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Content Details:

Aaron Matthew Gleiberman(Author) *Louisiana State University* **Jamie Kurash(Co-Author)** *Lamar University*	**Learning to Lead with AI: Financial Executive Social Media Literacy and Training**

Abstract

As technological innovation continues to reshape business strategy, financial executives face increasing pressure to adopt and leverage digital tools such as social media marketing. While artificial intelligence (AI) remains a transformative force, its practical outgrowths like data-driven marketing and online engagement are becoming essential for strategic leadership in finance-driven industries. Building on previous research (Clark 2024) on executive education for AI readiness, this study investigates how to most effectively train financial executives to operationalize and mobilize social media marketing in their organizations. We pay attention particularly to the real estate and development sectors. Anchored in adult learning theory (andragogy), this paper examines instructional strategies tailored to experienced professionals, emphasizing relevance, autonomy, and experiential learning. Data collection will include IRB-approved surveys and semi-structured qualitative interviews with senior financial professionals in real estate and development. The investigation aims to develop an academic and practitioner-informed framework for executive education that not only demystifies social media marketing but empowers leaders to integrate it effectively into financial and strategic planning. This research contributes to the evolving dialogue on digital literacy in executive roles, offering actionable insights for educators, consultants, and industry leaders working at the intersection of finance, development, and digital transformation. Specifically, experiential learning, gamification, and multimedia modalities are recommended.

Bounga; Ndadje Christelle(Author)	**Kangaroo Mother Care: Saving Babies' Lives**

ABSTRACT

Low birth weight and prematurity are strongly associated with neonatal morbidities and mortality. Caring for low birth weight infants' impose heavy burden on developing countries. The Kangaroo Mother Care is a measure recommended by the World Health Organization in scaling up low cost solutions that could reduce neonatal deaths associated with preterm birth and low birth weight by three-quarters in 2035. Kangaroo Mother Care offers promising potential for neonatal care, especially those with low birth weight, due to benefits of thermal control, successful breastfeeding and bonding, reduced hospitalization costs, irrespective of setting, weight, gestational age, and clinical conditions. This innovative strategy is being implemented in very few hospitals in Cameroon. Thus in order to reduce the prevalence of preterm birth and low birth weight, at first we should be able to understand the Kangaroo Mother Care, the way it's been practiced and know about its advantages.

SECTION ONE

INTRODUCTION

1.1 Background

Preterm is defined as babies born alive before 37 completed weeks of gestation. There are three sub-categories of preterm based on gestational age: Extremely preterm (<28 weeks), Very preterm (28 to <32 weeks) and moderate to late preterm (32 to <37 weeks) (WHO, 2016). Low birth weight and prematurity are strongly associated with neonatal morbidities and mortality (UNICEF, 2004). Low birth weight refers to birth weight below 2500 g (Avery *et al.,* 1987). Globally, babies with low birth weight, and preterm accounts 25 and 15 million, respectively. Almost all of them (96.0%) are in developing countries. The rates are highest in Africa which has 12% of the world's population but over 25% of the world's new-born deaths (WHO, 2003). In, Cameroon, the prevalence of low birth weight varies from place to place. It was reported to be 20.0% according to the Cameroonian Demographic and Health survey 2018 (CDHS, 2018).

Caring for low birth weight infants' impose heavy burden on developing countries. World Health Organization (WHO) has recommended scaling up low cost solutions that could reduce these deaths by three-quarters which includes Kangaroo Mother Care (KMC) as one of the measures (WHO, 2003). Kangaroo Mother Care (KMC) is defined as a method of holding a small nappy neonate in skin-to skin contact (STS), prone and upright on the maternal chest. The neonate is enclosed in maternal clothing in order to maintain temperature stability (Charpak *et al.,* 2005). It was invented by Dr. Rey in 1978 and developed by Dr. Martinez and Dr. Navarrete until 1994,

when the Kangaroo Foundation was created. Initially KMC was developed as response to overcrowding, and insufficient resources in neonatal intensive care units. But today KMC is formally endorsed by WHO (WHO, 2010).

KMC has a lot of benefits to the mother, for the preterm and low birth weight infants, for the institution, and for the community at large. For mothers, it increases milk volume, double rates of successful breastfeeding, feelings of confidence, competence, and satisfaction regarding baby care. For preterm and LBW infant, it normalizes temperature, heart rate, respiratory rate, and strengthens the infant's immune system. It also reduces physiologic and behavioural pain responses, increases weight gain and enhances mother-infant bonding. Furthermore it has Positive effects on infant's cognitive development, less nosocomial infection, and earlier discharge (WHO, 2010). For institutions it shorten hospital stay, more parental involvement with greater opportunities for teaching and assessing, and better use of healthcare budgets. For the community it decreases morbidity and mortality especially in developing countries, and opportunities for teaching during pregnancy and follow-up in preparation for postnatal implementation, decreased use of financial resource and Promotion of total family health (WHO, 2010). This innovative strategy is being implemented in very few hospitals in Cameroon. Thus in order to reduce the prevalence of preterm birth and LBW, at first we should be able to understand the KMC, the way it's been practiced and know about its advantages.

1.2 Objectives

1.2.1 General objective

At the end of this presentation, participants should be able to understand kangaroo mother care, and its benefits and should be able to practice the care.

1.2.2 Specific objectives

At the end of this presentation, participants should be able to;

- Define kangaroo mother care
- Enumerate the benefits of the kangaroo mother care
- Implement the kangaroo mother care

1.3 Structure of the Paper

This seminar book is divided in to five sections. Section one covers the background information, objectives and the structure of the paper. Section two, three and four covers the review of the various objectives respectively. Section five entails the conclusion and provides recommendations. The list of references and appendices follows these chapters.

SECTION TWO

KANGAROO MOTHER CARE

2.1 Origins of Kangaroo Mother Care (KMC)

Kangaroo Mother Care (KMC) evolved nearly 42 years ago, in 1978 when health facilities in Bogota, Columbia, were confronted with overcrowding and limited number of incubators in the neonatal minimal care units. It was invented by Dr. Rey in 1978 and developed by Dr. Martinez and Dr. Navarrete until 1994, when the Kangaroo Foundation was created. The concept of KMC emerged to cope with inadequate and insufficient incubator care for preterm or LBW neonates, who had overcome initial health concerns of breathing problems and required only to feed regularly without additional monitoring (Charpak *et al.,* 2017).Today, KMC is formally endorsed by WHO (WHO, 2010).

2.2 Definition of Kangaroo Mother Care

Kangaroo Mother Care (KMC) is defined as a method of holding a small nappy neonate in skinto skin contact (STS), prone and upright on the maternal chest. The neonate is enclosed in maternal clothing in order to maintain temperature stability (Charpak *et al.,* 2005).

The components of KMC included direct SSC between the mother and baby, exclusive breastfeeding, early discharge, and close follow-up (Charpak *et al.,* 2017; WHO, 2003). WHO endorsed KMC as an intervention for stable LBW babies in first referral hospitals of lowresourced settings with guidelines for its adaptation and use by HCWs in these settings in 2003. These guidelines were relevant to policy makers at the national level to develop policies, their own guidelines, and training materials according to the local context (WHO, 2003).

SECTION THREE

BENEFITS OF KANGAROO MOTHER CARE

Kangaroo Mother Care has a lot of benefits to the mother, for the preterm and low birth weight infants, for the institution, and for the community at large.

3.1 Benefits of Kangaroo Mother Care to the Mother

For mothers,

1. It increases milk volume,
2. Double rates of successful breastfeeding, feelings of confidence, competence, and satisfaction regarding baby care.

3.Babies initiated with KMC, have significant reduction in length of stay in the health facility, and this is associated with cost benefits both for the health facility and the family (Broughton *et al.,* 2013; Sharma *et al.,* 2016).

3.2 Benefits of Kangaroo Mother Care to the preterm and low birth weight infants For preterm and LBW infant,

1. It normalizes temperature, heart rate, respiratory rate,
2. It strengthens the infant's immune system,
3. It also reduces physiologic and behavioural pain responses,
4. KMC also increase the chance of weight gain, length gain and head circumference.
5. It enhances mother-infant bonding and create a better home environment with the involvement of fathers (Tessier *et al.,* 2009).
6. Furthermore it has Positive effects on infant's cognitive development (WHO, 2010).
7. KMC also improves exclusive breastfeeding rates (Vohra *et al.,* 2017),
8. It reduce risk of mortality at discharge or 40-41 weeks of gestation age;
9. It reduces nosocomial infections and sepsis risks (Diaz-Rossello, 2016).

3.3 Benefits of Kangaroo Mother Care to the institution

For institutions,

1. It shorten hospital stay. Babies initiated with KMC, have significant reduction in length of stay in the health facility, and this is associated with cost benefits both for the health facility and the family (Broughton *et al.,* 2013; Sharma *et al.,* 2016).

2.KMC also enhances more parental involvement with greater opportunities for teaching and assessing, and better use of healthcare budgets.

3.4 Benefits of Kangaroo Mother Care to the community at large

For the community,

1. It decreases morbidity and mortality especially in developing countries
2. It provides opportunities for teaching during pregnancy and follow-up in preparation for postnatal implementation
3. It decreased use of financial resource and Promotion of total family health (WHO, 2010).

SECTION FOUR

IMPLEMENTING KANGAROO MOTHER CARE

The WHO defined KMC as early, continuous, and prolonged skin to skin contact (SSC) between the mother and LBW baby; exclusive breastfeeding or breast-milk feeding; early discharge after hospital-initiated KMC with continuation at home; and adequate support and follow-up for mothers at home (Chan *et al.,* 2016). This definition gave clear guidance on the components of KMC and contexts where it could be practiced. One would presume, from this definition that KMC must be initiated in the health facility and continued at home. It also provided direction on the need for support of mothers to continue KMC at home through the terms "adequate support and follow-up".

4.1 Components of KMC

KMC was the recommended third package of essential care for LBW babies; thus, it was necessary that all its components were considered by implementers and users when strategizing for its scale-up (Chan *et al.,* 2016).
The components of KMC includes;

1. direct SSC between the mother and baby,
2. exclusive breastfeeding,
3. early discharge, and close follow-up (Charpak *et al.,* 2017; WHO, 2003).

4.2 Criteria for KMC initiation

When considering KMC scale-up, clear criteria need to be in place of when, it could be best initiated for a small baby. The guideline for KMC implementation partly specified this by indicating that KMC could be initiated immediately at birth for "stable" LBW babies weighing 1800-2500 gms (MoPH, 2014).

1.Recommendations include delaying KMC for days or weeks for babies weighing 1200 to 1800 gms at birth or those weighing <1200 gms as they could have serious morbidities (MoPH, 2014).

2. Consideration of the APGAR scoring as a standard. The APGAR is a viable option to operationalise the concept "stable" with a good APGAR score of >7 of 10 reflecting a baby hemodynamically stable, and thus a possible strategy to overcome the barrier of being "unsure on the eligibility for SSC at birth" itself (Alenchery *et al.,* 2018).

3. The MoPH guideline further classified duration of KMC for a day as short (SSC for 4 hours/day), extended (SSC for 5 – 8 hours); long (SSC for 9 – 12 hours /day) and

continuous (SSC was provided for 12 hours / day).
4. Mothers would be required to be well supported in the health facility and home (Seidman *et al.,* 2015; Chan *et al.,* 2016b) to provide the recommended duration of KMC daily.

5. The guideline for KMC implementation had also specified clear criteria for discharge such as the "LBW baby who was not on parenteral medication, had maintained body temperature for three consecutive days at room temperature; had gained weight by 1520 gms per day for three consecutive days; and was accepting feeds directly from breast or by spoon" (MoPH, 2014).

4.3 Place where KMC can be initiated

The WHO (2015) guidelines for KMC implementation stipulated that KMC must be initiated in a health facility but did not specify explicitly what type of health facility. This lack of specification could be a challenge for KMC scale-up in Cameroon, especially since childbirth could occur anywhere along the continuum from home to a primary level setting (PHC and CHC) or to secondary level facilities (SDH and district hospital) or even private health facilities.

In summary for KMC to be operationalize at scale along the health facility – community continuum, it is important to address the gaps in the delivery of KMC along this continuum and to facilitate a common understanding of how KMC could be implemented by all stakeholders.

4.3 How is KMC practiced

Kangaroo Mother Care (KMC) is done by holding the neonate in skin-to skin contact (STS), prone and upright on the maternal chest. The neonate is enclosed in maternal clothing in order to maintain temperature stability (Charpak *et al.,* 2005).

SECTION FIVE

CONCLUSION & RECOMMENDATION

5.1 Conclusion

Kangaroo Mother Care (KMC) is a measure recommended by the WHO in scaling up low cost solutions that could reduce neonatal deaths by three-quarters in 2035. KMC offers promising potential for neonatal care, especially those with LBW, due to benefits of thermal control, successful breastfeeding and bonding, reduced hospitalization costs, irrespective of setting, weight, gestational age, and clinical conditions.

5.2 Recommendations

1. Advocacy, education and training on KMC for post-natal mothers at all levels of health facilities should be encouraged and intensified for the benefit of the small babies and to reduce neonatal mortalities.

2. Hospitals should improve their nursing staff knowledge of KMC and establish wellequipped KMC wards.

3. Engagement of key stake-holders (e.g. the hospital director and management) is also a key factor in the success of KMC implementation, given their role in providing the necessary resources and ensuring optimum processes.

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Maryam Safa Schneider(Author) *University Canada West*	**Navigating Technostress: A Qualitative Exploration of Technology Stressors Faced by Knowledge Workers in Higher Education**

Abstract

This qualitative study examined technostress creators (techno-overload, techno-invasion, techno-complexity, techno-insecurity, and techno-uncertainty) in academia among knowledge workers, specifically faculty and administrators. Semi-structured interviews were conducted with knowledge workers in Canadian higher education (N = 22; 12 women, 10 men). Thematic analysis revealed that constant connectivity, which leads to blurred work-life boundaries (techno-invasion), and the continual learning of new information and communication technologies (techno-overload), are principal drivers of technostress in higher education in the post-pandemic world of education. Further analysis of participants' coping mechanisms indicated that technostress has a pronounced impact on professional women in academia, particularly regarding constant connectivity (e.g., techno-invasion intensifies caregiver guilt) and ageist attitudes (e.g., internalized ageism related to perceived technological proficiency). The study positions technostress as an occupational health issue, emphasizing the need for gender-responsive strategies, improved leadership communication, and inclusive digital policy development.

Keywords: technostress, information and communication technologies, higher education, knowledge workers, gender-sensitive policy, occupational health, work-life balance

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