ORIGINAL ARTICLE

Morbidities, Complications and Outcomes at Discharge in Newborns Admitted with Respiratory Distress at a Tertiary Care Hospital of Nepal: A Descriptive Cross-Sectional Study

Prakash Man Shah[1], Nisha Keshary Bhatta[2], Subash K.C[2], Sukrita Sah[3], Sri Ram K.C[1], Rajani Karki[1], Samikshya Pokharel[4]

[1] Department of Pediatrics, Nepal Armed Police Force Hospital, Balambu, Kathmandu, Nepal
[2] Department of Pediatrics, B.P Koirala Institute of Health Sciences, Dharan, Nepal
[3] Department of Community Medicine and Tropical Diseases, B.P Koirala Institute of Health Sciences, Dharan, Nepal
[4] Department of Gynecology and Obstetrics, B.P Koirala Institute of Health Sciences, Dharan, Nepal

Corresponding Author:
Dr. Prakash Man Shah
Department of Pediatrics
Nepal Armed Police Force Hospital,
Balambu, Kathmandu, Nepal.
Email: shahpms2012@gmail.com

Article History:
Received date: December 05, 2025
Revised date: January 14, 2026
Accepted date: January 16, 2026
Published date: February 14, 2026

Online Access

DOI: 10.64772/mjapfn32

Abstract

Introduction: Neonatal respiratory disorders are among the leading causes of admissions to neonatal intensive care units due to respiratory distress in the early neonatal period. However, studies on their spectrum and outcomes among Nepalese neonates are limited. This study aimed to find out the proportion and types of respiratory disorders among admitted newborns, along with associated complications and outcomes.

Methods: This descriptive cross-sectional study was conducted in the Neonatology Unit of a tertiary care hospital from July 1, 2023 to June 30, 2024, among all inborn neonates meeting the inclusion criteria. Convenience sampling was applied, and the sample size taken was 150. Ethical approval was obtained from the Institutional Review Committee (Ref no 241/080/081-IRC). Data were entered in Microsoft Excel 2007 and analyzed using Statistical Package for the Social Sciences version 11.5.

Results: Among 150 newborns, the most prevalent morbidity was Transient Tachypnoea of Newborn 56 (37.30%), followed by Meconium Aspiration Syndrome 46 (30.70%). Similarly, 27 (18%) had complications, and 123 (82%) had no complications. Likewise, 134 (89.30%) babies recovered and were discharged, and 7 (4.70%) mortality during the course of treatment.

Conclusions: This study concluded that the most common morbidity was Transient Tachypnea of the Newborn, followed by Meconium Aspiration Syndrome. This study emphasizes early identification of different types of respiratory disorders and common complications among neonates with respiratory distress which will help in early recognition and treatment thereby minimizing complications and mortality.

Keywords: *newborn; respiratory distress syndrome; transient tachypnea; treatment outcome.*

How to cite (Vancouver Style)
Shah PM, Bhatta NK, K.C S, Sah S, K.C SR, Karki R, et.al. Morbidities, Complications and Outcomes at Discharge in Newborns Admitted with Respiratory Distress at a Tertiary Care Hospital of Nepal: A Descriptive Cross-Sectional Study. Med J APF Nepal. 2026;2(1):15-21.

Introduction

Neonatal respiratory disorders account for most admissions to intensive care units in the immediate newborn period as they develop respiratory distress.[1] The causes of respiratory distress in the newborn are numerous and are due to pulmonary or extrapulmonary processes.[2] Significant respiratory morbidity affects 15% of term babies and 29% of late preterm babies admitted to the Neonatal Intensive Care Unit (NICU), the percentage rises to 34% for babies born before 34 weeks of gestation.[3] The common complications of respiratory distress in preterm newborns are divided into short term and long term complications.[4] Short term complications include Patent Ductus Arteriosus (PDA), Intraventricular hemorrhage, Necrotizing enterocolitis, whereas long term complications include Bronchopulmonary dysplasia.[4] The prognosis of infants with respiratory disorders depends on prompt identification of the underlying cause and timely initiation of appropriate interventions.[5]

There is a paucity of data in our part of the world however available reports have found that the incidence of respiratory disorders is 3.90% to 8% of all newborns getting admitted in neonatal units.[6,7] The Sustainable Development Goals (SDGs) of Nepal aim to end preventable deaths of newborns and children under five years of age by 2030, with all countries aiming to reduce neonatal mortality to at least 12 per 1,000 live births and under-five mortality to at least 25 per 1,000 live births.[8] Early detection and timely treatment of respiratory disorders in newborns are essential in order to reduce complications associated with respiratory disorders and mortality.[8]

This study aimed to find out the proportions and types of respiratory disorders among admitted newborns, along with associated complications and outcomes.

Methods

A descriptive cross-sectional study was conducted at the neonatology unit of the Department of Pediatrics and Adolescent Medicine, BPKIHS, Dharan. Ethical clearance was taken from the Institutional Review Committee (IRC), BPKIHS (Ref. no. 241/080/081-IRC). The study population included all inborn babies meeting the inclusion criteria from July 01, 2023, to June 30, 2024, using convenient sampling till sample size was reached. Inclusion criteria were only inborn neonates with respiratory distress and exclusion criteria was out born neonates and whose parents did not give consent.

Sample size was calculated using Cochran's formula.

$n = (Z^2 \times p \times q) / e^2$

$= (1.96^2 \times 0.34 \times 0.66) / 0.08^2$

$= 135$

Where,

n= minimum required sample size

Z= 1.96 at 95% Confidence Interval (CI)

p= prevalence of neonates with respiratory distress, prevalence was taken as 0.34 based on a study done by P Rijal and M Shrestha at Nepal Medical College and Teaching Hospital, Kathmandu, where 34.3% of all NICU admissions were contributed to respiratory distress[9]

q= 1-p

e= margin of error, was set at 8% (0.08)

After accounting for a 10% non-response rate, the final sample size was set at 150.

Operational Definitions:[10]

Preterm: Gestational age < 37 weeks

Term: Gestational age ≥ 37 weeks to <42 weeks

Birth weight has been classified into the following categories:

- Low birth weight: < 2500 grams
- Normal weight: ≥ 2500 grams to < 4000 grams

Diagnostic criteria for acute neonatal respiratory disorders

1. Respiratory distress syndrome (RDS): Increasing oxygen requirement during the first 24 hours, absence of any signs of infection; typical radiological pattern with reduced air content, reticulogranular pattern of the lung and air bronchograms.[11]
2. Transient tachypnea of newborn (TTNB): Requirement of supplemental oxygen within the first 6 hours of life that does not increase during the subsequent 18 hours. Chest radiograms can either be normal or show reduced translucency, infiltrates and hyperinflation of the lungs.[12]
3. Meconium aspiration syndrome (MAS): Presence of meconium in both amniotic fluid and neonatal trachea, with chest radiograms showing hyperinflation, massive bilateral patchy infiltrates of the lung and frequently pleural fluid effusions.[13]
4. Pneumonia: Variable oxygen dependence with suggestive maternal history (premature rupture of membranes, fever during the 12 hours antepartum, chorioamnionitis), clinical signs of infection, supportive laboratory studies, radiographic patterns similar to RDS with

bilateral or unilateral alterations.[14]

5. Sepsis: The presence of risk factors for sepsis, if clinical findings and lab findings (including absolute neutrophil count, C-reactive protein, and blood culture) are suggestive of sepsis.[15]

Respiratory disorders were classified into 5 subgroups: - respiratory distress syndrome, transient tachypnea of newborn, meconium aspiration syndrome, pneumonia, and sepsis.

After classifying respiratory disorders, neonates were observed for development of any complication, i.e. Necrotizing Enterocolitis (NEC), Patent Ductus Arteriosus (PDA), persistent pulmonary hypertension of newborn (PPHN), BronchoPulmonary Dysplasia (BPD), pulmonary air leak, and shock. Then the final outcome of babies was recorded in 4 major groups: 1) recovered and discharged, 2) discharged with complications, 3) left against medical advice, and 4) mortality.

Variables to be measured in the neonate included gestational age, birth weight, gender, type of respiratory disorders, their complications, and the newborn's final outcome. Point estimates at a 95% Confidence Interval (CI) were calculated along with frequency and percentage for binary data and mean with standard deviation for continuous data. Data were entered in Microsoft Excel 2007 and analyzed using Statistical Package for the Social Sciences version 11.5

Results

During the one-year study period, 150 newborns with respiratory distress were included in this study; of these, 100 (66.70%) were male. The mean gestational age was 37.13±3.01 weeks. The mean birth weight was 2650.71±769.94 grams (Table 1).

Table 1: Baseline characteristics of newborns admitted with respiratory distress

Characteristics	Categories	No of newborn n(%)
Gender	Male	100(66.70%)
	Female	50(33.30%)
Gestational age (in weeks)	Term (≥37)	94(62.70%)
	Preterm (<37)	56(37.30%)
Mean Gestational age ± SD (min – max) in weeks		37.13±3.01 (26 – 41)
Birth weight (in gram)	Normal	86(60.60%)
	Low birth weight (LBW)	44(29.30%)
	Very low birth weight (VLBW)	13(8.70%)
	Extreme low birth weight (ELBW)	2(1.30%)
Mean Weight ± SD (min – max) in gram		2650.71±769.94 (830-3970)

As seen in Table 2, the most common respiratory morbidity among newborns was Transient tachypnea of the newborn, observed in 56 (37.30%), followed by Meconium Aspiration Syndrome in 46 (30.70%).

Table 2: Distribution of Morbidities among newborns admitted with respiratory distress

Characteristics	Categories	No of newborns n(%)
Morbidities	TTNB	56(37.30%)
	MAS	46(30.70%)
	Pneumonia	20(13.30%)
	RDS	15(10%)
	Sepsis	13(8.70%)

Among 150 newborns, 123 (82%) had no complications, whereas 27 (18%) developed complications. Among those 27 newborns that developed complications, shock was the most common followed by PDA during the course of NICU stay (Table 3).

Table 3: Distribution of Complications among newborns admitted with respiratory distress

Characteristics	Categories	No of newborns n(%)
Complications	Yes	27(18%)
	No	123(82%)
Types of complications	Shock	10(37%)
	PDA	8(29.60%)
	NEC	3(11.10%)
	PPHN	3(11.10%)
	BPD	2(7.40%)
	Air Leak	1(3.70%)

Out of 150 babies, 134 (89.30%) newborns recovered and were discharged, 7 (4.70%) died during the course of treatment (Figure 1).

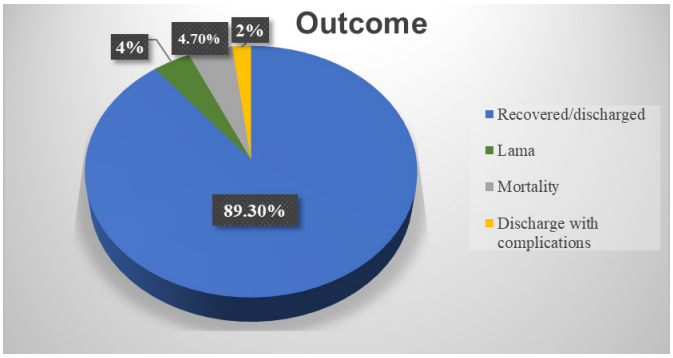

Figure 1: Distribution of outcome of newborns admitted with respiratory distress

Among the babies with RDS, 6 (40%) were recovered and discharged, 6 (40%) died, 2 (13.30%) left against medical advice, and 1 (6.70%) was discharged with complications (i.e., BPD).

All of the newborns with TTNB recovered and were discharged.

Among the babies with MAS, 42 (91.30%) were recovered and discharged, 2 (4.30%) left against medical advice, 1 (2.20%) was discharged with complications (i.e. PDA), and 1 (2.20%) died.

19 (95%) of the newborns who had pneumonia were discharged with recovery, whereas 1 (5%) was discharged with complications (i.e. BPD). Among the babies with sepsis, 11 (84.60%) recovered and were discharged, whereas 2 (15.40%) left against medical advice (Table 4).

Table 4: Distribution of outcomes in relation to cause of respiratory distress.

Morbidities	Outcome			
	Recovered & discharged	Lama	Mortality	Discharge with complications
RDS	6(40%)	2(13.30%)	6(40%)	1(6.70%)
TTNB	56(100%)	-	-	-
MAS	42(91.30%)	2(4.30%)	1(2.20%)	1(2.20%)
Pneumonia	19(95%)	-	-	1(5%)
Sepsis	11(84.60%)	2(15.40%)	-	-

Discussion

In this study consisting of 150 newborns, the mean gestational age of newborns was 37.13±3.01 weeks, with the majority of newborns being from the term gestational age 94 (62.70%), and the preterm gestational age was 56 (37.30%). Similar findings were found in a study done in Karachi in 2010 by Parkash et al. among 205 newborns with respiratory distress admitted at NICU, which showed the mean gestational age of 36.32 ± 2.72 weeks.[16] Similarly, a study done in Maharashtra, India, by Kshirsagar VY et al. in 2018 among 100 newborns admitted with respiratory distress showed 52% of term gestation and 48% of preterm gestation.[17] However, these findings are different from a study done in Nepal by Lamichhhane et al. among 111 newborns who developed respiratory distress after birth which showed 59.46% of preterm and 40.54% of term newborns.[18] This is because of a greater number of term gestational admissions at our center.

Most of the newborns 100 (66.70%) were male. Similar findings were found in a study done in Karachi in 2010 by Parkash et al., among 205 newborns with respiratory distress, which shows 58.6% were male.[16] Comparable findings were also observed in a study done in India by Kshirsagar VY et al. 51% male in Nepal by Anita Lamichane et al., 60.36% male.[17,18] It is known that male babies are more prone to respiratory distress at birth. Additionally, it is worth considering data from the Nepal Demographic Health Survey 2022, which reported an increase in the male-to-female ratio for children under five years old to 1.09:1, which may also contribute to this observed male predominance.[19]

Most of the baby with respiratory disorder were of normal birthweight (≥2500gm) i.e. 86(60.60%) while 44 (29.30%) were low birth weight and only 2 (1.30%) newborns were extremely low birth weight (<1000gm) with mean birth weight of 2650.71±769.94 grams which is similar to study done by Abdel baser et al. in 2018 among 145 newborn with respiratory distress in Qena, Egypt which reported a mean birth weight of 2108.19±810.92.[20] Similarly, a study done by Dey et al. in 2023 among 100 newborns in eastern India where 50% of babies were normal weight followed by 33% LBW, 9% VLBW and 8% ELBW.[21] Chandrasekhar R et al. in 2014, among 100 newborns who developed respiratory distress in India, also reported 73% of normal weight and 27% of LBW.[22] In contrast, Lamichhane et al. in Nepal in 2019, among 111 newborns, reported a higher proportion of low birth weight (50.45%) compared to normal birthweight (38.40%).[18] This difference could be due to more number of term gestational age newborns with respiratory disorders admitted in our study.

In this study, transient tachypnea of newborn 56 (37.30%) was the most common cause of respiratory distress followed by meconium aspiration syndrome 46 (30.70%). These findings are similar to a study done by Piparsania et al. in Indore among 100 newborns & by Erbu Yarci, MD et al. among 903 newborns in Turkey.[23,24] These similar trends across studies highlight the importance of strengthening perinatal care practices aimed at preventing, promptly recognizing respiratory disorders and early neonatal respiratory support.

The majority of newborns 123 (82.00%) with respiratory distress had no complications, whereas 27 (18.00%) had some complications. Among those with complications, the majority of newborns had shock 10 (37.00%), followed by PDA 8 (29.60%), NEC 3 (11.10%), PPHN 3 (11.10%), BPD 2 (7.40%) and air

leak 1 (3.70%). These findings are different from the study done by Erbu Yarci, MD et al. in 2020 among 903 newborns in Turkey, where 61% developed some complications in which Intraventricular hemorrhage (IVH) (24.90%) was the most common complication followed by PDA (19.8%), NEC (6.80%), air leak (5%) and BPD (4.70%).[24] The lower complication rate might be because of the inclusion of more term and normal birth weight babies in our study.

Most of the newborns 134 (89.30%) had recovered and were discharged. This finding is similar to a study done by Kshirsagar et al. among 100 newborns, where 88.84% were discharged and 4.70% died during hospital stay, [17], which is also similar to a study done by Lamichhane et al. in 2019, where 4% of newborns had left against medical advice, and only 2% were discharged with complications.[18]

The study was conducted in a single tertiary care center. Multicenter studies are required to validate the results. The most common causes of respiratory distress requiring newborn care in this study are transient tachypnea of the newborn and meconium aspiration syndrome, and these have generally favourable outcomes, which may have influenced the overall complication and mortality rates. The availability of trained personnel to take care of these newborns may also have contributed to improved outcomes. The newborns in our study were followed until their discharge, which hindered the evaluation of long-term complications.

Conclusions

The majority of affected newborns exhibited an average and manageable clinical course, and a notable proportion developed complications, highlighting the clinical significance of early and accurate diagnosis. Early intervention not only improves clinical outcomes but also helps shorten NICU stays and minimizes the risk of long-term morbidity and mortality.

Source of Funding: None

Acknowledgement: None

Conflict of Interest: None

Author's Contribution and ORCID iDs

Dr. Prakash Man Shah: Conceptualization, Study design, Literature search, Data acquisition, Data analysis, Statistical analysis, Manuscript preparation, Manuscript editing, Manuscript review.
: https://orcid.org/0009-0003-5721-072X

Dr. Nisha Keshary Bhatta: Conceptualization, Study design, Data acquisition, Data analysis, Statistical analysis, Manuscript editing, Manuscript review, Guarantor of the study.
: https://orcid.org/0000-0002-7904-9215

Dr. Subash K. C.: Study design, Literature search, Manuscript preparation, Manuscript editing, Manuscript review.
: https://orcid.org/0009-0002-0782-6895

Dr. Sukrita Sah: Study design, Literature search, Manuscript preparation, Manuscript editing, Manuscript review.
: https://orcid.org/0009-0004-9875-2477

Dr. Sriram K.C.: Study design, Literature search, Manuscript preparation, Manuscript editing, Manuscript review.
: https://orcid.org/0009-0008-4745-5316

Dr. Rajani Karki: Study design, Literature search, Manuscript preparation, Manuscript editing, Manuscript review.
: https://orcid.org/0009-0007-4646-7609

Dr. Samikshya Pokharel: Study design, Literature search, Manuscript preparation, Manuscript editing, Manuscript review.
: https://orcid.org/0009-0002-5389-4338

References

1. Warren JB, Anderson JM. Newborn Respiratory Disorders. Pediatr Rev. 2010 Dec;31(12):487–96. DOI: 10.1542/pir.31-12-487
2. Flidel-Rimon O, Shinwell ES. Respiratory Distress in the Term and Near-Term Infant. NeoReviews. 2005 Jun;6(6):e289–97. DOI: 10.1542/neo.6-6-e289
3. Edwards MO, Kotecha SJ, Kotecha S. Respiratory Distress of the Term Newborn Infant. Paediatr Respir Rev. 2013;14(1):29–37. DOI: 10.1016/j.prrv.2012.02.002
4. Reuter S, Moser C, Baack M. Respiratory Distress in the Newborn. Pediatr Rev. 2014 Oct;35(10):417–29. DOI: 10.1542/pir.35-10-417
5. National Heart, Lung, and Blood Institute (NHLBI). Newborn Breathing Conditions [Internet]. Bethesda (MD): NHLBI; 2024 [cited 2024 Jul 20]. Available from: https://www.nhlbi.nih.gov/health/newborn-breathing-conditions
6. Shrestha S, Shah A, Prajapati R, Sharma Y. Profile of Neonatal Admission at Chitwan Medical College. J Chitwan Med Coll. 2014 Jan;3(4):13–6. DOI: 10.3126/jcmc.v3i4.9547

7. Bajad M, Goyal S, Jain B. Clinical Profile of Neonates With Respiratory Distress. Int J Contemp Pediatr. 2016;3:1009–13. DOI: 10.18203/2349-3291.ijcp20162382

8. United Nations Nepal. Sustainable Development Goal 3: Good Health and Well-Being [Internet]. Kathmandu: United Nations; 2022 [cited 2022 Dec 21]. Available from: https://nepal.un.org/en/sdgs/3

9. Rijal P, Shrestha M. Analysis of Neonatal Respiratory Distress in Neonatal Intensive Care Unit at Nepal Medical College. J Nepal Health Res Counc. 2018 Jul;16(2):131–5. DOI: 10.3126/jnhrc.v16i2.20297

10. Karnati S, Kollikonda S, Abu-Shaweesh J. Late Preterm Infants: Changing Trends and Continuing Challenges. Int J Pediatr Adolesc Med. 2020 Mar;7(Suppl 1):38–46. DOI: 10.1016/j.ijpam.2020.02.006

11. Fanaroff AA, Fanaroff JM, editors. Klaus and Fanaroff's Care of the High-Risk Neonate. 7th ed. Philadelphia: Elsevier; 2019. p. 190. Available from: https://www.educate.elsevier.com/book/details/9780323608541

12. Halliday HL, McClure G, Reid MM. Transient Tachypnoea of the Newborn: Two Distinct Clinical Entities? Arch Dis Child. 1981 May;56(5):322–5. DOI: 10.1136/adc.56.5.322

13. Holtzman RB, Banzhaf WC, Silver RK, Hageman JR. Perinatal Management of Meconium Staining of the Amniotic Fluid. Clin Perinatol. 1989 Dec;16(4):825–38. DOI: 10.1016/S0095-5108(18)30605-5

14. Stoll BJ. The Global Impact of Neonatal Infection. Clin Perinatol. 1997 Mar;24(1):1–21. DOI: 10.1016/S0095-5108(18)30181-7

15. Agrawal R, Deorari A, Paul VK, Sankar MJ, Sachdeva A. AIIMS Protocols in Neonatology. 2nd ed. New Delhi: Noble Vision; 2019. p. 303–14. Available from: https://www.noblevision.in/product-page/aiims-protocols-in-neonatology?

16. Parkash A, Haider N, Khoso ZA, Shaikh AS. Frequency, Causes and Outcome of Neonates With Respiratory Distress Admitted to Neonatal Intensive Care Unit, National Institute of Child Health, Karachi. J Pak Med Assoc. 2015 Jul;65(7):771–5. Available from: https://pubmed.ncbi.nlm.nih.gov/26160089/

17. Kshirsagar VY, Kshirsagar AY, Mohite RV. Clinical Profile and Outcome of Respiratory Distress in Newborns Admitted in Rural Tertiary Health Care Centre of Maharashtra, India. Int J Contemp Pediatr. 2019 Feb;6(2):713–8. DOI: 10.18203/2349-3291.ijcp20190715

18. Lamichhane A, Panthee K, Gurung S. Clinical Profile of Neonates With Respiratory Distress in a Tertiary Care Hospital. J Nepal Med Assoc. 2019 Dec;57(220). DOI: 10.31729/jnma.4770

19. Ministry of Health and Population (Nepal), New ERA, ICF. Nepal Demographic and Health Survey 2022. Kathmandu: MoHP; 2023. Available from: https://www.dhsprogram.com

20. Baseer KAA, Mohamed M, Abd-Elmawgood EA. Risk Factors of Respiratory Diseases Among Neonates in Neonatal Intensive Care Unit of Qena University Hospital, Egypt. Ann Glob Health. 2020 Feb;86(1):1–8. DOI: 10.5334/aogh.2739

21. Sahoo S, Dey S. A Study of Risk Factors for the Development of Respiratory Distress in Newborns in a Tertiary Care Medical College Hospital in Eastern India. Int J Sci Res. 2023 Feb;12(2):34–6. DOI: 10.36106/ijsr/3210109

22. Chandrasekhar R, Mohan M, Lakshmi B. Clinical Study of Respiratory Distress in Newborn. Int J Contemp Pediatr. 2016;3:910–5. DOI: 10.18203/2349-3291.ijcp20162364

23. Shukla R, Piparsania S, Prashant S, Verma J. A Study to Correlate Risk Factors and Outcomes With Morbidity and Mortality Pattern of Respiratory Distress in Neonates in NICU of a Tertiary Care Centre in Rural Setup. Int J Sci Res. 2023 Mar;12(3):19–24. DOI: 10.36106/ijsr/6807071

24. Yarci E, Canpolat FE. Evaluation of Morbidities and Complications of Neonatal Intensive Care Unit Patients With Respiratory Disorders at Different Gestational Ages. Am J Perinatol. 2022 Oct;39(14):1533–40. DOI: 10.1055/s-0041-1722942

Bios

Dr. Prakash Man Shah, Consultant Pediatrician at Nepal APF Hospital, Kathmandu. He has received training on Pediatrics Advanced Life Support, ONTOP-IN, Neonatal Resuscitation. His field of interest is newborn care.
Email: shahpms2012@gmail.com

Dr. Nisha Keshary Bhatta, Professor at BPKIHS, Dharan. She is serving as the Head of the Department of Pediatrics and Chief of the Neonatal Division. She is a pioneer in the research field and is involved in various research programmes.
Email: nishakesharybhatta@yahoo.com

Dr. Subash K. C., Consultant Pediatrician. He has passed MD Pediatrics from BPKIHS, Dharan. His field of interest includes Neonatal care and Pediatric Nutrition.
Email: subashkc002@gmail.com

Dr. Sukrita Sah is working as a resident in the Department of Community Medicine and Tropical Diseases. Her research interest includes Pediatric care and occupational health.
Email: sukritasah456@gmail.com

Dr. Sriram K.C. is a Consultant Pediatrician at Nepal APF Hospital, Kathmandu. He has received training on Pediatrics Advanced Life Support, Neonatal Resuscitation Program, Palliative care and Advanced Trauma Life Support.
Email: worthsky75@gmail.com

Dr. Rajani Karki, Consultant Pediatrician at Nepal APF Hospital, Kathmandu. She has passed MD Pediatrics from IOM (TUTH). Her field of interest includes preterm care.
Email: rajnikarki35@gmail.com

Dr. Samikshya Pokharel has passed MD Gynecology and Obstetrics from BPKIHS, Dharan. Her field of interest includes reproductive health.
Email: samikshyapokharel118@gmail.com