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| **Promoting Kangaroo Mother Care in Selected Hospitals of Nepal through Training and Provision of Baby Wrap** |
| **To be filled by Jhpiego staff with mother of LBW/Preterm babies during stay at health facility, during phone survey and PNC follow up** |
| **Section A: To be filled at the time of discharge from health facility** |
| 1. **Background information**
 |
| * 1. District
 | * 1. Hospital
 |
| * 1. IP no
 | * 1. ID no.
 |
| * 1. Ethnicity[[1]](#footnote-1)
 | * 1. Educational status[[2]](#footnote-2)
 |
| * 1. Municipality/VDCs
 | * 1. Ward no
 |
| * 1. Age (completed yrs)
 | * 1. Parity:
 |
| * 1. Date of Delivery
 | * 1. Gestation week
 |
| * 1. Type of Delivery
 | Spontaneous Vaginal  |
| Forcep  |
| Vacuum |
| * 1. Birth weight ( grams)
 | * 1. Sex :
 | Male |
| Female |
| * 1. Contact number:
 |

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| 1. **KMC related information**
 |
| 1. Date of KMC admission
 | 1. Time of KMC admission
 |

|  |
| --- |
| 1. Sequence of random allocation
 |
| First wrap | Time started | Time ended |
| Second wrap | Time started  | Time ended  |

|  |  |
| --- | --- |
| 1. Wrap chosen after twelve hours:
 | Traditional |
| Care Plus |

|  |
| --- |
| 1. Reason for Choosing the particular **wrap**
 |
| **Variables** | **Agree** | **Unsure** | **Disagree** |
| Safe and Secure |  |  |  |
| Allows movement |  |  |  |
| Less fatigue |  |  |  |
| Easy to use |  |  |  |
| Facilitates breastfeeding |  |  |  |
| Easy to monitor baby condition |  |  |  |
| Gender neutral(Design of wrap is acceptable for fathers or male members.) |  |  |  |
| Other (specify)…………………………………………………………………………….. |
| 1. Important perceptions of the mother about selected wrap (*reason why she selected particular wrap*)

……………………………………………………………………………………….….……………………………………………………………………………………………………………………………………………………………………………………………………………… |
| 1. Important experiences of the mother about selected wrap (*any difficulties faced while practicing KMC*?)

……………………………………………………………………………………….….……………………………………………………………………………………………………………………………………………………………………………………………………………… |

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| --- | --- | --- | --- |
| 1. Type of KMC practiced during stay at health facility (please mention the duration in hours)
 | **Days** | **Hours** | **Discontinued***(go to question 2.9)* |
| Day 1 |  |  |
| Day 2 |  |  |
| Day 3 |  |  |
| Day 4 |  |  |
| Day 5 |  |  |
| Day 6 |  |  |
| Day 7 |  |  |
| Day 8 |  |  |
| Day 9 |  |  |
| Day 10 |  |  |

|  |  |  |
| --- | --- | --- |
| 1. Can you please provide the reason for discontinuation?

***(multiple answers )*** | Physical pain following labor |  |
| Fear of harming baby through cord stump |  |
| Fear of baby falling |  |
| Discomfort |  |
| Lack confident  |  |
| Lack of time  |  |
| Not beneficial |  |
| Felt tired |  |
| Lack of support from family |  |
| Social stigma |  |
| Baby doesnot want to be in KMC position |  |
| Healthy baby  |  |
| Others(Specify)……… …..…………..…… ……… |

|  |
| --- |
| 1. Weight of baby at time of discharge (grm)
 |
| 1. Health workers observation (*any important observation regarding use of the wrap which was not* chosen *by mother with respect to reason for not choosing and practice with on this wrap*.)

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………… |

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| **Section B: To be filled during phone survey (after 24 hours and within 48 hours of discharge)** |
| Hello!! Namaskar, My name is …………………..and I am calling from ……………………………………………. May I please speak to ………..? How are you? How is your baby? As you know, we are conducting a study on behalf of recently delivered mothers with stable LBW/preterm babies to explore adherence to KMC practice. You indicated your willingness to participate in the study during your delivery at ……..hospital. In continuation of the study I am calling you to discuss about KMC practices at your home. May I take your few minutes to ask few questions related to this? Thank you. |
| 1. **Background Information**
 |
| * 1. ID no.
 | * 1. Date of Follow up
 |
| * 1. **Status of follow up**
 |
| 1.3.1.Able to Contact | 1.3.2. Not able to contact(If not able to contact while contacting three times per day for three consecutive days) |
| Reason for not being able to contact:……………………………………………….. |
| **Follow up questions** |
| 1. **Condition of mother and baby**
 |
| * 1. How are you?
 | Fine |  | **2**2.3 |
| Not feeling well |  |
| * 1. What are the health problems?

(multiple response) | Fever |  |
| Pain in wound |  |
| Breast engorgement |  |
| Loos motion |  |
| Vomiting |  |
| Cough and congestion |  |
| Others specify………………………………………… |
| * 1. How is your baby
 | Fine |  | 2.5 |
| Not feeling well |  |
| * 1. What are the problems
 | Feeding problem |  |
| Sleeping problem |  |
| Fever |  |
| Loose motion |  |
| Vomiting |  |
| Cough and Congestion |  |
| Others specify………………………………………… |
| * 1. Are you exclusively breastfeeding your baby?
 | Yes | No |
| 1. **KMC practice**
 |
| * 1. Are you continuing KMC at home?
 | Yes | No 3.5 |
| * 1. How many hours did you perform KMC in last 24 hours?
 |  |

|  |  |  |
| --- | --- | --- |
| * 1. Are you practicing KMC during day time while performing household chores?
 | Yes | No |
| * 1. Are you practicing KMC at night?
 | Yes | No |

|  |  |  |
| --- | --- | --- |
| * 1. Can you please provide the reason for discontinuation?

**(Multiple answers)** | Physical pain following labor |  |
| Fear of harming baby through cord stump |  |
| Fear of baby falling |  |
| Discomfort |  |
| Lack confident  |  |
| Lack of time  |  |
| Not beneficial |  |
| Felt tired |  |
| Lack of support from family |  |
| Social stigma |  |
| Baby doesnot want to be in KMC position |  |
| Healhty baby |  |
| Others (Specify)……… …..…………..…… ……… ………………… …….. |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Perception of KMC wrap**
 | **Agree** | **Unsure** | **Disagree** |
| * 1. It is comfortable to perform KMC with chosen wrap.
 |  |  |  |
| * 1. The chosen wrap can hold the baby securely during KMC.
 |  |  |  |
| 1. **Benefits of KMC**
 |

|  |  |  |  |
| --- | --- | --- | --- |
| * 1. What are the benefits of KMC?

**(multiple response)** | Facilitates breastfeeding |  |  |
| Provides natural warmth to the baby |  |
| Reduce infection for baby |  |  |
| Promotes weight gain |  |
| Easy to monitor condition of baby |  |  |
| Facilitates mother and child bonding |  |
| Others (specify)…………………………… |
| 1. **Spousal and Family Acceptability**
 |
| * 1. Is your husband also providing KMC?

(doing KMC during your time for dinner, toilet, bathing, rest etc) | Yes | No | NA |
| * 1. Is your family member also providing KMC?

(doing KMC during your time for dinner, toilet, bathing, rest etc) | Yes | No | NA |

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| **Section C: To be filled during phone survey (week 1)** |
| Hello!! Namaskar, My name is …………………..and I am calling from ……………………………………………. May I please speak to ………..? How are you? How is your baby? As you know, we are conducting a study on behalf of recently delivered mothers with stable LBW/preterm babies to explore adherence to KMC practice. You indicated your willingness to participate in the study during your delivery at ……..hospital. In continuation of the study I am calling you to discuss about KMC practices at your home. May I take your few minutes to ask few questions related to this? Thank you. |
| 1. **Background Information**
 |
| * 1. ID no.
 | * 1. Date of Follow up
 |
| * 1. **Status of follow up**
 |
| 1.3.1.Able to Contact | 1.3.2. Not able to contact(If not able to contact while contacting three times per day for three consecutive days) |
| Reason for not being able to contact:……………………………………………….. |
| **Follow up questions** |
| 1. **Condition of mother and baby**
 |
| * 1. How are you?
 | Fine |  | **2.3** |
| Not feeling well |  |
| * 1. What are the health problems?

(multiple response) | Fever |  |
| Pain in wound |  |
| Breast engorgement |  |
| Loos motion |  |
| Vomiting |  |
| Cough and congestion |  |
| Others specify………………………………………… |
| * 1. How is your baby
 | Fine | 2.5 |
| Not feeling well |  |
| * 1. What are the problems
 | Feeding problem |  |
| Sleeping problem |  |
| Fever |  |
| Loose motion |  |
| Vomiting |  |
| Cough and Congestion |  |
| Others specify………………………………………… |
| * 1. Are you exclusively breastfeeding your baby?
 | Yes | No |

|  |
| --- |
| 1. **KMC practice**
 |
| * 1. Are you continuing KMC at home?
 | Yes | No  |
| * 1. How many hours do you practice KMC per day (including both day and night) in this week.
 | Dates | Hours |
|  |  |
|  |  |
|  |  |

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| **Section D: To be filled during phone survey (week 2)** |
| Hello!! Namaskar, My name is …………………..and I am calling from ……………………………………………. May I please speak to ………..? How are you and your baby? As you know, we are conducting a study on behalf of recently delivered mothers with stable preterm/LBW to explore adherence to KMC practice. As talked with you last week over the telephone. I am calling you to discuss about KMC practices at your home as continuation of the study. May I take your few minutes to ask few questions related to this? Thank you. |
| 1. **Background Information**
 |
| * 1. ID no.
 | * 1. Date of Follow up
 |
| * 1. **Status of follow up**
 |
| 1.3.1 Able to Contact | 1.3.2 Not able to contact(If not able to contact while contacting three times per day for three consecutive days) |
| Reason for not being able to contact:……………………………………………….. |
| **Follow up questions** |
| 1. **Condition of mother and baby**
 |
| * 1. How are you?
 | Fine |  | **2.3** |
| Not feeling well |  |
| * 1. What are the health problems?

(multiple response) | Fever |  |
| Pain in wound |  |
| Breast engorgement |  |
| Loos motion |  |
| Vomiting |  |
| Cough and congestion |  |
| Others specify………………………………………… |
| * 1. How is your baby
 | Fine |  | 2.5 |
| Not feeling well |  |
| * 1. What are the problems
 | Feeding problem |  |
| Sleeping problem |  |
| Fever |  |
| Loose motion |  |
| Vomiting |  |
| Cough and Congestion |  |
| Others specify………………………………………… |
| * 1. Are you exclusively breastfeeding your baby?
 | Yes | No 3.5 |
| 1. **KMC practice**
 |
| * 1. Are you continuing KMC at home?
 | Yes | No  |

|  |  |  |
| --- | --- | --- |
| * 1. How many hours do you practice KMC per day (including both day and night) in this week.
 | **Dates** | **hours** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| * 1. Are you practicing KMC in day time while performing household chores?
 | Yes | No |
| * 1. Are you practicing KMC at night?
 | Yes | No |
| * 1. Can you please provide the reason for discontinuation?

***(multiple answers )*** | Physical pain following labor |  |
| Fear of harming baby through cord stump |  |
| Fear of baby falling |  |
| Discomfort |  |
| Lack confident  |  |
| Lack of time  |  |
| Not beneficial |  |
| Felt tired |  |
| Lack of support from family |  |
|  Social stigma |  |
| Baby doesnot want to be in KMC position |  |
| Healthy baby  |  |
| Others(Specify)……… …..…………..…… ……… |
| 1. **Perception of KMC wrap**
 | **Agree** | **Unsure**  | **Disagree** |
| * 1. It is comfortable to perform KMC with chosen wrap.
 |  |  |  |
| * 1. The chosen wrap can hold the baby securely during KMC.
 |  |  |  |
| 1. **Benefits of KMC**
 |
| * 1. What are the benefits of KMC?

***(multiple response)*** | Facilitates breastfeeding |  |  |
| Provides natural warmth to the baby |  |  |
| Reduce infection for baby |  |  |
| Promotes weight gain |  |  |
| Easy to monitor condition of baby |  |  |
| Facilitates mother and child bonding |  |  |
| Others (specify)…………………………………… |
| 1. **Spousal and Family acceptability**
 |
| * 1. Is your husband also providing KMC?

(doing KMC during your time for dinner, toilet, bathing, rest etc) | Yes | No | NA |
| * 1. Is your family member also providing KMC?

(doing KMC during your time for dinner, toilet, bathing, rest etc) | Yes | No | NA |
| **Section E: To be filled during phone survey (week 3)** |
| Hello!! Namaskar, My name is …………………..and I am calling from ……………………………………………. May I please speak to ………..? How are you? How is your baby? As you know, we are conducting a study on behalf of recently delivered mothers with stable preterm/LBW babies to explore adherence to KMC practice. As talked with you last week over the telephone. I am calling you to discuss about KMC practices at your home as continuation of the study. May I take your few minutes to ask few questions related to this? Thank you. |
| 1. **Background Information**
 |
| * 1. ID no.
 | * 1. Date of Follow up
 |
| * 1. **Status of follow up**
 |
| 1.3.1 Able to Contact | 1.3.2 Not able to contact(If not able to contact while contacting three times per day for three consecutive days) |
| Reason for not being able to contact:……………………………………………….. |
| **Follow up questions** |
| 1. **Condition of mother and baby**
 |
| * 1. How are you?
 | Fine |  | **2.3** |
| Not feeling well |  |
| * 1. What are the health problems?

(multiple response) | Fever |  |
| Pain in wound |  |
| Breast engorgement |  |
| Loos motion |  |
| Vomiting |  |
| Cough and congestion |  |
| Others specify………………………………………… |
| * 1. How is your baby
 | Fine |  | 2.5 |
| Not feeling well |  |
| * 1. What are the problems
 | Feeding problem |  |
| Sleeping problem |  |
| Fever |  |
| Loose motion |  |
| Vomiting |  |
| Cough and Congestion |  |
| Others specify………………………………………… |
| * 1. Are you exclusively breastfeeding your baby?
 | Yes | No |
| 1. **KMC practice**
 |
| * 1. Are you continuing KMC at home?
 | Yes | No 3.5 |

|  |  |  |
| --- | --- | --- |
| * 1. How many hours do you practice KMC per day (including both day and night) in this week.

. | **Dates** | **hours** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| * 1. Are you practicing KMC in day time while performing household chores?
 | Yes | No |
| * 1. Are you practicing KMC at night?
 | Yes | No |
| * 1. Can you please provide the reason for discontinuation?

***(multiple answers )*** | Physical pain following labor |  |
| Fear of harming baby through cord stump |  |
| Fear of baby falling |  |
| Discomfort |  |
| Lack confident  |  |
| Lack of time  |  |
| Not beneficial |  |
| Felt tired |  |
| Lack of support from family |  |
|  Social stigma |  |
| Baby doesnot want to be in KMC position |  |
| Healthy baby  |  |
| Others(Specify)……… …..…………..…… ……… |
| 1. **Perception of KMC wrap**
 | **Agree** | **Unsure** | **Disagree** |
| * 1. It is comfortable to perform KMC with chosen wrap.
 |  |  |  |
| * 1. The chosen wrap can hold the baby securely during KMC.
 |  |  |  |
| 1. **Benefits of KMC**
 |
| * 1. What are the benefits of KMC?

***(multiple response)*** | Facilitates breastfeeding |  |  |
| Provides natural warmth to the baby |  |  |
| Reduce infection for baby |  |  |
| Promotes weight gain |  |  |
| Easy to monitor condition of baby |  |  |
| Facilitates mother and child bonding |  |  |
| Others (specify)…………………………………… |
| 1. **Spousal and Family acceptability**
 |
| * 1. Is your husband also providing KMC?

(doing KMC during your time for dinner, toilet, bathing, rest etc) | Yes | No | NA |
| * 1. Is your family member also providing KMC?

(doing KMC during your time for dinner, toilet, bathing, rest etc) | Yes | No | NA |
| Thank you very much for participating in the study from the beginning. I would like to remind you for the PNC follow up visit at health facility next week. You will be provided with transportation cost of NRs 500. Thank you again. |
| **Section F: To be filled during PNC follow up at health facility (after week 4)** |
| 1. **Background Information**
 |
| * 1. ID no
 | * 1. Date of Follow up
 |
| * 1. Weight of baby
 | * 1. Attended PNC YES NO
 |

|  |
| --- |
| **Follow up questions** |
| 1. **Condition of mother and baby**
 |
| * 1. How are you?
 | Fine |  | **2.3** |
| Not feeling well |  |
| * 1. What are the health problems?

(multiple response) | Fever |  |
| Pain in wound |  |
| Breast engorgement |  |
| Loose motion |  |
| Vomiting |  |
| Cough and congestion |  |
| Others specify………………………………………… |
| * 1. How is your baby
 | Fine |  | 2.5 |
| Not feeling well |  |
| * 1. What are the problems
 | Feeding problem |  |
| Sleeping problem |  |
| Fever |  |
| Loose motion |  |
| Vomiting |  |
| Cough and Congestion |  |
| Others specify………………………………………… |
| * 1. Are you exclusively breastfeeding your baby?
 | Yes | No |
| 1. **KMC practice**
 |
| * 1. Are you continuing KMC at home?
 | Yes | No 3.5 |
| * 1. How many hours do you practice KMC per day (including both day and night) in this week
 | **Dates** | **hours** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| * 1. Are you practicing KMC at night?
 | Yes | No |
| * 1. Are you practicing KMC while performing household chores?
 | Yes | No |
| * 1. Can you please provide the reason for discontinuation?

***(multiple answers )*** | Physical pain following labor |  |
| Fear of harming baby through cord stump |  |
| Fear of baby falling |  |
| Discomfort |  |
| Lack confident  |  |
| Lack of time  |  |
| Not beneficial |  |
| Felt tired |  |
| Lack of support from family |  |
|  Social stigma |  |
| Baby doesnot want to be in KMC position |  |
| Healthy baby  |  |
| Others(Specify)……… …..…………..…… ……… |
| 1. **Perception of KMC wrap**
 | **Agree** | **Unsure** | **Disagree** |
| * 1. It is comfortable to perform KMC with chosen wrap.
 |  |  |  |
| * 1. The chosen wrap can hold the baby securely during KMC.
 |  |  |  |
| 1. **Benefits of KMC**
 |
| * 1. What are the benefits of KMC?

***(multiple response)*** | Facilitates breastfeeding |  |  |
| Provides natural warmth to the baby |  |  |
| Reduce infection for baby |  |  |
| Promotes weight gain |  |  |
| Easy to monitor condition of baby |  |  |
| Facilitates mother and child bonding |  |  |
| Others (specify)…………………………………… |
| 1. **Family and Community acceptability**
 |
| * 1. Is your husband also providing KMC?

(doing KMC during your time for dinner, toilet, bathing, rest etc) | Yes | No | NA |
| * 1. Is your family member also providing KMC?

(doing KMC during your time for dinner, toilet, bathing, rest etc) | Yes | No | NA |
| * 1. What is the community attitude towards KMC?
 | Supportive |  |
| Surprise |  |
| To know more |  |
| Make fun of |  |
| No idea |  |
| Others**……………………….** |
| 1. **Problems**
 |
| * 1. What were the practical problems while doing KMC? Please elaborate ……………………………………………………………………………………………………………………………………………………………………………………
 |
| 1. **Satisfaction and Recommendation**
 |
| * 1. Are you satisfied with the chosen wrap?
 | Yes8.3 | No |
| * 1. Can you please provide the reason why you are not satisfied with the wrap?

…………………………………………………………………………………………………………………………………………………………………………………………………… |
| * 1. Do you recommend KMC to other mothers with preterm/LBW babies?
 | Yes | No |
| **Probe for reason** …………………………………………………………………………………………………………………………………………………………………………………………………………….. |
| * 1. Do you recommend the selected KMC wrap to other mothers with preterm/LBW babies?
 | Yes | No |
| **Probe for reason** …………………………………………………………………………………………………………………………………………………………………………………………………………….. |
| Thank participant for the continuing support from the beginning of the study and ask if she wants to share something important about the perception, usefulness and challenges or story/ verbatim of KMC practice and wrap that she might think has not been covered by the conversation till date.**……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………** |

Thank you

1. Use HMIS ethnicity classification. [↑](#footnote-ref-1)
2. Completed years of schooling [↑](#footnote-ref-2)