

Review Article

Kangaroo Mother Care in Nigeria: A Narrative Review of Maternal and Infant Benefits and Implementation Determinants

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Abstract: **Background:** Nigeria is a country with a heavy burden of global neonatal mortality caused by preterm births and low birth weight. Kangaroo Mother Care (KMC) is an established low-cost intervention that enhances the survival of babies and maternal outcomes, but its adoption and retention are of poor quality, despite a high level of policy support. **Aim:** This narrative review synthesises evidence on the benefits of KMC for mothers and infants in Nigeria and analyses the determinants of multilevel implementation using an implementation science approach. **Methods:** The search took place in PubMed, Scopus, and Web of Science databases by searching peer-reviewed articles that were published not older than 2025. Purposive sampling of evidence in Nigeria was done and synthesized using both the WHO KMC framework and CFIR. **Findings:** 12 studies were included in the study. KMC enhanced maternal psychological outcomes, thermoregulation, breastfeeding, and infection prevention, as well as survival. The limitations in implementation were a poor facility space, guidelines, inadequate provider training, poor leadership, socially held beliefs, the cost of hospitalization and support of the family. **Conclusion:** KMC's impact in Nigeria is effective, with an established impact, albeit with barriers to implementation. **Recommendation:** To achieve sustainable KMC scale-up and reduction in neonatal mortality, it is necessary to address the identified facility, workforce, leadership, sociocultural, and cost-related limitations. **Keywords:** Kangaroo Mother Care, Premature, Neonatal, Mortality, Implementation, Infant.

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INTRODUCTION

Neonatal mortality is one of the key public health problems globally, accounting for nearly half (47%) of under-five deaths around the world. Even though the neonatal mortality has decreased in the last 20 years, the decline in child survival has been less pronounced, especially in low- and middle-income countries (LMICs) (World Health Organization, 2022). The leading cause of neonatal mortality worldwide and the reason why much of the neonatal mortality can be prevented is preterm birth, particularly in areas where access to high-quality newborn care is limited (Blencowe *et al.*, 2012; Conde-Agudelo & Diaz-Rosesello, 2016).

The neonatal mortality and preterm birth rate in Nigeria are among the most significant burdens on the country. Being the most populous country in Africa, Nigeria has a disproportionate amount of global neonatal mortality, and rates of neonatal mortality are not decreasing despite the slight increase in child survival

(UNICEF, 2023; Mokuolu *et al.*, 2022). The complications associated with preterm birth also constitute a high percentage of these deaths, and this is a manifestation of the systemic issues in the accessibility, quality, and use of the necessary newborn care services (Blencowe *et al.*, 2019). The burden of subnational disparities is also disproportionate, as the worst outcomes have consistently been recorded in resource-scarce parts of the country (Mokuolu *et al.*, 2022).

Nigeria has, however, demonstrated a formal purpose to manage this challenge and increase the survival of newborns by following the international initiatives to eradicate newborn mortality, such as the Every Newborn Action Plan, and by incorporating newborn health into the national policy and strategies (WHO, 2014). These policy pledges focus on expanding evidence-based, affordable measures to support small and preterm babies, such as Kangaroo Mother Care (KMC), which has demonstrated significant reductions in neonatal mortality, hypothermia, and infection and has

been shown to enhance breastfeeding outcomes (Federal Ministry of Health, 2021).

Although there is strong policy support, reports from Nigeria indicate that the discrepancies between recommended interventions and actual implementation are severe. Several facility- and community-based studies indicate that most health facilities have low KMC coverage and irregular use, despite national and local guidelines (Tella *et al.*, 2023). Challenges that are often identified during implementation are insufficient training of health workers, incomplete infrastructure and space, weak health system support, low awareness among mothers and families, and socio-cultural factors that affect acceptability and continued practice (Onubogu & Okoh, 2016). These evidence-implementation gaps are a significant disadvantage to the population-wide effectiveness of evidence-based newborn interventions.

Nigeria is hence a significant case study to consider when analyzing how to translate evidence-based newborn care interventions into routine practice in settings with high burden. It has a large population, heterogeneous sociocultural background, and heterogeneous health system performance, which presents a good opportunity to study the interaction between policy promises and implementation realities (Olorunsaiye *et al.*, 2020). These gaps should be considered and targeted to speed up the process of neonatal mortality reduction in Nigeria and to enhance the implementation strategies applicable to other LMICs with the same problems (Okereke *et al.*, 2019). This narrative review synthesises evidence on the benefits of KMC for mothers and infants in Nigeria and analyses the determinants of multilevel implementation using an implementation science approach.

METHOD

Peer-reviewed studies, qualitative research, implementation evaluations, and policy documents that reported on KMC in Nigeria were used as a source for a narrative review. The articles of 2000-2025 were found by searching PubMed, Scopus, and Web of Science with Nigeria-specific search terms. Data synthesis and analysis of the implementation determinants at health system levels were based on the World Health Organization KMC framework and the Consolidated Framework for Implementation Research (CFIR), through purposive sampling.

The purposive sampling was applied to select a certain scope of KMC research and present a detailed overview of the study with a focus on a particular phenomenon (KMC Maternal and Infant Benefits and Implementation Determinants in Nigeria). Literature search was done using the following keywords: implementation barrier or hindrance or obstacle or difficulty and Kangaroo Mother Care or Kangaroo Care or Skin to skin care, Maternity or Mother or postpartum or after birth and Newborn intensive care unit. Thesaurus

in the databases searched, and MeSH terms were used to identify keywords. All articles that were relevant were to be included in the study through the inclusion and exclusion criteria. A search was conducted in the years 2000 to 2025 (this was an attempt at offering a historical impression of the implementation of KMC by nurses and the perceived obstacles to its implementation) on the search by subjects such as, (i) articles of 2000-2025, (ii) peer-reviewed journal articles, (iii) original research within the country of Nigeria, and (iv) articles in the English language.

The females and children targeted were women and infants. Exclusion criteria. Abstracts in conference proceedings, unpublished manuscripts (abstracts or dissertations) or articles, articles in press, letters to the editor, articles in non-English languages and articles that were aimed at non-nurse participants. Search results: an extensive survey of Kangaroo Mother Care implementation practice in the databases listed above was performed based on the inclusion and exclusion criteria. By using a Boolean search, 15 articles were identified. Based on the reading of the abstracts, 14 abstracts were taken out of the study. Following the reading of the entire article, 10 articles passed the inclusion criteria. Five took qualitative methods, four took quantitative methods, and one took a mixed-method approach. Manual searches of the included studies were also done to retrieve other articles that met the inclusion criteria, and 2 more articles were found. Lastly, there were 12 articles in this review. The authors were independent in their search at the end of this search process. The clinical knowledge on KMC was informed by the World Health Organization KMC framework. Simultaneously, the Consolidated Framework of Implementation Research (CFIR) was used to conduct an analysis of determinants of implementation in five domains, namely, intervention characteristics, outer setting, inner setting, characteristics of individuals, and implementation process.

RESULTS

The review considered studies conducted in Nigeria on the benefits and barriers hindering the practice of KMC by mothers who had given birth to preterm babies and had practiced kangaroo mother care wholly or in part at home. From the narrative studies conducted, we found high-certainty evidence that kangaroo mother care can substantially reduce the risk of moderate-to-severe, postpartum, maternal depressive symptoms. In addition, there was low-certainty evidence for a slight or moderate decrease in postpartum, maternal depressive symptoms of any severity. In addition, a 2021 meta-analysis reported by Cong *et al.*, (2021) revealed that kangaroo mother care for premature infants significantly reduced the level of maternal anxiety (SMD: -0.72; 95% CI: -1.08 to -0.35; I² = 75%; six trials) and maternal stress (SMD: -0.84; 95% CI: -1.59 to -0.09; I² = 90%; four trials) compared with no kangaroo mother care. However, that meta-analysis did

not include studies involving low-birth-weight infants born at full term, and did not report other maternal or paternal health outcomes. Moreover, no previous review assessed the overall quality of the evidence. Our narrative review contributes to the existing literature by providing an up-to-date synthesis of evidence from trials evaluating the effect of kangaroo mother care on maternal or paternal health outcomes in preterm and low-birth-weight infants. We report pooled estimates for a wide range of outcomes, including postpartum maternal depressive symptoms, stress, anxiety, distress, sensitivity, mood variance, and sense of competence and mother-infant attachment and bonding—full details of our findings on the maternal sense of competence, with an interpretation. KMC is currently considered the highest-impact intervention in the care of LBW infants, alongside antenatal corticosteroids, and is highly feasible to scale up in low-resource settings. (Lawn *et al.*, 2010).

Almost three decades of implementation and research have made it clear that KMC is more than an alternative to incubator care. It can prevent up to half of all infant deaths weighing <2000g (Lawn *et al.*, 2010). Furthermore, KMC can be integrated with other supportive care as needed and emphasizes the central role of the mother in her baby's survival and well-being. KMC is an intervention that benefits everybody. It provides enormous benefits to the baby, the mother, the entire family, and the health system as a whole. For infants, KMC stabilizes the baby's temperature, reducing energy use and preventing cold stress. It provides ready access to the breast, thereby promoting and improving breastfeeding. KMC also supports optimal infant growth and development and has been found to reduce the frequency of infections, including hospital-acquired infections. Keeps the baby's heart and breathing rates stable, as the mother's heartbeat, breathing, and voice help stimulate the newborn and prevent apnoea (Uwaezuoke S.N., 2017). KMC also keeps oxygenation, oxygen consumption, and blood glucose levels equal to or better than those of infants receiving incubator care. It maintains baby's sleep patterns and reduces stress, leading to less crying (Nguah *et al.*, 2011).

Findings by da Silva *et al.*, (2015) suggested that the cultural and contextual factors may hinder the facilitation of KMC: i) The traditional way of carrying babies on the back and providing them warmth through lighting lamps or charcoal makes kangaroo mother care appear odd and shameful (level of confidence: low). ii) The practice of kangaroo mother care is perceived to be technically cumbersome, mainly because it has to be continuous; there is fear of making the baby's cord bleed; it creates difficulty in positioning for breastfeeding; and there is difficulty in maintaining the position while sleeping and doing other household chores (level of confidence: moderate). iii) Health system factors: The health care systems have no clear strategies to promote kangaroo mother care at the community level. Most mothers learned about the practice for the first time from

health care workers only after birth; however, peer-to-peer information sharing was noted as a powerful source of trusted information about kangaroo mother care strategies to improve KMC implementation. Evidence offers strategies that may improve KMC utilization in healthcare settings. Three authors recommended educating healthcare professionals and mothers about the benefits of early KMC and implementing clear guidelines to promote it (Dykes *et al.*, 2016; Braun, V., & Clarke, V., 2006; and Koopman *et al.*, 2016). Another author proposed concentrating on the needs of the newborn and the needs of the mother (e.g., communication based on interactions, encouraging the development of an affective bond, and maternal-newborn safety) and working together with the healthcare providers (da Silva *et al.*, 2015).

DISCUSSION

This narrative review demonstrates that Kangaroo Mother Care is an intervention that has been well established as a highly effective neonatal intervention in Nigeria, but is not applied in a very systematic way that is inequitable. In spite of the demonstrated clinical and psychosocial advantages, multilevel obstacles are still unaddressed in order to affect the entire population. Among other facts, it is important to note that the questions regarding the efficacy of KMC do not add to the implementation issues, but the health system and contextual constraints do. There are no written guidelines, special rooms, and universal care paths that reflect the increased vulnerability of the facility and organizational shortcomings. These inner-setting limitations correspond to CFIR evidence in other low- and middle-income settings, which endorse the need to solve problems at the system level, other than individually.

On the outer-setting level, social and cultural beliefs and financial restrictions are important factors that influence the maternal involvement with KMC. Less prenatal exposure to KMC correlates with anxiety and slow uptake, which implies the absence of past opportunities of prenatal counselling and family intervention. The father, grandmothers and community influencers involvement is regarded as a valuable measure on improving the acceptability and continuity of care beyond the hospital. Health worker capacity is one of the barriers to one of the opportunities. Although most providers acknowledge the significance of KMC, insufficiency of training and proper supervision to facilitate counselling and long-term implementation, integration of KMC in pre-service courses of action, to be followed by frequent in-service training and instructions, would assist increase the implementation fidelity and standardisation of KMC as the newborn care best practice.

Perceived barriers could be minimized and KMC practice improved through mothers and infant management and sustainable training strategies to

improve policy and interventions that support education about the importance of KMC between mothers and nurses (Stikes R., & Barbier D., 2016). The most reported reason as to why KMC was not implemented was the absence of a written protocol. The lack of an appropriate guideline to KMC is an obstacle to its application (Onubogu U.C., Okoh B.A., 2016). Written protocols assist the institutions in standardizing their practices; they allow the staff members to adhere to the procedures continuously in order to reach agreed objectives with minimal mistakes. Written protocols would assist in standardizing decisions on the eligibility of people to receive care, the location of such care and discharge process in the practice of KMC. The second consideration, which influences KMC practice in our study, is the absence of suitable environment. In other countries where KMC has been effectively implemented, a special KMC ward has beds occupied by the mothers (Watkins *et al.*, 2018). The majority of health facilities in low-income areas in Nigeria do not have sufficient space to place baby cots and incubators, and lack a ward where the mothers with stable conditions can spend their time and practice KMC. In addition to this, there is the issue of the cost of this transferred KMC ward occupation as passed on to the family already bearing the financial cost of an extended stay preterm infant. Providing KMC wards would pose a question of who would maintain the wards at no extra cost to the mothers who would be practicing KMC within the hospital. With this trend of public-private partnership in the Nigerian health industry, KMC wards may be subsidized and charged on a biweekly and monthly basis. Higher discounts could also be offered to mothers that have to spend more time in KMC wards. This would sooth the parents economically and would also benefit the hospital as it would increase baby survival and patronage. Another reason why not all who did not practice KMC had implemented it was lack of training (9 or 12.3%). This training ought to have the various components and advantages of KMC. The concept of the practical training involved the use of pre-service programs of the nursing and medical programs, with the systems of constant in-service training, face-to-face training on the materials and training in the form of meetings, workshops, and acquaintance with the latest literature on the subject (Kinshella *et al.*, 2020).

This corroborates the claims that in the majority of low-income nations, the majority of the health workers have been trained in the tertiary institutions (Watkins *et al.*, 2018). Unbelievably, none of the health workers said that he/she has not attained any gains of practicing KMC. This may be attributed to the fact that, over forty years after KMC had been developed, the advantages of the practice are not doubted by health workers. The actual issue is the bottlenecks in implementation of a practice we believe to be helpful on the side of children who require it. The other explanation given as to why KMC was not implemented was the absence of KMC support pouch. Furthermore, Koopman

et al., (2016) suggested quality KMC programmes in labour and delivery units, such as the creation of focus group discussion and with the nursing staff to express their views and difficulties in performing KMC practice. On this level, nurses should come to consensus and assume responsibility of enhancing KMC implementation. Poor facilities and supplies were most often identified as impediments to implementation. These are absence of space and avenue of KMC, insufficiency of beds, insufficiency of chairs in which the mother can sit, lack of privacy and those of overcrowding, absence of hats to cover the newborns and cloth wraps to facilitate KMC or equipment such as effective weighing scales or monitoring equipment (Onubogu U.C., Okoh B.A., 2016). In a Ugandan study, intermittent versus continuous care was found to be practiced as there were no appropriate environments because of a shortage of beds and space to accommodate relatives attending to KMC mothers in the area (Watkins *et al.*, 2018). In addition, implementing KMC as a part of maternal health care, including in the context of antenatal counselling (Feucht *et al.*, 2016), is less expensive compared to incubators, which demand a lot of electricity (Adzitey *et al.*, 2017).

Premature mothers of premature infants. The biggest obstacle mentioned in support of KMC practice was stress associated with long hospital stays, such as the extra expenses to families to cover the cost of living of the mother and infant in the hospital and worries about family activities at home, such as taking care of other children (Morgan *et al.*, 2018). It was also reported that hospitals were not providing sufficient food, and members of the family were encouraged to bring food or money (Morgan *et al.*, 2018). The attitude of families and cultural beliefs that babies should be carried on the back and not the front, the feeling of guilt over having premature infants and a lack of motivation because of doubts that they would survive were also common (Ibe *et al.*, 2004). Morgan *et al.*, (2018) used to report fears and displeasures with KMC and discovered that some mothers complained about fearing to hold small babies. Continuous positioning of the infant on the chest that causes backache, sleeping problems and fatigue, boredom, isolation as the mother is no longer with her family and other factors were also experienced during practicing of KMC (Leonard A., & Mayers, P., 2008). Other barriers, as stated by Leonard and Mayers (2008), were unawareness of KMC before birth, inadequate support or negative relationships with the medical staffs (Morgan *et al.*, 2018), that decision-making was very much influenced by the grandmothers and fathers who had no experience in the KMC counselling, and maternal medical issues such as caesarean births that did not allow skin-to-skin contacts (Morgan *et al.*, 2018). In general, family, peer, and health worker support played a significant role in the support of KMC practice (Morgan *et al.*, 2018). Family support involved regular visits to the hospital to bring money and supplies, companions, who remained with the mother to assist with care, and

acceptance of the fathers and the grandmothers, who were very powerful decision-makers, which contributed to the reduction of concerns at the house. The peer support involved counseling and encouragement by other mothers in the ward on positioning and emotional and practical support by the health workers, such as KMC positioning, repeated assurances that infants were doing fine, and discussing their fears. Facilitators to practice, in turn, were reported as knowledge of KMC benefits and a sense of empowerment (Cai *et al.*, 2024). High knowledge mothers in Zambia were nearly four times further inclined to practice (Kampeketete, G.S., Ngoma, C., and Masumo, M., 2018).

In Nigeria, it was stated that it was necessary to reduce hospital expenses to families to facilitate a long stay in the course of KMC (Onubogu U.C., Okoh B.A., 2016). Onubogu and Okoh (2016) also found out that mothers needed their families, peers, and health workers to support them at the mother-and-family levels as they practiced KMC. Similar issues were revealed in a review conducted by Morgan *et al.*, (2018) that ranked barriers and facilitators of studies in the field of low- and middle-income countries (LMICs). Lack of awareness about KMC, lack of space and supplies in the facility, and fears of abusing the small baby were significant obstacles to mothers in LMICs. Meanwhile, the obstacles to the implementation of KMC in nurses included workload, inadequate guidelines, insufficient training, and low self-esteem about its effectiveness (Seidman *et al.*, 2015). Our review resulted in similar findings, indicating that the momentum towards sustainable KMC implementation in Nigeria is not an easy task (possibly due to the complexity of the latter, which needs a high level of user and stakeholder engagement) (Onubogu U.C., Okoh B.A., 2016). There were reports of leadership, governance and health workforce building as major bottlenecks to scaling up KMC in Nigeria (Vesel *et al.*, 2015).

During an evaluation conducted by the Save the Children in 31 states, 202/757 (27) facilities reported having KMC services available. Nevertheless, the various definitions of KMC could have resulted in the overestimation of this figure. Based on the evaluation, the majority of the facilities offering KMC include the general types of hospitals (61%), tertiary and specialist types of hospitals (16%). KMC is done in some secondary health facilities. The health facilities at the primary levels do not offer KMC services but refer the preterm babies to the facilities of higher level, where KMC is provided (Save the Children, MCSP, FMOH, 2017). The 14 KMC spaces have been developed through the Maternal and Child Survival Program (MCSP) in 14 locations across the states of Ebonyi and Kogi (MCSP, 2017). Proportions of newborns who are started on immediate skin-to-skin postpartum. Nigeria has not made skin-to-skin care a policy. Moreover, an evaluation that was done in the Lagos Teaching Hospital shows that 1 out of 10 babies is put in skin-to-skin contact with the

mother immediately after birth. When the pediatricians insist, the babies are only subjected to skin-to-skin contact in their presence. The quality of care assessment carried out in Kogi and Ebonyi states showed that 13% of babies are laid in a skin-to-skin position immediately after delivery. KMC is part of the Essential Newborn Care Course (ENCC) training package, which was introduced in 2016. In addition, 949 individuals have received training on maternal and newborn health practices, including KMC, since March 2014, 17 in Ebonyi and Kogi states (MCSP, 2017).

The implementation process is limited by the use of KMC data in monitoring and decision-making. Enhancing data systems and connecting KMC indicators to facility-quality improvement processes would make it possible to implement them more responsively and accountably. In general, these results indicate that developing KMC in Nigeria will necessitate concerted efforts in CFIR domains, such as the commitment of the leadership, investment in the infrastructure, human resources development, community involvement, and the use of data to implement KMC. These factors are interrelated, which is why it is vital to address them to translate policy commitments in Nigeria into a lasting decrease in neonatal deaths and maternal wellbeing.

CONCLUSION

Kangaroo Mother Care is a proven, low-cost intervention with substantial benefits for neonatal survival, physiological stability, breastfeeding, and maternal mental well-being. In Nigeria, however, its population-level impact remains constrained not by uncertainty about effectiveness, but by persistent implementation gaps. This review demonstrates that KMC practice is shaped by interacting barriers across health system readiness, sociocultural norms, financial pressures on families, and weak implementation processes. The absence of standardized protocols, limited infrastructure, inconsistent training, and delayed exposure to KMC through antenatal care continue to undermine sustained uptake, despite firm national policy commitments.

Addressing these challenges requires reframing KMC as a system-embedded component of essential newborn care rather than a stand-alone clinical practice. Strengthening leadership and governance, institutionalizing clear guidelines, investing in workforce capacity, engaging families and communities, and using routine data for quality improvement are critical to translating policy into practice. As a highly scalable and equity-promoting intervention, effective KMC implementation offers Nigeria a practical pathway to accelerating reductions in neonatal mortality while generating transferable lessons for other low- and middle-income settings confronting similar newborn health challenges.

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