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Original Research Article

DETERMINANTS OF COMPLIANCE WITH NEONATAL INTENSIVE CARE UNIT FOLLOW-UP APPOINTMENTS AMONG HIGH-RISK NEONATES IN A TERTIARY CARE HOSPITAL: A CROSS-SECTIONAL STUDY

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ABSTRACT

Background: Advances in neonatal intensive care have significantly improved survival among high-risk neonates. However, infants discharged from the Neonatal Intensive Care Unit (NICU) remain vulnerable to growth failure, neurodevelopmental delay, and other long-term complications, necessitating structured post-discharge follow-up. Despite its clinical importance, adherence to scheduled follow-up visits remains suboptimal in many settings. **Objective:** To determine the rate of compliance with scheduled NICU follow-up and identify neonatal and maternal factors associated with follow-up adherence. **Materials and Methods:** A retrospective analytical study was conducted among neonates discharged from the NICU of a tertiary care hospital. Clinical and maternal characteristics were extracted from hospital records. Follow-up compliance at one year was assessed. Factors associated with compliance were analyzed using univariate and multivariable logistic regression to estimate crude and adjusted odds ratios with 95% confidence intervals. **Results:** A total of 999 neonates were included in the study. Follow-up compliance was observed in 217 infants (21.7%), while 782 (78.3%) were lost to follow-up. In univariate analysis, higher birth weight, term gestation, shorter NICU stay, absence of respiratory support, and absence of sepsis were associated with non-compliance. After multivariable adjustment, **shorter NICU stay (≤7 days)** remained the only independent predictor of follow-up non-compliance (adjusted OR 3.86; 95% CI 2.48–5.99; p<0.001). **Conclusion:** Follow-up compliance among NICU graduates was low. Infants discharged after shorter NICU stays were significantly more likely to miss follow-up visits. Targeted discharge counselling and reminder systems may improve adherence to follow-up and support early detection of developmental and medical complications.

INTRODUCTION

Advances in neonatal intensive care have significantly improved the survival of high-risk newborns over the past few decades. Improvements in respiratory support, infection control, nutritional management, and neonatal monitoring have contributed to better outcomes among preterm and critically ill infants. Globally, an estimated 15 million babies are born preterm each year, many of whom require specialized care in Neonatal Intensive Care Units (NICUs) to survive the neonatal period.[1] With the expansion of neonatal intensive care services, particularly in tertiary care hospitals,

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survival rates among very low birth weight and preterm infants have increased substantially.[2]

Despite improved survival, discharge from the NICU does not indicate the end of medical vulnerability. Infants who require intensive neonatal care remain at increased risk for growth failure, feeding difficulties, neurodevelopmental delay, sensory impairments, and recurrent illnesses during infancy and early childhood.[3] Structured follow-up programs after NICU discharge are therefore essential for monitoring growth and development, ensuring adherence to immunization schedules, identifying complications early, and providing timely interventions when required.

Several studies have highlighted the importance of regular follow-up among high-risk neonates. Long-term follow-up studies have demonstrated higher rates of neurodevelopmental impairment and chronic health problems among NICU graduates compared with term infants.[4] However, adherence to scheduled follow-up visits remains a challenge in many healthcare settings. Studies from India have reported considerable loss to follow-up among infants discharged from NICUs and Special Newborn Care Units (SNCUs), which may compromise early detection and management of developmental problems.[5,6]

Previous research has identified multiple factors influencing follow-up compliance, including socioeconomic status, parental education, distance from healthcare facilities, and caregiver awareness regarding the importance of follow-up care.[7] Understanding these factors is particularly important in resource-limited settings where barriers to healthcare access may affect long-term neonatal outcomes.

Therefore, the present study was undertaken to assess compliance with scheduled NICU follow-up visits and to identify neonatal and maternal factors associated with follow-up adherence among infants discharged from a tertiary care NICU.

MATERIALS AND METHODS

Study Design and Setting

This study was conducted as a retrospective analytical cohort study in the Neonatal Intensive Care Unit (NICU) at Government Nagapattinam Medical College and Hospital, Tamilnadu, India. The NICU provides level III neonatal care and serves as a referral center for neonates from urban and rural regions in the surrounding districts. The unit manages high-risk neonates including preterm infants, low birth weight babies, and neonates with medical or surgical complications requiring intensive monitoring and specialized care.

Study Population and Period

The study population included neonates admitted to the NICU during the study period of One year between January 2022 to December 2022. Infants who survived the NICU stay and were discharged with advice for routine developmental follow-up were included in the study. Follow-up compliance was assessed at one year after discharge from the NICU, which is a critical time point for evaluating growth and neurodevelopment in high-risk infants.

Neonates who died during their NICU stay or before completion of one year of age were excluded from the analysis. Cases with incomplete medical records or missing follow-up information were also excluded.

Outcome Variable

The primary outcome of interest was compliance with scheduled NICU follow-up at one year after discharge. Follow-up compliance was defined as attendance at the scheduled follow-up clinic visit around the corrected age of one year. Infants who attended the clinic during the recommended follow-up window were categorized as compliant, whereas infants who failed to attend the scheduled follow-up visit despite prior discharge advice were classified as non-compliant or lost to follow-up.

Study Variables

Data regarding neonatal and maternal characteristics were obtained from hospital records and follow-up clinic registers. Neonatal variables included demographic characteristics such as sex, birth weight, gestational age, plurality of pregnancy, and place of birth. Birth weight was defined as the first recorded weight of the neonate after delivery and categorized as normal birth weight (≥2500 g), low birth weight (<2500 g), and very low birth weight (<1500 g). Gestational age was determined using the last menstrual period, early obstetric ultrasound findings, or postnatal clinical assessment using the New Ballard scoring system. Preterm birth was defined as delivery occurring before 37 completed weeks of gestation.

Neonates were also categorized as inborn if delivered within the study hospital and outborn if delivered at another facility and subsequently referred for NICU care. Multiple gestation referred to pregnancies resulting in more than one neonate, including twins or higher-order multiples.

Clinical variables related to the NICU course were also documented. These included the duration of NICU stay, which was defined as the total number of days from admission to discharge. Respiratory support variables included the need for invasive mechanical ventilation and the use of continuous positive airway pressure (CPAP). Mechanical ventilation was defined as invasive respiratory support delivered via endotracheal intubation during NICU admission, while CPAP referred to non-invasive respiratory support used to maintain positive airway pressure in neonates with respiratory distress.

Other treatment-related variables included administration of surfactant therapy for respiratory distress syndrome in preterm infants. Neonatal sepsis was defined as clinical signs of infection requiring antibiotic therapy, with or without laboratory confirmation, as documented by the

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treating neonatologist. Neonatal seizures were defined as clinically observed seizure activity recorded during NICU admission.

Retinopathy of prematurity (ROP) was defined as abnormal retinal vascular development diagnosed during routine ophthalmologic screening for preterm infants. Oxygen requirement at discharge was defined as the need for supplemental oxygen therapy at the time of NICU discharge.

Maternal characteristics including maternal age, education level, parity, and pregnancy-related complications were also recorded. Maternal age was defined as the age of the mother at the time of delivery. Maternal education was categorized according to the highest level of formal schooling completed. Parity was categorized as primiparous (first childbirth) or multiparous (two or more childbirths). Maternal comorbidities included gestational diabetes mellitus (GDM), defined as glucose intolerance first detected during pregnancy based on obstetric diagnostic criteria, and pregnancy-induced hypertension (PIH), defined as hypertension developing after 20 weeks of gestation in previously normotensive women.

Accessibility to healthcare services was assessed using the distance between the family residence and the hospital, calculated in kilometers based on the recorded address in hospital records.

Data Collection

Data were extracted retrospectively from multiple hospital sources including NICU admission registers, patient medical records, discharge summaries, and follow-up clinic registers. A structured data collection proforma was used to ensure uniform data extraction. All records were reviewed systematically, and the collected data were cross-verified to minimize errors in data entry and transcription.

Statistical Analysis

Data were entered into Microsoft Excel and subsequently analyzed using Statistical Package for the Social Sciences (SPSS) version 19. Continuous variables were summarized using mean and standard deviation or median with interquartile range depending on the distribution of data. Categorical variables were expressed as frequencies and percentages.

Comparisons between infants who were compliant with follow-up and those lost to follow-up were performed using appropriate statistical tests. The independent t-test or Mann–Whitney U test was used for continuous variables, while the chi-square test or Fisher's exact test was used for categorical variables.

To identify factors associated with follow-up compliance, univariate logistic regression analysis was initially performed to estimate crude odds ratios with 95% confidence intervals. Variables demonstrating a p-value less than 0.20 in the univariate analysis were subsequently included in a multivariate logistic regression model to determine independent predictors of follow-up compliance. Adjusted odds ratios with 95% confidence intervals were calculated. and a p-value less than 0.05 was considered statistically significant.

Ethical Considerations

The study protocol was reviewed and approved by the Institutional Ethics Committee of the hospital. As the study involved retrospective analysis of existing hospital records, the requirement for individual informed consent was waived.

RESULTS

Among the 999 study participants, 553 (55.4%) were males, and 446 (44.6%) were females. The mean birth weight was 2618.67 ± 620.83 grams. A majority of neonates were inborn (86.4%), while 13.6% were outborn. The median gestational age at delivery was 38 weeks (IQR: 37–39), and the median duration of NICU stay was 5 days (IQR: 3–8). The median age at admission was 6 hours (IQR: 1–72), and the median age at discharge was 7 days (IQR: 5–10).

With respect to neonatal morbidities, 31 (3.1%) required resuscitation, 120 (12.0%) required CPAP, and 12 (1.2%) required mechanical ventilation. Phototherapy was administered in 654 (65.5%) neonates. Sepsis (clinical or culture positive) was documented in 131 (13.1%) cases. Multiple gestation was present in a small proportion of cases (3.1%). The mean maternal age was 25.86 ± 4.13 years. Most mothers had education beyond class 8 (95.6%), and 52.5% were primiparous. [Table 1]

Among the 999 neonates discharged from the NICU, 217 (21.7%) were compliant with the scheduled one-year follow-up, while 782 (78.3%) were non-compliant. [Figure 1]

After adjustment, only shorter NICU stay (≤7 days) remained independently associated with poor compliance (aOR: 3.86; 95% CI: 2.48–5.99; $p<0.001$). Birth weight ≥2500 g (aOR: 1.41; 95% CI: 0.94–2.12; p=0.096), term gestation (aOR: 1.23; 95% CI: 0.78–1.93; p=0.380), absence of multiple gestation (aOR: 1.74; 95% CI: 0.79–3.86; p=0.171), absence of CPAP requirement (aOR: 1.24; 95% CI: 0.74–2.08; p=0.416), absence of ventilation (aOR: 2.07; 95% CI: 0.52–8.20; p=0.300), absence of sepsis (aOR: 0.97; 95% CI: 0.59–1.59; p=0.890), PIH (aOR: 1.78; 95% CI: 0.87–3.62; p=0.114), and other maternal illness (aOR: 1.77; 95% CI: 0.93–3.38; p=0.081) did not retain statistical significance. The overall model demonstrated moderate explanatory power with a Nagelkerke R^2 of 0.193.

Of the 999 babies discharged from the NICU, only 21.7% were Compliant. Among the rest, 46 didn't disclose the reason for non-compliance, and 18 were migrated. Coming to the reasons for non-compliance as stated by the rest (72%), the most common major reason was that the child seemed well, and a minor reason was follow-up at different healthcare facilities. [Figure 2]

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Table 1: Description of the study participants

Variable	Category	Number, %/ Mean, SD
Sex	Male	553 (55.4%)
	Female	446 (44.6%)
Birth weight kg (Mean ±SD)		2.6 ± 1.2
Place of delivery	Inborn	863 (86.4%)
	Outborn	136 (13.6%)
Gestational age at delivery (Median, IQR)		38 (37-39)
Duration of days of NICU stay (Median, IQR)		5 (3-8)
Age at admission (hours) (Median, IQR)		6 (1-72)
Weight at time of admission(Median, IQR)		2650 (2250-3000)
Weight at time of discharge (Median, IQR)		2610 (2170-2930)
Age at discharge (in days)(Median, IQR)		7 (5-10)
APGAR score at 1 minute(Median, IQR)		7 (7-8)
APGAR score at 5 minutes(Median, IQR)		8 (7-9)
Presence of multiple gestation	Yes	31 (3.1)
	No	968 (96.9)
Resuscitation		
CPAP **(n=996)**	Yes	876 (88.0)
	No	120 (12.0)
Ventilation	Yes	12 (1.2)
	No	987 (98.8)
Phototherapy	Yes	654 (65.5)
	No	345 (34.5)
Surfactant dose	1 dose	24 (2.4)
	2 dose	2 (0.2)
	3 dose	2 (0.2)
	No dose	971 (97.2)
Antibiotics	Yes	409 (40.9)
	No	590 (59.1)
Presence of sepsis	Culture positive sepsis	43 (4.3)
	Clinical sepsis	88 (8.8)
	No sepsis	868 (86.9)
Neonatal seizure	Yes	11 (1.1)
	No	988 (98.9)
ROP	Yes	1 (0.1)
	No	998 (99.9)
Anti seizure at discharge	Yes	3 (0.3)
	No	996 (99.7)
Mother's age		25.86 (4.13)
Mother's education	Upto class 7	44 (4.4)
	Class 8- class 12	605 (60.6)
	More than 12	350 (35.0)
Parity	1	524 (52.5)
	2	329 (32.9)
	3	104 (10.4)
	4	35 (3.5)
	>4	7 (0.7)
GDM	Yes	98 (9.8)
	No	901 (90.2)
PIH	Yes	43 (4.3)
	No	956 (95.4)
Distance from NICU		23.33 (38.70)

Table 2: Factors associated with compliance to follow-up

Variable	Category	Non-compliant	Compliant	cOR (95% CI)	p- value	aOR (95% CI)	p-value
		Number (%)	**Number (%)**				
Sex	Male	434 (78.5%)	119 (21.5%)	Ref.	Ref.		
	Female	348 (78.0%)	98 (22.0%)	0.97 (0.72-1.32)	0.863		
Birthweight	<2500 grms	244 (66.7%)	122 (33.3%)	Ref.	Ref.	Ref.	Ref.
	≥2500 grms	538 (85.0%)	95 (15.0%)	2.83 (2.08-3.85)	<0.001	1.41 (0.94–2.12)	0.096
Place of birth	Inborn	684 (79.3%)	179 (20.7%)	1.48(0.98-2.23)	0.060	1.34 (0.84–2.12)	0.220
	Outborn	98 (72.1%)	38 (27.9%)	Ref.	Ref.	Ref.	Ref.
Gestational age at	<37 weeks	138 (60.0%)	92 (40.0%)	Ref.	Ref.	Ref.	Ref.

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birth							
	≥37 weeks	644 (83.7%)	125 (16.3%)	3.44(2.48-4.76)	<0.001	1.23 (0.78–1.93)	0.380
NICU stay duration	≤7 days	647 (86.7%)	99 (13.3%)	5.71 (4.13-7.91)	<0.001	3.86 (2.48–5.99)	**<0.001**
	> 7 days	135 (53.4%)	118 (46.6%)	Ref.	Ref.	Ref.	Ref.
Multiple gestation	Yes	14 (45.2%)	17 (54.8%)	Ref.	Ref.	Ref.	Ref.
	No	768 (79.3%)	200 (20.7%)	4.66 (2.26-9.62)	<0.001	1.74 (0.79–3.86)	0.171
Resuscitation required	BMV	20 (66.7%)	10 (33.3%)	Ref.	Ref.	Ref.	Ref.
	Oxygen	124 (70.5%)	52 (29.5%)	1.19 (0.52-2.72)	0.676	1.44 (0.53–3.89)	0.476
	Only stimulation/ nothing	638 (80.5%)	155 (19.5%)	2.06 (0.94-4.49)	0.069	1.35 (0.52–3.50)	0.535
Requirement of CPAP	Yes	74 (61.7%)	46 (38.3%)	Ref.	Ref.	Ref.	Ref.
	No	708 (80.5%)	171 (19.5%)	2.57(1.72-3.86)	<0.001	1.24 (0.74–2.08)	0.416
Requirement of ventilation	Yes	4 (33.3%)	8 (66.7%)	Ref.	Ref.	Ref.	Ref.
	No	778 (78.8%)	209 (21.2%)	7.45 (2.22-24.96)	0.001	2.07 (0.52–8.20)	0.300
Requirement of phototherapy	Yes	510 (78.0%)	144 (22.0%)	Ref.	Ref.		
	No	272 (77.8%)	73 (21.2%)	1.05 (0.77-1.45)	0.754		
Presence of sepsis	Culture positive/ clinical sepsis	76 (58.0%)	55 (42.0%)	3.15 (2.14-4.64)	<0.001	0.97 (0.59–1.59)	0.890
	No sepsis	706 (78.9%)	162 (21.1%)	Ref.	Ref.	Ref.	Ref.
Mothers age	<20 years	29 (76.3%)	9 (23.7%)	0.89 (0.42-1.91)	0.769		
	20-35 years	737 (78.3%)	204 (21.7%)	Ref.	Ref.		
	> 35 years	16 (80.0%)	4 (20.0%)	1.11 (0.37-3.35)	0.857		
Mothers education	Up to class 8	109 (81.3%)	25 (18.7%)	1.24 (0.78-1.98)	0.356		
	More than class 8	673 (77.8%)	192 (22.2%)	Ref.	Ref.	Ref.	Ref.
Parity	Primi	421(80.3%)	103 (19.7%)	2.04 (1.04-4.02)	0.371	1.40 (0.67–2.95)	1.40 (0.67–2.95)
	1/2	333 (76.9%)	100 (23.1%)	1.67 (0.84-3.28)	0.694	1.16 (0.55–2.45)	1.16 (0.55–2.45)
	3 or more	28 (66.7%)	14 (33.3%)	Ref.	Ref.	Ref.	Ref.
GDM	Yes	77 (78.6%)	21 (21.4%)	Ref.	Ref.		
	No	705 (78.2%)	196 (21.8%)	0.98 (0.59-1.63)	0.941		
PIH	Yes	27 (62.8%)	16 (37.2%)	Ref.	Ref.	Ref.	Ref.
	No	755 (79.0%)	201(21.0%)	2.23 (1.18-4.21)	0.014	1.78 (0.87–3.62)	0.114
Other maternal illness	Yes	38 (67.9%)	18 (32.1%)	Ref.	Ref.	Ref.	Ref.
	No	744 (78.9%)	199 (21.1%)	1.77 (0.99-3.17)	0.054	1.77 (0.93–3.38)	0.081
Distance from NICU (in km)	Up to 10 km	379 (79.8%)	96 (20.2%)	Ref.	Ref.		
	More than 10 km	403(76.9%)	121(23.1%)	0.84 (0.62-1.14)	0.270		

Model parameters

Nagelkerke R Square= 0.193

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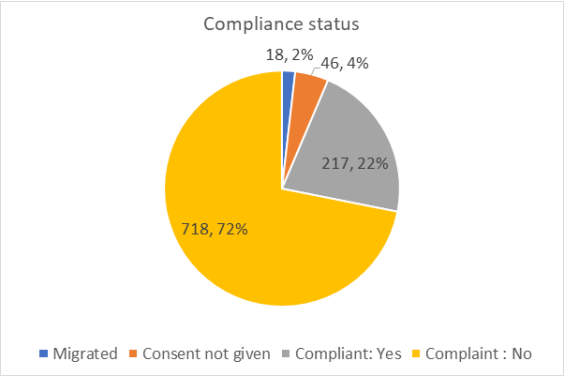

Figure 1: Study population according to compliance

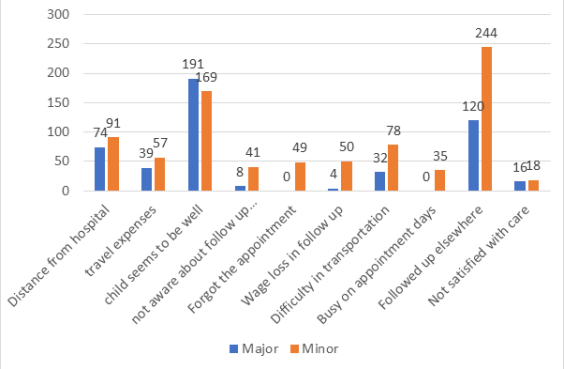

Figure 2: Reasons of non-compliance

DISCUSSION

In the present study, compliance with scheduled NICU follow-up visits was 21.7%. Regular follow-up of NICU graduates is essential for monitoring growth, development, and early identification of complications among high-risk neonates.

The follow-up compliance observed in the present study is comparable with findings reported in other Indian studies. Prithvichandra et al. reported that a substantial proportion of infants discharged from NICU did not attend scheduled follow-up visits, highlighting the challenge of maintaining continuity of care after discharge.[8] Similarly, Guar et al. observed loss to follow-up among high-risk neonates discharged from a tertiary care NICU.[9] Comparable findings were also reported by Sudhir et al., who documented significant attrition during follow-up among infants discharged from neonatal care units.[10]

In the present study, duration of NICU stay was significantly associated with follow-up compliance. Infants who had a longer NICU stay were more likely to attend scheduled follow-up visits. This may be because prolonged hospitalization increases caregiver interaction with healthcare providers and improves parental awareness regarding the importance of follow-up care. Similar observations were reported by.[11] Mukhopadhyay et al., who found that infants with prolonged NICU stay required closer monitoring and were more likely to be brought for follow-up visits.[11]

Longer NICU stay may also reflect increased illness severity, which could influence caregivers to adhere more strictly to medical advice and follow-up recommendations. Paul et al. also emphasized that caregiver perception of illness severity plays an important role in determining follow-up attendance among high-risk neonates.[12] In contrast, infants with shorter NICU stay may be perceived as clinically stable by caregivers, leading to reduced perceived need for follow-up visits.

Caregiver awareness plays an important role in follow-up compliance. In the present study, lack of awareness regarding the importance of follow-up was identified as a potential barrier among some caregivers. Comparable findings were reported by Singh et al., who highlighted that parental knowledge and understanding of neonatal health significantly influence follow-up attendance.[13]

Regular follow-up is particularly important for high-risk neonates as it facilitates early identification of growth failure, neurodevelopmental delay, and other complications. Strengthening discharge counselling, improving caregiver awareness, and implementing reminder systems may improve adherence to follow-up visits and ultimately enhance long-term outcomes among NICU graduates.[14,15]

CONCLUSION

Regular follow-up of neonates discharged from the Neonatal Intensive Care Unit (NICU) is essential for monitoring growth, development, and early identification of complications among high-risk infants. In this study, duration of NICU stay was found to be significantly associated with follow-up compliance, with infants who had longer NICU stays being more likely to attend scheduled follow-up visits. This may be attributed to increased caregiver interaction with healthcare providers and greater awareness of the infant's health needs during prolonged hospitalization.

Strengthening discharge counselling, emphasizing the importance of follow-up visits, and improving caregiver awareness may help improve follow-up adherence. Enhancing follow-up systems and ensuring continuity of care after NICU discharge can contribute to better monitoring and improved long-term outcomes among high-risk neonates.

REFERENCES

1. Blencowe H, Cousens S, Oestergaard MZ, Chou D, Moller AB, Narwal R, et al. National, regional, and worldwide estimates of preterm birth rates in the year 2010 with time trends since 1990. Lancet. 2012;379:2162-2172.
2. Stoll BJ, Hansen NI, Bell EF, Walsh MC, Carlo WA, Shankaran S, et al. Trends in care practices, morbidity, and mortality of extremely preterm neonates, 1993-2012. JAMA. 2015;314:1039-1051.
3. Saigal S, Doyle LW. An overview of mortality and sequelae of preterm birth from infancy to adulthood. Lancet. 2008;371:261-269.

ISSN (O): 2687-5365; ISSN (P): 2753-6556

4. Johnson S, Marlow N. Early and long-term outcome of infants born extremely preterm. Arch Dis Child. 2017;102:97-102.
5. Kumar P, Sankar MJ, Sapra S, Agarwal R, Deorari AK, Paul VK. Follow-up of high-risk neonates. Indian J Pediatr. 2008;75:479-487.
6. Elenjickal MG, Thomas K, Sushamabai S, Ahamed SKZ. Development of high-risk newborns: a follow-up study from birth to one year. Indian Pediatr. 2009;46:497-503.
7. Kumar H, Bhat AA, Alwadhi V, Khanna R, Neogi SB, Choudhry P, et al. Special newborn care plus project in India: Preliminary findings from community-based follow-up of newborns discharged from facilities. Indian Pediatr. 2021;58:354-357.
8. Prithvichandra KC, Ghanghoriya PK. Follow-up of growth, development and clinical outcome in neonates discharged from the NICU of a tertiary care hospital in central India. Int J Contemp Pediatr. 2020;7:731-736.
9. Gaur A, Petchimuthu P. Growth outcome, feeding practices and comorbidities in follow-up of discharged newborns from special newborn care unit. Int J Contemp Pediatr. 2019;6:1490-1495.
10. Sudhir U, Ghanghoriya P, Barman M, Joshi T. Growth and neurodevelopmental outcome of high-risk premature neonates at 1 year in a tertiary level NICU of central India. Int J Contemp Pediatr. 2017;4:1787-1791.
11. Mukhopadhyay K, Malhi P, Mahajan R, Narang A. Neurodevelopmental and behavioral outcome of very low birth weight babies at corrected age of two years. Indian J Pediatr. 2010;77:963-967.
12. Paul VK, Singh M, Deorari AK, Radhika S. Neurodevelopmental outcome of “at-risk” nursery graduates. Indian J Pediatr. 1998;65:857-862.
13. Singh K, Parikh YN, Hapani P. Neurodevelopmental outcomes in high-risk infants at 12 months: a prospective observational study from Western India. Int J Contemp Pediatr. 2025;12:2600.
14. Rajkumar R, Roy N, Pournami F, Prithvi AK, Jain N. Telemedicine as an adjunct to follow-up of low-risk neonates: a prospective cohort study. Indian Pediatr. 2025;62:437-439.
15. Meenai ZM, Nair MKC, Dalwai S, Nair LD, Gulati S, Mukherjee SB, et al. Consensus guidelines of the Indian Academy of Pediatrics on developmentally supportive follow-up for high-risk infants. Indian Pediatr. 2025;62:554-573.

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