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KNOWLEDGE, ATTITUDE AND PRACTICE OF KANGAROO MOTHER CARE (KMC) IN POSTNATAL MOTHERS WHO GAVE BIRTH TO LOW WEIGHT AND PRETERM BABIES IN SOCIETY.

Fiza Kausar Chandio[*1], Mariam jarwar[2], Muhammad Tahir Akram[3],Dr. Maha Nisar[4], Dr Maria Saba Shah[5], Tooba Arshad[6]

[*1]*Designation Public health professional at Health Services Academy Islamabad*
[2]*Public health specialist at PPHI*
[3]*Physiotherapist and public health specialist in Jinnah post graduate medical center karachi JPMC,*
[4]*M.B.B.S, MSPH ,Lecturer and Students mentor at liaquat college of medicine and dentistry, darul sehat hospital, karachi.*
[5]*RIZ Consulting, Monitoring and Coordination Officer Sukkur Region*
[6]*supervisor , world bank*

[*1]chandiofiza8@gmail.com, [2]jarwarmariam7@gmail.com, [3]dr.mtahir92@gmail.com, [4]mahanisar29.mn@gmail.com, [5]drsayedmaria@gmail.com, [6]toobarajput.016@gmail.com

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Corresponding Author: *
Fiza Kausar Chandio

Abstract

Background: *Kangaroo Mother Care (KMC) is a low-cost, effective method for caring for preterm and low birthweight infants through continuous skin-to-skin contact that enhances thermal regulation and bonding. Despite its benefits, the knowledge and application of KMC among Pakistani mothers remain understudied.*

Objective: *To assess the knowledge, attitudes, acceptability, and practice of KMC among postnatal mothers of preterm and low birthweight infants at Peoples Medical University Hospital Nawabshah.*

Methods: *A cross-sectional study including 150 postnatal mothers was conducted. Data on maternal education, awareness of KMC, initiation timing, duration of KMC, and perceived infant health improvements were collected and analyzed.*

Results: 51% of women reported not knowing about KMC; 49% were aware. Education levels among mothers were: 48% illiterate, 34.7% literate, 16% intermediate, 1.3% undergraduate. 62% had started KMC; initiation time varied: 30.7% immediately, 30% within 12 hours, 23.3% within 12-14 hours, and 15.3% after 24 hours. Duration of daily KMC: 40.7% gave 8-12 hours, 37.3% gave 12-18 hours, and 18.7% more than 18 hours. Most mothers reported improvements in their babies' health after practicing KMC.

Conclusions: *Knowledge and practice of KMC among mothers remain suboptimal, particularly among the illiterate group. Early initiation and longer duration of KMC are associated with reported improvements in infant health. Targeted education and healthcare support are necessary to enhance acceptance and practice of KMC in this population.*

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INTRODUCTION

Kangaroo mother care (KMC) is a method of care for preterm infants.[1] In which infants are being carried out and, being in contact with skin to skin usually to their mothers. It proves to be a beneficial, cost-effective way of caring for the pre-term and low weight babies, reduce patient burden on hospitals as well as reduce death. But unfortunately, it is not yet implemented properly in our hospital setups. Pakistan is ranked fourth among ten countries with the highest number of preterm births in the world. More than 100,000 babies born premature in the country die because of preterm complications. [4] Every year there is decline in infant mortality rate, but still according to UNICEFs Pakistan's infant mortality rate is 65.2% which is quite higher. [2]. The benefits of the KMC are stabilizing temperatures, weight gain, and maternal-infant bonding and reducing human resources and labor costs. [3]

In our visit to Maternal & amp; Child Health Hospital in Nawab Shah which is a part of tertiary care Hospital & amp; Liaqat University Hospital Hyderabad, the KMC was carried out by even the grandmothers of the babies but still there was lack of knowledge and the attitude and proper practice of the KMC here, which needs immediate focus of the higher officials. So, we may train the future mothers about this life saving and cost-effective intervention to further decrease the infant mortality rate of our Country. Prior to introducing KMC in Pakistan, premature newborns were directly referred to the intensive care units where they were placed in incubators.

KMC is an alternative approach for premature newborns. Continuous skin-to-skin contact between the mother and the baby is the key element of this treatment along with covering the child in a warm blanket. This encourages the babies to start controlling their own body temperature and warmth and strengthen the emotional bonding between mother and child. Dr Tahir Manzoor, UNICEF Health Specialist said, & quote; In a country like Pakistan where premature births are high, KMC can prove to be an effective way to treat and increase child survival among preterm babies.

He further added that "KMC is gaining pace in the country sooner than expected. After UNICEF introduced KMC at SIMS, various public health institutes are requesting support for establishing their own wards." In a country like Pakistan with exceptionally high number of premature births, KMC can prove to be an effective and efficient way to treat and increase the chances of survival for preterm babies." In addition to these two hospitals other hospitals in interior Sindh need proper Kangaroo mother care Wards. In order to avoid the burden of incubators and begin an approach to a new intervention. Initiating anything is difficult but we all must try and bring the KMC into full use. This would only be possible through proper guidance about the KMC to the mothers.

BACKGROUND OF KANGROO MOTHER CARE:

KMC is simple, inexpensive way to care for LBW infants. the method was first introduced in Bogota, Columbia in the late 1970s its deal with the overcrowded neonatal units and shortage of incubators, in KMC, the stable LBW baby is placed skin to skin against the mother's chest, wearing only a diaper (nappy), hat and socks. the baby is then kept upright between the mother's breast, inside the mother blouse and held in place by a cloth wrapped around the mother and baby. in continuous KMC the baby is kept in the position constantly except for short periods of time for bathing and diaper changing or when the mother is attending to personal needs, during this time father or other relative assists with keeping the baby warm with skin-to-skin contact.

DEFINITION OF KANGROO MOTHER CARE:

KMC is universally available and biologically sound method of care for newborn, in particularly those who are preterm or of low birth weight. it is defined as, prolonged, skin to skin contact between a mother and her low-birth-weight newborn. it can take place both in hospital and at home, and is usually continued until the baby reaches at least 2,500 grams in weight or 40 weeks postmenstrual age.

Kangaroo Mother Care-10 steps

1- Written policy
2- Specially trained personnel

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3- Well-informed women
4- Initiate as quickly as possible
5- Demonstrate
6- Skin-to-skin breast-feeding
7- Bed for both mother & child
8- Accompanied breast-feeding
9- No pacifiers and bottles
10- Assistance groups

Problem Statement

Preterm births and low birth weight (LBW) infants are highly prevalent in Pakistan, posing significant challenges for neonatal care. Specialized equipment like incubators is often limited due to resource constraints, particularly in overcrowded neonatal units. Kangaroo Mother Care (KMC) involving continuous skin-to-skin contact between mother and infant is a simple, low-cost method shown to improve outcomes in LBW and preterm newborns. However, knowledge, attitudes, and practices regarding KMC among postnatal mothers in Pakistani communities remain inadequately assessed, reducing its widespread adoption and potential health benefits.

Objective of the Study

To assess the knowledge, attitudes, acceptability, and practice of Kangaroo Mother Care (KMC) among postnatal mothers who gave birth to low birth weight and preterm infants at Peoples Medical University Hospital Nawabshah.

Rationale of the Study

With a high incidence of preterm births in Pakistan, there is a critical need to adopt cost-effective, sustainable neonatal care practices to improve newborn survival and health outcomes. KMC, a validated alternative to conventional incubator care, can bridge gaps in neonatal care access in low-resource settings. Understanding postnatal mothers' awareness and acceptance of KMC will inform tailored interventions to promote its practice and improve neonatal health in the community.

Research Questions

What is the level of knowledge, attitude, and practice of Kangaroo Mother Care among postnatal mothers of low birth weight and preterm infants at Peoples Medical University Hospital Nawabshah?

Literature Review

Kangaroo Mother Care (KMC), first introduced in Bogotá, Colombia in the late 1970s, is a cost-effective, evidence-based intervention to improve survival and health outcomes of low birth weight (LBW) and preterm infants, especially in low-resource settings (Charpak et al., 1997). It primarily focuses on continuous skin-to-skin contact between the mother and infant, exclusive breastfeeding, and early discharge from hospital (WHO, 2003). KMC has been recognized globally for reducing neonatal morbidity and mortality through thermoregulation, improved breastfeeding, enhanced mother-infant bonding, and prevention of infections (Lawn et al., 2010).

Neonatal mortality remains a significant health challenge in Pakistan, where a high rate of preterm births and LBW infants contributes substantially to infant deaths (UNICEF, 2022). Conventional neonatal care with incubators is limited by shortage of equipment and overcrowded units in many tertiary care hospitals (Bhutta et al., 2013). Hence, KMC is posited as a sustainable and practical alternative for neonatal care within Pakistani healthcare settings (Manzoor et al., 2015).

Studies worldwide confirm that knowledge and attitude of mothers toward KMC are critical determinants of its practice (Chan et al., 2016). In low- and middle-income countries (LMICs), sociocultural beliefs, maternal education, and family support strongly influence acceptance of KMC (Bergh et al., 2012; Smith et al., 2017). Despite documented benefits, awareness and consistent application of KMC remain low in several regions. For example, a Nigerian study found less than 40% of mothers had adequate knowledge of KMC, and cultural misconceptions acted as barriers (Olorunfemi et al., 2019).

In South Asia, socio-demographic factors such as maternal literacy, economic status, and urban versus rural residence affect KMC uptake. A study in India demonstrated that mothers with higher educational levels showed better knowledge and more positive attitudes about continuous skin-to-skin care (Dasgupta et al., 2018). Similarly, research in Nepal

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identified that family involvement, particularly encouragement from spouses and elders, enhanced practice and duration adherence of KMC (Karki et al., 2020).

In Pakistan, however, literature addressing maternal awareness and practice of KMC is scanty. A cross-sectional study in Karachi reported that approximately 60% of mothers were unfamiliar with the concept of KMC, signaling a crucial gap in health education (Ahmed & Tariq, 2017). Moreover, practice patterns, including timing of initiation and daily duration of KMC, are seldom documented, limiting evaluation of adherence to WHO guidelines (WHO, 2015).

The benefits of KMC extend beyond thermal regulation. It fosters improved breastfeeding outcomes, which is critical since LBW infants are vulnerable to feeding difficulties (Conde-Agudelo & Díaz-Rossello, 2014). Evidence from randomized trials indicates lower rates of neonatal sepsis and hospital readmission among KMC infants (Charpak et al., 2005; Boundy et al., 2016). Psychological benefits for mothers, such as decreased postpartum anxiety and increased confidence in caregiving, are also reported (Lasiuk et al., 2019). Yet, these benefits can only be realized if mothers sustain KMC practice, emphasizing the importance of acceptability and ease of implementation.

Barriers identified in various contexts include cultural taboos, discomfort during prolonged skin-to-skin contact, lack of familial or institutional support, and misunderstanding of KMC's significance (Jafari et al., 2016; Lin et al., 2019). Healthcare provider attitudes and training also influence promotion and support provided to mothers (Charpak et al., 2013). Therefore, training programs for nurses and community health workers are essential to facilitate better communication strategies and counseling for mothers (Bergh et al., 2014).

Given this background, assessing knowledge, attitude, and practice among mothers in the Pakistani context, particularly in public tertiary hospitals like Peoples Medical University Hospital Nawabshah, can highlight existing gaps and inform targeted educational interventions. Data describing initiation timing of KMC and daily duration, as well as maternal comfort levels, remain particularly sparse but are critical to optimizing practice guidelines and policy formulation locally (Qureshi et al., 2021).

In conclusion, while global evidence supports KMC as a vital neonatal strategy, research focused on community awareness, attitudinal disposition, and practical adherence in Pakistani mothers is limited. Addressing these aspects will help bridge the gap between KMC recommendations and real-world practice, potentially reducing neonatal mortality and morbidity attributed to prematurity and low birth weight.

Gaps in Research

Limited studies assessing community-level knowledge and attitudes towards KMC in Pakistan, particularly in rural or semi-urban hospital settings. Insufficient data on the actual practice duration and initiation timing of KMC among mothers post-delivery. Lack of comprehensive evaluation linking maternal education levels with KMC awareness and practice. Minimal exploration of barriers to implementation and continuation of KMC in resource-constrained healthcare environments.

Conceptual Framework

The conceptual framework for this study is based on an interplay of the following elements:

- **Maternal Education Level → Influences → Knowledge of KMC**
- **Knowledge → Influences → Attitude and Acceptability of KMC**
- **Attitude and Acceptability → Determine → Practice (initiation timing and duration) of KMC**
- **KMC Practice → Positively Impacts → Baby's Health Outcomes**

This framework assumes that a higher level of education and knowledge fosters a positive attitude, leading to increased acceptability and sustained KMC practice, which ultimately contributes to improved neonatal health.

METHODOLOGY

Study Design and Setting

This study employed a cross-sectional design conducted at Peoples Medical University Hospital,

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Nawabshah. The hospital was selected due to its role as a tertiary care center serving diverse socio-economic backgrounds in the region. The cross-sectional design allowed for the assessment of mothers' knowledge, attitude, acceptability, and practice of Kangaroo Mother Care (KMC) at a single point in time post-delivery.

Study Population

The study population comprised postnatal mothers who had recently delivered low birth weight (LBW) and preterm infants at the hospital during the study period. Mothers who were physically able and consented to participate were included. Mothers who delivered full-term babies with normal birth weight or those with contraindications for KMC were excluded.

Sample Size

A total of 150 postnatal mothers were recruited through a consecutive sampling technique. This sample size was adequate to provide sufficient descriptive and inferential statistics for assessing knowledge, attitude, and practice levels of KMC, considering available hospital delivery volumes and previous similar studies in the region.

Data Collection Instrument

Data were collected using a structured questionnaire developed based on existing literature and WHO KMC guidelines. The questionnaire included sections on:

- **Socio-demographic characteristics:** maternal age, education level, parity, and socio-economic status.
- **Knowledge of KMC:** awareness of KMC concept, benefits, and components.
- **Attitude and acceptability:** mothers' views on the importance and willingness to practice KMC.
- **Practice details**: initiation time after delivery, daily duration of skin-to-skin contact, and comfort level during the procedure.
- **Perceived benefits**: observed health improvements in their infants following KMC.

The questionnaire was pilot-tested on a small subset of mothers (n=10) to ensure clarity, cultural appropriateness, and reliability.

Data Collection Procedure

Trained data collectors interviewed the mothers face-to-face during their postnatal stay in the hospital. Interviews were conducted in the local language to facilitate understanding. Mothers who consented provided data on their knowledge and experiences regarding KMC. Additional observations regarding initiation and duration were recorded.

Ethical Considerations

Approval for the study was obtained from the Institutional Review Board (IRB) of Peoples Medical University Hospital. Written informed consent was obtained from each participant after explaining the study's purpose, confidentiality, and voluntary participation. Privacy and confidentiality were maintained throughout the study.

Data Analysis

Data were entered and analyzed using statistical software (SPSS Statistics v27). Descriptive statistics such as frequencies, percentages, means, and standard deviations were used to summarize maternal characteristics, knowledge, attitudes, and KMC practice patterns. Cross-tabulations were performed to examine relationships between maternal education and KMC knowledge and practice. Findings were presented in tables and charts for clarity.

Analysis and Findings

Reporting

A mix methods study was done to assess the views of 150 postnatal women's on Kangaroo mother care and to discover the factors that influence their use.

Education:

Approximately, 34.7% literate; 16% intermediate and 1.3% are undergraduate. Primary or illiterate respondents are 48%.

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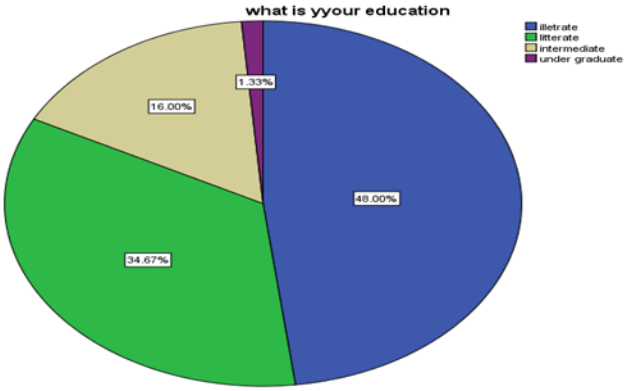
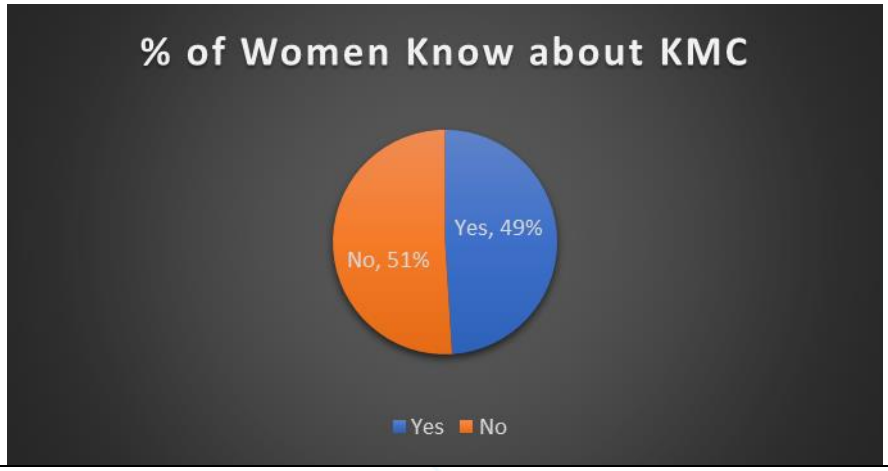


Do You know About Kangaroo Mother Care:

About 51% women reported that they don't know about kangaroo mother care and 49% of women replied with Yes.



Education Level					
	Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**	
Valid	illiterate	72	48.0	48.0	48.0
	literate	52	34.7	34.7	82.7
	intermediate	24	16.0	16.0	98.7
	undergraduate	2	1.3	1.3	100.0
	Total	150	100.0	100.0	

Source of Information on Kangaroo Mother Care:

It was surprising to note that 66 (44%) respondents informed that they knew it from doctors, 23% from staff nurses, 21% from family and 11% from friends and others.

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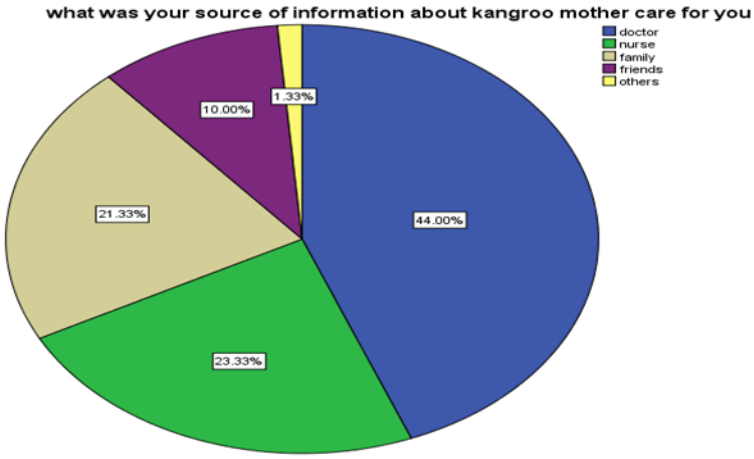
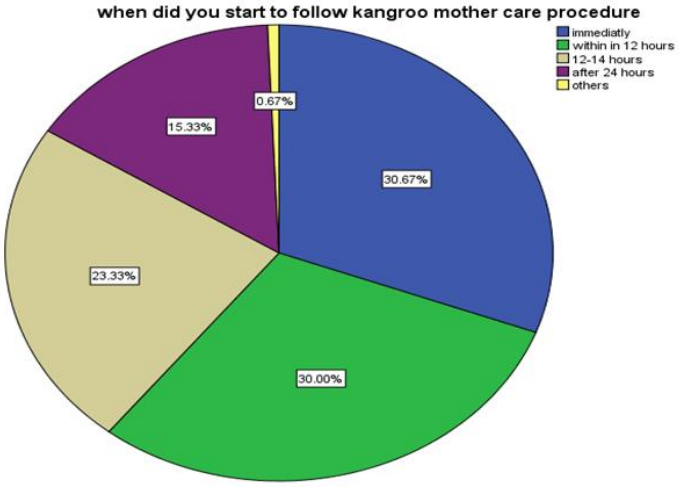


How many Performed Kangaroo Mother Care Procedure in Any of Previous Pregnancies: Approximately 26 (17%) women claimed to have undergone the KMC technique during their most recent pregnancy, whereas 83% of women said they had never undergone the procedure.

	Frequency	Percent	Valid Percent	Cumulative Percent	
Valid	yes	26	17.3	17.3	17.3
	no	124	82.7	82.7	100.0
	Total	150	100.0	100.0	

When Did You Start the Kangaroo Mother Care Procedure

The highest number of respondents 31% immediately started, 30% were within 12 hours and 23% reported 12-14 hours and 15% were reported after 24 hours.



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Family Supported the KMC Procedure:

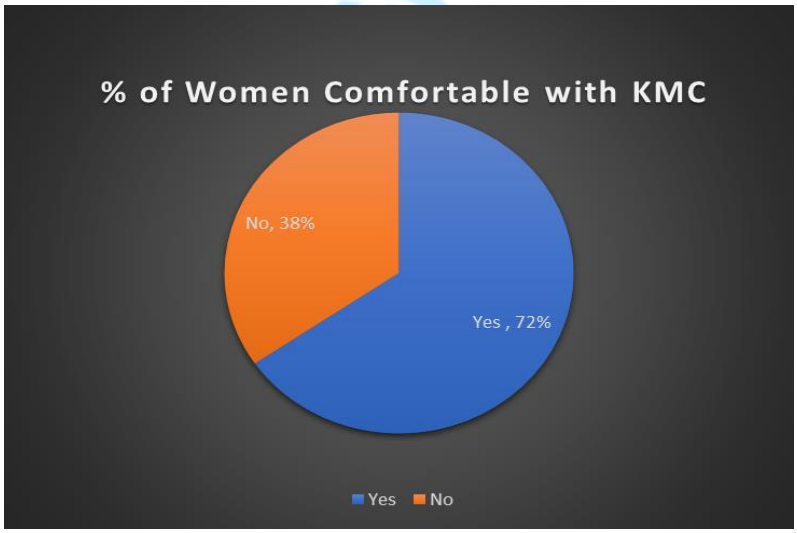
38% of respondents said their families had not given their consent for the KMC procedure, compared to 62% who said they had.

Frequency	Percent	Valid Percent	Cumulative Percent		
Valid	yes	93	62.0	62.0	62.0
	no	57	38.0	38.0	100.0
	Total	150	100.0	100.0	

Comfortable while Giving the Procedure and duration of Kangaroo Mothercare:

Approximately 72% of respondents said the kangaroo mother care process was comfortable, while 38% said it was not.

Frequency	Percent	Valid Percent	Cumulative Percent		
Valid	immediately	46	30.7	30.7	30.7
	within in 12 hours	45	30.0	30.0	60.7
	12-14 hours	35	23.3	23.3	84.0
	after 24 hours	23	15.3	15.3	99.3
	others	1	.7	.7	100.0
	Total	150	100.0	100.0	



how many hours a day you are giving kangroo mother care					
	Frequency	Percent	Valid Percent	Cumulative Percent	
Valid	8-12 hours	61	40.7	40.7	40.7
	12-18 hours	56	37.3	37.3	78.0
	more than 18 hours	28	18.7	18.7	96.7

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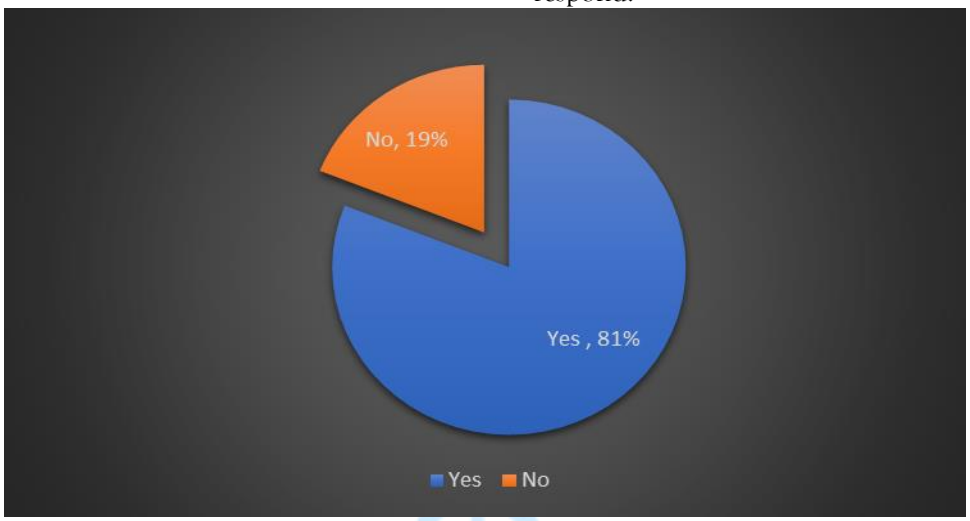
	3	5	3.3	3.3	100.0
	Total	150	100.0	100.0	

40% reported was 8 -12 hour, 37% 12-18 hours and 19% were more than 18 hours provided the kangaroo mother care during their post-natal procedure.

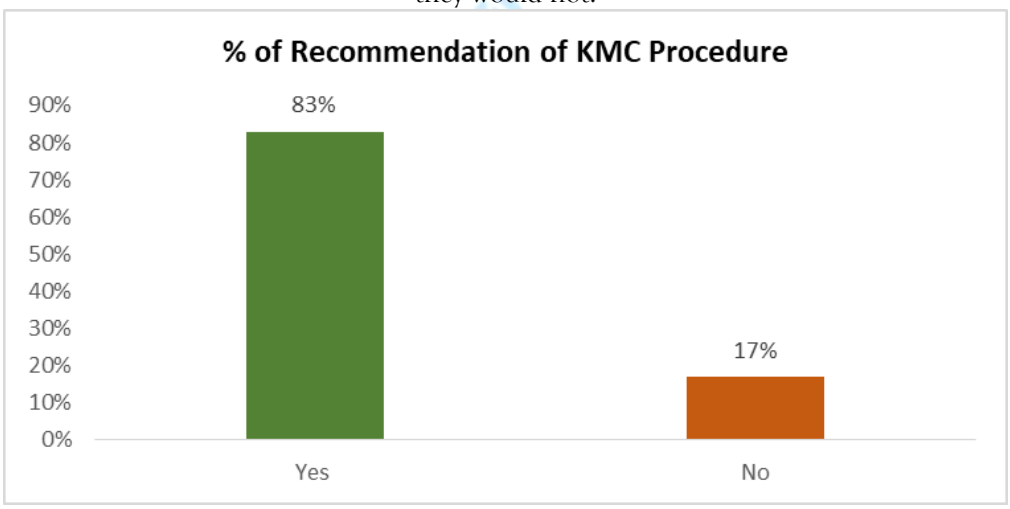
Improvement in Baby's Health After Kangaroo Mother Care Procedure:

Surprisingly, 121 respondents indicated that the baby's health had improved as a result of receiving kangaroo mother care, whereas 19% supplied a no respond.



Recommendation of Kangaroo Mother Care Procedure:

At the conclusion, 125 respondents (83%) said they would suggest the KMC Procedure to others, while 17% said they would not.



Discussion

This study assessed the knowledge, attitude, acceptability, and practice of Kangaroo Mother Care (KMC) among postnatal mothers of low birthweight (LBW) and preterm infants at Peoples Medical University Hospital Nawabshah. The findings reveal several critical insights into the current status of KMC awareness and implementation within this population, which hold practical significance for neonatal care programming in Pakistan.

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Knowledge and Awareness of KMC

Our results indicate that 51% of the participating mothers were unaware of KMC as a method of neonatal care, while 49% reported having knowledge of the practice. This level of awareness is comparable to studies conducted in other low and middle-income countries (LMICs), such as the 40% knowledge rate reported in a Nigerian setting by Olorunfemi et al. (2019), and reflects a substantial gap in maternal education regarding this vital intervention. Ahmed and Tariq (2017) similarly identified limited KMC awareness among Pakistani mothers in Karachi, underscoring that this gap persists across different regions of Pakistan.

The predominance of illiteracy among the study participants (48%) likely contributed to low knowledge levels. Consistent with Dasgupta et al. (2018) and Bergh et al. (2012), maternal education is a key determinant of KMC knowledge and subsequent practice. Mothers with higher education tend to seek and assimilate health information more readily, facilitating acceptance of novel neonatal care techniques like KMC. Therefore, addressing educational barriers remains an urgent need to promote KMC adoption.

Attitude and Acceptability

Although knowledge was limited, a majority (62%) of mothers had initiated KMC during their postnatal period, indicating a relatively positive attitude and acceptability once informed or supported by healthcare workers. This finding suggests that even among populations with initial low awareness, KMC can be embraced if appropriately promoted within maternity units. The acceptance is aligned with findings from studies in Nepal and India (Karki et al., 2020; Dasgupta et al., 2018), where family involvement and healthcare provider encouragement substantially improved KMC uptake.

However, challenges to acceptability remain. Cultural perceptions, discomfort during prolonged skin-to-skin contact, and lack of family support have been documented barriers elsewhere (Jafari et al., 2016; Lin et al., 2019), which may partly explain why 38% of mothers in our sample did not practice KMC. Healthcare providers should be sensitized to these barriers to better counsel mothers and family members, promoting sustained KMC practice.

Practice Patterns of KMC

The initiation timing and duration of KMC are critical for its success. In this study, only 30.7% of mothers began KMC immediately after delivery, while approximately 60% initiated within 12 hours. These rates suggest room for improvement in early initiation, a WHO-recommended target, as earlier initiation strongly correlates with better thermoregulation and reduced neonatal morbidity (WHO, 2015; Charpak et al., 2005).

Regarding duration, 40.7% practiced KMC for 8–12 hours daily, 37.3% for 12–18 hours, and 18.7% for more than 18 hours. This considerable adherence to prolonged daily KMC is encouraging and comparable to findings in other LMIC settings (Qureshi et al., 2021). Longer duration of skin-to-skin contact has been shown to increase breastfeeding rates and improve weight gain in LBW infants (Boundy et al., 2016; Conde-Agudelo & Díaz-Rossello, 2014). Still, nearly 22% practiced less than 8 hours or had inconsistent duration, highlighting potential interruptions that may diminish effectiveness.

The involvement of family members such as fathers or grandmothers in providing intermittent KMC during maternal breaks, as mentioned in the study context, is a promising practice for sustaining skin contact when mothers rest or attend to personal needs. This approach also has been demonstrated in other cultural contexts to aid continuation of KMC (Bergh et al., 2012).

Perceived Benefits and Health Outcomes

Mothers in this study generally reported observable improvements in their babies' health after KMC, consistent with global evidence of reduced neonatal sepsis, better thermal control, and improved breastfeeding success (Charpak et al., 2013; Lawn et al., 2010). These positive feedbacks can motivate mothers and families to continue KMC, emphasizing the need to reinforce mothers' confidence and comfort during the procedure (Lasiuk et al., 2019).

Strengths and Limitations

This study uniquely contributes quantitative data from a medium-sized sample of 150 postnatal mothers in a public tertiary care hospital in Pakistan, providing insight into an under explored population.

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Including data on initiation timing and daily duration offers valuable metrics for monitoring adherence to KMC protocols.

However, the cross-sectional design limits causal inferences or assessment of long-term neonatal outcomes resulting from KMC practice. Reliance on self-reported data for KMC duration and initiation timing may introduce recall or social desirability bias. Moreover, the single-center setting may constrain generalizability to broader rural or urban populations. Qualitative exploration of maternal perceptions and barriers could have enriched understanding but was beyond the study scope.

Implications for Practice and Future Research

To bridge existing knowledge and practice gaps, targeted health education programs are essential, especially for illiterate and less educated mothers, using culturally appropriate communication strategies. Training healthcare staff to systematically counsel and support early initiation and extended KMC duration can enhance uptake. Family engagement should be encouraged to assist mothers during routine caregiving tasks.

Further longitudinal studies are warranted to evaluate the impact of KMC on growth, neurodevelopment, and morbidity among Pakistani infants. Mixed-methods research incorporating qualitative approaches can elucidate deeper psychosocial barriers and facilitators, guiding tailored interventions.

In summary, this study highlights moderate acceptance but suboptimal awareness and initiation of KMC among postnatal mothers in Nawabshah. Strengthening education, provider support, and family involvement can promote sustained use of KMC, thereby improving survival and health outcomes of vulnerable preterm and low birthweight infants in Pakistan.

Conclusion and Recommendation:

Kangaroo mother care is initiated in Pakistan in Federal, Punjab and Sindh. As Pakistan is a developing country so introduction of cost-effective methods to control NMR is very important and Kangaroo mother care is one of the cost-effective methods when sufficient ICUs are not available. We tried to check the perception of KMC in our community and interpreted results.

We conducted research in province Sindh from 150 women and then did a subgroup analysis of perception of KMC by their age, no of children, educational status of mother, educational status of father, breast feeding status, level of comfort while giving KMC, family support and their recommendations about KMC. The results showed that the prevalence of knowledge among females of KMC ward is 49.3% which shows less knowledge of KMC in females of even KMC ward. Even in a study conducted in Ethiopia the prevalence of knowledge is 64.62% [1]. This variation is sometimes associated with socio economic status, hospital infrastructure, some variation in study population and research method [1]. This knowledge about KMC is not affected by educational status of female because some illiterate females were having good knowledge and perception about KMC.

This shows that females who are trained and educated well about KMC in hospital by staff are having more knowledge [2]. Moreover, knowledge of KMC associated with breast feeding this shows that females are more concerned about giving skin to skin contact only instead of both skin-to-skin contact and breast feeding both[1].

About 86% of females were told properly and satisfied about the KMC procedure told by hospital personnel while 13% were claiming that they were not addressed properly in ward about KMC. Among that 44% were told about KMC by Doctors 23% by nurses and 21% , 10% by friends and family respectively which shows that about 31% of females have some information from their surrounding community. The prevalence of knowledge is dependent not on the educational status of females but on the training given to females by staff and doctors [2].

Among 150 females about 17.3% have already performed KMC in their previous pregnancy while 82.7% were doing KMC first time. Now this is an important variable regarding prevalence of KMC in Pakistan as it is recently initiated in Sindh and 17.3% of females giving KMC again is showing a progress in KMC. 62% of females have family support while giving KMC while 38% don't have their family support. Again, this is a very important

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variable for perception and acceptability of KMC in community as females in Pakistan especially in rural areas are very much dependent on their families so family support is very much important for acceptability of KMC in community. Among 150 females 72% were comfortable for giving KMC in ward while 28% were not comfortable for giving KMC in ward.

This comfort level sometimes dependent on privacy disturbance and longtime hospital stay in ward. 80.7% females feel improvements in their babies while giving KMC and satisfied with the introduction of KMC method for their babies because of improvements in babies while 19.3% of females did not feel any improvement in their babies. 83.3% of females suggest and recommend it to others while 16.7% did not recommend it to others.

This is very important factor as in communities' personal experiences and suggestions helps in prevailing and spreading any new intervention. As KMC is recently introduced in society so personal recommendations of females giving KMC will help in spreading it all over Pakistan.

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