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Strengthening Family, Midwife, and Community Health Cadre Support in Home Care for Low Birth Weight Infants

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ABSTRACT

Low birth weight infants require continuous care after discharge from health facilities due to their vulnerability to nutritional problems, hypothermia, infection, and growth disturbances. During home-based care, mothers serve as the primary caregivers; however, the quality and continuity of care are strongly influenced by support from family members, midwives or health professionals, and community health cadres. This community service activity aimed to describe the role of family, midwife, and cadre support in home care for low birth weight infants as a basis for strengthening community-based assistance. The activity used a descriptive approach involving partner coordination, baseline data collection, descriptive tabulation, discussion of care needs, and formulation of recommendations for strengthening community support. The target participants were 12 mothers who had infants with a birth weight of less than 2,500 grams. Data were collected using a structured questionnaire covering maternal and infant characteristics, home-care practices, family support, midwife or health professional support, cadre support, maternal difficulties, and mothers' readiness as primary caregivers. The findings showed that most mothers still experienced difficulties in caring for low birth weight infants, particularly in breastfeeding, managing infants with poor feeding, overcoming fear when handling fragile infants, and accessing health services. Family and midwife support were relatively available, whereas cadre support still required further strengthening. This activity indicates that strengthening community support is essential to assist mothers in providing safe, continuous, and appropriate home care for low birth weight infants

Keywords: Low Birth Weight Infants; Family Support; Midwives; Community Health Cadres; Home Care

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INTRODUCTION

Low birth weight infants are a vulnerable group that requires special attention because they are at increased risk of temperature instability, feeding difficulties, infection, impaired growth, and other health problems after discharge from health facilities. Care does not end when the infant is declared stable and discharged; it continues at home through daily monitoring by the mother and family. Mothers need to understand how to maintain warmth, provide breast milk according to the infant's ability, maintain hygiene, recognize danger signs, and ensure follow-up visits as recommended by health professionals. Evidence shows that simple care, including skin-to-skin contact, breastfeeding support, and infant monitoring, is important in caring for preterm and low birth weight infants (Sivanandan & Sankar, 2023).

The transition from hospital to home is a sensitive phase for mothers of low birth weight infants. After discharge, mothers often move from receiving information in a health facility to becoming the primary caregivers who must make daily decisions at home. They need more than medical information; they also need practical guidance on care routines, breastfeeding, maintaining warmth, danger signs, and when to seek help. Clear discharge planning is important because routine-care information, emotional support, and access to health services determine continuity of care after discharge (Kristiawati et al., 2023).

Maternal knowledge is an important foundation for successful home care. Mothers who understand the specific needs of low birth weight infants are generally better prepared to provide basic care, monitor the infant, and seek help when problems arise. Conversely, limited information may increase anxiety, uncertainty, and difficulty in providing care. Knowledge of low birth weight care is associated with maternal coping strategies (Tambunan et al., 2020). . Other findings show that maternal knowledge is related to self-efficacy in caring for low birth weight infants, making needs-based education and support essential for strengthening mothers' confidence (Amaliya et al., 2022).

Family support is important because family members are the closest support system for mothers at home. Support may include preparing infant needs, caring for the infant while the mother rests, providing encouragement, reminding the mother about care schedules, and helping her make decisions when worrying symptoms appear. Such support can reduce mothers' physical and psychological burden, particularly during postpartum recovery. Social support, motivation, and maternal knowledge are important factors in essential care for preterm and low birth weight infants. Families should therefore be actively involved in community service focused on home care (Nindrea et al., 2025).

Midwives and health professionals are trusted sources of information for mothers caring for low birth weight infants. Their role includes education before discharge, continued monitoring, clarification of care instructions, assessment of maternal difficulties, and referral when danger signs are identified. Health professional involvement is important because mothers often need confirmation that their home care practices are appropriate. A qualitative synthesis found that families of preterm and low birth weight infants expect care that involves them, provides clear

communication, and helps them understand the infant's condition in hospitals and communities (Hurt et al., 2023).

Community health cadres can strengthen the continuity of low birth weight care at home. They can listen to maternal concerns, remind families about integrated health-post or follow-up schedules, provide simple information on hygiene and warmth, and connect mothers with midwives or health facilities. Their role is particularly important where access is limited, services are distant, or health-professional time is constrained. A community-based peer-support program for low birth weight infants showed that trained companions can help address gaps in post-discharge care and follow-up (Wright et al., 2023).

The need for community support is also shaped by social and cultural context and home-care practices. In some families, infant-care decisions are influenced not only by the mother but also by the husband, parents, parents-in-law, or other relatives. This can be a strength when families support appropriate care, but it can become a barrier when beliefs or practices conflict with low birth weight care principles. Studies in Indonesia show that culture, family dynamics, and local practices influence how mothers care for low birth weight infants at home after facility-based care (Rahayuningsih et al., 2024; Situmorang et al., 2025).

Initial data from this community service activity showed that the participants were 12 mothers with a history of having a low birth weight infant. Most mothers did not work, most infants weighed 2,000–2,499 at birth, many had received care in a hospital, NICU, or perinatology unit, and most mothers had delivered by cesarean section. The data also showed that mothers had practiced breastfeeding, kangaroo mother care, follow-up visits, and communication with health professionals. Nevertheless, some mothers reported difficulties with feeding, fear of handling the infant, and the need for assistance when problems occurred at home.

Based on these conditions, the community service activity focused on strengthening community support for the home care of low birth weight infants. The activity did not assess the effectiveness of the intervention; it described the initial condition of support from family members, midwives and health professionals, and cadres as a basis for more targeted community assistance. The activity aimed to describe family, midwife health professional, and cadre support in home care and identify the needs for strengthening community support based on baseline data from mothers of low birth weight infants.

METHOD

This community service activity used a needs-identification and community-support approach for mothers caring for low birth weight infants at home. It was conducted from May 19 to June 20 2026 in the area served by the Wonogiri District Health Office. The target group consisted of mothers whose infants had a birth weight below 2,500, had been discharged from a health facility, and were receiving home care. Twelve mothers participated in the baseline data collection.

The activity consisted of four stages: partner coordination, baseline data collection, discussion of assistance needs, and formulation of recommendations for strengthening

community support. Coordination was conducted with midwives and community health cadres to identify eligible mothers, agree on the implementation schedule, and explain the activity to prospective participants. The team also prepared the questionnaire, informed-consent form, and simple discussion materials on home care for low birth weight infants.

Baseline data were collected using a structured questionnaire covering maternal and infant characteristics, infant care history, home care practices, family support, midwife or health professional support, cadre support, maternal difficulties, access to health facilities, and maternal readiness as the primary caregiver. The questionnaire was completed after the participants received an explanation and agreed to participate. Respondent identities are not reported in this article to maintain confidentiality.

The assistance-needs discussion was held after questionnaire completion. It explored mothers' experiences in caring for low birth weight infants at home, particularly breastfeeding, maintaining warmth, kangaroo mother care, monitoring danger signs, follow-up visits, and the need for assistance from families, midwives, and cadres. Families, midwives, and cadres were positioned as community-support resources that could help with daily care, provide emotional support, convey health information, and direct mothers to seek help when danger signs appeared.

Data were analyzed descriptively using frequency distributions and percentages. The reported data were selected according to the article focus: maternal and infant characteristics, home-care practices, family support, midwife or health-professional support, cadre support, maternal difficulties, and readiness as the primary caregiver. Family, midwife or health-professional, and cadre support were categorized as good, moderate, or poor based on the dominant response across indicators. "Always" and "often" indicated good support, "sometimes" indicated moderate support, and "rarely" and "never" indicated poor support. Simple cross-tabulation was used to describe community support in relation to maternal difficulties and readiness. This analysis did not test effectiveness; it described initial conditions and support needs

RESULTS AND DISCUSSION

The results are presented descriptively using baseline data from 12 mothers of low birth weight infants. The presentation focuses on three components aligned with the activity objectives and methods: maternal and infant characteristics, home-care practices and maternal difficulties, and family, midwife or health-professional, and cadre support. This structure keeps the article focused on community support rather than intervention effectiveness.

Characteristics of Mothers and Low Birth Weight Infants

The participants were mostly mothers with a high school education who did not work and whose families had varied economic conditions. Most infants had a birth weight of 2,000–2,499, a history of hospitalization in a hospital, NICU, or perinatology unit, and had been delivered by cesarean section. These characteristics indicate that mothers of low birth weight infants require sustained family and health-professional support after discharge.

Table 1. Characteristics of mothers and low birth weight infants

Variable	Category	n	%
Maternal education	SD	2	16,7
	SMP	3	25,0
	SMA	7	58,3
Employment status	Not employed	11	91,7
	Full-time employment	1	8,3
Family income	< UMR	5	41,7
	= UMR	4	33,3
	> UMR	3	25,0
Infant birth-weight category	<1500 g	1	8,3
	1500–1999 g	2	16,7
	2000–2499 g	9	75,0
Gestational age	<32 weeks	2	16,7
	32–36 weeks	7	58,3
	≥37 weeks/unknown	3	25,0
History of hospital/NICU/ perinatology care	Yes	9	75,0
	No	3	25,0
Delivery method	Cesarean section	10	83,3
	Vaginal delivery	2	16,7

Table 1 shows that most mothers did not work, so much of the daily infant care was provided at home. This does not mean that mothers require no support. Low birth weight infants have specific needs related to thermoregulation, nutrition, infection prevention, and danger-sign monitoring. Family, midwife, and cadre support is therefore still needed so that mothers do not manage care alone without reinforcement from their immediate environment.

Home-Care Practices and Maternal Difficulties

The care-practice data show that all mothers breastfed their infants, although most used a combination of breast milk and formula. Most mothers also practiced kangaroo mother care, but its frequency varied. In addition, most mothers still experienced difficulties in caring for low birth weight infants at home, particularly with

breastfeeding, poor feeding, fear of handling the infant, and limited access to health services.

Table 2. Home-care practices and maternal difficulties

Variable	Category	n	%
Mother breastfed the infant	Yes	12	100
Infant nutrition	Breast milk + formula	9	75
	Exclusive/predominant breast milk	3	25
Practiced KMC/kangaroo care	Yes	9	75
	No	3	25
KMC frequency	Every day	3	25
	Several times a week	3	25
	Rarely	5	41,7
	Never	1	8,3
Experienced difficulty caring for LBW infant	Yes	10	83,3
	No	2	16,7
Main difficulty	Breastfeeding	4	33,3
	Poor feeding	3	25
	Fear of handling the infant	2	16,7
	Distant services	2	16,7
	Infant often ill	1	8,3
Visited by a midwife after discharge	Yes	9	75,0
	No	3	25,0
Readiness to be primary caregiver	Very ready/ready	10	83,3
	Moderately ready	2	16,7

Table 2 shows a gap between maternal readiness and the challenges of daily care. Most mothers considered themselves ready to be primary caregivers, yet most also reported difficulties. This finding is important because readiness is shaped not only by knowledge but also by practical guidance and accessible social support when mothers face problems at home.

Family, Midwife or Health Professional, and Cadre Support

Community support in this article is grouped into three main sources: family members, midwives or health professionals, and cadres. Families are the closest source of practical and emotional support. Midwives and health professionals provide information, education, assessment, and referral when difficulties arise. Cadres can connect families with health professionals, particularly through simple monitoring and reinforcement of health messages in the community.

Table 3. Family, midwife/health-professional, and cadre support

Support Source	Support Category	n	%
Family support	Good	9	75,0
	Moderate	1	8,3
	Poor	2	16,7
Midwife/health-professional support	Good	10	83,3
	Poor	2	16,7
Cadre support	Good	7	58,3
	Moderate	1	8,3
	Poor	4	33,3

Table 3 shows that midwife or health-professional support was the strongest, followed by family support. Cadre support was present but requires strengthening because the proportion of low support was higher than for the other sources. Community service activities can therefore focus on strengthening cadres as community companions without replacing the role of midwives or health professionals.

The following photographs document community service activities with health workers







The findings indicate that participating mothers required continued support after their low birth weight infants returned home. As shown in Table 1, most infants weighed 2,000–2,499 at birth, were born at 32–36 weeks of gestation, and had a history of care in a hospital, NICU, or perinatology unit. Home care must therefore be understood as part of the transition from hospital to home. Mothers and families assume daily-care responsibilities while infants remain vulnerable to feeding problems, hypothermia, infection, and missed danger signs. Schuler et al. (2023) emphasized that continuity of care for low birth weight infants requires collaboration between families and health professionals across the continuum of care(Schuler et al., 2023). This finding is consistent with Rahayuningsih et al. (2024), who reported that home care is challenging because families must continue care previously supported by professionals in health facilities (Franck et al., 2020; Kaewwimol et al., 2025; Rahayuningsih et al., 2024b).

Table 1 also shows that most mothers did not work and had secondary education. This may provide more time for direct care, but it does not ensure that mothers have the knowledge, skills, psychological calm, and decision-making ability required for low birth weight care. Limited information can increase maternal stress and affect coping strategies. Simple, repeated, and practical education remains necessary even when basic discharge information has been provided (Hadi et al., 2022; Mohammaddoost et al., 2016; O'Brien et al., 2018; Tambunan et al., 2020). Table 2 shows that all mothers breastfed, although most also used formula. Breastfeeding was therefore practiced, but additional support is needed to strengthen mothers' confidence in maintaining breast milk according to the infant's condition. Low birth weight infants may have feeding difficulties because their sucking reflex and stamina are not fully developed. Structured nurse-led education can improve maternal knowledge and practice (Prabhakaran & Arulappan, 2021). In community service, midwives and cadres can help mothers understand breastfeeding position, feeding frequency, signs of adequate intake, and when to consult a health professional.

Table 2 shows that most mothers had practiced kangaroo mother care, but its frequency varied. This indicates awareness of the importance of maintaining infant warmth, although practice was not fully consistent. KMC is relevant for low birth weight infants because it supports thermal stability, mother–infant closeness, and continued breastfeeding. It can reduce morbidity and mortality (Conde-Agudelo & Díaz-Rossello, 2016), and recent evidence shows benefits for mortality, hypothermia,

sepsis, and length of hospital stay(Sivanandan & Sankar, 2023; Yu & Zhu, 2023). The variation observed here supports the need for simple education and family-friendly demonstrations of KMC at home.

Although most mothers considered themselves ready to be primary caregivers, Table 2 shows that most still experienced difficulties, including breastfeeding, poor feeding, fear of handling the infant, distant services, and concern when the infant became ill. Readiness does not mean that practical problems are absent. It may reflect psychological readiness, whereas difficulties emerge when mothers face real situations at home. The WHO Immediate KMC Study Group (2021) showed that mothers or caregivers are central to kangaroo mother care. Greater maternal involvement therefore increases the need for family and health-professional support so that mothers do not face care problems alone (WHO, 2022).

Table 3 shows that most respondents received good family support. This is important because family members are the closest source of support. Support may be practical, such as helping with infant needs and household tasks, or emotional, such as encouragement, listening, and reducing maternal fear. Astuti et al. (2019) found that maternal knowledge and family support were associated with mothers' ability to prevent infection when caring for low birth weight infants (Astuti et al., 2019). Social support also strengthens motivation and knowledge in providing essential care for preterm and low birth weight infants. Families should therefore be included in education rather than treated as passive companions (Galvin et al., 2017; Nindrea et al., 2025; Shah et al., 2016)Table 3 also shows strong midwife or health-professional support. Most mothers received good support and were visited by a midwife after discharge. Midwives therefore have a strategic role as information providers, infant-health monitors, and links to health facilities. They can help mothers recognize danger signs, monitor infant weight, reinforce breastfeeding, teach kangaroo mother care, and arrange follow-up. Family members and health professionals must remain connected so that support does not end at discharge (Hariati et al., 2020; Schuler et al., 2025). Cadre support was more varied than family and midwife support. Cadres have substantial potential as community companions, but their role needs clarification and strengthening. They can listen to maternal concerns, remind families about follow-up, convey simple messages about warmth, hygiene, and danger signs, and encourage prompt contact with a midwife. Wright et al. (2023) showed that community-based peer support can strengthen follow-up after discharge (Wright et al., 2023). Strengthening cadres may therefore bridge mothers' home-based needs and formal health services (Astuti et al., 2019; Oluoch et al., 2023; Stelwagen et al., 2021; Wright et al., 2023).

The findings also show that community support must consider family and cultural contexts. Home-care decisions may be influenced by family advice, parental experience, local practices, and access to health professionals. Cultural barriers and family dynamics can affect low birth weight care in Indonesia (Arzani et al., 2017; Situmorang et al., 2025). Culture may also shape parents' decisions about infant health after hospital care (Rahayuningsih et al., 2024a). Education should therefore involve families and cadres so that health messages are consistent with the social support mothers receive at home.

Overall, Tables 1–3 show that home care for low birth weight infants requires layered support. Mothers are the primary caregivers, families provide daily support, midwives or health professionals provide information and monitoring, and cadres can connect families with community services. These data cannot establish program effectiveness because the activity was descriptive and involved few participants. Nevertheless they provide a useful basis for community service planning by identifying practical problems in breastfeeding, consistent kangaroo mother care, handling fragile infants, and equitable access to community support. Strengthening family, midwife, and cadre support should focus on practical education, emotional assistance, simple monitoring, and timely referral when danger signs appear.

CONCLUSION

Baseline data show that mothers of low birth weight infants at home still require stronger community support. Most mothers breastfed, practiced kangaroo mother care, and felt ready to be primary caregivers. However, most still experienced difficulties with breastfeeding, poor feeding, fear of handling the infant, and access to health services.

Family and midwife or health-professional support were relatively good, whereas cadre support requires strengthening. Future community service should increase family involvement, strengthen cadres' role in simple monitoring, and maintain communication among mothers, families, cadres, and midwives in home care for low birth weight infants.

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Ethical Compliance

Participants received an explanation of the activity's purpose and procedures before completing the questionnaire and participated voluntarily. Participant identities are not reported, and the data were used to assess support needs.

Data Access Statement

Summary data supporting the findings are available from the corresponding author upon reasonable request, subject to protection of participant confidentiality.

Conflict of Interest declaration

The authors declare no conflict of interest related to the implementation of the activity or preparation of this article.

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