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**RESEARCH ARTICLE**

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

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**Key words:-**

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

**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 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.

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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.

### **Introduction:-**

Kangaroo Mother care (KMC) is a special way in which the baby is continuously kept in skin-to-skin contact by the mother for promoting effective thermal control, breastfeeding infection prevention and bonding in low birth weight. Video Assisted teaching provide innovative approach to bridge the gap in maternal education, particularly for new mothers in low Resources 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 a visual and auditory learning to be likely experiences, which is more likely to be remembered & and practiced than traditional verbal instruction alone. For postnatal mothers, especially those with low both weight infants who require extra care, VAT can be a valuable resources, ensuring that the mothers feel more confident and capable in performing kmc. this approach is particularly careful in situations where direct, in person training may be limited due to time or resource constraints.

### **Objectives:-**

1. To Assess The Pretest Knowledge And The Practice Among Postnatal Mother On Kmc Among With Low Birth Weight"
2. To Evaluate The Effectiveness Of Video Assisted Teaching Programme On Knowledge And Practice On Kmc Knowledge
3. To Assess The Posttest Knowledge And The Practice On Kmc Among Postnatal Mother With Low Birth Weight
4. To Find The Association Of Knowledge And The Practice On Kmc Among Postnatal Mothers With Low Birth Weight Selected Demographic Variables

### **Hypotheses:-**

There will be a significant increase in knowledge and practices on KMC among the postnatal mothers with low birth weight babies after video assisted teaching

### **Review of Literture:-**

#### **Kangaroo mother care:**

World Health Organization (WHO) 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:**

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:-**

The 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, analyse, and interpret data.

**Research Approach:**

A research approach refers to the general strategy or plan a researcher uses to conduct their study. It guides how data will be gathered, analyzed, and interpreted. In this present study, a qualitative research approach was taken as it is appropriate to accomplish the objectives of the study.

**Research Design:**

Research design for study is Quasi Experimental research design

**Setting of The Study:**

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

**Population:**

Population for the study comprises of postnatal mothers with low birth weight babies from 1.5kg to 2.5 kg at Sapthagiri Super Specialty Hospital, Chikkasandra, Bangalore.

**Conceptual Framework:-**

**Input:-**

(Input refers to factors that influence the process)

**Demographic variables of postnatal mothers:-**

- Age
- Education
- Occupation
- Type of family
- Socio-economic status
- Place of residence
- Previous knowledge/experience about KMC
- Support system at home

**Baseline status:-**

- Pre-test knowledge regarding Kangaroo Mother Care
- Pre-test practice regarding Kangaroo Mother Care

**Intervention:-**

- Video Assisted Teaching programme on Kangaroo Mother Care
- Meaning and importance of KMC
- Benefits of KMC
- Correct position and duration
- Monitoring during KMC
- Role of family members

**Throughput:-**

**(Activities carried out during the study):-**

- Administration of pre-test questionnaire and practice checklist
- Implementation of Video Assisted Teaching on KMC
- Motivation and clarification of doubts
- Reinforcement through audiovisual learning

**Output:-**

**(Immediate results after intervention):-**

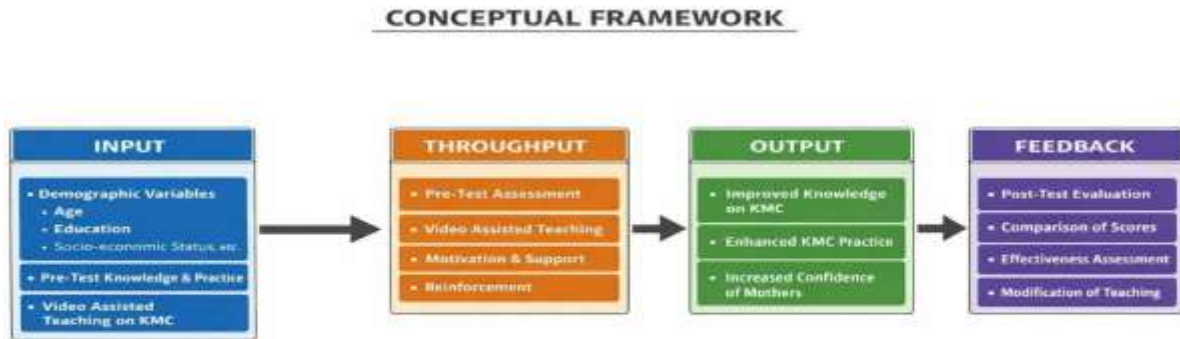
- Improved knowledge score regarding Kangaroo Mother Care
- Improved practice score regarding Kangaroo Mother Care
- Increased confidence among postnatal mothers in providing KMC

**Feedback:-**

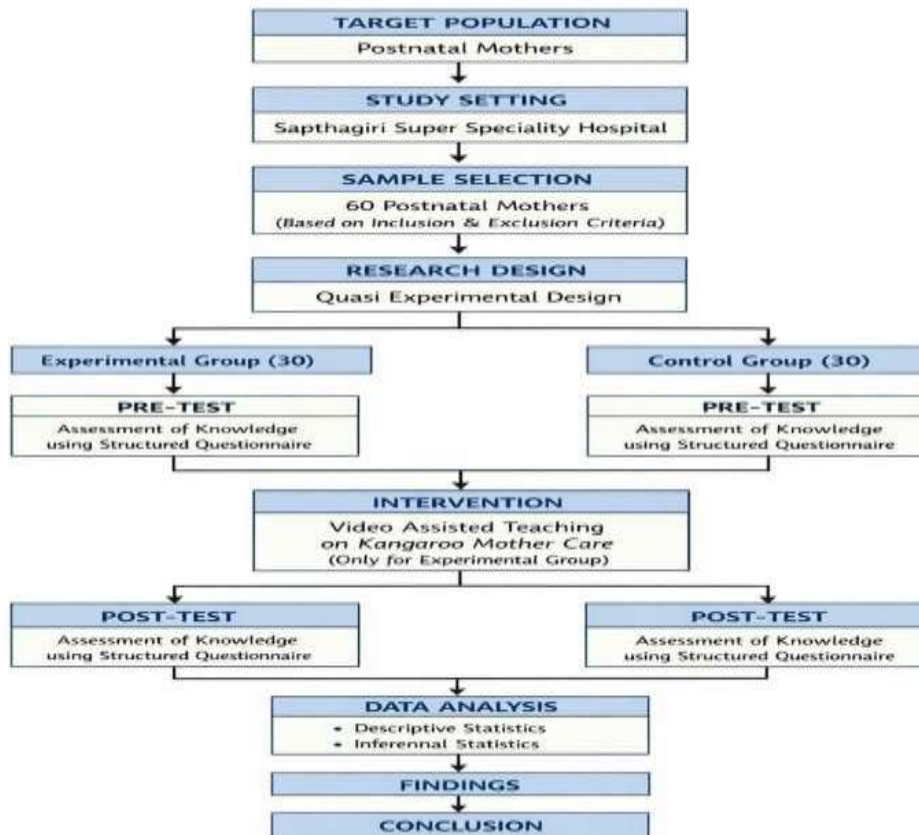
(Long-term effect and evaluation)

- 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 -Experimental research design (Experimental & Control group with pre-test and post-test)

**Sample and Sampling Techniques:**

**Sample:**

The sample is a subject of population selected to participate in a research study. The sample for the present study comprises of postnatal mothers with lowbirth weight from 1.5kg to 2.5 kg from postnatal ward ,NICU, and OBG OPD

**Sample Size:**

Sample size for the intended study consists of a total of 60 postnatal mothers

**Sampling Technique:**

It is a 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:**

Post natal mothers who are With low birth weight babies 1.5kg to 2.5k

**Exclusion Criteria:**

Other post natal mothers

- 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 study’s objectives and literature review. Section 1 included a semi-structured interview assessing demographic variables like age, education, occupation, marital status, and KMC experience. Section 2 contained four-option questions related to care bundles derived from relevant studies, journals, and books.

**Description of The Instrument:**

**Section 1: Demographic Variables**

**Section 2: A structured questionnaire with four responsive options regarding care bundles.**

Data were collected over 10 days from postnatal mothers and nurses meeting inclusion criteria using purposive sampling. After obtaining informed consent, participants completed a semi-structured questionnaire. Data were analyzed using descriptive and inferential statistics, including mean, percentage, range, standard deviation, and chi-square tests. Findings were presented through figures and percentages, summarizing the study methodology.

**Data Analysis and Interpretations:-**

**Table 5.1.1 AGE OF RESPONDENT**

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

(Source : primary data)

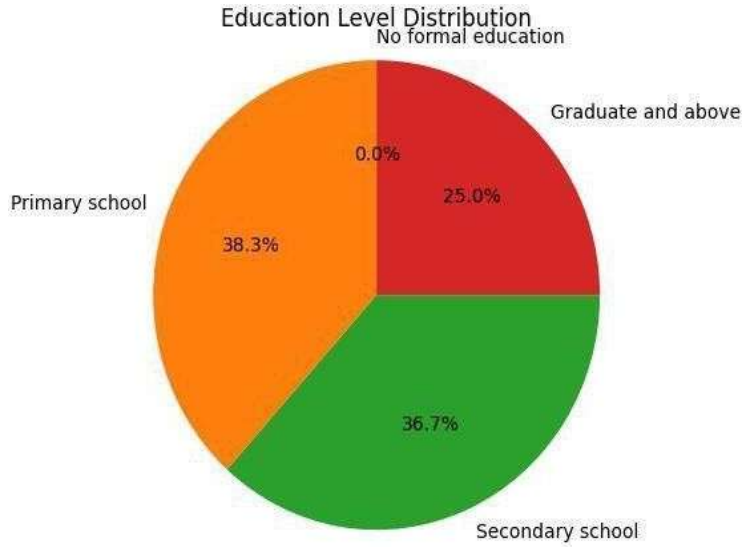


Figure 5. 1.1 AGE OF RESPONDENTS

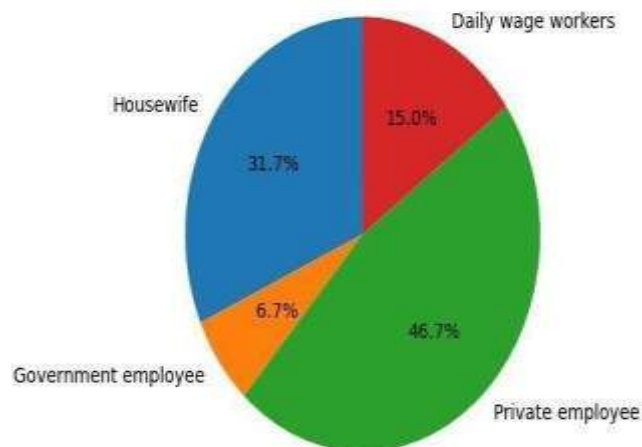
Table 5.1.2 Education of RESPONDENT

Education level	No.of Respondents	PERCENTAGE
No formal education	0	0%
Primary school	23	38.3%
Secondary school	22	36.7%
Graduate and above	15	25%
<b>Total</b>	<b>60</b>	<b>100</b>

(Source : primary data)

FIGURE 5.1.2 Education of respondent

Distribution of Postnatal Mothers by Occupation



**Table 5.1.3 Occupation**

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

**Table 5.1.4 Marital Status**

MARITAL STATUS	NO OF RESPONDENTS	PERCENTAGE
Married	60	100%
Unmarried	0	0%
Widowed	0	0%
Divorced	0	0%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

(Source Primary Data)



**Figure 5.1.3 Occupation**

Figure 5.1.4 Marital Status

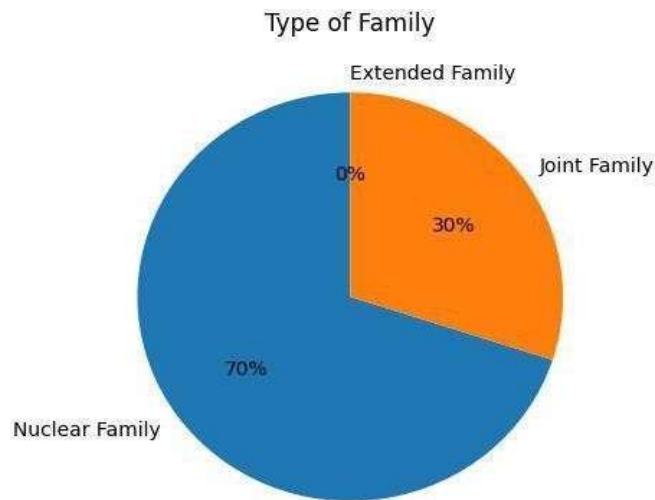


Table 5.1.5 Type of Family

TYPE OF FAMILY	NO OF RESPONDENTS	PERCENTAGE
Nuclear family	42	70%
Joint family	18	30%
Extended family	0	0%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.1.5 Type of Family



**Table 5.1.6 Number Of Delivery**

NUMBER OF DELIVERY	NO OF RESPONDENTS	PERCENTAGE
Primigravida	18	30%
Multipara	42	70%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

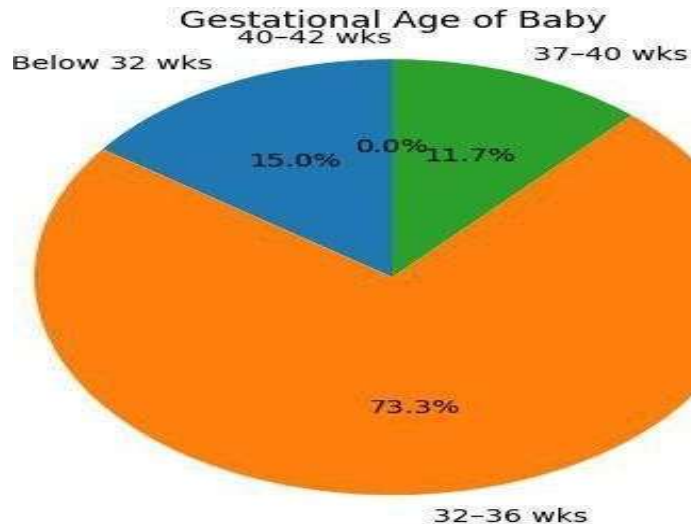
**Figure 5.1.6 Number Of Delivery**



**Table 5.1.7 Mode Of Delivery**

MODE OF DELIVERY	NO OF RESPONDENTS	PERCENTAGE
Normal vaginal delivery	30	50%
Cesarean section	19	31.7%
Forceps delivery	8	13.3%
Vaccum extraction	3	5%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.1.8 Mode Of Delivery**



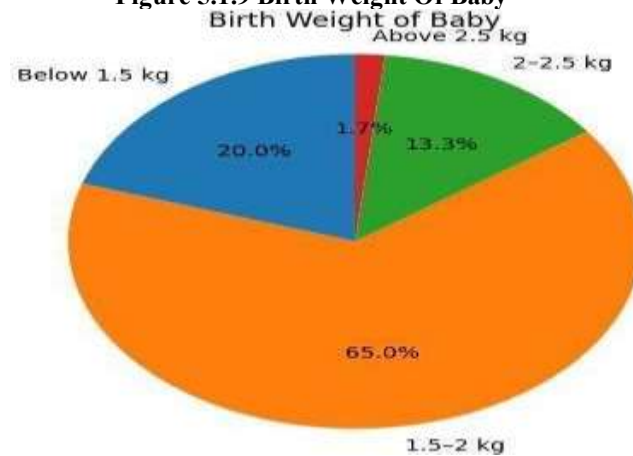
**Table 5.1.8 Gestational Age Of Baby**

GESTATIONAL AGE OF BABY	NO OF RESPONDENTS	PERCENT AGE
Below 32 weeks	9	15%
32-36 weeks	44	73.3%
37-40 weeks	7	11.7%
40-42 weeks	0	0%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Table 5.1.9 Birth Weight Of Baby**

BIRTH WEIGHT OF BABY	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%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.1.9 Birth Weight Of Baby**



**Table 5.1.10 Socio-Economic Status**

SOCIO ECONOMIC STATUS	NO OF RESPONDENTS	PERCENTAGE
Low	11	18.3%
Middle	42	70%
Upper middle	6	10%
High	1	1.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

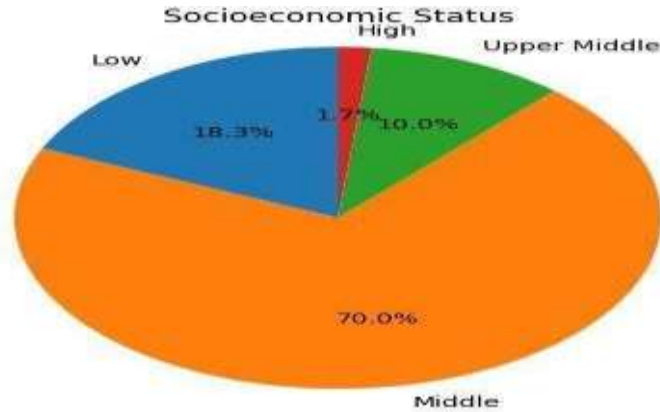


Figure 5.1.10 Socio-Economic Status

Table 5.1.11 Place Of Residence

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

Table 5.1.12 Religion

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

Figure 5.1.12 Religion

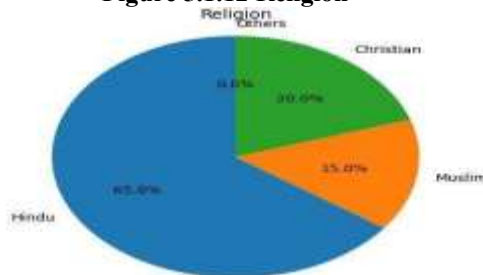
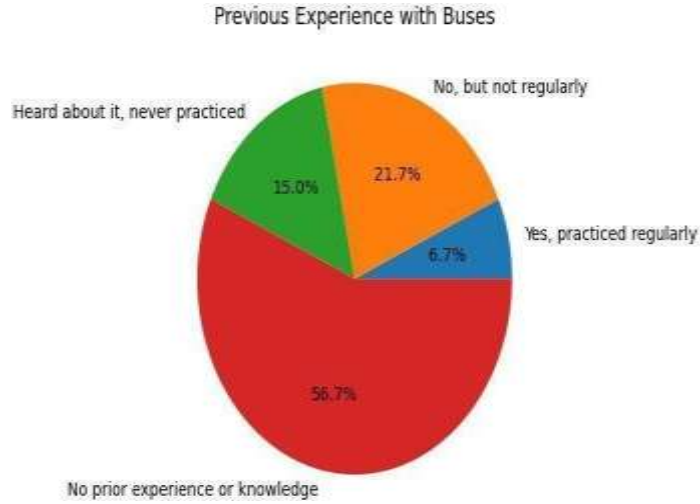


Table 5.1.13 Previous Experience With Kmc

PREVIOUS EXPERIENCE	NO OF RESPONDENTS	PERCENTAGE
Yes, practiced regularly	4	6.7%
Yes, but not practiced regularly	13	21.7%
Heard about it ,never Practiced	9	15%
No prior experience or	34	56.7%

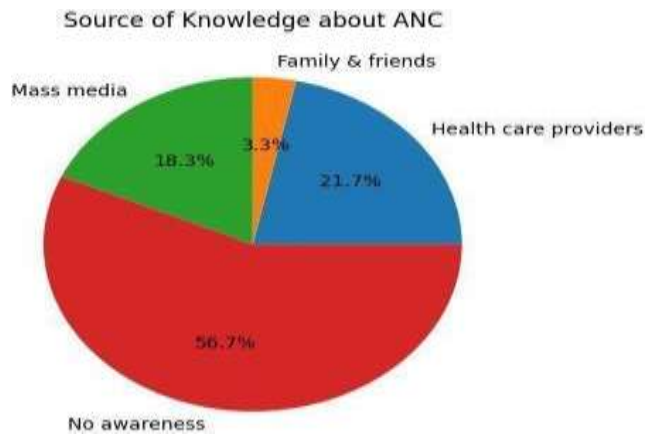
knowledge		
TOTAL	60	100

**Figure 5.1.13 Previous Experience With Kmc**



**Table 5.1.14 From Where Did You Get The Knowledge About Kmc?**

FROM WHERE DID YOU 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%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

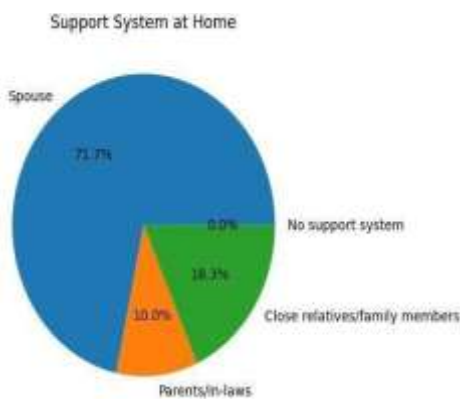


**Figure 5.1.14 From Where Did You Get The Knowledge About Kmc**

**Table 5.1.15 Support System At Home**

SUPPORT SYSTEM AT HOME	NO OF RESPONDENTS	PERCENTAGE
Spouse	43	71.7
Parents / in laws	6	10
Care giver / family members	11	18.3
No support system	0	0
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.1.15 Support System At Home**



**Pre Test**

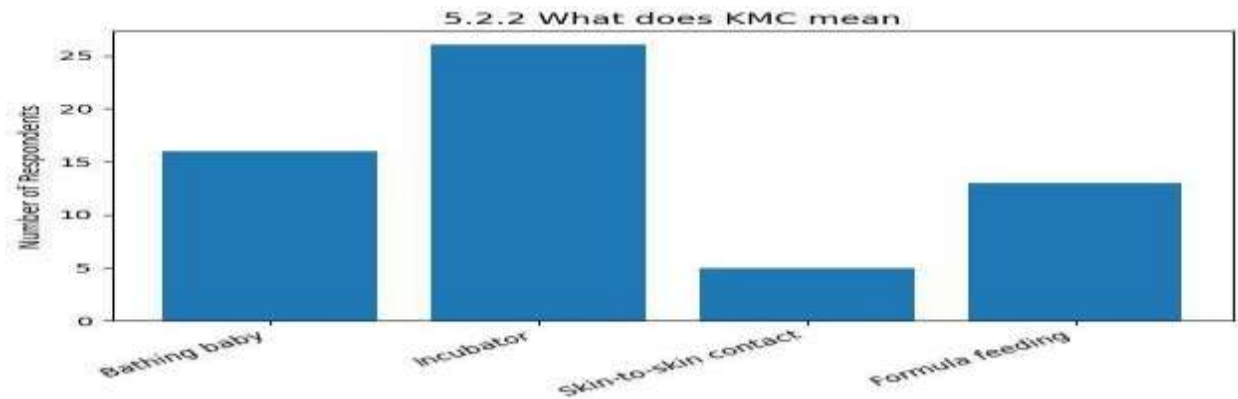
**Table 5.2.1 Kmc Stands For?**

KMC STANDS FOR	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%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

(Source: Primary Data) Figure 5.2.1 Kmc Stands For?

**Table 5.2.2 What Does Kmc Means**

WHAT DOES KMC MEANS	NO OF RESPONDENTS	PERCENTAGE
Bathing the baby regularly	16	26.7%
Keep the baby in an incubator	26	43.3%
Providing skin-skin contact between mother and baby	5	8.3%
Feeding the baby formula milk	13	21.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.2.2 What Does Kmc Means****Table 5.2.3 Which Babies Mainly Benefits From Kangaroo Mother Care**

WHICH BABIES MAINLY BENEFITS FROM KMC	NO OF RESPONDENTS	PERCENTAGE
All full term babies	27	45%
Only sick babies	16	26.7%
Low birth weight and preterm babies	8	13.3%
Babies with infections	9	15%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.2.3 Which Babies Mainly Benefits From Kangaroo Mother Care

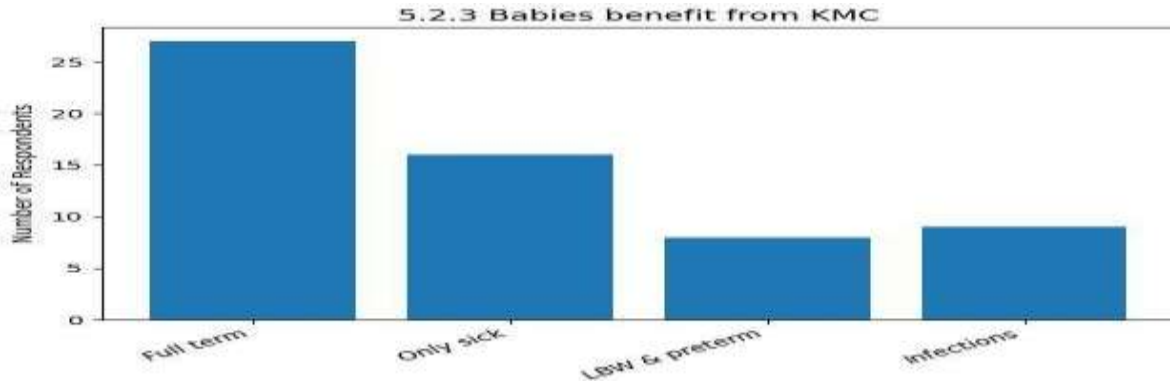
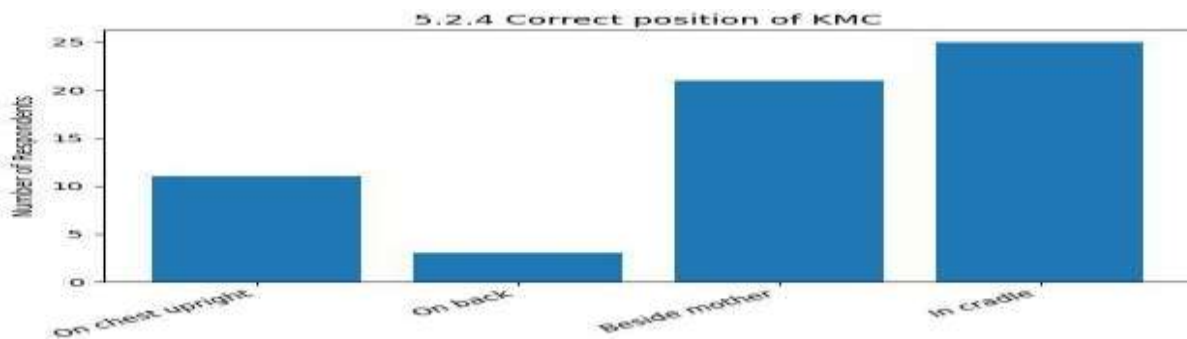


Table 5.2.4 Which Is The Correct Position Of Kmc

WHICH IS THE CORRECT POSITION OF KMC	NO OF RESPONDENTS	PERCENTAGE
Baby is placed on mother's chest upright between her breast	11	18.3%
Baby is placed on mother's back	3	5%
Baby is laid beside the mother on bed	21	35%
Baby is wrapped and kept in cradle	25	41.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

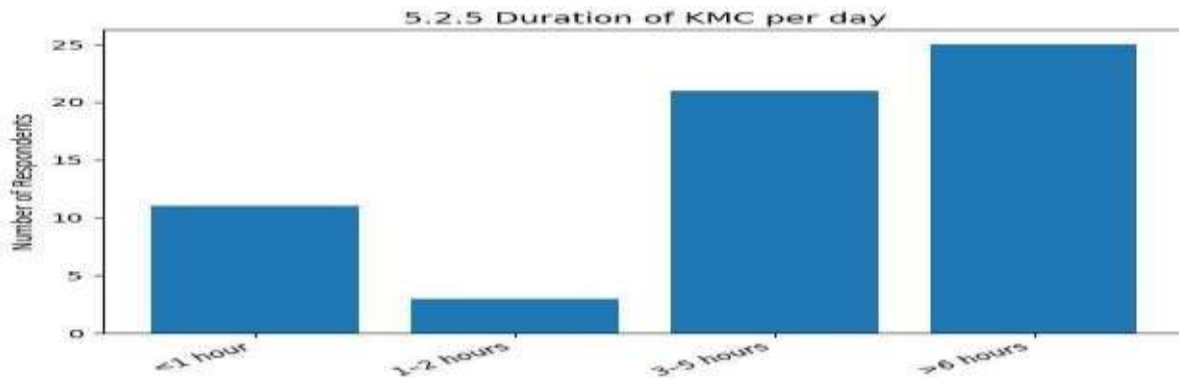
Figure 5.2.4 Which Is The Correct Position Of Kmc



**Table 5.2.5 How Long Should Kmc Be Provided Each Da**

HOW LONG SHOULD KMC BE PROVIDED EACH 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%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.2.5 How Long Should Kmc Be Provided Each Day**



**Table 5.2.6 What Clothing Is Preferred During Kmc?**

WHAT CLOTHING IS PREFERRED DURING KMC	NO OF RESPONDENTS	PERCENTAGE
Tight clothes	3	5%
Loose front - open garment to hold baby securely	9	15%
Thick woolen clothes	27	45%
Normal blouse and saree	21	35%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.2.6 What Clothing Is Preferred During Kmc

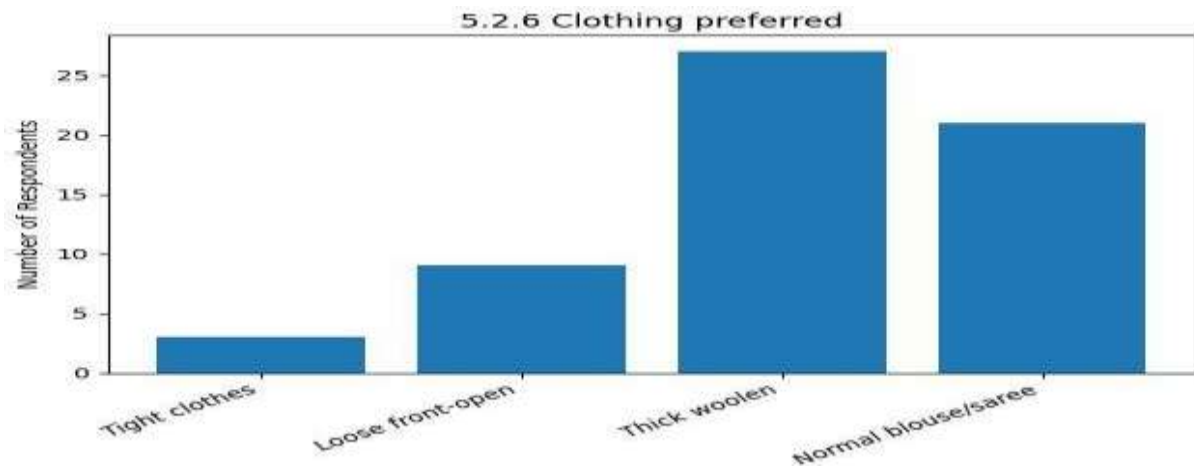
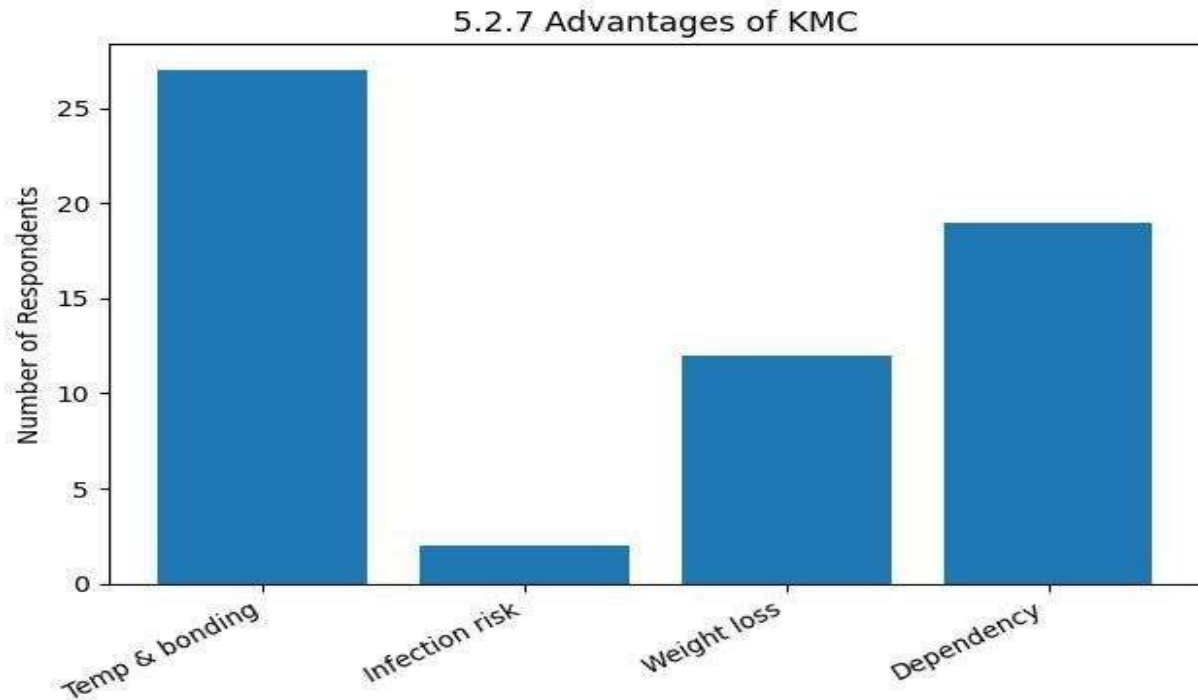


Table 5.2.7 What Are The Main Advantages Of Kmc?

WHAT ARE THE MAIN ADVANTAGES OF KMC	NO OF RESPONDENTS	PERCENTAGE
Improves baby's temperature and bonding with mother	27	45%
Increases infection risk	2	3.3%
Causes weight loss in baby	12	20%
Makes baby dependent on mother	19	31.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.2.7 What Are The Main Advantages Of Kmc



**Table 5.2.8 How Does Kmc Help In Breastfeeding?**

HOW DOES KMC HELP IN BREASTFEEDING	NO OF RESPONDENTS	PERCENTAGE
Delays milk secretion	7	11.7%
Helps establish early and exclusive breastfeeding	23	38.3%
Reduces milk flow	12	20%
Has no effect	18	30%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.2.8 How Does Kmc Help In Breastfeeding

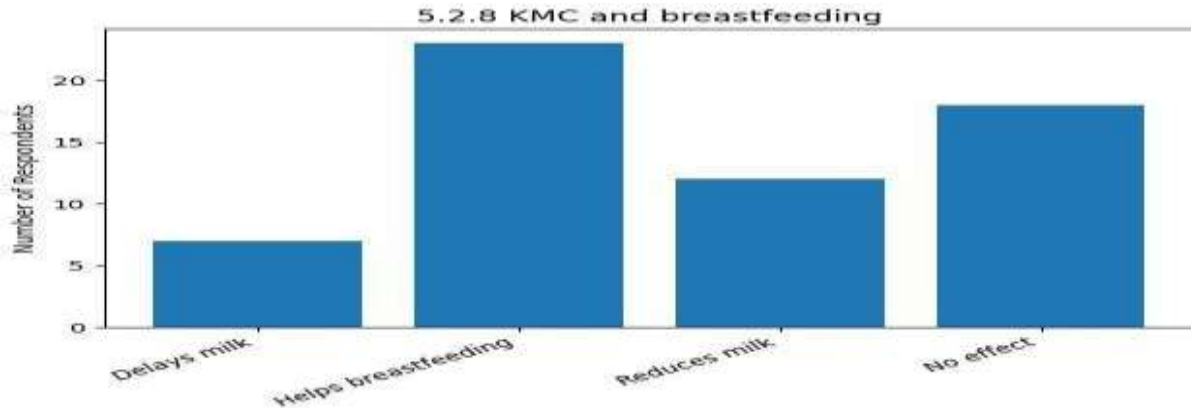


Table 5.2.9 When Can Kmc Be Started?

WHEN CAN KMC BE STARTED?	NO OF RESPONDENTS	PERCENTAGE
Only after one month of delivery	11	18.3%
After baby gains 3kg	22	36.7%
As soon as the baby is stable after birth	10	16.7%
After discharge from hospital	17	28.3%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

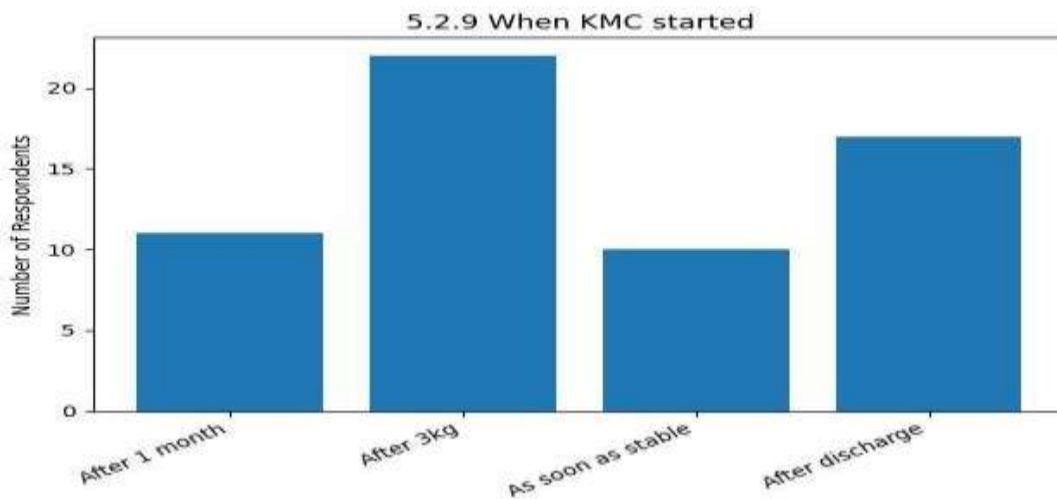
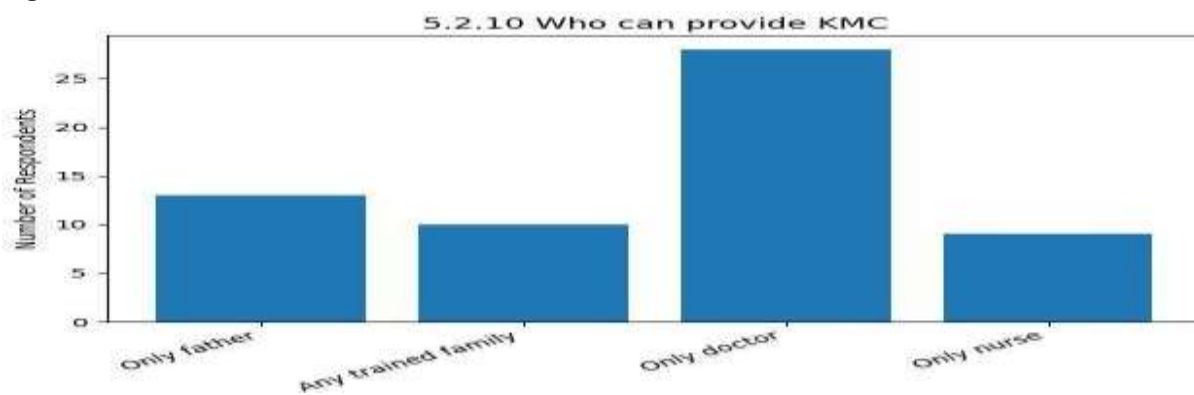


Figure 5.2.9 When Can Kmc Be Started

**Table 5.2.10 Who Can Provide Kmc Other Than The Mother?**

WHO CAN PROVIDE KMC OTHER THAN THE MOTHER	NO OF RESPONDENTS	PERCENTAGE
Only father	13	22%
Any family member trained to do so ( father, grandmother,etc.)	10	17%
Only doctor	28	47%
Only nurse	9	15%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.2.10 Who Can Provide Kmc Other Than The Mother?****Table 5.2.11 What Should Be Monitored During Kmc?**

WHAT SHOULD BE MONITORED DURING KMC	NO OF RESPONDENTS	PERCENTAGE
Babies breathing, temperature, and feeding pattern	9	15%
Only weight	19	32%
Only crying	29	48%
Nothing special	3	5%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.2.11 What Should Be Monitored During Kmc?

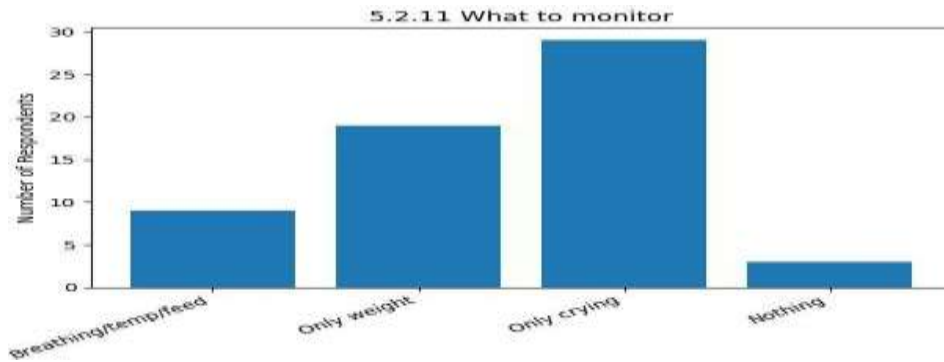
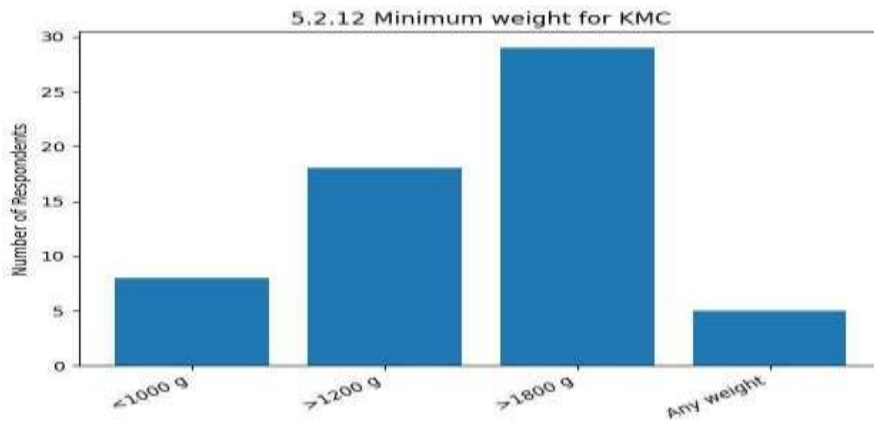


Table 5.2.12 What Is The Minimum Weight Recommended To Start Kmc At Home?

WHAT IS THE MINIMUM WEIGHT RECOMMENDED 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%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.2.12 What Is The Minimum Weight Recommended To Start Kmc At Home

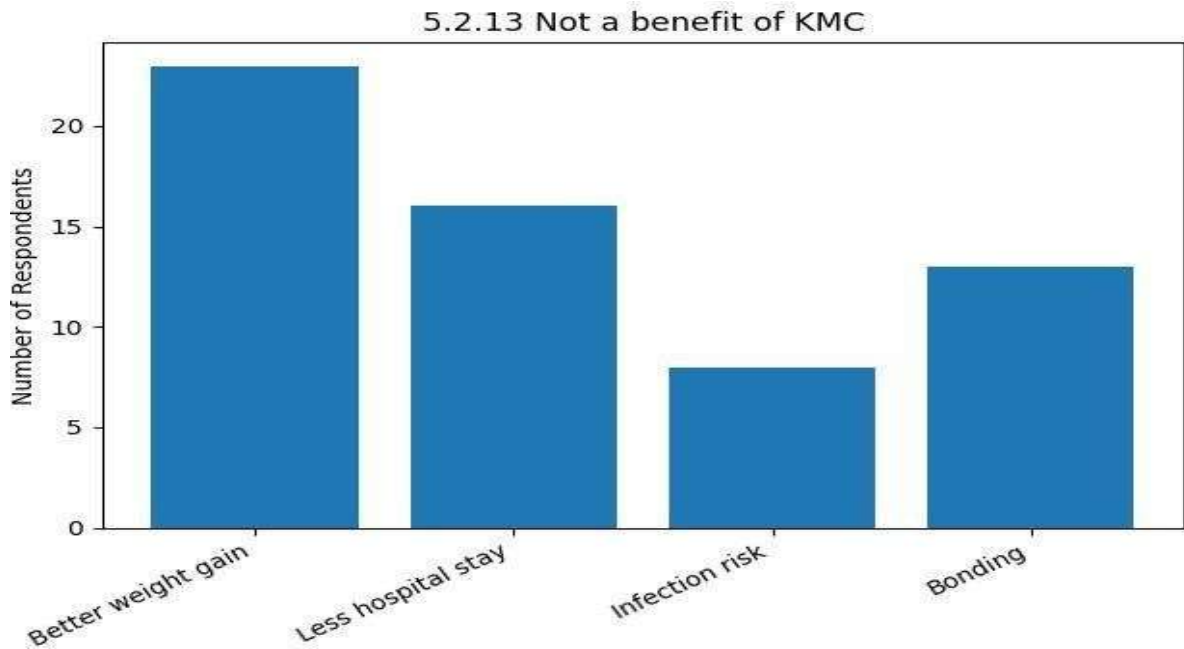


**Table 5.2.13 Which Of The Following Is Not A Benefit Of Kmc?**

WHICH OF THE FOLLOWING IS NOT A 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%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

(Source: Primary Data)

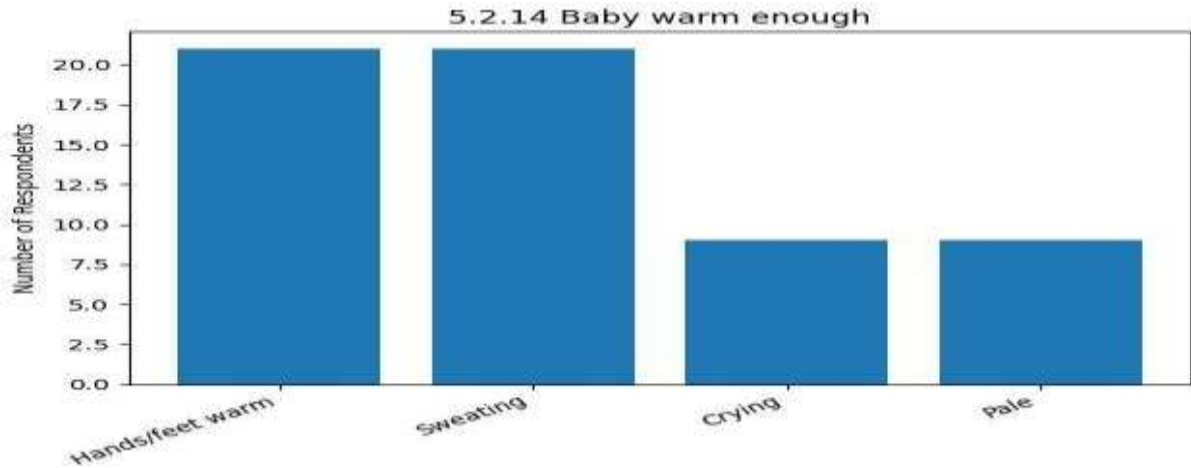
**Figure 5.2.13 Which Of The Following Is Not A Benefit Of Kmc?**



**Table 5.2.14 How Can You Know That The Baby Is Warm Enough During Kmc?**

HOW CAN YOU KNOW THAT THE BABY IS WARM ENOUGH DURING KMC	NO OF RESPONDENTS	PERCENTAGE
Baby's hands and feet feel warm	21	35%
Baby is sweating	21	35%
Baby is crying	9	15%
Baby looks pale	9	15%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.2.14 How Can You Know That The Baby Is Warm Enough During Kmc?**



**Table 5.2.15 How Is Kmc Discontinued?**

HOW IS KMC DISCONTINUED	NO OF RESPONDENTS	PERCENTAGE
Suddenly stop after discharge	16	26.7%
Gradually reduce duration as baby gains weight and maintains temperature	13	21.7%
Stop if mother feels tired	14	23.3%
Stop after one week	17	28.3%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

(Source:Primary Data)

Figure 5.2.15 How Is Kmc Discontinued?

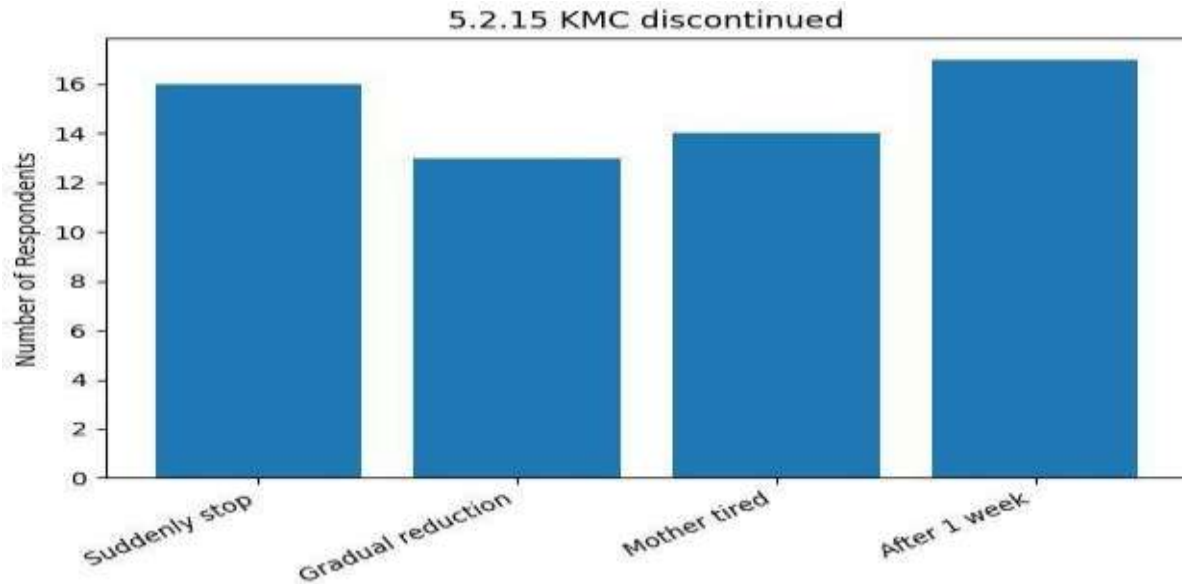
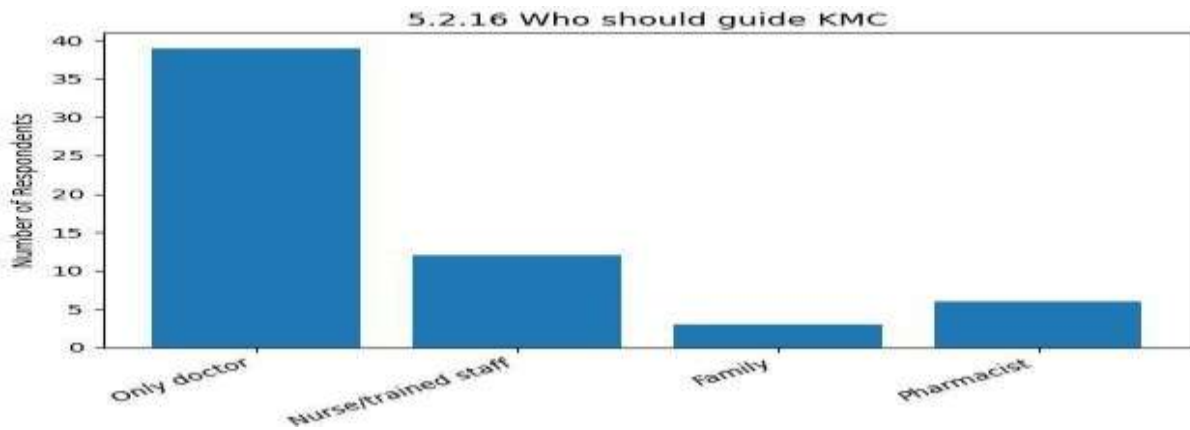


Table 5.2.16 Which Health Worker Should Guide Mother's About Kmc?

WHICH HEALTH WORKER SHOULD GUIDE MOTHER'S ABOUT KMC	NO OF RESPONDENTS	PERCENTAGE
Only doctor	39	65%
Nurse or any trained health personnel	12	20%
Only family members	3	5%
Pharmacist	6	10%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.2.16 Which Health Worker Should Guide Mother's About Kmc

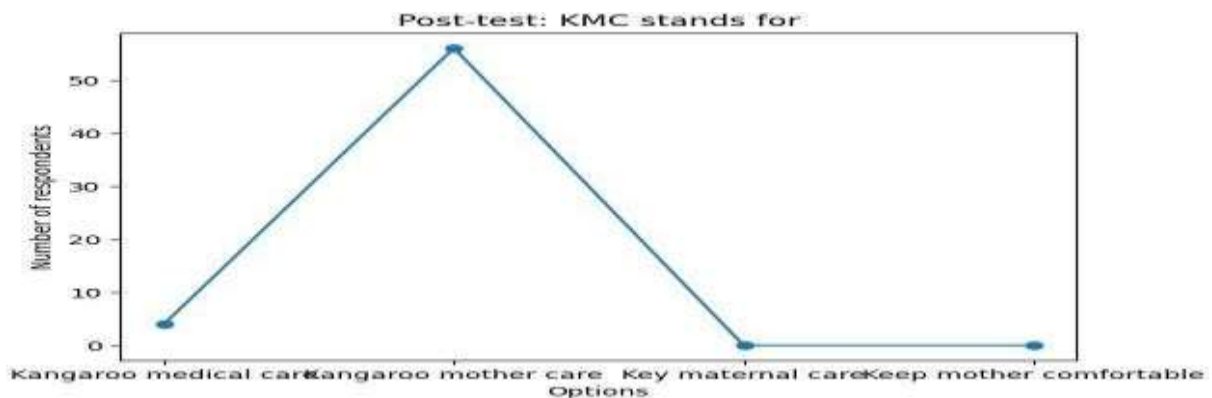


Post Test:-

Table 5.3.1 Kmc Stands For?

KMC STANDS FOR	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%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

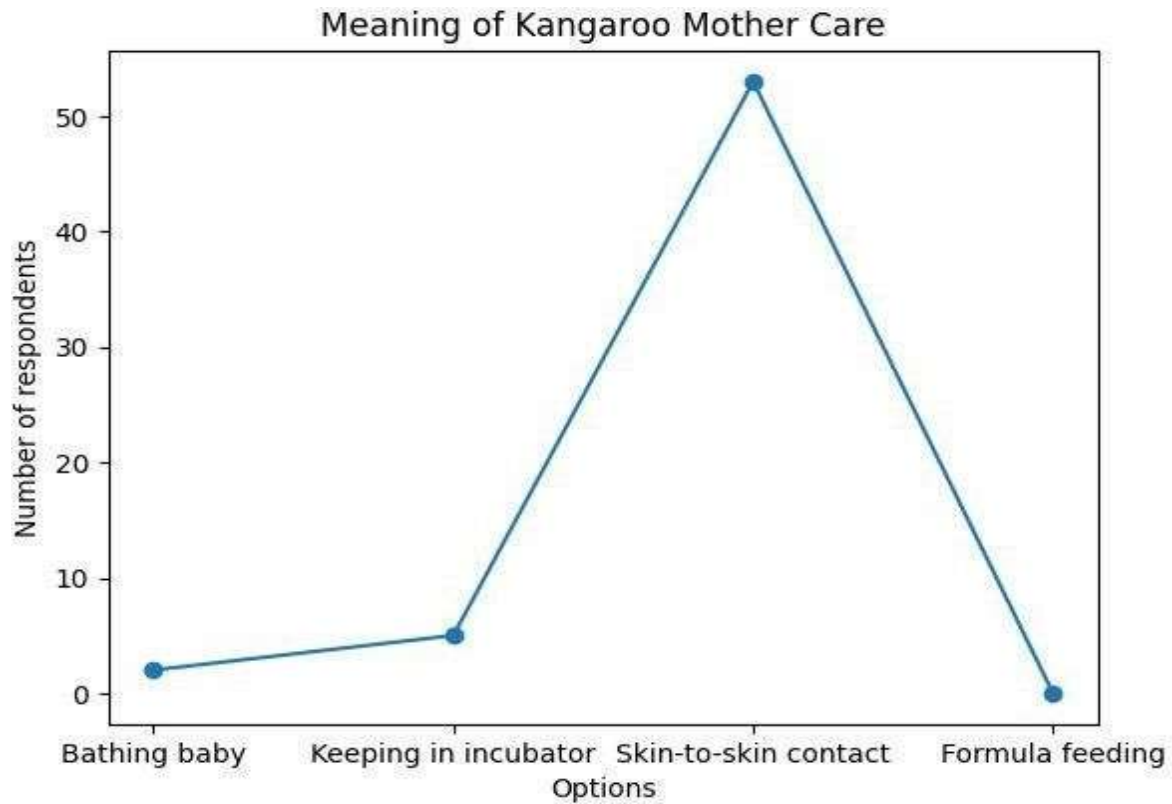
Figure 5.3.1 Kmc Stands



**Table 5.3.2 What Does Kmc Means**

WHAT DOES KMC MEANS	NO OF RESPONDENTS	PERCENTAGE
Bathing the baby regularly	2	3.3%
Keep the baby in an incubator	5	8.3%
Providing skin-skin contact between mother and baby	53	88.3%
Feeding the baby formula milk	0	0%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

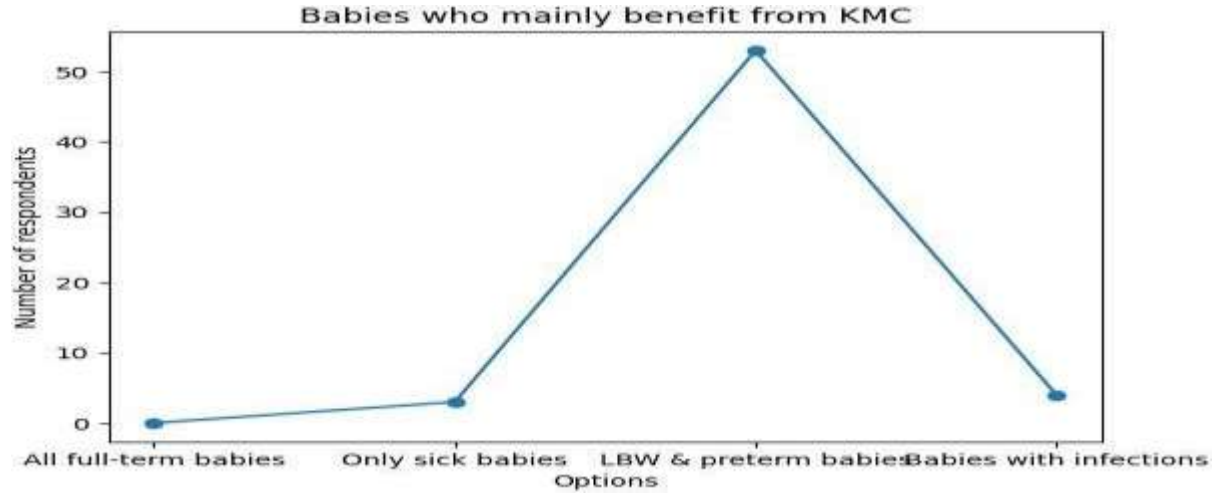
**Figure 5.3.2 What Does Kmc Means**



**Table 5.3.3 Which Babies Mainly Benefits From Kangaroo Mother Care**

WHICH BABIES MAINLY BENEFITS FROM KMC	NO OF RESPONDENTS	PERCENTAGE
All full term babies	0	0%
Only sick babies	3	5%
Low birth weight and preterm babies	53	88.3%
Babies with infections	4	6.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.3.3 Which Babies Mainly Benefits From Kangaroo Mother Care**



**Table 5.3.4 Which Is The Correct Position Of Kmc**

WHICH IS THE CORRECT POSITION OF KMC	NO OF RESPONDENTS	PERCENTAGE
Baby is placed on mother's chest upright between her breast	53	88.3%
Baby is placed on mother's back	0	0%

Baby is laid beside the mother on bed	5	8.3%
Baby is wrapped and kept in cradle	2	6.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.3.4 Which Is The Correct Position Of Kmc

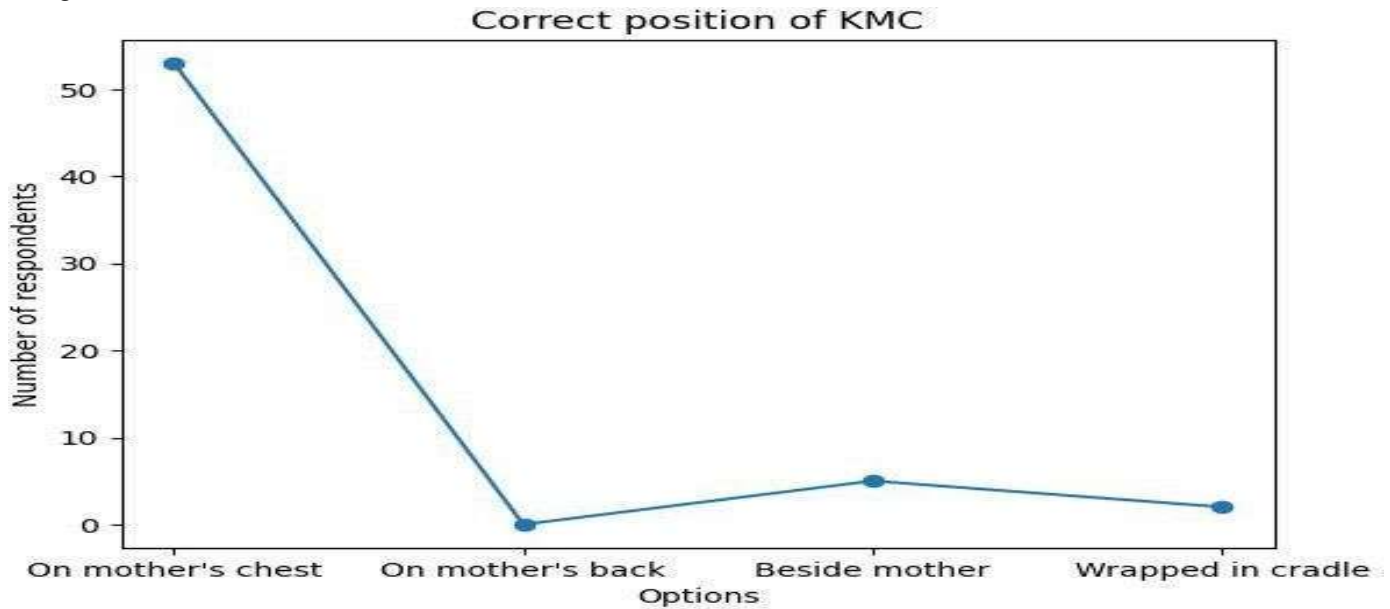


Table 5.3.5 How Long Should Kmc Be Provided Each Day?

HOW LONG SHOULD KMC BE PROVIDED EACH 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%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.3.5 How Long Should Kmc Be Provided Each

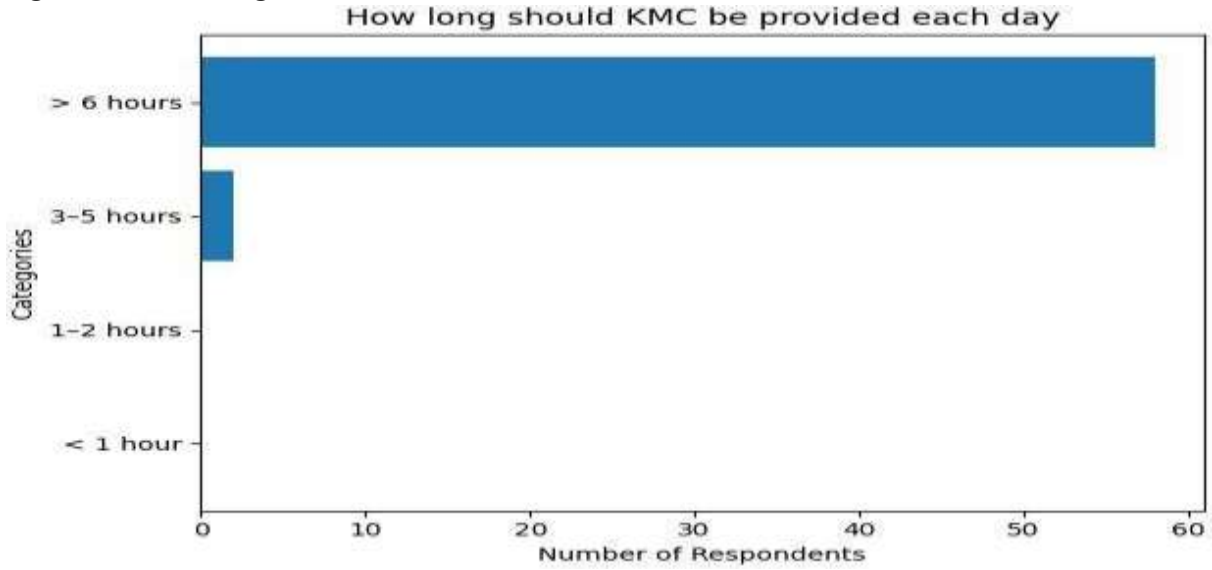


Table 5.3.6 What Clothing Is Preferred During Kmc?

WHAT CLOTHING IS PREFERRED DURING KMC	NO OF RESPONDENTS	PERCENTAGE
Tight clothes	1	1.7%
Loose front - open garment to hold baby securely	57	95%
Thick woolen clothes	0	0%
Normal blouse and saree	2	3.3%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

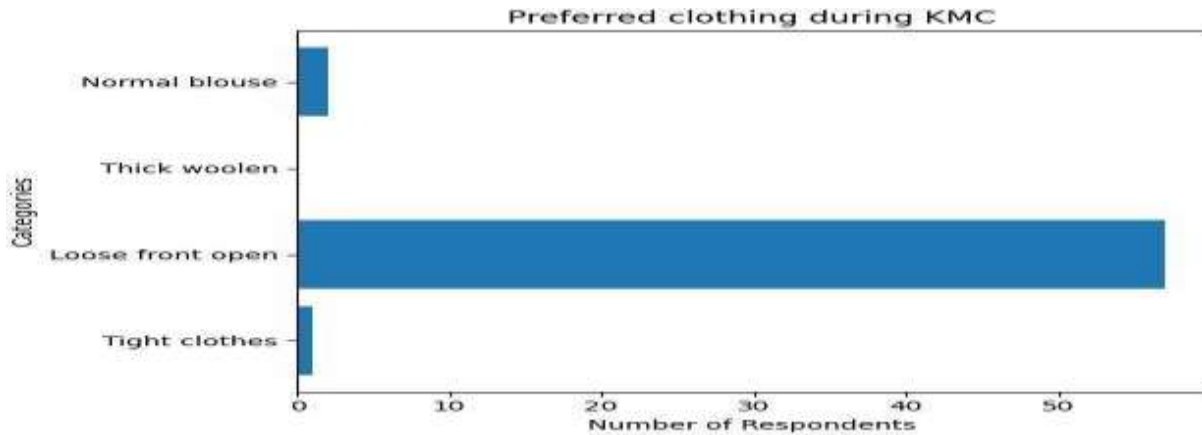
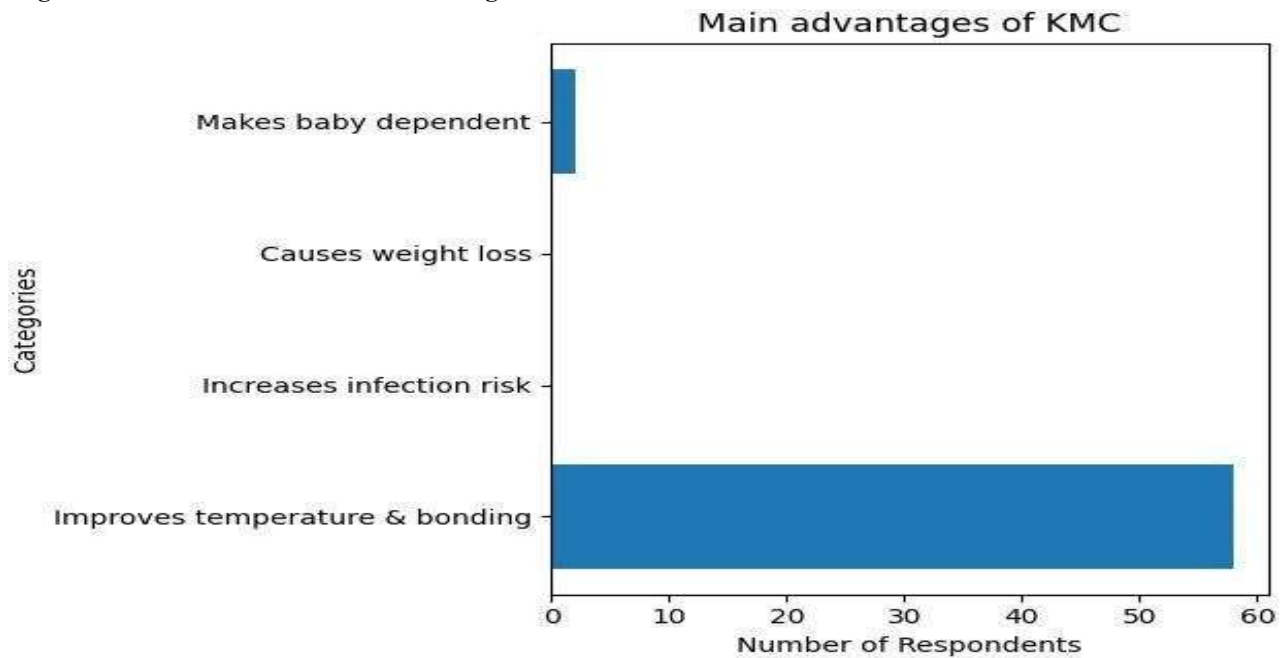


Figure 5.3.6 What Clothing Is Preferred During Kmc

**Table 5.3.7 What Are The Main Advantages Of Kmc?**

WHAT ARE THE MAIN ADVANTAGES OF KMC	NO OF RESPONDENTS	PERCENTAGE
Improves baby's temperature and bonding with mother	58	96.7%
Increases infection risk	0	0%
Causes weight loss in baby	0	0%
Makes baby dependent on mother	2	3.3%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.3.7 What Are The Main Advantages Of Kmc**



**Table 5.3.8 How Does Kmc Help In Breastfeeding?**

HOW DOES KMC HELP IN BREASTFEEDING	NO OF RESPONDENTS	PERCENTAGE
Delays milk secretion	0	0%
Helps establish early and exclusive breastfeeding	53	88.3%
Reduces milk flow	0	0%
Has no effect	7	11.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.3.8 How Does Kmc Help In Breas

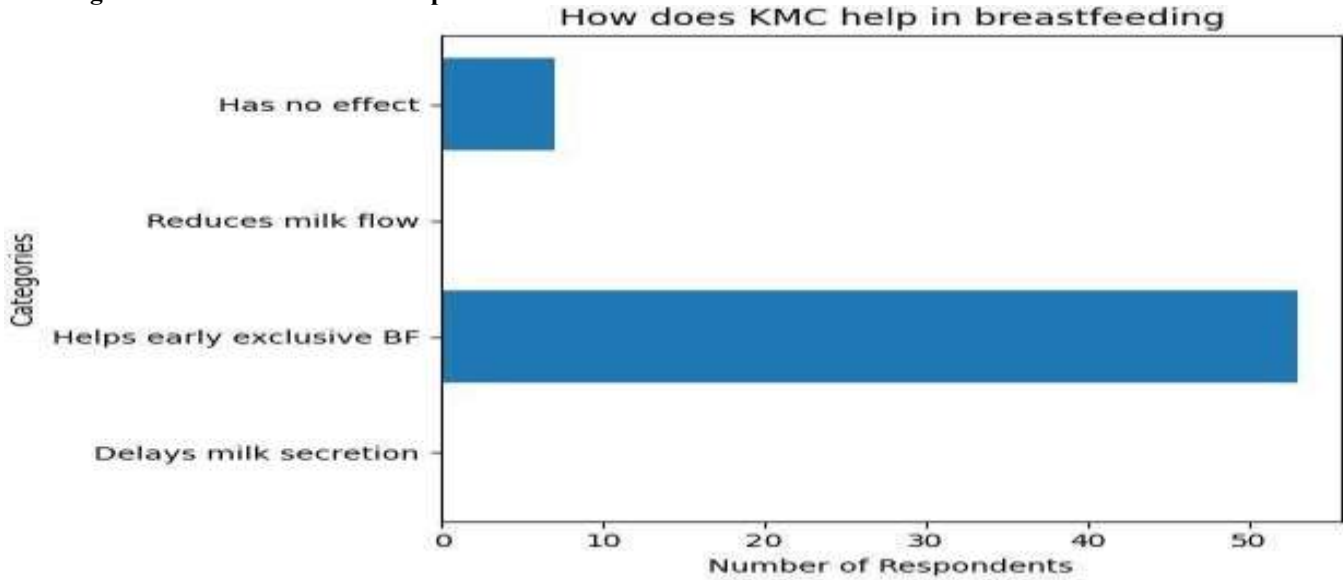
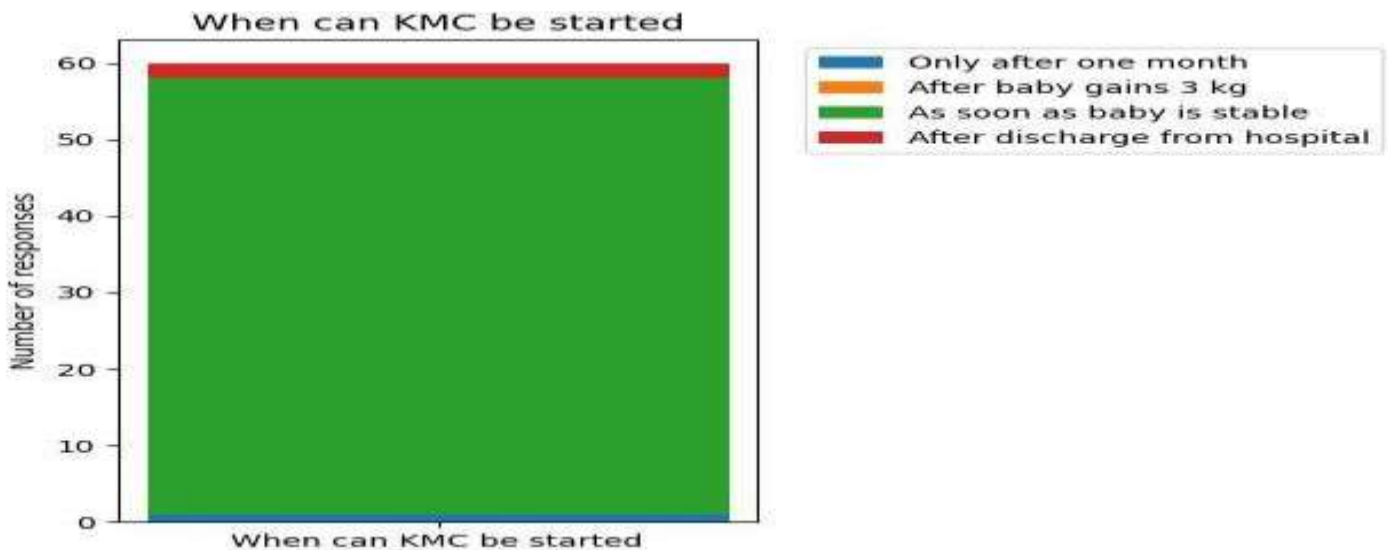


Table 5.3.9 When Can Kmc Be Started?

WHEN CAN KMC BE STARTED?	NO OF RESPONDENTS	PERCENTAGE
Only after one month of delivery	1	1.7%
After baby gains 3kg	0	0%
As soon as the baby is stable after birth	57	95%
After discharge from hospital	2	3.3%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.3.9 When Can Kmc Be Started

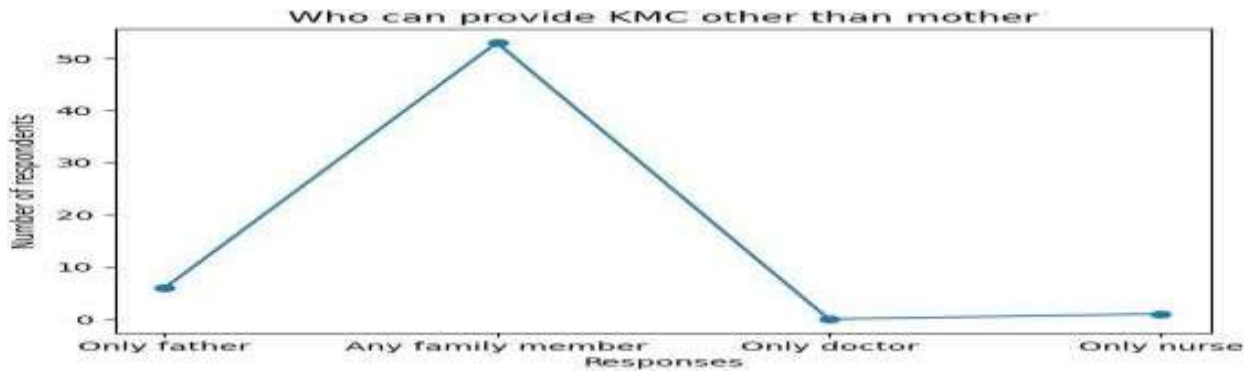


**Table 5.3.10 Who Can Provide Kmc Other Than The Mother?**

WHO CAN PROVIDE KMC OTHER THAN THE MOTHER	NO OF RESPONDENTS	PERCENTAGE
Only father	6	10%
Any family member trained to do so ( father, grandmother,etc.)	53	88.3%

Only doctor	0	0%
Only nurse	1	1.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

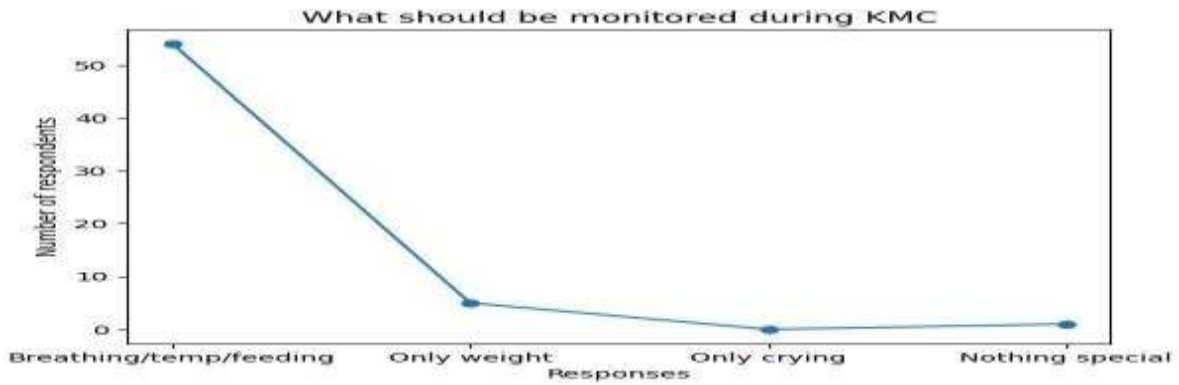
**FIGURE 5.3.10 WHO CAN PROVIDE KMC OTHER THAN THE MOTHER?**



**Table 5.3.11 What Should Be Monitored During Kmc?**

WHAT SHOULD BE MONITORED DURING KMC	NO OF RESPONDENTS	PERCENTAGE
Babies breathing, temperature, and feeding pattern	54	90%
Only weight	5	8.3%
Only crying	0	0%
Nothing special	1	1.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**FIGURE 5.3.11 WHAT SHOULD BE MONITORED DURING KMC ?**



**Table 5.3.12 What Is The Minimum Weight Recommended To Start Kmc At Home?**

WHAT IS THE MINIMUM WEIGHT RECOMMENDED 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%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Figure 5.3.12 What Is The Minimum Weight Recommended To Start Kmc At Home?**

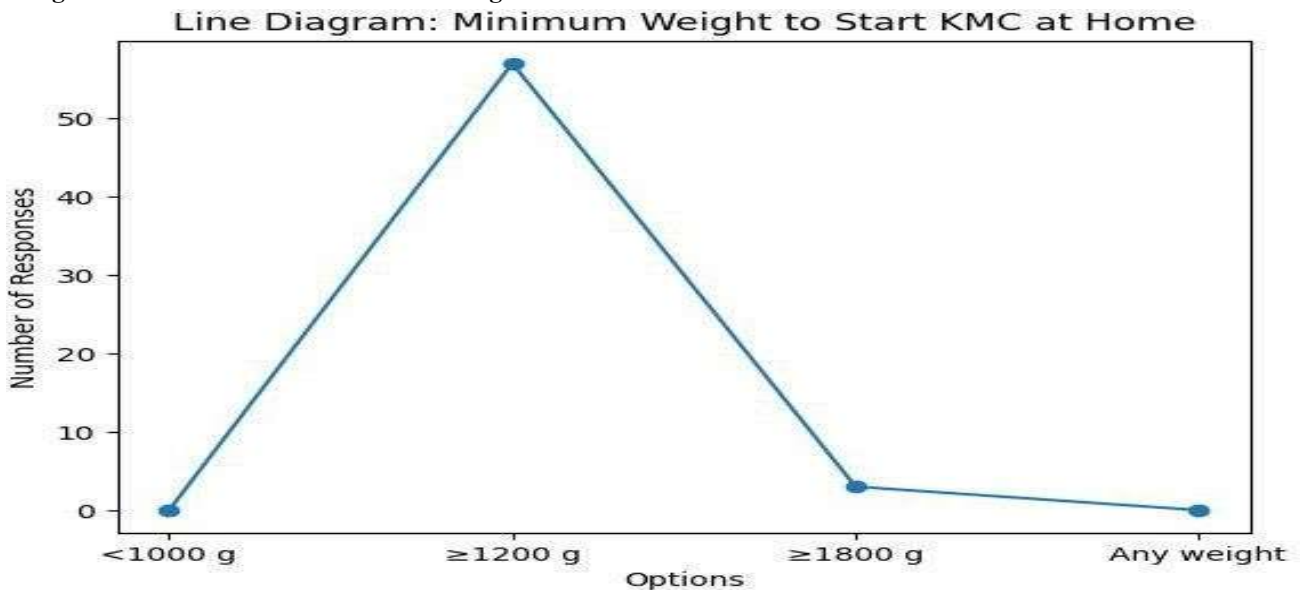


Table 5.3.13 Which Of The Following Is Not A Benefit Of Kmc?

WHICH OF THE FOLLOWING IS NOT A 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
WHICH OF THE FOLLOWING IS NOT A 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

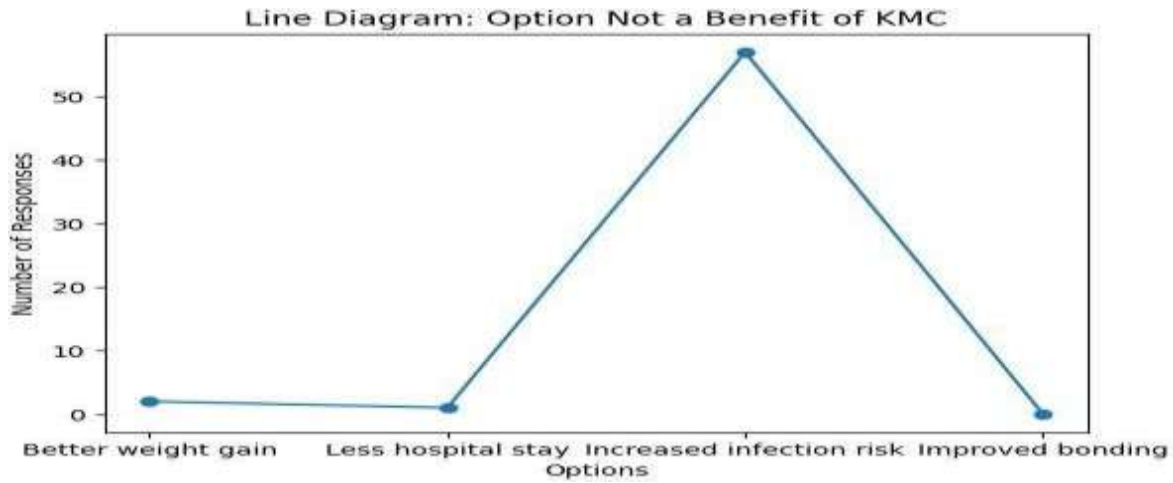


Table 5.3.14 How Can You Know That The Baby Is Warm Enough During Kmc?

X	NO OF RESPONDENTS	PERCENTAGE
Baby's hands and feet feel warm	59	98.3%
Baby is sweating	1	1.7%
Baby is crying	0	0%
Baby looks pale	0	0%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

Figure 5.3.14 How Can You Know That The Baby Is Warm Enough During Kmc?



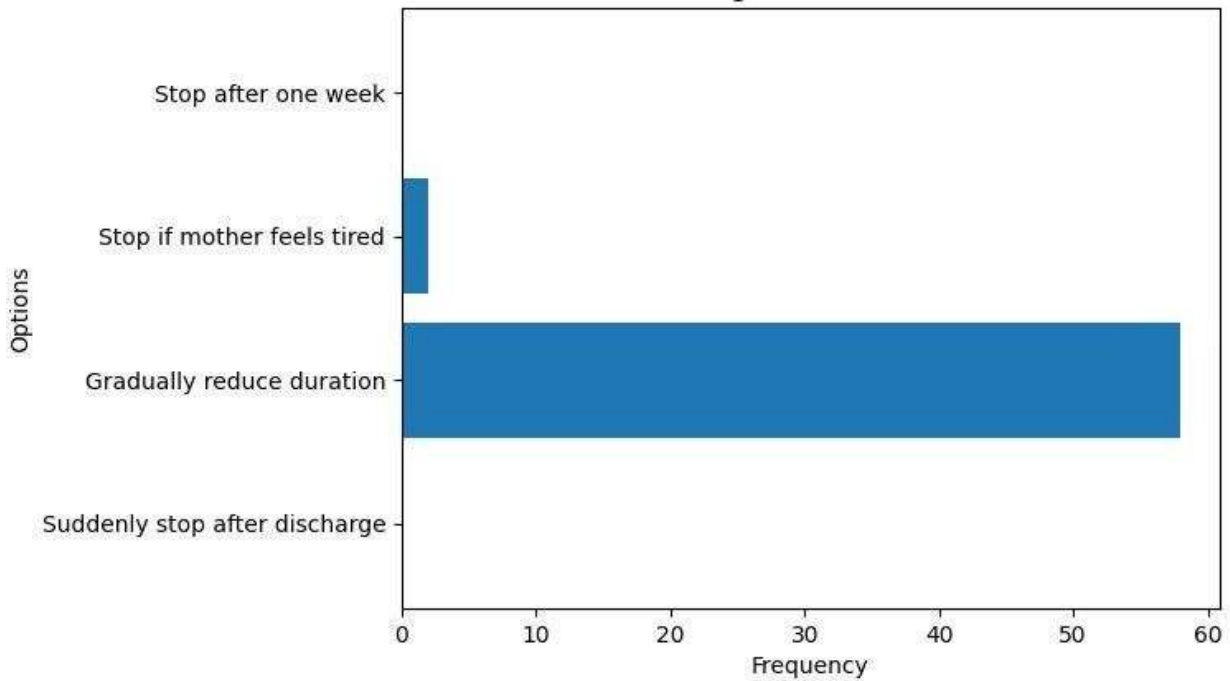
**Table 5.3.15 How Is Kmc Discontinued?**

HOW IS KMC DISCONTINUED	NO OF RESPONDENTS	PERCENTAGE
Suddenly stop after discharge	0	0%
Gradually reduce duration as baby gains weight and maintains temperature	58	96.7%
Stop if mother feels tired	2	3.3%
Stop after one week	0	0%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

(Source:Primary Data)

**Figure 5.3.15 How Is Kmc Discontinued?**

Horizontal Bar Diagram: Discontinuation of KMC



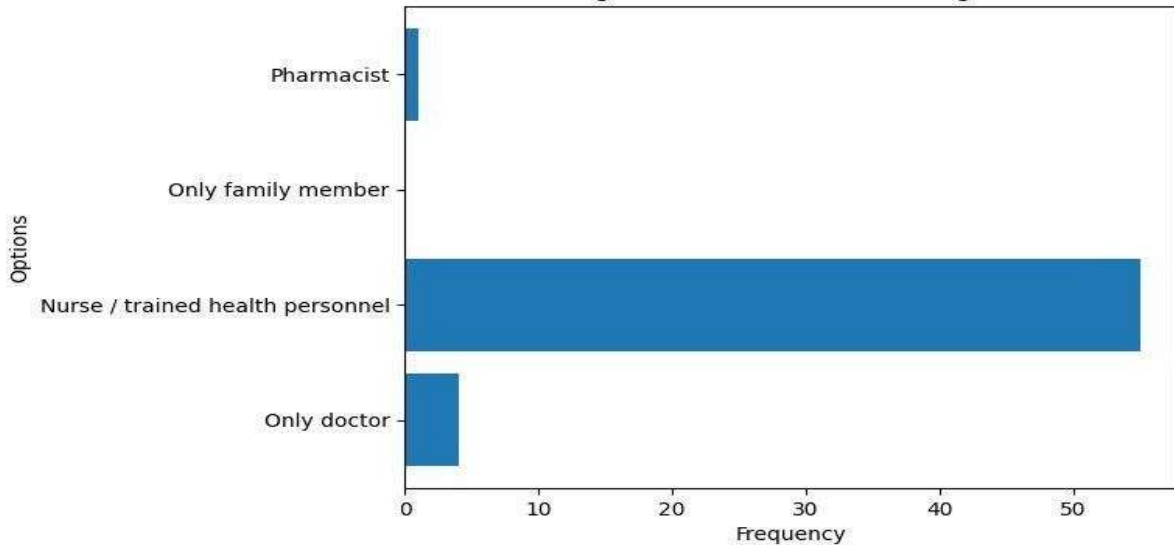
**Table 5.3.16 Which Health Worker Should Guide Mothers About Kmc?**

WHICH HEALTH WORKER SHOULD GUIDE MOTHERS ABOUT KMC	NO OF RESPONDENTS	PERCENTAGE
Only doctor	4	6.7%
Nurse or any trained health personnel	55	91.67%
Only family members	0	0%
Pharmacist	1	1.7%
<b>TOTAL</b>	<b>60</b>	<b>100</b>

(Source:primary data)

**Figure 5.3.13 Which Of The Following Is Not A Benefit Of Kmc?**

Horizontal Bar Diagram: Health Worker Guiding Mother About KMC



The data collected from 60 postnatal mothers was organized, analyzed, and interpreted based on the objectives of the study. Descriptive and inferential statistics were used for analysis. The data was coded and entered into Microsoft Excel and further statistical calculations were performed using Pearson's correlation coefficient to assess the knowledge among the postnatal mothers about Kangaroo mother care.

#### Scoring procedure:-

The knowledge of postnatal mothers regarding Kangaroo Mother Care was assessed using a structured knowledge questionnaire prepared by the investigator. The tool consisted of 23 multiple choice questions related to Kangaroo Mother Care.

- Each correct answer was given one (1) mark
- Each incorrect answer was given zero (0) mark
- There was no negative marking

The maximum obtainable score was 23 and the minimum score was 0.

Based on the total score obtained, the level of knowledge was classified as follows:

**Table 6 Level Of Knowledge Among The Postnatal Mother's About Kmc**

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

#### Interpretation of Scoring:-

- Inadequate knowledge: Mothers having poor understanding regarding Kangaroo Mother Care
- Moderately adequate knowledge: Mothers having partial knowledge regarding Kangaroo Mother Care
- Adequate knowledge: Mothers having good knowledge regarding Kangaroo Mother Care

#### Description of the Tool:-

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

#### Application of Tool:-

Pretest: Knowledge was assessed before administering video assisted teaching

Posttest: Knowledge was reassessed after the video assisted teaching programme. The difference between pretest and posttest scores was used to evaluate the effectiveness of video assisted teaching.

#### Result Interpretation Statement (for Chapter 5):-

The comparison of pretest and posttest knowledge scores revealed a significant improvement in the posttest scores, indicating that video assisted teaching was effective in improving the knowledge of postnatal mothers regarding Kangaroo Mother Care.

**Comparison Of Knowledge Scores Of Pretest And Posttest:-**

**Table.7 Mean,Range,And Standard Deviation Of Pretest And**

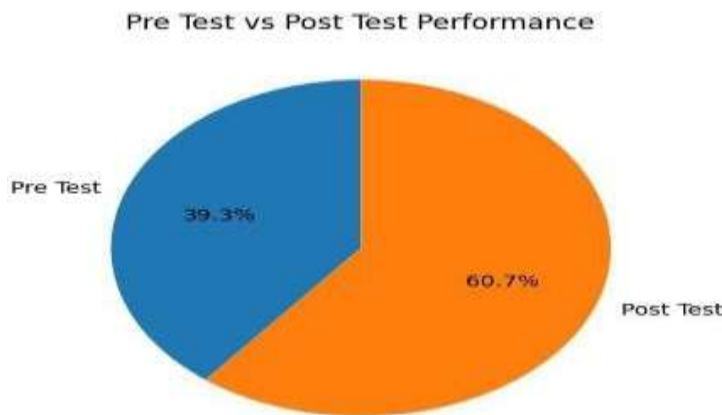
Knowledge scores	Max.score	Range	Mean	Mean percentage	Standard deviation
Pretest	10	10	4.39	43.9%	2.11
Posttest	15	8	12.41	82.7%	1.97

**Posttest Knowledge Scores Of The Postnatal Mother's About Kmc:-**

The data in table reveals that the mean and standard deviation of knowledge of score in pretest is  $4.39 \pm 2.11$  and in the posttest is  $12.41 \pm 1.97$  which indicated there is significant improve in the knowledge of the postnatal mothers after the video assisted teaching program

**Figure 7.Knowledge Score Of Pretest And Posttest Of Postnatal Mother's About Kmc:-**

**Correlation Of Knowledge Scores Of Pretest And Posttest Among Postnatal**



**Table 8 Correlation Of Knowledge Scores With Pretest And Posttest**

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

The data in the above table depicts that there is statistically significant correlation between 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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