INTRODUCTION
Kangaroo mother care (KMC) implies placing the newborn baby in intimate skin-to-skin contact with the mother's chest and abdomen coupled with frequent and preferably exclusive breast-feeding. KMC has emerged as a non-conventional low cost method for newborn care that provides warmth, touch, and security to the newborn and is believed to confer significant survival benefit. An updated Cochrane review has reported that KMC benefits breastfeeding outcomes and cardio-respiratory stability in infants without negative effects. Kangaroo mother care is developmentally supportive type of newborn care.

Benefits of KMC to infants are:
1. Faster weight gain
2. Improve thermal, cardiovascular, respiratory regulation
3. Enhanced neurological development
4. Reduce frequency of infectious illness
5. Improve baby and mother bonding.

Benefits of KMC to mother are:
1. Oxytocin release
2. Less breast feeding difficulty
3. Reduce postpartum psychosis.

AIM:
To identify expectant mothers knowledge about an attitude towards Kangaroo mother care.

HYPOTHESIS:
Despite benefits, kangaroo care use in the delivery room is low and infants are often separated from their mother at birth, evidencing a need for interventions such as Kangaroo care to reinstitute contact between mother and newborn.

Based on previous research, we expect that

KMC attitudes and knowledge would correlate positively with attitudes towards breast feeding, SES own education level, income and spouse education level, perceived social support, perception of control over decisions related to pregnancy/labor and delivery, and interest in a more "natural" pregnancy and birth experience.

KMC attitudes and knowledge would correlate negatively with depression level.

METHOD:
It is an observational study conducted in department of Obstetrics & Gynaecology, National Institute of Medical Sciences and Hospital and Primary health care centre Achrol, Jaipur. The period of study done was from July 2014 to July 2015. A total of 100 antenatal women were recruited.

• Participant (N= 100 antenatal women)
• Mean age = 23.4 years
• 41% of women were pregnant for the first time.
Data Analysis
SPSS for windows was used for all analyses. Inventories were reverse coded such that higher scored indicated increased depression (BDI), more positive attitudes toward breast feeding (IIFAS), and increased knowledge and interest in KMC (KCAI).

Descriptive Statistics:
KCAI mean = 4.24, SD= 0.45 (possible range = 1-5 on a Likert-type scale)
IIFAS mean = 4.29, SD= (possible range = 1-5 on a Likert-type scale)
BDI mean = 11.23, SD = 8.69 (possible range was 0-64; minimal depression =0-13, mild=14-19 moderate =20-28, severe=29-63)

Breastfeeding:
Women with favorable attitudes toward breastfeeding (IIFAS) were more knowledgeable about and interested in KMC (KCAI); r (100) = .629, p < .001. They were also more interested in beginning KMC immediately after birth before the infant has been cleaned or assessed; r (100) = .505, p < .001, and continuing KMC after 6 weeks; r (100) = .233, p < .05. Intention to breastfeed exclusively correlated positively with higher KCAI score; r (94) = .508, p < .001.

Social Support:
Having a spouse/partner who would be willing to do KMC at birth was highly correlated with higher maternal KCAI scores; r (100) = .533, p < .001, with interest in doing KMC immediately after birth; r (100) = .630, p < .001 and with interest in continuing KMC after 6 weeks, r (100) = .345, p < .01.

Having a spouse/partner who would be willing to do KMC at birth was highly correlated with higher maternal KCAI scores; r (100) = .533, p < .001.

Medical System Usage and Attitudes
Women who received prenatal care from an obstetrician scored higher on the KCAI than women receiving care from another source; F = 6.652, df = 1, p < .05. Women planning for hospital deliveries scored higher KCAI, F = 5.365, df = 3, p < .01 as shown by an ANOVA of the effect of place of planned delivery.

The higher women scored on the KCAI, the less interested they were in a C-section, r (93) = .293, p < .05. More general social support during pregnancy did not have a significant effect.

Although KCAI was phrased as objectively as possible, potential social desirability effects cannot be ruled out. In this case, it is likely that individuals may have inferred that the researchers were supportive of KMC based on the fact that they were interested in women’s perception of practice.

FUTURE DIRECTIONS
This study laid the groundwork for the development of the kangaroo Care attitudes inventory. Further studies should narrow the item pool to increase variability and discriminate ability, and should employ longitudinal methods to determine to determine the predictive power of this tool.

RECOMMENDATIONS
Proper counseling and prenatal education is required for spouse/partner/family for the benefits of KMC.

Mother should be educated about the benefits of breast feeding and how KMC can help in enhancing the breast feeding experience and also helps in reducing the breast feeding difficulties.

Women using traditional birth attendants/other sources care instead of trained birth attendants or obstetricians care may be at a disadvantage for learning about KMC and would benefit from increased education about KMC.

REFERENCES
3. Ferber SG. The effect of skin-to-skin contact (kangaroo care) shortly after birth on the neurobehavioral responses of the term newborn: a randomized, controlled trial. 2004 Apr;113(4):858-65