]
Mekhwa:

3.1. Tlhokomelo ya lesea
Mekhwa e meng hape: mesebetsi ya ho tsatella, ho fepa, nako, seboka

3.2. Lehaeng
Mekhwa e meng hape: hlokomela bona ba bang, mesebetsi ya lapeng

3.3. Ho khutlela mosebetsing kapa sekolong

3.4. Latela ho etela sepetlele
Probe e hole, mofuta wa dipalangoang, ditshenyehelo tsa dipalangoang, nako,jwalo jwalo.

4. Haeba re khutlela tlhokomelong ya masea kamora ho tswa sepetlele. O ka etsa eng jwaloka metswalle ya bongaka / basebetsi ba bophelo bo botle ba sechaba ho tshehetsa bo mme le malapa? [Ba-Nka karolo ba qala ho bua ka bolokolohi]
Phuputso: Tshehetso ya hao e hloka ho fana ka tshebeletso e ntle ho malapa a nang le masea a pele kapa a tlase a tswalo?

5. Ha re nahana ka puisano ya rona, lintlha tsa bohlokoa ka ho fetisisa tseo re lokelang ho di nka ho ya pele ke dife?

6 Na ho na le ho hong hape hoo o ka ratang ho ho eketsa ho ka bang bohlokwa ho nna ho ba le kutlwisiso e ntle ya maemo a Sepetlele sa Boitumelo kapa Setereke sa Fezile Dabe?

Ke leboha ba nka karolo.

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APPENDIX I(3)

FOKUSGROEPBESPREKINGSKEDULE

(Kliniese medewerkers; gemeenskapsgesondheidswerkers)

Onthounotas:

- Bespreek inligtingsblad (beklemtoon vertroulikheid)
- Enige vrae?
- Toestemmingsvorm onderteken

[Die moderator sal buigsaam wees met betrekking tot die volgorde van vrae en die uitsteek van verdere voelers hieronder en die manier hoe hulle bewoord word. Alhoewel gemeenskapsgesondheidswerkers Engels redelik magtig is, sal 'n tweede moderator/assistent wat vlot Sesotho praat teenwoordig wees om te help as 'n deelnemer nie die spesifieke vraag mooi verstaan nie. Die vrae hieronder is ook beskikbaar in Sesotho]

1. Wat is julle/jou hoof- werksverantwoordelikhede? [Deelnemers praat eers vryelik]
   Vind verder uit:
   1.1. Wat is julle/jou betrokkenheid by die versorging van pasgebore babas in die gemeenskap? [Deelnemers praat eers vryelik]
   Verdere vrae as huisbesoeke genoem word: Hoeveel babas besoek julle/jy per maand? Wat doen jy by 'n huisbesoek? [Vra vir voorbeelde waar toepaslik]
   1.2. Wat doen julle/jy as 'n baba prematuur of'n klein geboortegewig het/baie klein by geboorte is? [Vra vir voorbeelde waar toepaslik]
   1.3. Watter opleiding het julle/jy gehad om na pasgebore babas om te sien?
   As hulle opleiding gehad het, vra verder uit oor opleiding om na premature en lae geboortegewig-babas om te sien
   1.4. Wanneer het julle/jy die eerste keer gehoor van kangaroemoedersorg?
   Verdere vrae: Help julle/jy moeders met KMS? Indien Ja, kan julle/jy 'n bietjie meer verduidelik? Indien Nee, is daar 'n rede hiervoor? [Vra vir voorbeelde, waar toepaslik]
   1.5. Hoe skakel julle/jy in by Boitumelo Hospitaal?
   Verdere vrae: Is julle/jy teenwoordig wanneer 'n ma van 'n klein baba uit die hospitaal ontslaan word? Indien Ja: Kan julle/jy my vertel hoe dit werk? Het julle/jy iets te doen met die opvolg van babas by die hospitaal na ontslag? [vra vir voorbeelde waar toepaslik]

2. Wat vertel moeders en ander gemeenskapslede vir julle/jou oor die sorg van klein babas in die Boitumelo Hospitaal? [Deelnemers praat eers vryelik]
   Vind verder uit:
   2.1. Hoe tevrede is hulle met die behandeling? [Vra vir voorbeelde, waar toepaslik]
   2.2. Hoe reageer ma's as hulle hoor hulle moet nog vir'n geruime tyd met hul baba in die hospitaal bly? [Vra vir voorbeelde waar toepaslik]

2.3. Watter uitdagings het die hospitaal met die versorging van klein en siek pasgeborenes?
Vra verder uit oor KMS indien nie spontaan genoem word nie

2.4. Hoe dink julle/jy kan pasgeborenesorg en KMS in die hospitaal verbeter word?

3. Wat sou julle/jy sê is die hooduitdagings vir moeders en hul gesinne ten opsigte van die versorging van hul babas na ontslag uit die hospitaal? [Deelnemers praat eers vryelik]
Vind verder uit:

3.1. Versorging van baba
Verdere vrae: versorgingstake, voeding, tyd, ruimte

3.2. Huishouding
Verdere vrae: sorg van ander kinders, huishoudelike take.

3.3. Gaan terug werk of skool toe

3.4. Opvolgbesoeke aan die hospitaal
Vra verder uit oor afstand, tipe vervoer, koste van vervoer, tyd, ens.

4. As ons terugkom na die sorg van babas na onslag uit die hospitaal, wat kan julle/jy as 'n kliniese medewerker/gemeenskapsgesondheidswerker doen om hierdie moeders en gesinne te ondersteun? [Deelnemers praat eers vryelik]
Vind verder uit: Wat is julle/jou eie ondersteuningsbehoeftes om 'n beter diens te kan lewer aan ma's met premature of lae geboortegewig-babas?

5. As ons terugdink aan ons bespreking, wat is die belangrikste punte wat ons verder moet opneem?

6. Is daar enige iets anders wat julle/jy wil byvoeg wat vir my belangrik sal wees om 'n beter begrip te kry van die konteks van Boitumelo Hospitaal en die Fezile Dabi Distrik?

Bedank die deelnemers

Appendix J: Distress protocol for participants (mothers)

Distress		
Participant indicates that she is experiencing a high level of stress or emotional disstress	**OR**	Behaviour indicates that the discussion or interview is too stressful, resulting in shaking, difficulty talking or heavy breathing

↓

Step 1: Response

↓

Stop interview immediately

↓

The researcher who is a healthcare professional requests the clinical associate (also a healthcare professional) to offer support in the language of choice

↓

Clinical associate reviews mental status of participant:
(Tell me what thoughts are you having?Tell me how are you feeling?Are you feeling safe?)

↓

Do you feel you can or want to continue with the interview?

↓

Review

↓ Participant feels she is able to continue ↓ **CONTINUE WITH INTERVIEW**	↓ Participant feels she is not able to continue ↓ **GO TO STEP 2**

Step 2: Response

↓

The interview will be conducted in a private area. If necessary, assist participant to a quiet area and continue with the following:

↓

With participant consent, refer her to the doctor or professional nurse in charge of the neonatal unit

↓

If needed or requested, health professional refers participant to the psychological support services in the hospital

↓

Follow-up

↓

Follow participant up (if participant consents)	**OR**	Encourage participant to call the attending doctor or nurse if she experiences increased distress in the hours/days following the interview

(Modified from: Draucker C B, Martsolf D S, Poole C. Developing distress protocols for research on sensitive topics. Arch Psychiatr Nurs. 2009;23(5): 343-350.)

Appendix K: Plagiarism declaration report

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

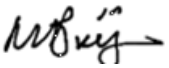
SENATE PLAGIARISM POLICY: APPENDIX ONE

I **Muellatt van Biljon** (Student number: **2373163**) am a student registered for the degree of

Master in Public Health in the academic year **2024.**

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature:  Date: 25/02/2025

Appendix L: Turnitin report



26/02/2025

MvBiljon KMC research report FINAL (1) PDF.pdf

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