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Knowledge, Attitude and Perception of Planning Regarding Birth Preparedness and Complication Readiness at Tertiary Care Hospital Lucknow

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Abstract: ***Background: Globally, eight hundred women die every day due to pregnancy or child birth related complications. Aim: A descriptive study to assess the level of birth preparedness and complication readiness among antenatal women at a tertiary care hospital. Method: A descriptive cross sectional study was undertaken by using purposive sampling technique to assess the knowledge, attitude and planning of perception among antenatal women. Total 82 samples of antenatal women in third trimester were selected through purposive sampling from Tertiary care Hospital, Lucknow. Non experimental quantitative approach in which structured interview questionnaire was used for assessing the socio demographic data. Knowledge by interview method, attitude by likert scale and perception of planning by contingency questionnaire. Descriptive and Inferential statistics were used for the analysis of the tabulated data. Results: Out of total study samples (n=82) 34(41%) of antenatal women were well prepared regarding BPCR whereas 47(57%) are average prepared and 1(1%) are less prepared regarding BPCR. Conclusion: Birth preparedness and complication readiness (BPCR) is a key component of globally accepted safe motherhood programs, which helps ensure women to reach professional care when labor begins and to reduce delays that occur when mothers in labor experience obstetric complications.***

Keywords: Assess, level, antenatal women, BPCR

I. INTRODUCTION

Every pregnancy is a joyful moment for all mothers who dream of a safe pregnancy and a healthy baby. However, every pregnant woman faces the risk of sudden, unpredictable complications that could end in death or injury to herself or to her infant. Birth preparedness and complication readiness (BPCR) is a strategy that encourages pregnant women, their families, and communities to effectively plan for births and deal with emergencies, if they occur. It is a key component of globally accepted safe motherhood programs.

II. METHODOLOGY

Non experimental descriptive design was used to assess the level of birth preparedness and complication readiness among antenatal mothers at a tertiary care hospital. The tool consisted of four sections as follows:

Section A- Socio-Demographic data and baseline variables which includes 13 items to collect information regarding selected variables like Age, Education, Monthly income of family, Type of family, Place of residence, Average distance from hospital, Gravida , Birth order, Antenatal checkup, Present week of gestation, Any previous still birth/IUD, Decision- maker in the family, Source of Knowledge regarding BPCR .

Section B- Semi- structured questionnaires (interview schedule) which consist of three closed format questions with dichotomous answers regarding danger signs.

Section C-Likert scale, a five point likert scale of 07 questions to assess attitude regarding BPCR among antenatal women.

Section D- Check list which consists of 10 closed format dichotomous answers regarding to assess the perception of planning among antenatal women.

The tool was developed both in English and Hindi, used for data collection. The tool was validated by seven experts to obtain valuable suggestions towards refinement of tool. Prior administrative permission was obtained to conduct the study from the members of ethical committee reviewers. Pilot study was conducted among 10 participants to check the clarity of questionnaire and feasibility of study. The split half method was done for tool reliability. The subjects were informed regarding the purpose of study, written informed consent was obtained, and confidentiality was maintained.

III. ANALYSIS

The response of the respondents were coded and tabulated into Microsoft excel sheet. The knowledge scores were counted between 1-25 , 25,the attitude scores were given between 0- 35, the perception of planning scores were between 1-10 and scores for level of BPCR was calculated as less prepared, averagely prepared and well prepared. To find the association between level of BPCR and demographic data and variables , inferential statistics chi square was used. Data was analyzed at confidence interval of 95% with P value of > 0.05.

IV. RESULTS

Out of total study samples (n=82), majority 41(50%) of the antenatal women were between the Age Group 26-30yrs old and there were no observations in the age groups <20 and >40 year old. Majority 41(50%) were graduate and 3(4%) had obtained primary education .Monthly family income of 41(44%) of the antenatal women were between Rs.41,000-Rs.50,000 and 3(4%) were between <Rs25000.Majority of antenatal women 43(52%)were from nuclear family and 39(48%) were from joint family .Majority79(96%) of antenatal women were from urban area and 3(4%) were from rural area. Majority 70(85%) of antenatal women can access hospital within 2hrs and 12(15%) had to spend more than 2hrs to reach the hospital. Majority 44(54%) of antenatal women were multi gravida and the rest is primi gravida 38(46%). 50% of the entire population is First Birth Order. All the antenatal women had undertaken antenatal check-up for >=4 times. Majority 42(51%) of the antenatal women of 37-40 weeks period of gestation and very less 6(7%) are having above 40 weeks period of gestation. Majority 37(45%) of the family used to make decision jointly and in 33(40%) family , the husband is the only decision maker. Source of Knowledge for majority 36(44%) of antenatal women were media and 3(4%) had knowledge from health centre.

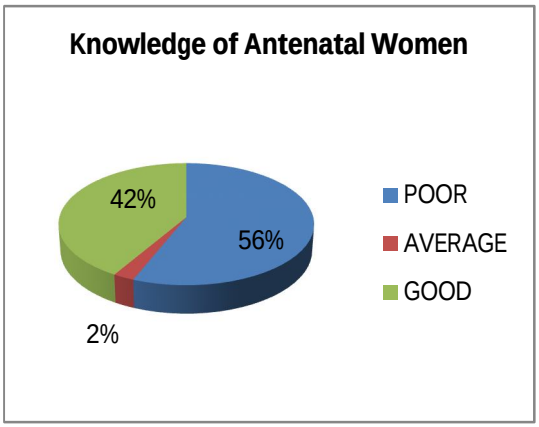
Sl. No.	Heads	Categories	Frequency (f)	Percentage (%)
1	Age Group	<20	0	0%
		21-25	23	28%
		26-30	41	50%
		31-35	9	11%
		36-40	9	11%
2	EDUCATION	Illiterate	0	0%
		Primary Education	3	4%
		Secondary Education	15	18%
		Higher Sec. Education	23	28%
		Graduation & Above	41	50%
3	MONTHLY INCOME	< Rs.30, 000/-	15	18%
		Rs. 31,000 - Rs.40,000/-	28	34%
		Rs. 41,000 - Rs.50,000/-	36	44%
		> Rs.50,000/-	3	4%
4	TYPE OF FAMILY	Nuclear Family	43	52%
		Joint Family	39	48%
		Extended Family	0	0%
5	PLACE OF RESIDENCE	Rural	3	4%
		Urban	79	96%
6	AVG DISTANCE FROM HOSPITAL	<2 Hrs	70	85%
		>2 Hrs	12	15%

7	GRAVIDA	Primigravida	38	46%
		Multigravida	44	54%
8	BIRTH ORDER	First	41	50%
		Second	32	39%
		Third	9	11%
		> Three	0	0%

Sl. No.	Heads	Categories	Frequency(f)	Percentage(%)
9	ANTENATAL CHECKUP	< 4	0	0%
		>= 4	82	100%
10	PRESENT WEEK OF GESTATION	28 – 32 Weeks	14	17%
		33 – 36 Weeks	20	24%
		37 – 40 Weeks	42	51%
		> 40 Weeks	6	7%
11	ANY PREVIOUS COMPLICATION	Yes	9	11%
		No	73	89%
12	DECISION MAKER	Self	0	0%
		Husband	33	40%
		Jointly With Husband	37	45%
		Parents	0	0%
		In Laws	12	15%
13	SOURCE OF KNOWLEDGE	Family	34	41%
		Friends	6	7%
		Media	18	22%
		Health Center	24	29%

A. Knowledge

Out of 82 respondents the Knowledge level of antenatal women regarding BPCR according to Knowledge Score. Maximum 56% had poor knowledge, 42% had good knowledge and 2% had an average knowledge.



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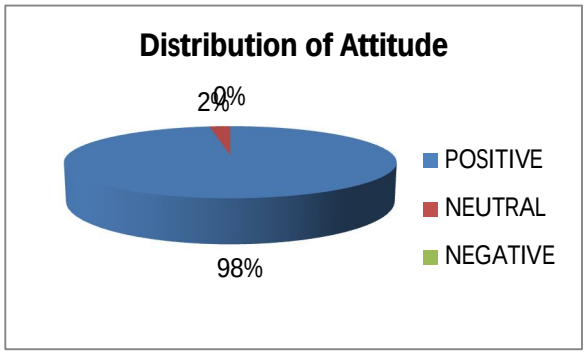
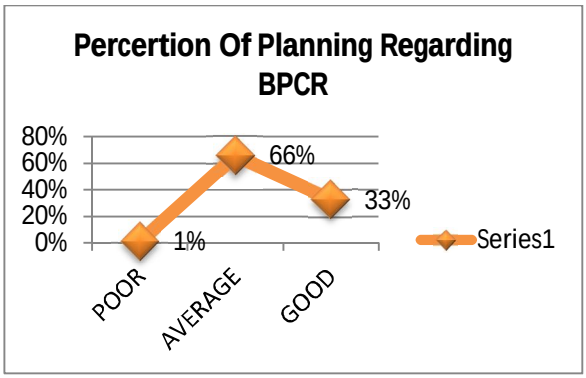
B. Attitude

Out of 82 respondents, 98 % has shown positive attitude while only 2% has shown neutral attitude, regarding BPCR.



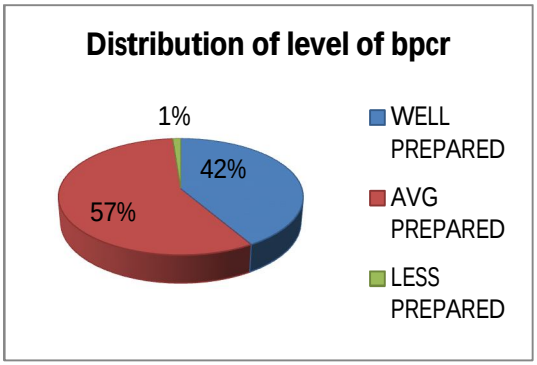
C. Perception of Planning

Out of 82 respondents, 66% have an average perception of planning, 33% have good and 1% have poor planning of perception regarding BPCR.



D. Level of BPCR

Out of 82 respondents ,57% of antenatal women according to level of BPCR were averagely prepared,41%were well prepared and 1% were less prepared.



V. DISCUSSION

Prevention is the daughter of intelligence. In case of BPCR also these interventions are widely promoted by governments and international agencies to reduce maternal and neonatal health risks in developing countries.

A cross-sectional study was conducted by John Ekabua , et al in Calabar, Nigeria in 2011, on awareness of BPCR . Survey of 800 women, who gave birth between 1st January and 31st December 2008, attending two urban (Calabar) and two rural (Biase Local Government Area) maternal and child health clinics in Cross River State, Nigeria, was undertaken between January and April, 2009. Awareness of the concept of birth preparedness was high (70.6%), knowledge of specific key danger signs was poor (15%).Logistic regression analysis showed that of the four variables, age, educational status, marital status, and parity.

Educational status was the best predictor of awareness of the concept of birth preparedness. Whereas in the present study 46.09% of antenatal women knew about danger signs during pregnancy, 26.82% of antenatal women knew about danger signs during labor
A similar cross sectional study was conducted by Dr.Vasundhara Kamineni, Dr. Anuradha D. Murki , and Dr.Venkata Lakshmi Kota at Hyderabad Telengana in 2017 on birth preparedness and complication readiness among 600 pregnant women attending outpatient clinic. Mean age of respondents was 25.2 (±4) years. The mean gestation at enrolment was 18.7 ± 8 weeks. Among the women who participated in the survey, 20% were illiterate, 70% were homemakers and nearly 70% had a monthly family income >Rs. 15,197 (n = 405). One hundred and sixty-four women (27%) made no arrangements in the event of an emergency, 376 women (63%) were not aware of their blood group, and 89% (n = 531) did not identify any blood donor. Whereas in this study 81(99%) of antenatal women have identified health facility for delivery and follow up, 22(27%) of antenatal women have saved money for delivery, 26(32%) of antenatal women have saved money for transportation to hospital, 24(29%) of antenatal women have identified blood donor during delivery in case of emergency,74(90%) of antenatal women have prepared kit for their admission & receiving baby.

VI. CONCLUSION

Among all antennal women who were under study maximum had poor knowledge regarding BPCR but maximum of them had shown positive attitude and average perception of planning regarding BPCR. In total maximum were averagely prepared about level of BPCR. Thus they need to be educated about danger signs of pregnancy, labour and post partum period so that on time recognition can prevent complications during these crucial periods which can endanger life of both women and neonate. Pamphlets, booklets can be distributed at clinics and also media should be used to increase awareness.

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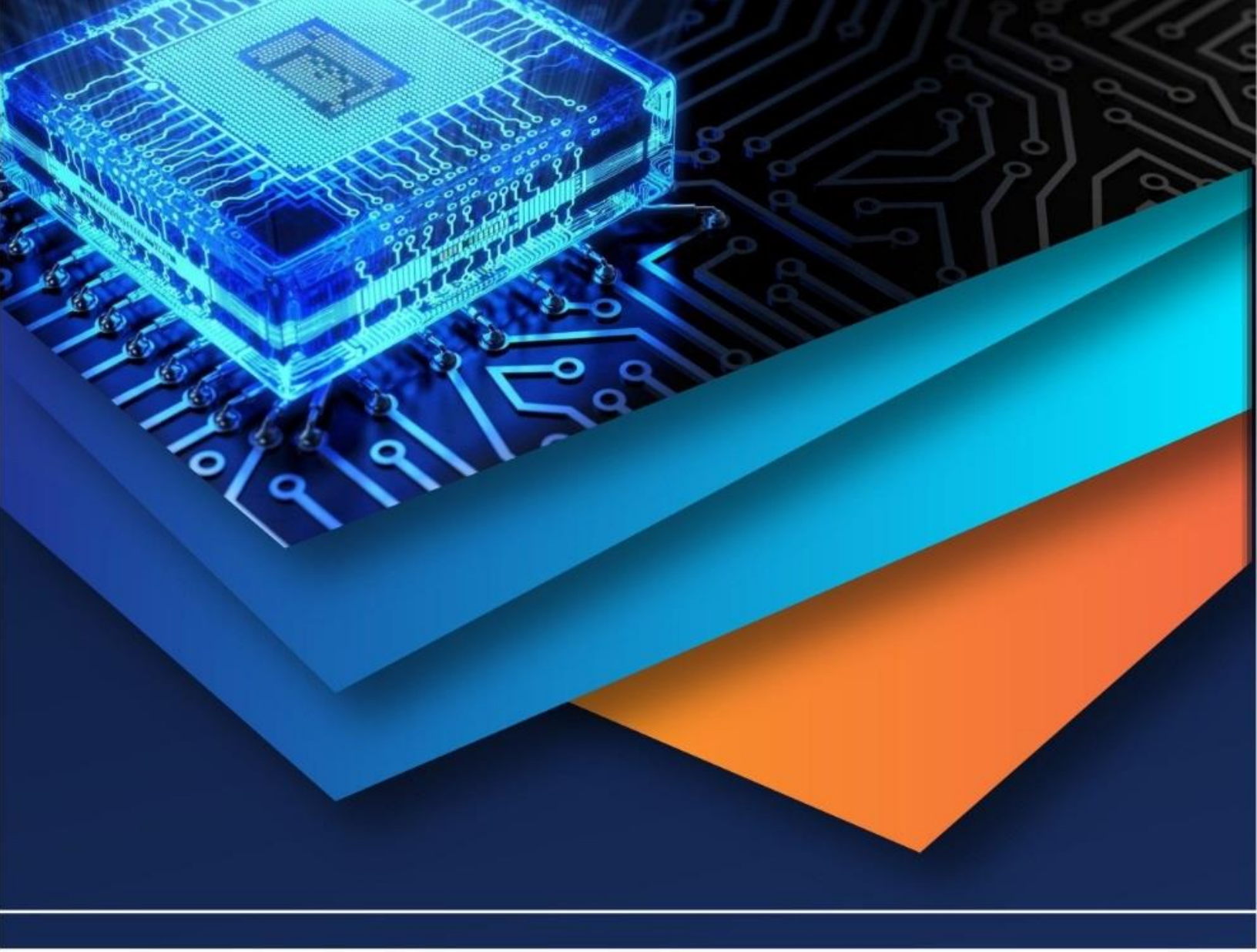

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