"IMPACT OF VIDEO ASSISTED TEACHING ON KANGAROO MOTHER CARE AMONG THE POSTNATALMOTHER'S WITH LOW BIRTH WEIGHT BABIES FROM 1.5KG TO 2.5KG AT SELECTED HOSPITAL IN BENGALURU".

ABSTRACT

Low birth weight (LBW) infants are more vulnerable to hypothermia, infection, delayed growth, and increased neonatal mortality. Kangaroo Mother Care (KMC) is an evidence-based, cost-effective intervention that improves thermal regulation, breastfeeding, bonding, and survival of LBW babies. However, inadequate knowledge and poor practice among postnatal mothers often limit its effective implementation.

The present study was undertaken to assess the effectiveness of Video Assisted Teaching on knowledge and practice regarding Kangaroo Mother Care among postnatal mothers of low birth weight babies (1.5 kg to 2.5 kg) at a selected hospital in Bengaluru.

Methods:
A quasi-experimental research design was adopted for the study. The sample consisted of postnatal mothers of low birth weight babies selected using a non-probability sampling technique. Data were collected using a structured knowledge questionnaire and practice checklist. A pre-test was conducted to assess baseline knowledge and practice levels. Video Assisted Teaching on Kangaroo Mother Care was then administered, followed by a post-test to evaluate the effectiveness of the intervention. The collected data were analyzed using descriptive and inferential statistics.

Results:
The pre-test findings revealed that the majority of postnatal mothers had inadequate knowledge and poor practice regarding Kangaroo Mother Care. Following Video Assisted Teaching, a significant improvement was observed in post-test knowledge and practice scores. The results demonstrated that Video Assisted Teaching was effective in enhancing mothers' understanding and correct practice of Kangaroo Mother Care.

Interpretation:
The improvement in post-test scores indicates that structured audiovisual teaching enhances comprehension, retention of information, and confidence among postnatal mothers. Video Assisted Teaching was found to be a practical and effective educational strategy in promoting Kangaroo Mother Care practices in hospital settings.

Conclusion:
The study concludes that Video Assisted Teaching significantly improves the knowledge and practice of Kangaroo Mother Care among postnatal mothers of low birth weight babies. Incorporating such teaching programmes into routine postnatal care can contribute to improved neonatal outcomes, strengthened mother–infant bonding, and reduction in neonatal morbidity.

Keywords: Kangaroo Mother Care, Video Assisted Teaching, Low Birth Weight Babies, Postnatal Mothers, Knowledge and Practice

INTRODUCTION

Kangaroo Mother Care (KMC) is a special method in which the baby is continuously kept in skin-to-skin contact with the mother to promote effective thermal control, breastfeeding, infection prevention, and bonding in low birth weight infants.

Video Assisted Teaching (VAT) provides an innovative approach to bridge the gap in maternal education, particularly for new mothers in low-resource settings. By using multimedia formats, VAT can engage and educate mothers on the importance of KMC, correct techniques, and its long-term benefits for their low birth weight infants. This method offers both visual and auditory learning experiences, which are more likely to be remembered and practiced than traditional verbal instruction alone.

For postnatal mothers, especially those with low birth weight infants who require extra care, VAT can be a valuable resource, ensuring that mothers feel more confident and capable in performing KMC. This approach is particularly useful in situations where direct, in-person training may be limited due to time or resource constraints.

OBJECTIVES

1. To assess the pre-test knowledge and practice among postnatal mothers regarding Kangaroo Mother Care for low birth weight babies.
2. To evaluate the effectiveness of a Video Assisted Teaching programme on knowledge and practice regarding KMC.
3. To assess the post-test knowledge and practice on KMC among postnatal mothers with low birth weight babies.
4. To find the association between knowledge and practice of KMC among postnatal mothers and selected demographic variables.

HYPOTHESIS

There will be a significant increase in knowledge and practice regarding Kangaroo Mother Care among postnatal mothers with low birth weight babies after Video Assisted Teaching.

REVIEW OF LITERATURE

Kangaroo Mother Care:
The World Health Organization (WHO) has emphasized Kangaroo Mother Care as an effective and low-cost intervention for improving survival and health outcomes of low birth weight and preterm infants. KMC, which includes skin-to-skin contact, exclusive breastfeeding, and early discharge with adequate follow-up, has been shown to reduce neonatal morbidity and mortality. Studies have

reported that KMC promotes thermal regulation, enhances breastfeeding practices, and strengthens mother–infant bonding, particularly in resource-limited settings.

Charpak et al. conducted a randomized controlled trial to assess the effectiveness of Kangaroo Mother Care among low birth weight infants. The study revealed that infants who received KMC showed significantly better weight gain, reduced incidence of infections, and shorter hospital stays compared to those who received conventional care. The authors concluded that KMC is a safe and beneficial alternative to traditional neonatal care, especially in developing countries.

Ramanathan and Paul studied the impact of Kangaroo Mother Care on physiological stability among preterm neonates in India. The findings indicated improved temperature regulation, stabilized heart rate, and enhanced oxygen saturation levels among neonates receiving KMC. The study highlighted that early initiation of KMC plays a crucial role in improving neonatal outcomes and reducing complications associated with prematurity.

Preterm babies:

Blencowe et al. conducted a global analysis of preterm birth rates across 184 countries and reported that nearly 15 million babies are born preterm each year. The study identified maternal infections, inadequate antenatal care, poor nutrition, and low socioeconomic status as major contributors to preterm birth. The authors emphasized that improved antenatal interventions and timely neonatal care could significantly reduce preterm-related mortality and morbidity.

Goldenberg, Culhane, Iams, and Romero examined the epidemiology and causes of preterm birth and found that preterm babies are at higher risk for respiratory distress syndrome, low birth weight, infections, and long-term neurodevelopmental impairments. The study highlighted the role of quality antenatal care, early identification of high-risk pregnancies, and appropriate referral systems in preventing preterm deliveries.

March of Dimes, WHO, and UNICEF jointly reported that preterm birth is the leading cause of neonatal mortality worldwide. The report revealed that preterm babies who received essential newborn care, including thermal protection, early initiation of breastfeeding, and infection prevention, showed improved survival rates. The authors concluded that strengthening maternal education and neonatal health services is crucial for improving outcomes among preterm infants.

Effectiveness of Kangaroo Mother Care

A study by Lawn, Cousens, and Zupan evaluated the effectiveness of community-based newborn care interventions for preterm babies. The results indicated that home-based care, maternal counseling, and follow-up by trained health workers significantly reduced neonatal mortality. The authors emphasized that awareness among mothers regarding danger signs and care practices is essential for the survival of preterm infants.

Bhutta et al. reviewed evidence-based interventions for preterm and low birth weight babies and reported that Kangaroo Mother Care, exclusive breastfeeding, and timely medical management substantially improved growth and developmental outcomes. The study concluded that low-cost,

simple interventions can have a significant impact on the survival and quality of life of preterm babies, especially in low-resource settings.

Conde-Agudelo, Belizán, and Diaz-Rossello conducted a meta-analysis of randomized controlled trials to assess the effectiveness of Kangaroo Mother Care among preterm and low birth weight infants. The study reported that preterm babies receiving Kangaroo Mother Care showed a significant reduction in neonatal mortality, hypothermia, and severe infections compared to those receiving conventional care. The authors concluded that Kangaroo Mother Care is an effective, low-cost intervention for improving survival and health outcomes of preterm infants.

Kangaroo Mother Care for Preterm Babies

The World Health Organization reviewed evidence on Kangaroo Mother Care for preterm and low birth weight infants and recommended its routine use in neonatal care. The report highlighted that Kangaroo Mother Care improves thermal regulation, promotes early breastfeeding, and reduces neonatal mortality. The organization concluded that Kangaroo Mother Care should be integrated into standard newborn care practices, particularly in low- and middle-income countries.

Boundy et al. conducted a systematic review to examine the effect of Kangaroo Mother Care on neonatal survival and morbidity. The study reported a significant reduction in mortality and severe morbidity among preterm infants receiving Kangaroo Mother Care. The authors concluded that widespread implementation of Kangaroo Mother Care could substantially improve survival outcomes for preterm babies.

Mazumder et al. carried out a randomized controlled trial in India to assess the effectiveness of Kangaroo Mother Care on physiological stability and weight gain among preterm babies. The study revealed that infants receiving Kangaroo Mother Care showed better temperature regulation, improved oxygen saturation, and higher daily weight gain compared to those receiving routine care. The authors concluded that Kangaroo Mother Care significantly improves physiological outcomes among preterm infants.

METHODOLOGY

Methodology

Methodology refers to the system of methods, principles, and rules that guide the research process. It encompasses the overall strategy or approach used to collect, analyze, and interpret data.

Research Approach

A research approach refers to the general strategy or plan a researcher uses to conduct a study. It guides how data are gathered, analyzed, and interpreted. In the present study, a qualitative research approach was adopted, as it is appropriate for accomplishing the objectives of the study.

Research Design

The research design adopted for the study is a quasi-experimental research design.

Setting of the Study

In the present study, the setting is Sapthagiri Super Specialty Hospital, Chikkasandra, Bangalore.

Population

The population for the study comprises postnatal mothers with low birth weight babies (1.5 kg to 2.5 kg) at Sapthagiri Super Specialty Hospital, Chikkasandra, Bangalore.

Conceptual Framework

INPUT

(Input refers to factors that influence the process)

1. Demographic variables of postnatal mothers
    - -Age
    - -Education
    - -Occupation
    - -Typeoffamily
    - -Socio-economic status
    - -Place of residence
    - -Previous knowledge/experience about KMC
    - -Support system at home
2. Baseline status
    - -Pre-test knowledge regarding Kangaroo Mother Care
    - -Pre-test practice regarding Kangaroo Mother Care

3. Intervention

- **Video Assisted Teaching Programme on Kangaroo Mother Care**Meaning and importance of KMC
- Benefits of KMC
- Correct position and duration
- Monitoring during KMC
- Roleoffamilymembers

THROUGHPUT

(Activities carried out during the study)

- Administration of pre-test questionnaire and practice checklist
- ImplementationofVideoAssistedTeachingon KMC
- Motivation and clarification of doubts
- Reinforcement through audiovisual learning

OUTPUT

(Immediate results after intervention)

- Improved knowledge score regarding Kangaroo Mother Care
- Improved practice score regarding Kangaroo Mother Care
- IncreasedconfidenceamongpostnatalmothersinprovidingKMC

FEEDBACK

(Long-termeffectandevaluation)

- Post-test evaluation of knowledge and practice
- Comparison of pre-test and post-test scores

Identification of effectiveness of Video Assisted Teaching

Modification and strengthening of future teaching programme

MODIFIED SYSTEM MODEL

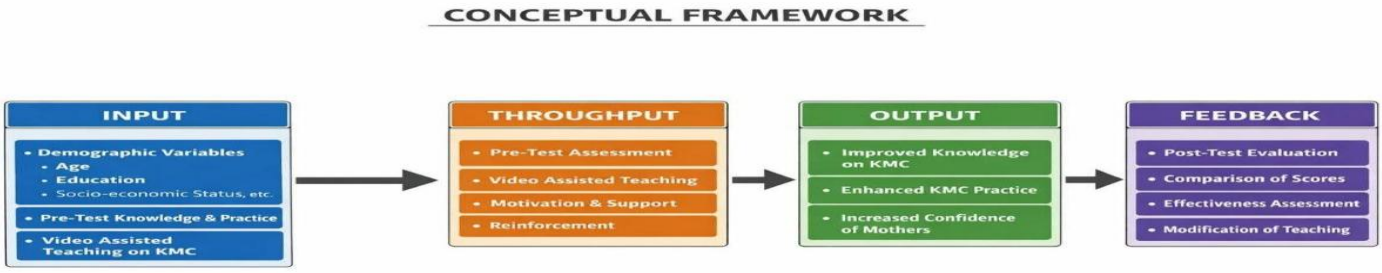
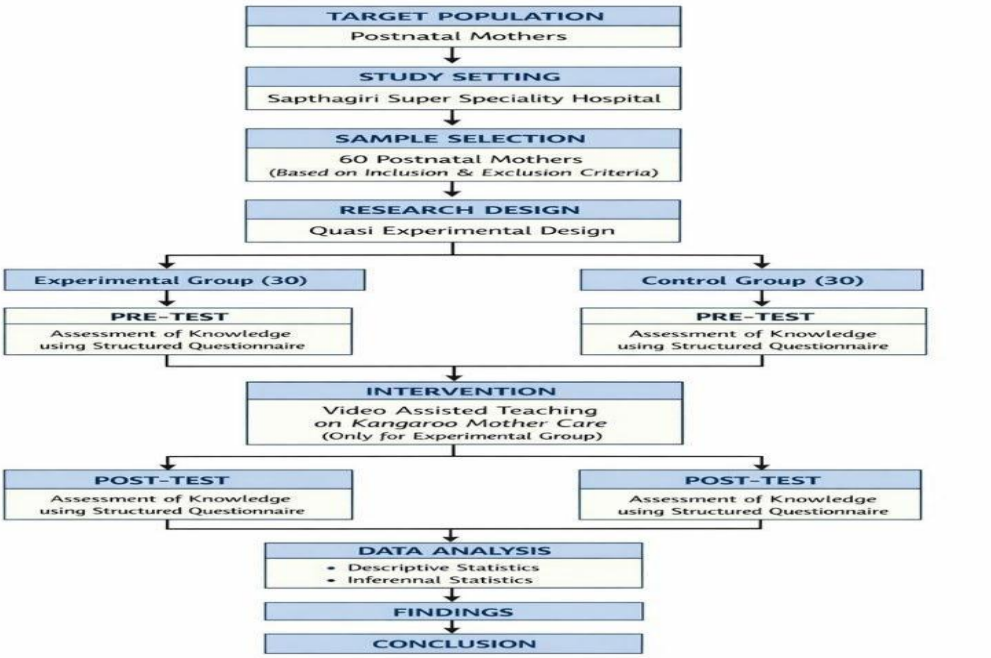


Fig No: 1 *Schematic Representation of Research Design*



Quasi-Experimentalresearchdesign(Experimental&Controlgroupwithpre-testand post-test)

Sample

A sample is a subset of the population selected to participate in a research study. The sample for the present study comprises postnatal mothers with low birth weight babies (1.5 kg to 2.5 kg) from the postnatal ward, NICU, and OBG OPD.

Sample Size

The sample size for the intended study consists of a total of 60 postnatal mothers.

Sampling Technique

Sampling is the process of selecting a portion of the population to represent the entire population. The sampling technique used in this study is purposive sampling.

Criteria for Selection of Sample

Inclusion Criteria

Postnatal mothers who:

- Have low birth weight babies (1.5 kg to 2.5 kg)
- Are admitted in the postnatal ward, NICU, or attending OBG OPD
- Are willing to participate in the study

Exclusion Criteria

Postnatal mothers who:

- Have babies weighing less than 1.5 kg or more than 2.5 kg
- Have critically ill neonates requiring NICU care, ventilator support, or incubator care
- Have babies with congenital anomalies or major birth defects

Development of the Instrument

A structured questionnaire was developed based on the objectives of the study and review of literature.

- **Section 1:** A semi-structured interview schedule was used to collect demographic variables such as age, education, occupation, marital status, and previous experience with Kangaroo Mother Care (KMC).
- **Section 2:** A structured questionnaire consisting of multiple-choice questions (four options) related to Kangaroo Mother Care practices, developed from relevant studies, journals, and textbooks.

Description of the Instrument

- **Section 1:** Demographic variables
- **Section 2:** Structured questionnaire with four response options regarding KMC practices

Data Collection Procedure and Analysis

Data were collected over a period of 10 days from postnatal mothers who met the inclusion criteria using purposive sampling. After obtaining informed consent, participants were asked to complete the semi-structured questionnaire.

The collected data were analyzed using descriptive and inferential statistics, including mean, percentage, range, standard deviation, and chi-square test. The findings were presented using tables, figures, and percentages.

DATAANALYSISAND INTERPRETATIONS

Table5.1.1AGEOFRESPONDENT

AGE	NO O.F RESPONDENTS	PERCENTAGE
Below 20 years	12	20%
21-25 years	28	46.7%
26-30 years	15	25%
Above 30 years	5	8.3%
TOTAL	**60**	**100**

(Source : primary data)

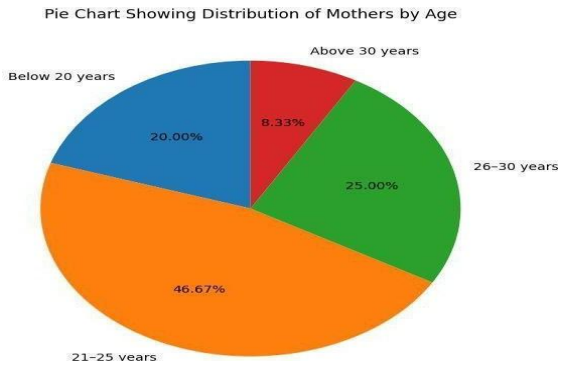


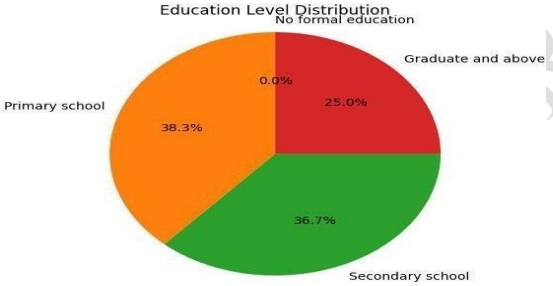
Figure5.1.1AGEOFRESPONDENTS

Table5.1.2EducationofRESPONDENT

Education level	**No.ofRespondents**	PERCENTAGE
No formal education	0	0%
Primary school	23	38.3%
Secondary school	22	36.7%
Graduate and above	15	25%
Total	**60**	**100**

(Source : primary data)

FIGURE 5.1.2 Education of respondent



OCCUPATION	NO OF RESPONDENTS	PERCENTAGE
Housewife	19	31.7%
Government employee	4	6.7%
Private employee	28	46.7%
Daily wage worker	9	15%
TOTAL	**60**	**100**

TABLE5.1.3OCCUPATION

FIGURE 5.1.3 OCCUPATION

MARITAL STATUS	NO OF RESPONDENTS	PERCENTAGE
Married	60	100%
Unmarried	0	0%
Widowed	0	0%
Divorced	0	0%
TOTAL	**60**	**100**

TABLE5.1.4MARITALSTATUS
(SOURCE PRIMARY DATA)

FIGURE5.1.4MARITALSTATUS

TABLE5.1.5TYPEOFFAMILY

TYPE OF FAMILY	NO OF RESPONDENTS	PERCENTAGE
Nuclear family	42	70%
Joint family	18	30%
Extended family	0	0%
TOTAL	**60**	**100**

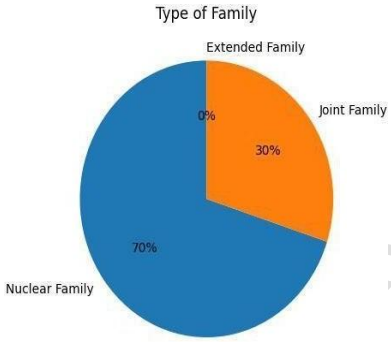


FIGURE 5.1.5 TYPE OF FAMILY

TABLE5.1.6NUMBEROFDELIVERY

NUMBER OF DELIVERY	NO OF RESPONDENTS	PERCENTAGE
Primigravida	18	30%
Multipara	42	70%
TOTAL	**60**	**100**

(

FIGURE 5.1.6 NUMBER OF DELIVERY

TABLE5.1.7MODEOFDELIVERY

MODE OF DELIVERY	NO OF RESPONDENTS	PERCENTAGE
Normal vaginal delivery	30	50%
Cesarean section	19	31.7%
Forceps delivery	8	13.3%
Vaccumextraction	3	5%
TOTAL	**60**	**100**

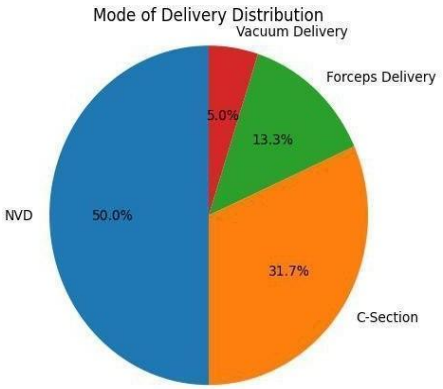


FIGURE 5.1.8 MODE OF DELIVERY

TABLE5.1.8GESTATIONALAGEOFBABY

GESTATIONALAGEOF BABY	NO OF RESPONDENTS	PERCENTAGE
Below 32 weeks	9	15%
32-36 weeks	44	73.3%
37-40 weeks	7	11.7%
40-42 weeks	0	0%
TOTAL	**60**	**100**

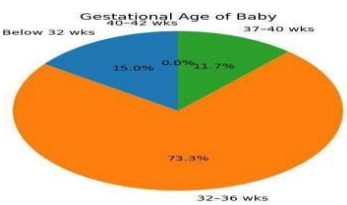


TABLE5.1.9BIRTHWEIGHTOFBABY

BIRTHWEIGHTOFBABY	NO OF RESPONDENTS	PERCENTAGE
Below 1.5 kg	12	20%
1.5 - 2 kg	39	65%
2 - 2.5 kg	8	13.3%
Above 2.5 kg	1	1.7%
TOTAL	**60**	**100**

FIGURE5.1.9BIRTHWEIGHTOFBABY

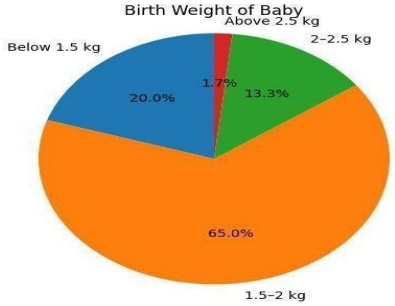


TABLE5.1.10SOCIO-ECONOMICSTATUS

SOCIOECONOMIC STATUS	NO OF RESPONDENTS	PERCENTAGE
Low	11	18.3%
Middle	42	70%
Upper middle	6	10%
High	1	1.7%
TOTAL	**60**	**100**

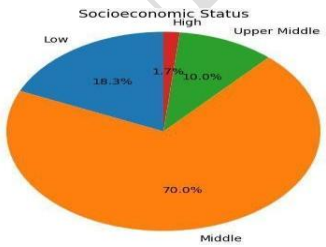


FIGURE 5.1.10 SOCIO-ECONOMICSTATUS

TABLE5.1.11PLACEOFRESIDENCE

PLACE OF RESIDENCE	NO OF RESPONDENT	PERCENTAGE
Urban	28	46.7%
Rural	25	41.7%
Semi urban	7	11.7%
Slum	0	0%
TOTAL	**60**	**100**

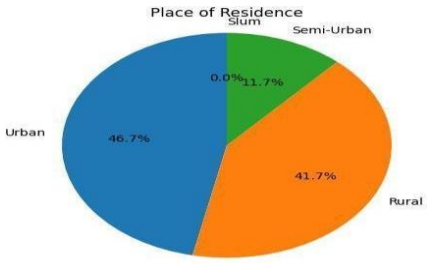


TABLE5.1.12RELIGION**FIGURE 5.1.12 PLACE OF RESIDENCE**

RELIGION	NO OF RESPONDENTS	PERCENTAGE
Hindu	39	65%
Muslim	9	15%
Christian	12	20%
Others	0	0%
TOTAL	**60**	**100**

FIGURE 5.1.12 RELIGION

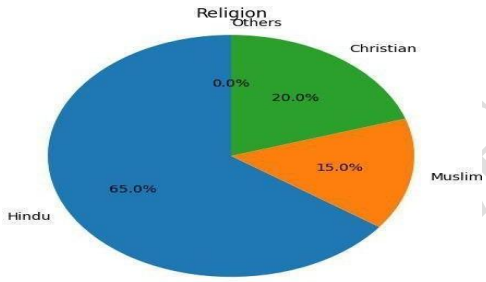


TABLE5.1.13PREVIOUSEXPERIENCEWITHKMC

PREVIOUS EXPERIENCE	NO OF RESPONDENTS	PERCENTAGE
Yes,practicedregularly	4	6.7%
Yes,butnotpracticed regularly	13	21.7%
Heardaboutit,neverPracticed	9	15%
No prior experience or	34	56.7%
knowledge		
TOTAL	60	100

FIGURE 5.1.13 PREVIOUS EXPERIENCE WITH KMC

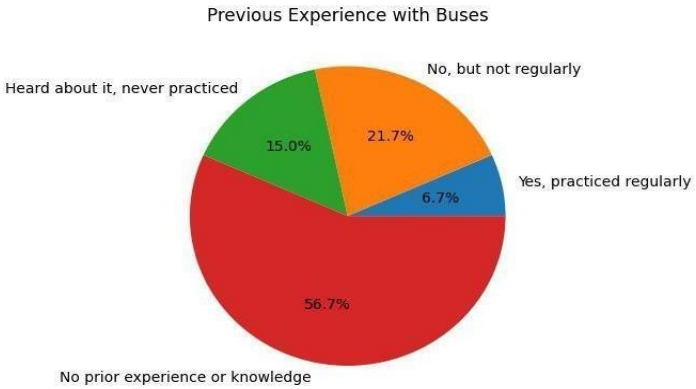


TABLE5.1.14FROMWHEREDIDYOUGETTHEKNOWLEDGEABOUTKMC?

FROMWHEREDIDYOU GET THE KNOWLEDGE ABOUT KMC	**NO OF RESPONDENTS**	**PERCENTAGE**
Health care provider	13	21.7%
Family, friends	2	3.3%
Mass media	11	18.3%
No aware	34	56.7%
TOTAL	**60**	**100**

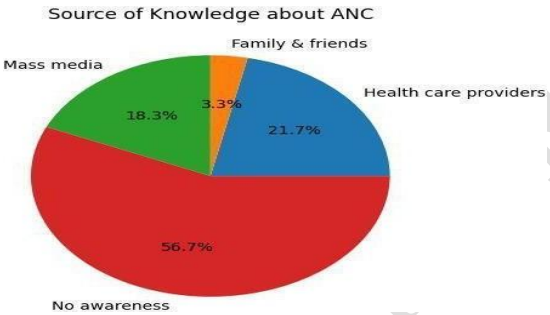
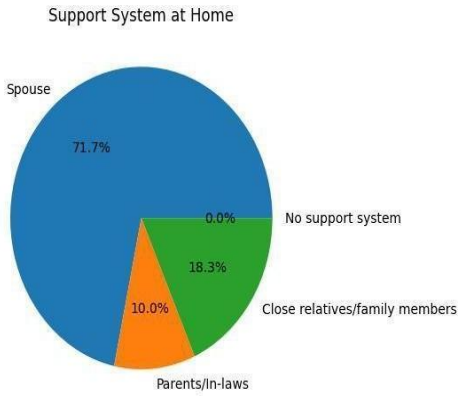


FIGURE 5.1.14 FROM WHERE DID YOU GET THE KNOWLEDGE ABOUT KMC

TABLE5.1.15SUPPORTSYSTEMATHOME

SUPPORTSYSTEMAT HOME	**NO OF RESPONDENTS**	**PERCENTAGE**
Spouse	43	71.7
Parents / in laws	6	10
Caregiver/family members	11	18.3
No support system	0	0
TOTAL	**60**	**100**

FIGURE5.1.15SUPPORTSYSTEMATHOME



PRE TEST
TABLE5.2.1KMCSTANDSFOR?

KMCSTANDSFOR	NO OF RESPONDENTS	PERCENTAGE
Kangaroo medical care	21	35%
Kangaroo mother care	6	10%
Key maternal care	29	48.3%
Keep mother comfortable	4	6.7%
TOTAL	**60**	**100**

(SOURCE: PRIMARY DATA)

FIGURE5.2.1KMCSTANDSFOR?

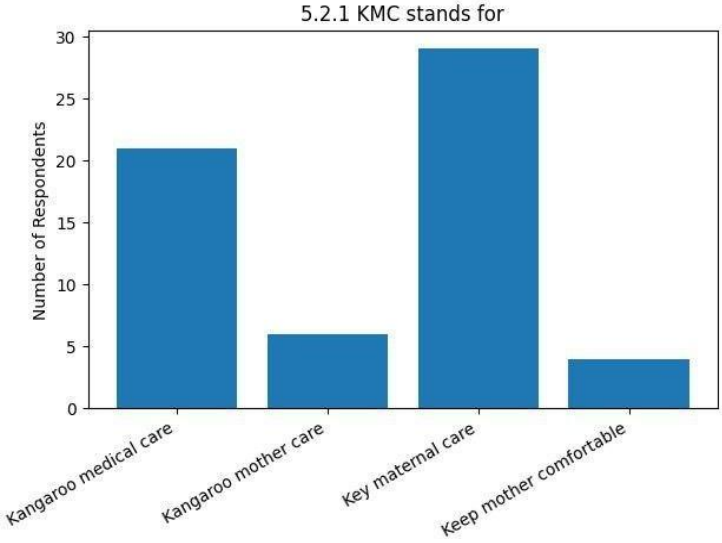


TABLE5.2.2WHATDOESKMCMEANS

WHATDOESKMCMEANS	NO OF RESPONDENTS	PERCENTAGE
Bathing the baby regularly	16	26.7%
Keep the baby in an incubator	26	43.3%
Providingskin-skincontact between mother and baby	5	8.3%
Feedingthebabyformula milk	13	21.7%
TOTAL	**60**	**100**

FIGURE5.2.2WHATDOESKMCMEANS

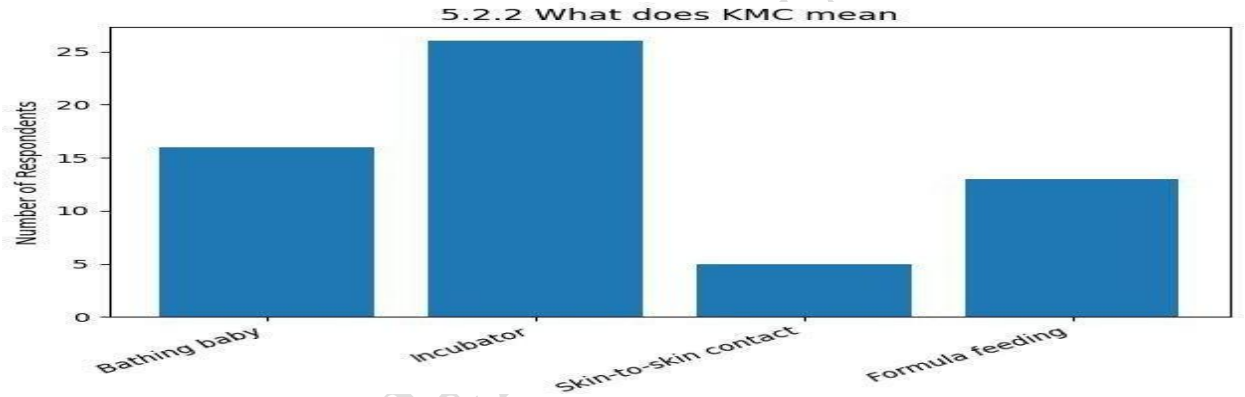


TABLE5.2.3WHICHBABIESMAINLYBENEFITSFROMKANGAROOMOTHERCARE

WHICHBABIESMAINLY BENEFITS FROM KMC	NO OF RESPONDENTS	PERCENTAGE
All full termbabies	27	45%
Only sick babies	16	26.7%
Lowbirthweightandpreterm babies	8	13.3%
Babies with infections	9	15%
TOTAL	**60**	**100**

FIGURE5.2.3WHICHBABIESMAINLYBENEFITSFROMKANGAROOMOTHERCARE

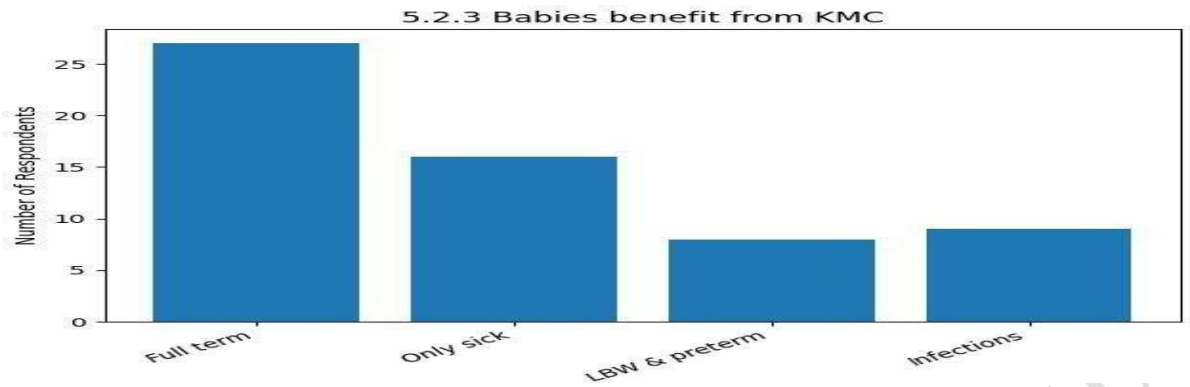


TABLE5.2.4WHICHISTHECORRECTPOSITIONOFKMC

WHICHISTHECORRECT POSITION OF KMC	NO OF RESPONDENTS	PERCENTAGE
Babyisplacedonmother's chest upright between her breast	11	18.3%
Babyisplacedonmother's back	3	5%
Babyislaidbesidethe mother on bed	21	35%
Babyiswrappedandkeptin cradle	25	41.7%
TOTAL	**60**	**100**

FIGURE 5.2.4 WHICH IS THE CORRECT POSITION OF KMC

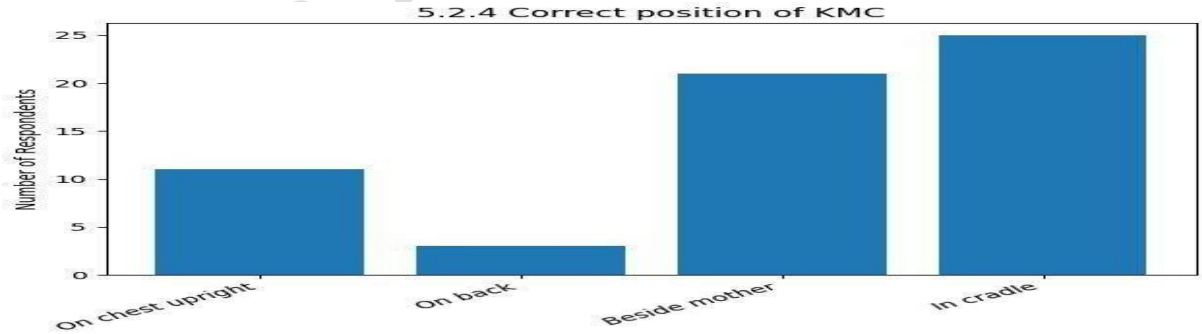


TABLE5.2.5HOWLONGSHOULDKMCBEPROVIDEDEACHDA

HOW LONG SHOULD KMCBEPROVIDEDEACH DAY	NO OF RESPONDENTS	PERCENTAGE
Less than 1 hour	11	18.3%
1-2 hours	3	5%
3-5 hours	21	35%
More than 6 hours	25	41.7%
TOTAL	**60**	**100**

FIGURE 5.2.5 HOW LONG SHOULD KMC BE PROVIDED EACH DAY

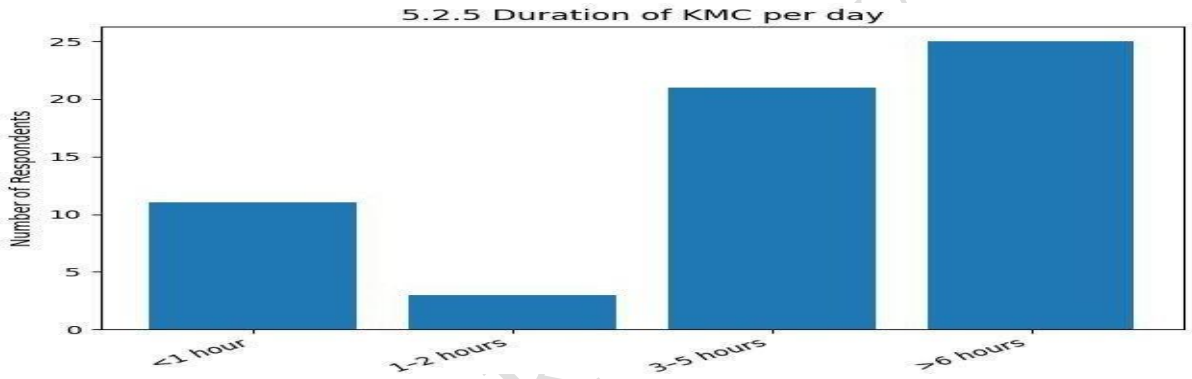


TABLE5.2.6WHATCLOTHINGISPREFERREDDURINGKMC?

WHAT CLOTHING IS PREFERREDDURING KMC	NO OF RESPONDENTS	PERCENTAGE
Tightclothes	3	5%
Loosefront-opengarmentto hold baby securely	9	15%
Thick woolen clothes	27	45%
Normal blouse and saree	21	35%
TOTAL	**60**	**100**

FIGURE5.2.6WHATCLOTHINGISPREFERREDDURINGKMC

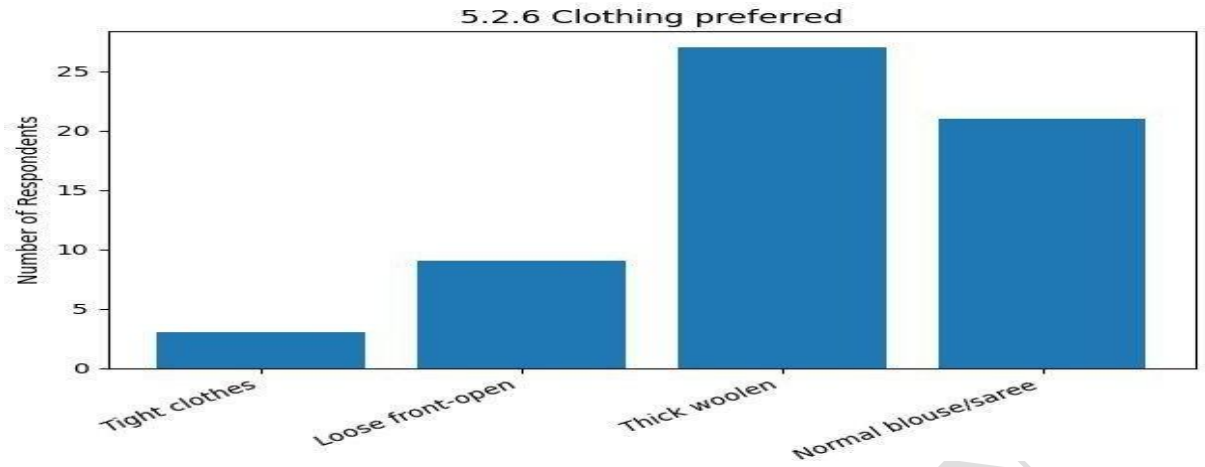


TABLE5.2.7WHATARETHEMAINADVANTAGESOFKMC?

WHAT ARE THE MAIN ADVANTAGESOFKMC	NO OF RESPONDENTS	PERCENTAGE
Improvesbaby'stemperature and bonding with mother	27	45%
Increases infection risk	2	3.3%
Causes weight loss in baby	12	20%
Makesbabydependenton mother	19	31.7%
TOTAL	**60**	**100**

FIGURE5.2.7WHATARETHEMAINADVANTAGESOFKMC

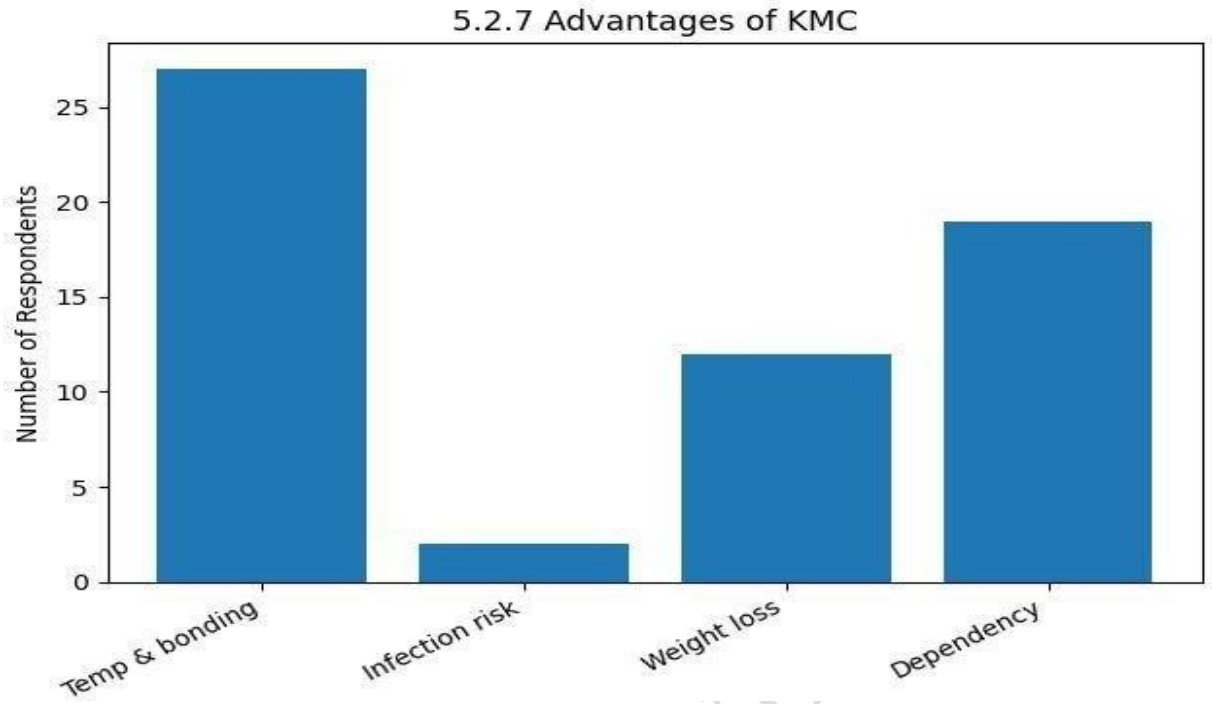


TABLE5.2.8HOWDOESKMCHELPIN BREASTFEEDING?

HOWDOESKMCHELPIN BREASTFEEDING	NO OF RESPONDENTS	PERCENTAGE
Delays milk secretion	7	11.7%
Helpsestablishearlyand exclusive breastfeeding	23	38.3%
Reduces milk flow	12	20%
Hasno effect	18	30%
TOTAL	**60**	**100**

FIGURE 5.2.8 HOW DOES KMC HELP IN BREASTFEEDING

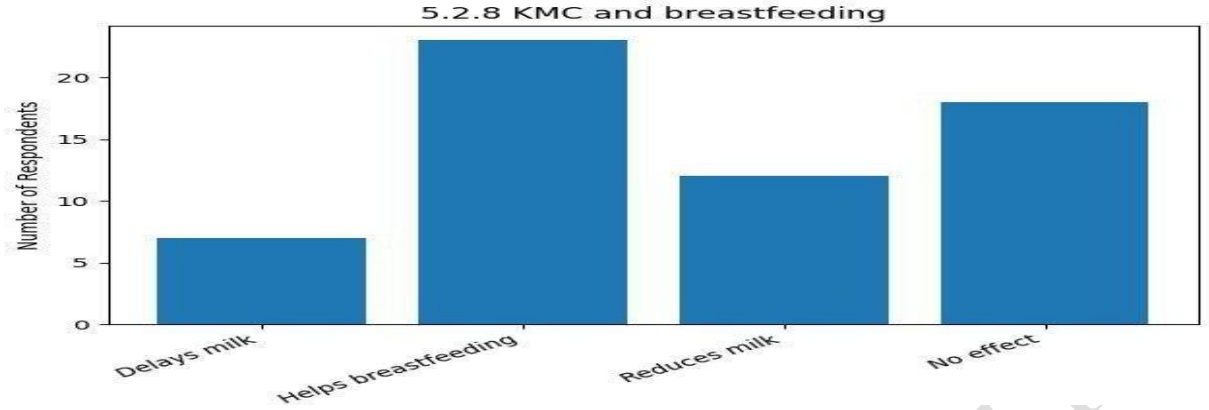


TABLE5.2.9WHENCANKMCBE STARTED?

WHENCANKMCBE STARTED?	NO OF RESPONDENTS	PERCENTAGE
Onlyafteronemonthof delivery	11	18.3%
After baby gains 3kg	22	36.7%
Assoonasthebabyisstable after birth	10	16.7%
Afterdischargefromhospital	17	28.3%
TOTAL	**60**	**100**

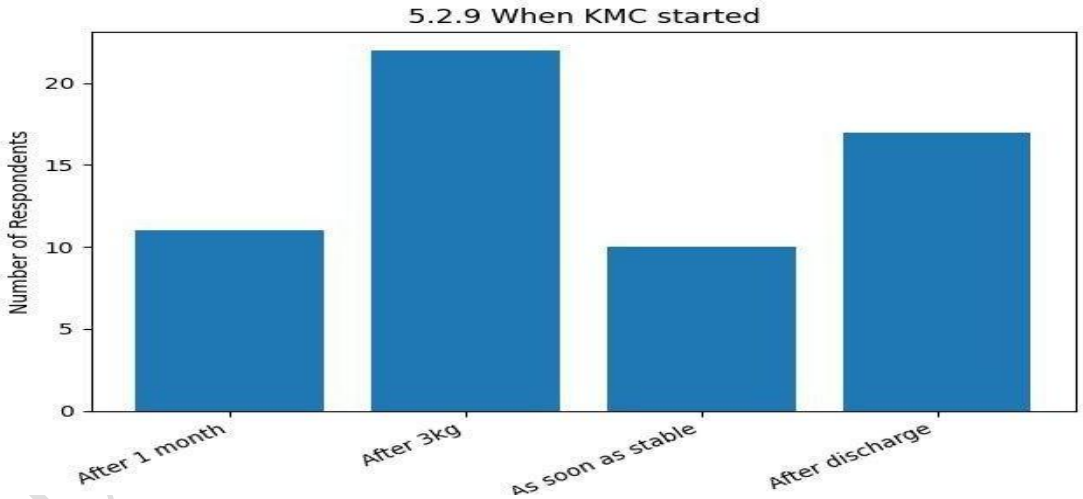


FIGURE 5.2.9 WHEN CAN KMC BE STARTED

TABLE5.2.10WHOCANPROVIDEKMCOTHERTHANTHE MOTHER?

WHOCANPROVIDEKMC OTHER THAN THE MOTHER	NO OF RESPONDENTS	PERCENTAGE
Only father	13	22%
Anyfamilymembertrained to do so (father,grandmother,etc.)	10	17%
Only doctor	28	47%
Only nurse	9	15%
TOTAL	**60**	**100**

FIGURE 5.2.10 WHO CAN PROVIDE KMC OTHER THAN THE MOTHER?

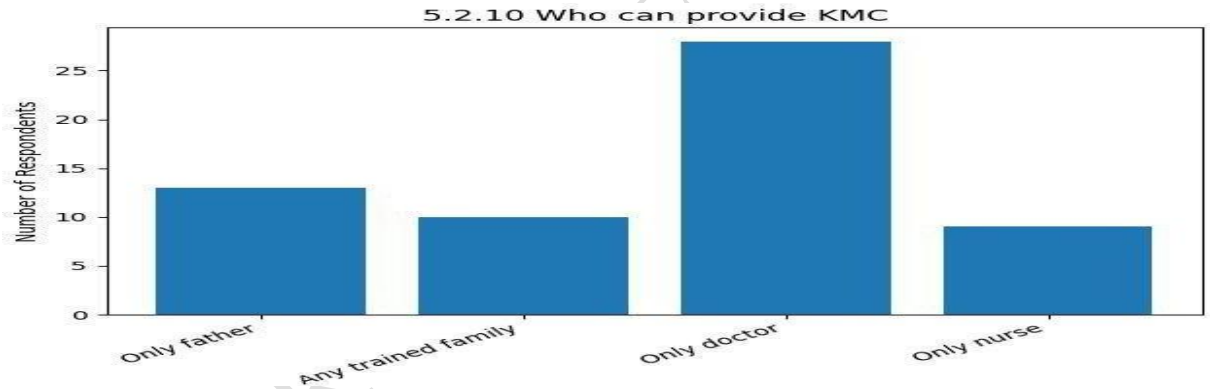


TABLE5.2.11WHATSHOULDBEMONITOREDDURINGKMC?

WHAT SHOULD BE MONITOREDDURING KMC	NO OF RESPONDENTS	PERCENTAGE
Babies breathing, temperature,andfeeding pattern	9	15%
Only weight	19	32%
Only crying	29	48%
Nothing special	3	5%
TOTAL	**60**	**100**

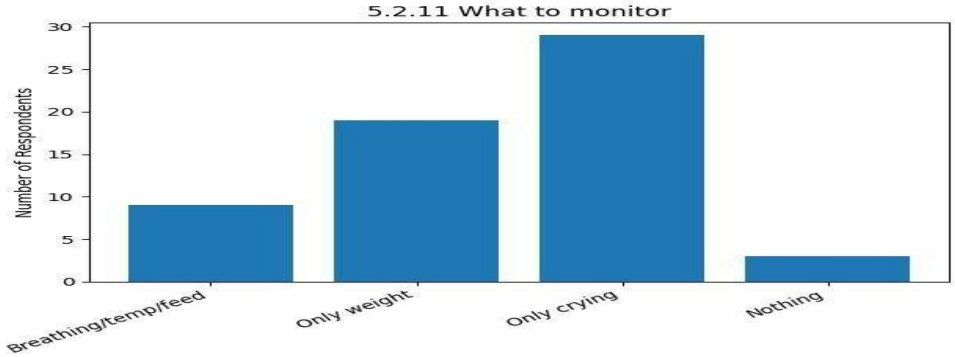


FIGURE5.2.11WHATSHOULDBEMONITOREDDURINGKMC?

TABLE5.2.12WHATISTHEMINIMUMWEIGHTRECOMMENDEDTOSTARTKMCAT HOME?

WHAT IS THE MINIMUM WEIGHTRECOMMENDED TO START KMC AT HOME?	NO OF RESPONDENTS	PERCENTAGE
Below 1000 grams	8	13%
Above 1200 grams	18	30%
Above 1800 grams	29	48%
Any weight	5	8%
TOTAL	**60**	**100**

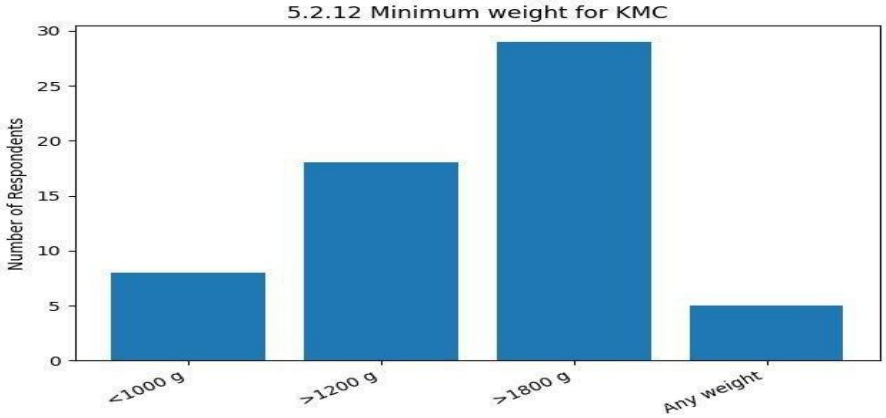


FIGURE5.2.12WHATISTHEMINIMUMWEIGHTRECOMMENDEDTOSTARTKMCAT HOME

TABLE5.2.13WHICHOFTHEFOLLOWINGISNOTABENEFITOFKMC?

WHICH OF THE FOLLOWINGISNOTA BENEFIT OF KMC	NO OF RESPONDENTS	PERCENTAGE
Better weight gain	23	38.3%
Less hospital stay	16	26.7%
Increased infection risk	8	13.3%
Improves bonding	13	21.7%
TOTAL	**60**	**100**

(SOURCE:PRIMARYDATA)

FIGURE 5.2.13 WHICH OF THE FOLLOWING IS NOT A BENEFIT OF KMC?

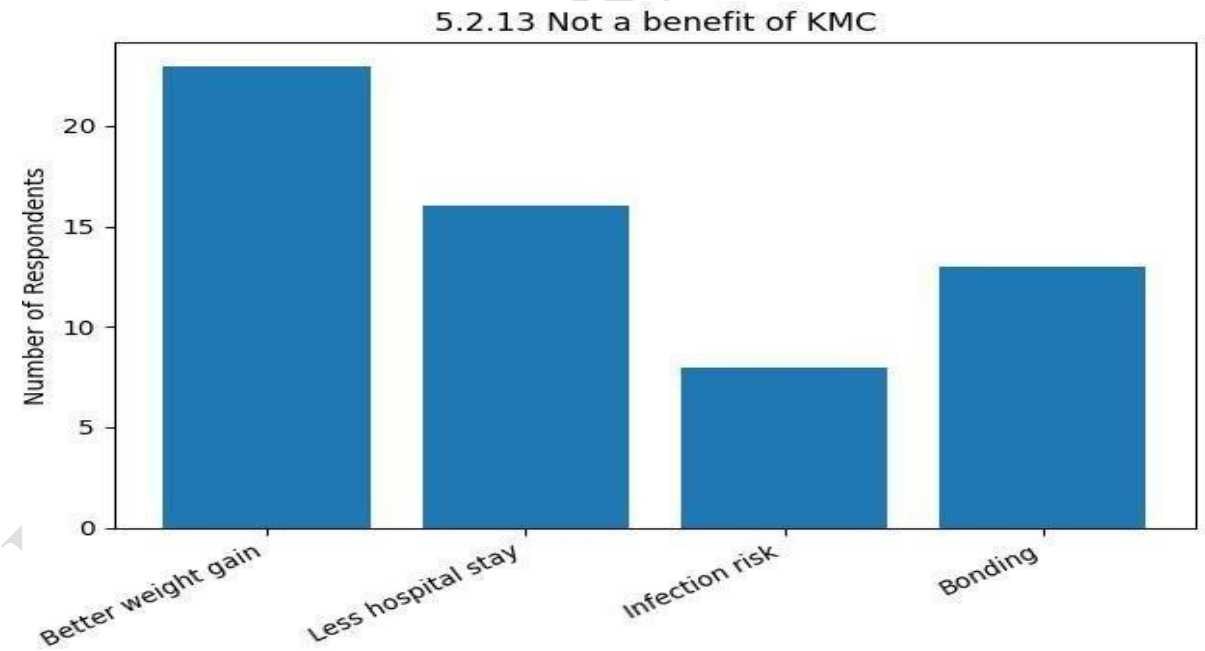


TABLE5.2.14HOWCANYOUKNOWTHATTHEBABYISWARMENOUGHDURING KMC?

HOWCANYOUKNOW THAT THE BABY IS WARMENOUGHDURING KMC	NO OF RESPONDENTS	PERCENTAGE
Baby'shandsandfeetfeel warm	21	35%
Baby is sweating	21	35%
Baby is crying	9	15%
Baby looks pale	9	15%
TOTAL	**60**	**100**

FIGURE5.2.14HOWCANYOUKNOWTHATTHEBABYISWARMENOUGHDURING KMC?

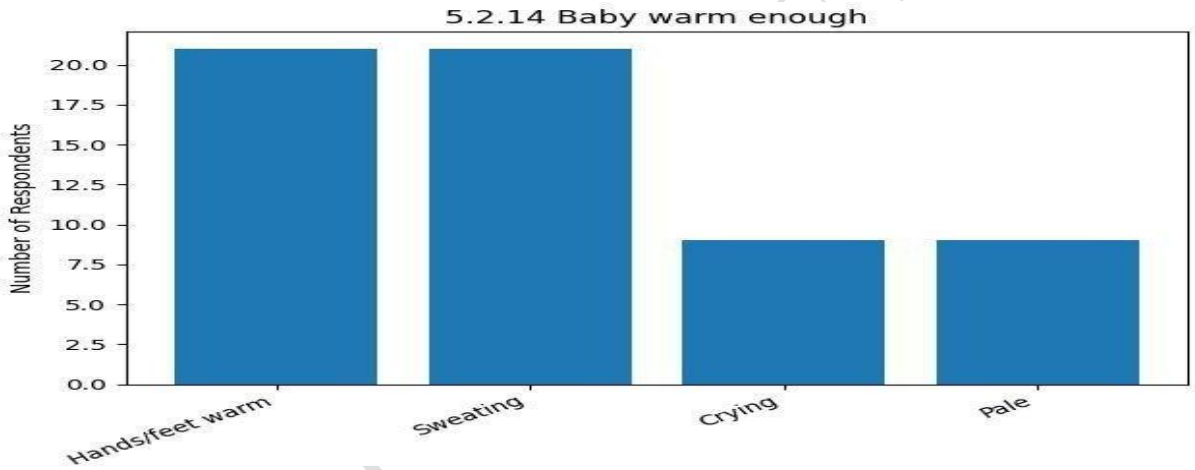


TABLE5.2.15HOWISKMCDISCONTINUED?

HOW IS KMC DISCONTINUED	NO OF RESPONDENTS	PERCENTAGE
Suddenly stop after discharge	16	26.7%
Graduallyreducedurationas baby gains weight and maintains temperature	13	21.7%
Stop if mother feels tired	14	23.3%
Stop after one week	17	28.3%
TOTAL	**60**	**100**

(SOURCE:PRIMARYDATA)

FIGURE 5.2.15 HOW IS KMC DISCONTINUED?

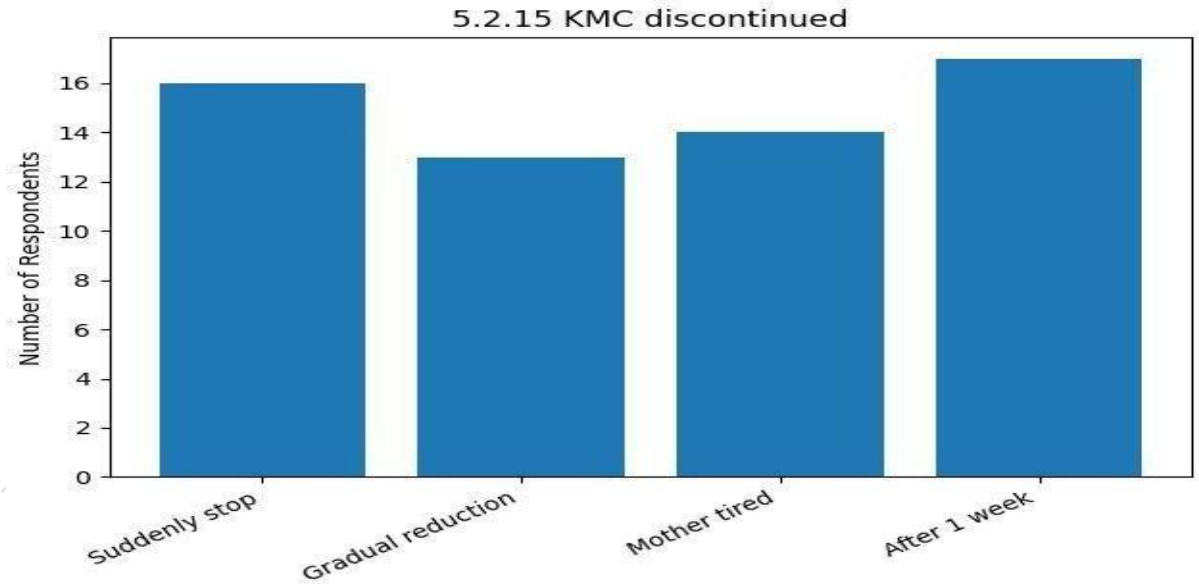
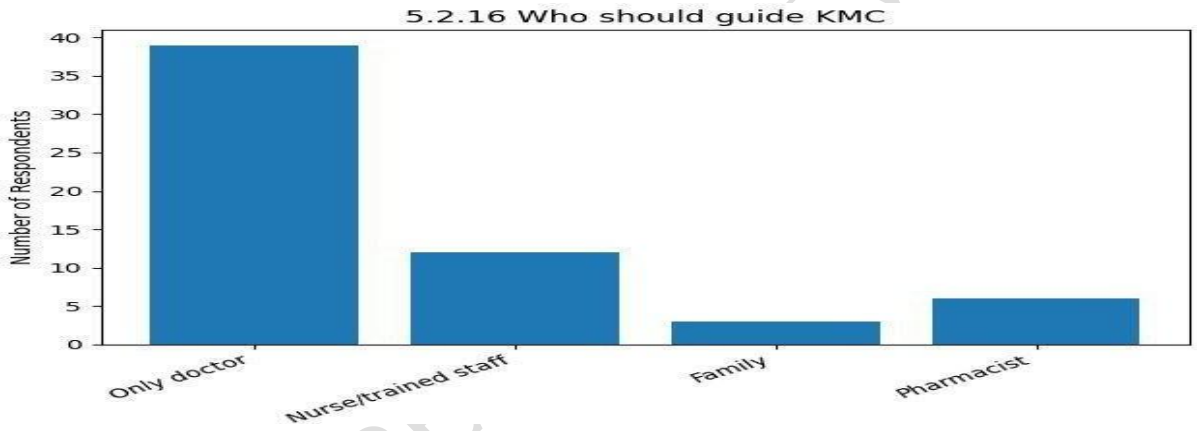


TABLE5.2.16WHICHHEALTHWORKERSHOULDGUIDEMOTHER'SABOUT KMC?

WHICH HEALTH WORKERSHOULDGUIDE MOTHER'S ABOUT KMC	NO OF RESPONDENTS	PERCENTAGE
Only doctor	39	65%
Nurseoranytrainedhealth personnel	12	20%
Only family members	3	5%
Pharmacist	6	10%
TOTAL	**60**	**100**

FIGURE5.2.16WHICHHEALTHWORKERSHOULDGUIDEMOTHER'SABOUTKMC



POST TEST

TABLE5.3.1KMCSTANDSFOR?

KMCSTANDSFOR	NO OF RESPONDENTS	PERCENTAGE
Kangaroo medical care	4	6.7%
Kangaroo mother care	56	93.3%
Key maternal care	0	0%
Keep mother comfortable	0	0%
TOTAL	**60**	**100**

FIGURE5.3.1KMCSTANDS

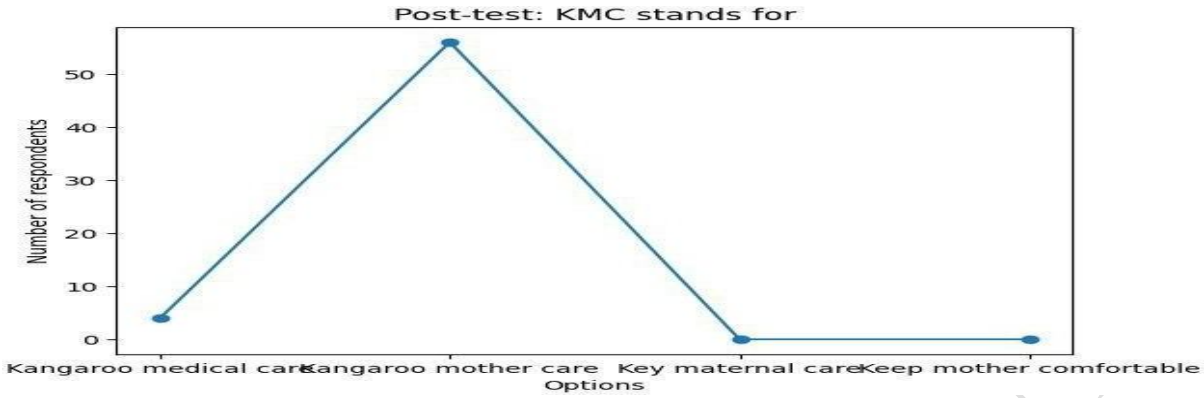


TABLE5.3.2WHATDOESKMCMEANS

WHATDOESKMCMEANS	NO OF RESPONDENTS	PERCENTAGE
Bathing the baby regularly	2	3.3%
Keep the baby in an incubator	5	8.3%
Providingskin-skincontact between mother and baby	53	88.3%
Feedingthebabyformula milk	0	0%
TOTAL	**60**	**100**

FIGURE5.3.2WHATDOESKMCMEANS

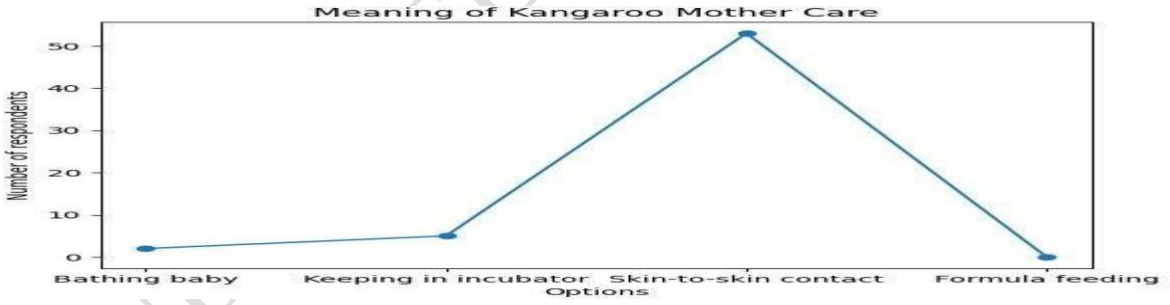


TABLE5.3.3WHICHBABIESMAINLYBENEFITSFROMKANGAROOMOTHERCARE

WHICHBABIESMAINLY BENEFITS FROM KMC	NO OF RESPONDENTS	PERCENTAGE
All full termbabies	0	0%
Only sick babies	3	5%
Lowbirthweightandpreterm babies	53	88.3%
Babies with infections	4	6.7%
TOTAL	**60**	**100**

FIGURE5.3.3WHICHBABIESMAINLYBENEFITSFROMKANGAROOMOTHERCARE

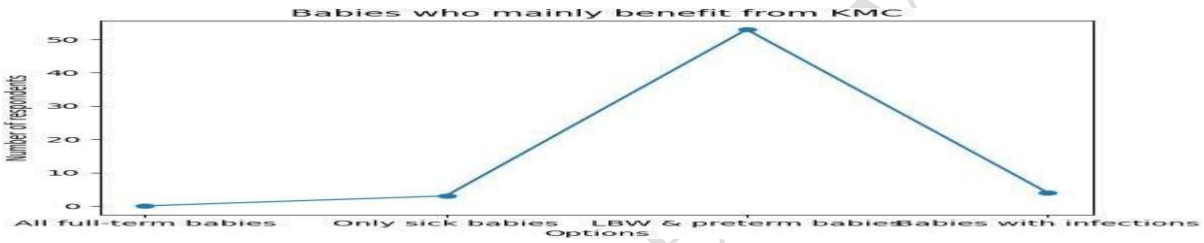


TABLE5.3.4WHICHISTHECORRECTPOSITIONOFKMC

WHICHISTHECORRECT POSITION OF KMC	NO OF RESPONDENTS	PERCENTAGE
Babyisplacedonmother's chest upright between her breast	53	88.3%
Babyisplacedonmother's back	0	0%

Babyislaidbesidethe mother on bed	5	8.3%
Babyiswrappedandkeptin cradle	2	6.7%
TOTAL	**60**	**100**

FIGURE 5.3.4 WHICH IS THE CORRECT POSITION OF KMC

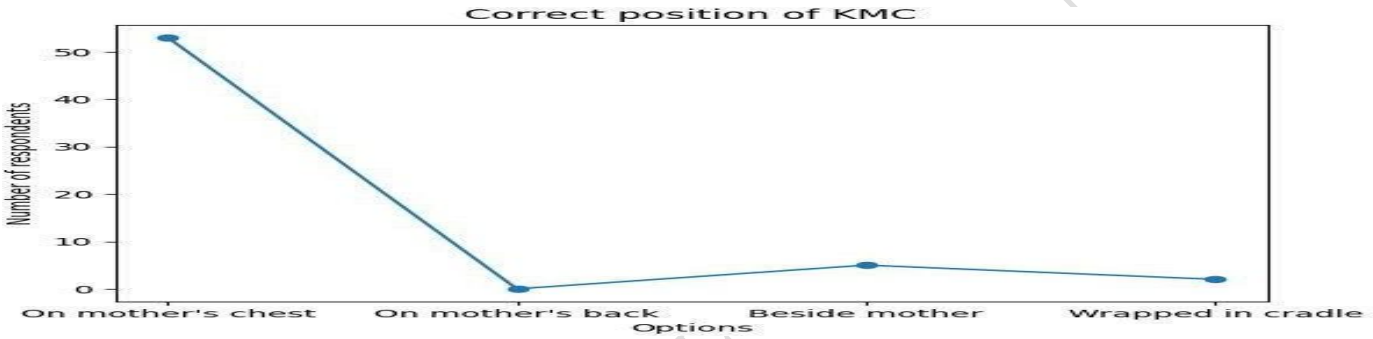


TABLE5.3.5HOWLONGSHOULDKMCBEPROVIDEDEACHDAY?

HOW LONG SHOULD KMCBEPROVIDEDEACH DAY	NO OF RESPONDENTS	PERCENTAGE
Less than 1 hour	0	0%
1-2 hours	0	0%
3-5 hours	2	3.3%
More than 6 hours	58	96.7%
TOTAL	**60**	**100**

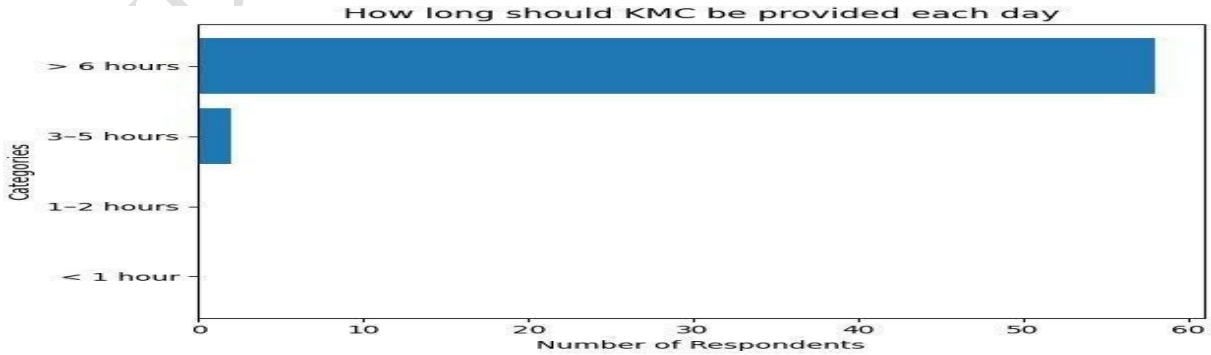


FIGURE 5.3.5 HOW LONG SHOULD KMC BE PROVIDED EACH

TABLE5.3.6WHATCLOTHINGISPREFERREDDURINGKMC?

WHAT CLOTHING IS PREFERREDDURING KMC	NO OF RESPONDENTS	PERCENTAGE
Tightclothes	1	1.7%
Loosefront-opengarmentto hold baby securely	57	95%
Thick woolen clothes	0	0%
Normal blouse and saree	2	3.3%
TOTAL	**60**	**100**

FIGURE5.3.6WHATCLOTHINGISPREFERREDDURINGKMC

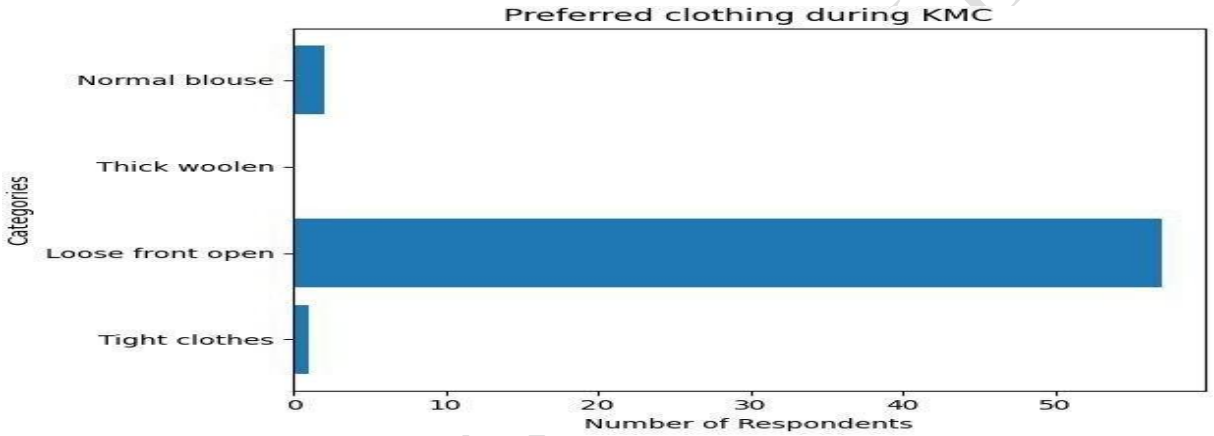


TABLE5.3.7WHATARETHEMAINADVANTAGESOFKMC?

WHAT ARE THE MAIN ADVANTAGESOFKMC	NO OF RESPONDENTS	PERCENTAGE
Improvesbaby'stemperature and bonding with mother	58	96.7%
Increases infection risk	0	0%
Causes weight loss in baby	0	0%
Makesbabydependenton mother	2	3.3%
TOTAL	**60**	**100**

FIGURE5.3.7WHATARETHEMAINADVANTAGESOFKMC

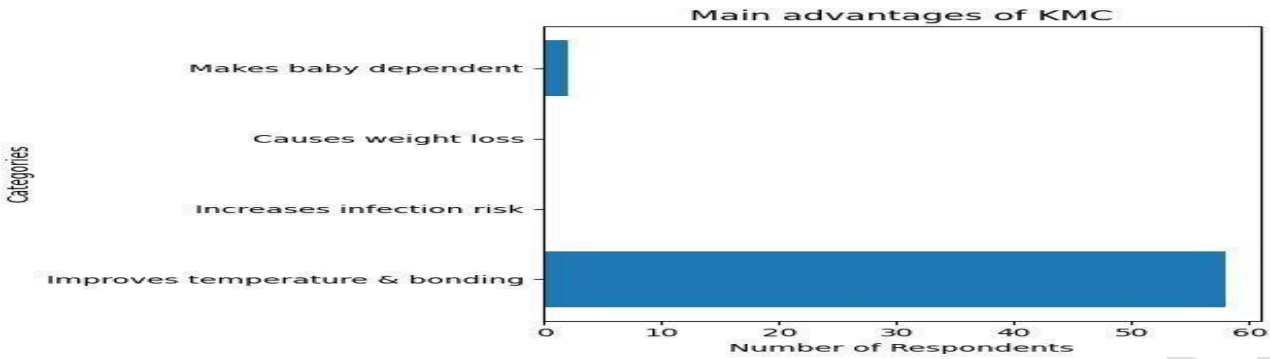
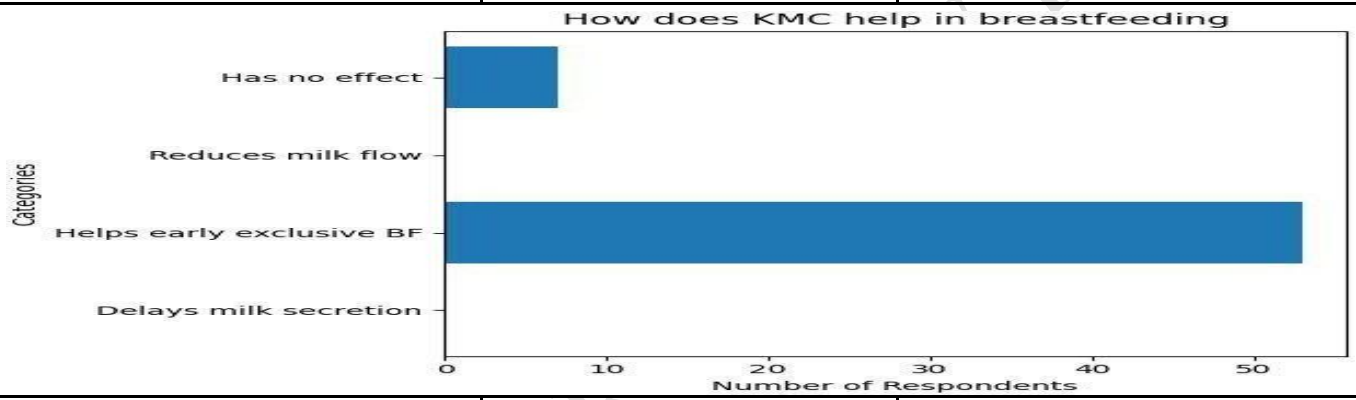


TABLE5.3.8HOWDOESKMCHELPIN BREASTFEEDING?

HOWDOESKMCHELPIN BREASTFEEDING	NO OF RESPONDENTS	PERCENTAGE



Delays milk secretion	0	0%
Helpsestablishearlyand exclusive breastfeeding	53	88.3%
Reduces milk flow	0	0%
Hasno effect	7	11.7%
TOTAL	**60**	**100**

FIGURE 5.3.8 HOW DOES KMC HELP IN BREAS

TABLE5.3.9WHENCANKMCBE STARTED?

WHENCANKMCBE STARTED?	NO OF RESPONDENTS	PERCENTAGE
Onlyafteronemonthof delivery	1	1.7%
After baby gains 3kg	0	0%
Assoonasthebabyisstable after birth	57	95%
Afterdischargefromhospital	2	3.3%
TOTAL	**60**	**100**

FIGURE 5.3.9 WHEN CAN KMC BE STARTED

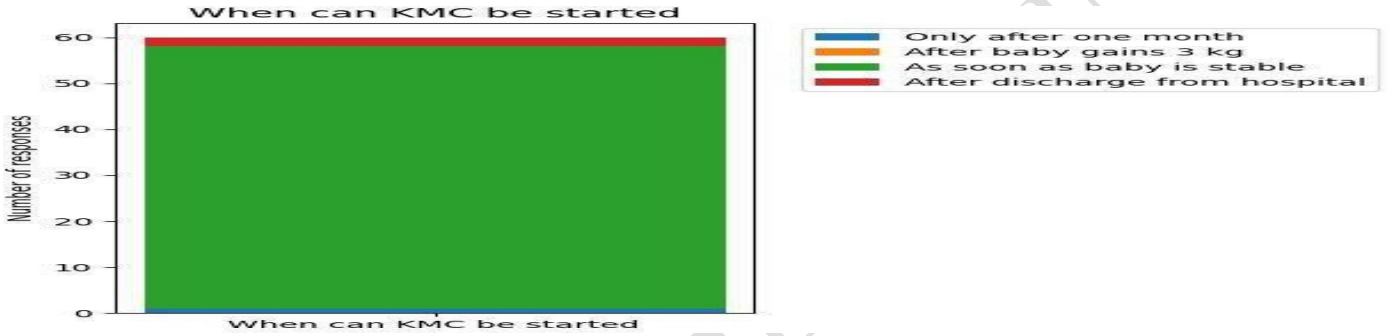


TABLE5.3.10WHOCANPROVIDEKMCOTHERTHANTHE MOTHER?

WHOCANPROVIDEKMC OTHER THAN THE MOTHER	NO OF RESPONDENTS	PERCENTAGE
Only father	6	10%
Anyfamilymembertrained to do so (father, grandmother,etc.)	53	88.3%
Only doctor	0	0%
Only nurse	1	1.7%
TOTAL	**60**	**100**

FIGURE 5.3.10 WHO CAN PROVIDE KMC OTHER THAN THE MOTHER?

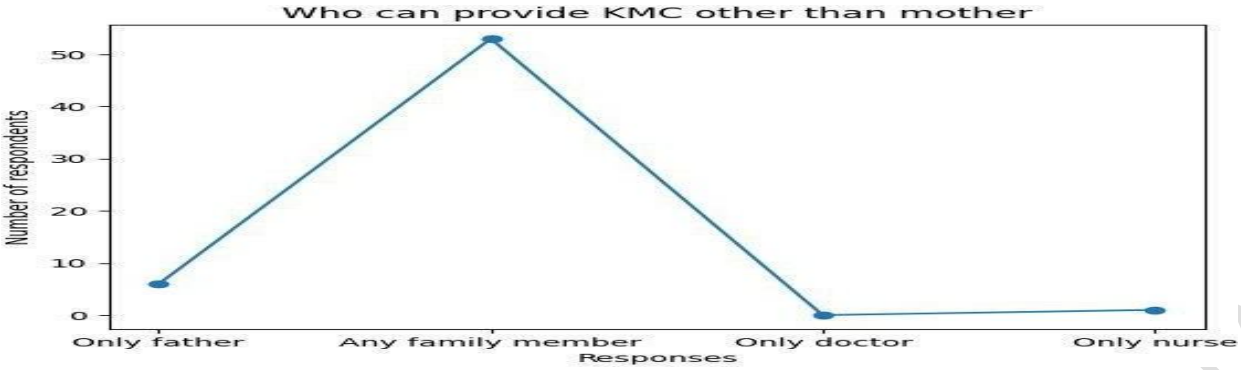


TABLE5.3.11WHATSHOULDBEMONITOREDDURINGKMC?

WHAT SHOULD BE MONITOREDDURING KMC	NO OF RESPONDENTS	PERCENTAGE
Babies breathing, temperature,andfeeding pattern	54	90%
Only weight	5	8.3%
Only crying	0	0%
Nothing special	1	1.7%
TOTAL	**60**	**100**

FIGURE5.3.11WHATSHOULDBEMONITOREDDURINGKMC?

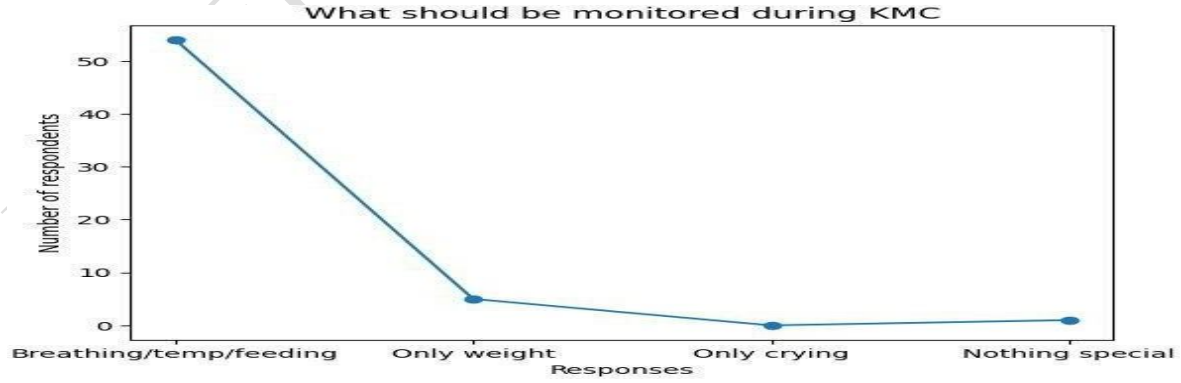
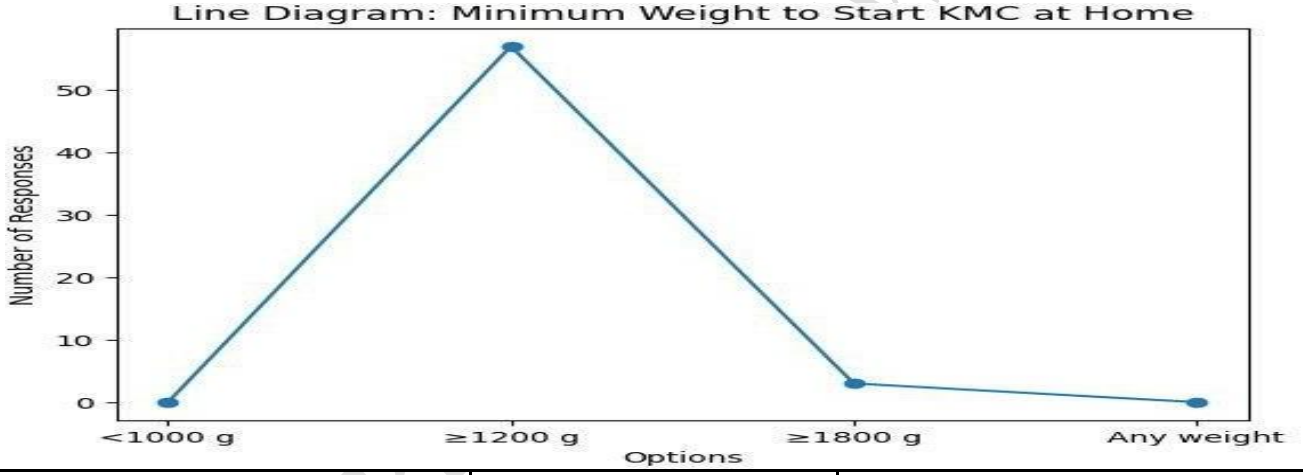


TABLE5.3.12WHATISTHEMINIMUMWEIGHTRECOMMENDEDTOSTARTKMCAT HOME?

WHAT IS THE MINIMUM WEIGHTRECOMMENDED TO START KMC AT HOME?	NO OF RESPONDENTS	PERCENTAGE
Below 1000 grams	0	0%
Above 1200 grams	57	95%
Above 1800 grams	3	5%
Any weight	0	0%
TOTAL	**60**	**100**

FIGURE5.3.12WHATISTHEMINIMUMWEIGHTRECOMMENDEDTOSTARTKMCAT HOME?

TABLE5.3.13WHICHOFTHEFOLLOWINGISNOTABENEFITOFKMC?



WHICH OF THE FOLLOWINGISNOTA BENEFIT OF KMC	NO OF RESPONDENTS	PERCENTAGE
Better weight gain	2	3.3%
Less hospital stay	1	1.7%
Increased infection risk	57	95%
Improves bonding	0	0%
TOTAL	60	100

FIGURE 5.3.13 WHICH OF THE FOLLOWING IS NOT A BENEFIT OF KMC

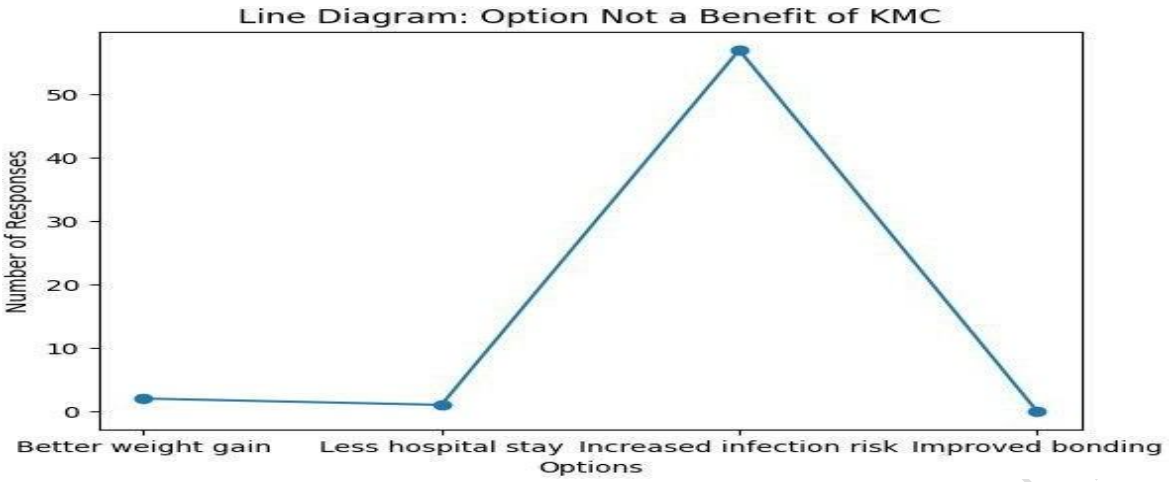


TABLE5.3.14HOWCANYOUKNOWTHATTHEBABYISWARMENOUGHDURING KMC?

X	NO OF RESPONDENTS	PERCENTAGE
Baby'shandsandfeetfeel warm	59	98.3%
Baby is sweating	1	1.7%
Baby is crying	0	0%
Baby looks pale	0	0%
TOTAL	**60**	**100**

FIGURE5.3.14HOWCANYOUKNOWTHATTHEBABYISWARMENOUGHDURING KMC?

TABLE5.3.15HOWISKMCDISCONTINUED?

HOW IS KMC DISCONTINUED	NO OF RESPONDENTS	PERCENTAGE
Suddenly stop after discharge	0	0%
Graduallyreducedurationas baby gains weight and maintains temperature	58	96.7%
Stop if mother feels tired	2	3.3%
Stop after one week	0	0%
TOTAL	**60**	**100**

(SOURCE:PRIMARYDATA)

FIGURE 5.3.15 HOW IS KMC DISCONTINUED?

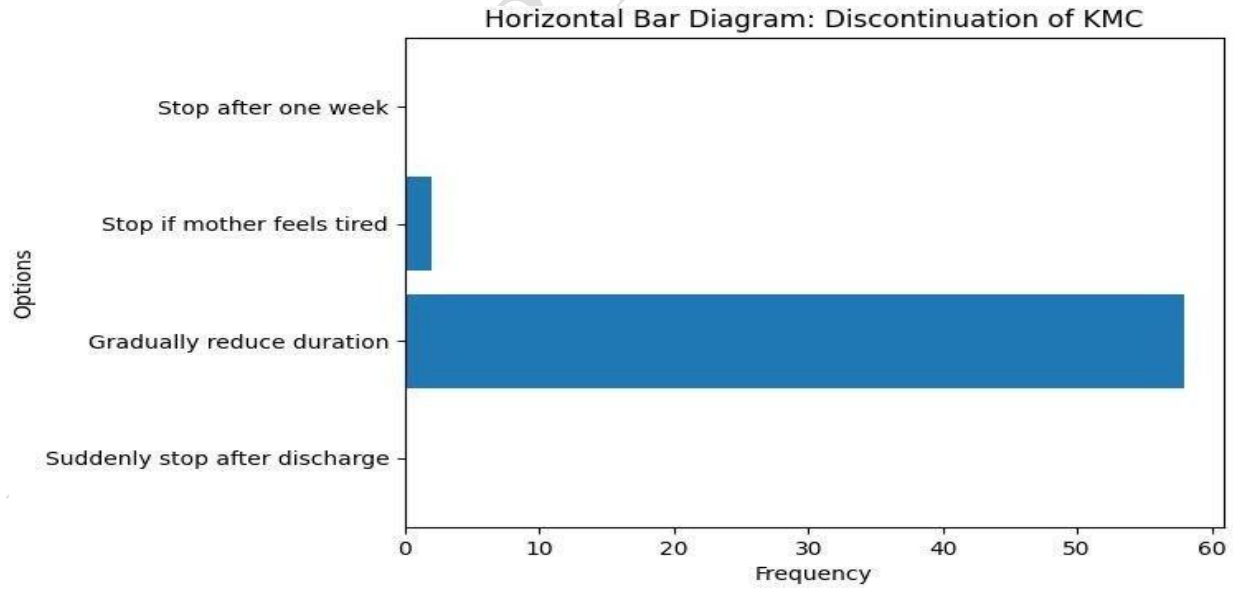
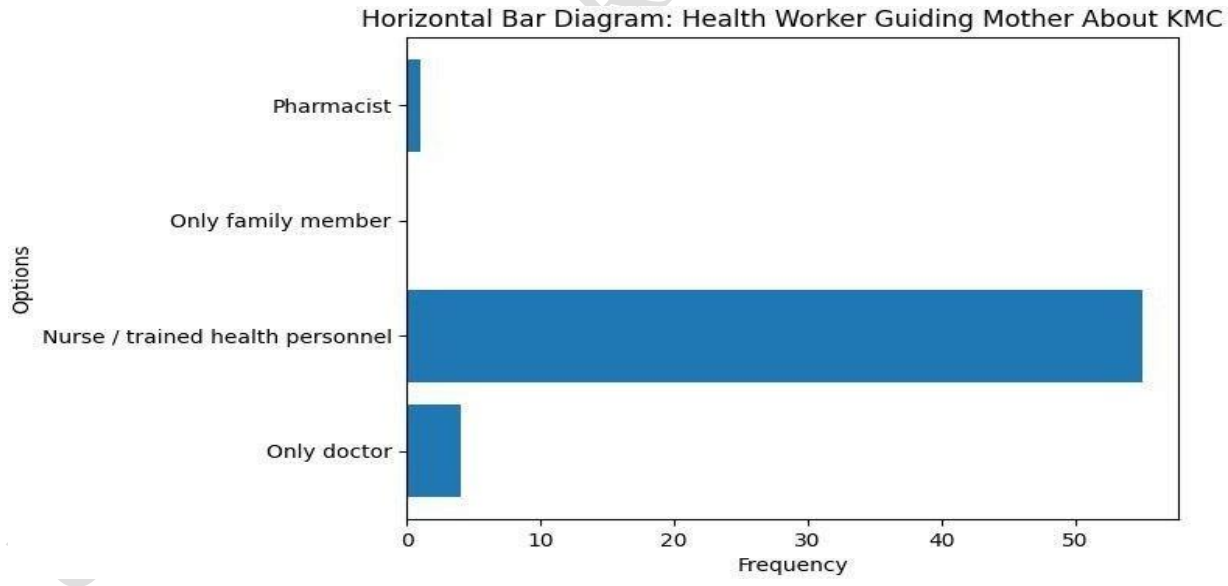


TABLE5.3.16WHICHHEALTHWORKERSHOULDGUIDEMOTHERSABOUT KMC?

WHICH HEALTH WORKERSHOULDGUIDE MOTHERS ABOUT KMC	NO OF RESPONDENTS	PERCENTAGE
Only doctor	4	6.7%
Nurseoranytrainedhealth personnel	55	91.67%
Only family members	0	0%
Pharmacist	1	1.7%
TOTAL	**60**	**100**

(Source:primarydata)

FIGURE 5.3.13 WHICH OF THE FOLLOWING IS NOT A BENEFIT OF KMC?



Thedatacollectedfrom60postnatalmotherswasorganized,analyzed,andinterpretedbasedon theobjectivesofthestudy.Descriptiveandinferentialstatisticswereusedforanalysis.Thedata wascodedandenteredintoMicrosoftExcelandfurtherstatisticalcalculationswereperformed using Pearson's correlation coefficient to assess the knowledge among thepostnatal mothers about Kangaroo mother care.

Scoring procedure

TheknowledgeofpostnatalmothersregardingKangarooMotherCarewasassessedusing a structured knowledge questionnaire prepared by the investigator.
Thetoolconsistedof23multiple choicequestionsrelatedtoKangarooMother Care.

- Eachcorrectanswerwas givenone(1) mark
- Eachincorrectanswerwasgivenzero(0)mark
- Therewasnonegativemarking

Themaximumobtainablescorewas23andtheminimumscorewas 0.

Basedon thetotal score obtained,the levelof knowledge wasclassified as follows:

TABLE6LEVELOFKNOWLEDGEAMONGTHEPOSTNATALMOTHER'SABOUT KMC

LEVEL OF KNOWLEDGE	SCORE	PERCENTAGE
Inadequate knowledge	**0-7**	**≤ 33%**
Moderatelyadequate knowledge	**8-15**	**34-66%**
Adequate knowledge	**16-23**	**≥ 67%**

Interpretationof Scoring

- **Inadequateknowledge:MothershavingpoorunderstandingregardingKangaroo Mother Care**

- **Moderatelyadequateknowledge:Mothershavingpartialknowledgeregarding Kangaroo Mother Care**

- **Adequateknowledge:MothershavinggoodknowledgeregardingKangarooMother Care**

Descriptionof the Tool

A structured questionnaire, developed through literature review and expert consultation, assessed postnatal mothers' knowledge on Kangaroo Mother Care in pretest and posttest.

Applicationof Tool

Pretest:Knowledgewasassessedbeforeadministeringvideoassistedteaching
Posttest:Knowledgewas reassessedafter thevideo assistedteaching programme
Thedifferencebetweenpretestandposttestscoreswasusedtoevaluatetheeffectivenessof video assisted teaching.

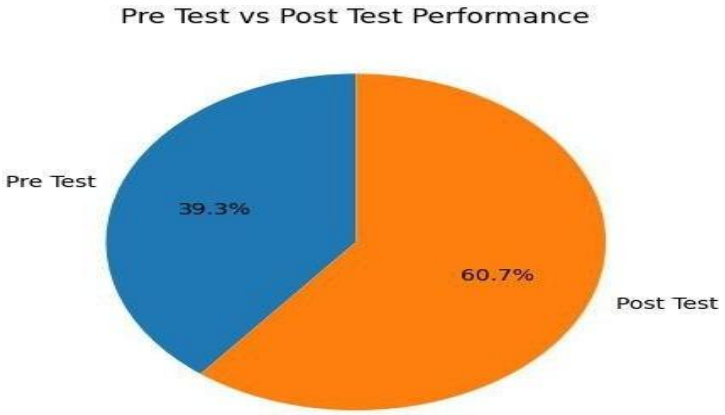
ResultInterpretationStatement(forChapter5)
Thecomparisonofpretestandposttestknowledgescoresrevealedasignificant improvementintheposttestscores,indicatingthatvideoassistedteachingwaseffectivein improving the knowledge of postnatal mothers regarding Kangaroo Mother Care.

COMPARISONOFKNOWLEDGESCORESOFPRETESTAND POSTTEST
TABLE.7MEAN,RANGE,ANDSTANDARDDEVIATIONOFPRETESTAND POSTTESTKNOWLEDGESCORESOFTHEPOSTNATALMOTHER'SABOUTKMC

Knowledge scores	Max.score	Range	Mean	Mean percentage	Standard deviation
Pretest	**10**	**10**	**4.39**	**43.9%**	**2.11**
Posttest	**15**	**8**	**12.41**	**82.7%**	**1.97**

The data in table reveals that the mean and standard deviation of knowledge of score in pretestis4.39±2.11andintheposttestis12.41±1.97whichindicatedthereissignificant improve in the knowledge of the postnatal mothers after the video assisted teaching program

FIGURE7.KNOWLEDGESCOREOFPRETESTANDPOSTTESTOFPOSTNATAL



MOTHER'S ABOUT KMC

CORRELATIONOFKNOWLEDGESCORESOFPRETESTANDPOSTTESTAMONG POSTNATAL MOTHER'S ABOUT KMC

TABLE8CORRELATIONOFKNOWLEDGESCORESWITHPRETESTAND POSTTEST

Variables	Mean	Standard deviation	"r"Value	"p"Value
Pretest	4.39	2.11	0.21	0.109
Posttest	12.41	1.97		

Thedataintheabovetabledepictsthatthereisstatisticallysignificantcorrelationbetween the pretest and posttest scores of knowledge among the postnatal mothers about kmc

Discussion The present study aimed to assess the effectiveness of Video Assisted Teaching (VAT) on knowledge and practice regarding Kangaroo Mother Care (KMC) among postnatal mothers of low-birth-weight babies in a selected hospital in Bengaluru. The findings are discussed according to the objectives of the study and supported by relevant literature.

Discussion Based on Demographic Variables

The results showed that 46.7% of postnatal mothers were aged 21–25 years, indicating young mothers more receptive to health education, consistent with Charpak et al. (2017). Most had primary or secondary education, suggesting limited awareness of neonatal care practices like Kangaroo Mother Care. Many were working mothers from nuclear families. Most infants were preterm or low birth weight. Pre-test results revealed inadequate maternal knowledge regarding KMC practices and benefits.

Discussion Based on Post-Test Knowledge

Post-test results showed significant improvement in mothers' knowledge after Video Assisted Teaching. Mothers understood KMC meaning, skin-to-skin contact, infant eligibility, positioning, duration, and monitoring, supporting studies highlighting effectiveness of video-based education.

Discussion on Practice-Related Knowledge

Post-test findings also showed improvement in practice-related knowledge of KMC. Many mothers recognized that trained family members can assist in providing KMC, and they understood the importance of continuous monitoring during the procedure. They also identified benefits such as improved breastfeeding, temperature regulation, and bonding.

Conclusion of Discussion

The study showed postnatal mothers initially had inadequate knowledge of Kangaroo Mother Care. After Video Assisted Teaching, knowledge improved significantly, proving audiovisual education effective for enhancing maternal awareness and neonatal care practices.

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- WorldHealthOrganization.(2016).WHOrecommendationsoninterventionstoimprove preterm birth outcomes. Geneva: WHO.
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