

# Assessment of Knowledge Regarding Child Birth Preparedness among Primigravida Mothers in Antenatal OPD in A Selected Hospital of Guwahati, Assam with a View to Develop an Information Booklet: A Descriptive Study

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**Abstract:** *Introduction:* Becoming a mother is an important stage in every women's life. Though pregnancy is wonderful and very joyful news in most women's lives, on the same part the women will have emotional disturbances and physical changes in her and the process of childbirth. Every mother in the world yearns for a healthy baby at the time of delivery. Pregnancy is a very sensitive period in which unexpected life - threatening complications may arise at any period, from conception to the postpartum period. Maternal and neonatal mortality is an ongoing major public health problem in developing countries. It has been seen that in some parts of India, women get married at an early age. Soon after marriage, they get pregnant without proper knowledge of childbirth preparedness. Women do not have adequate knowledge on antenatal care. So, many complications arise during pregnancy and childbirth. This may be the cause of morbidity and mortality among the women in India. The study was conducted with the objective of assessing the knowledge regarding childbirth preparedness among primigravida mothers, and to find out the association between knowledge about childbirth preparedness with selected demographic variables. *Objectives:* 1) To assess the level of knowledge regarding birth preparedness among primigravida women in a selected Hospital Guwahati Assam. 2) To find out the association of knowledge regarding birth preparedness among primigravida mothers with demographic variables. 3) To develop an information booklet regarding primigravida mothers. *Methods and Materials:* A descriptive design was used in the study to accomplish the objectives using non - probability convenient sampling technique for obtaining adequate sample for the study. Study was done on 110 primigravida mothers in a selected Hospital Guwahati Assam. Respondents were selected on the basis of inclusion and exclusion criteria. Structured knowledge questionnaire was used to assess the knowledge regarding child birth preparedness among primigravida mothers in Antenatal OPD in a selected hospital of Guwahati, Assam. *Results:* The analysis revealed that out of 110 primigravida mothers in antenatal OPD, Majority i. e. 61 (55.4%) of the primi mothers belonged to the age group between 19 - 24 years of age, 49 (44.5%) of the primi mothers had passed H. S. L. C, 67 (60.9%) of the primi mothers had family income of Rs.9232 - 2764, 73 (66.4%) of the primi mothers occupation were housewife, 40 (36.4%) of the primi mothers were 2<sup>nd</sup> Visit, 54 (49.1%) of the primi mothers belonged to joint family, 56 (50.9%) primi mothers belongs from rural area, 48 (43.6%) respondents previous source of information were from relatives. On assessing the level of knowledge, majority of the primi mothers i. e. 90 (81.8%) had adequate knowledge and 20 (18.2%) respondents had moderately adequate knowledge with mean 16.25 and SD 2.96. r value is 0.72; that indicates the tool is reliable. The association was statistically tested and the results shows that there was association between level of knowledge regarding childbirth preparedness among primigravida mothers with selected demographic variables like monthly family income at p<0.05 level. The others demographic variables such as age, education, occupation, number of antenatal visits during pregnancy, types of family, place of residence, previous source of information, had not shown statistically significant associated with the level of knowledge regarding childbirth preparedness among primigravida mothers. *Conclusion:* After analysing data collected, this study shows that primi mothers have adequate knowledge regarding child birth preparedness. Therefore, it is recommended to organize awareness programmes regarding birth preparedness among primi mothers to enhance their knowledge and will help primi mothers in better planning of pregnancy and childbirth in advance. The health care worker can conduct health education on child birth preparedness in clinical and community settings to update mothers knowledge.

**Keywords:** Knowledge, Childbirth preparedness, Maternal mortality.

## 1. Introduction

Womanhood is that period in a human female's life after she has passed through childhood, puberty, and adolescence, generally at the age of 18.1When a girl goes through menarche, the possibility for her becoming pregnant arises. A magical time that every woman awaits to have in her lifetime, to carry a soul within her, being pregnant is such an inspirational time for any woman. It brings the joy of being able to nurture an angel coupled with the pain that does not

let her sleep for weeks or months. A magnificent time which brings a new life to the world, pregnancy makes a woman grow into a kind and loving mother.2Pregnancy is the carrying of a fetus or embryo in the womb of the mother. It begins at fertilization and end at the delivery of the fetus. It is a normal and natural occurrence, and it results in a series of both bodily and mental changes in the expectant mothers while at the same time it requires a complex series of events to occur in a precise order so as to ensure success<sup>3</sup>. Even though pregnancy is considered to be a normal process, it

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may at times be accompanied by some problems and complications which is potentially life threatening to the mother and/ or the fetus. While most women have uneventful pregnancies and childbirths, all pregnancies are at risk and around 15% of pregnant women will develop a potentially life - threatening obstetrics complication that requires obstetrical interventions to survive.

Every mother in the world yearns for a healthy baby at the time of delivery. The well - being of a woman and her newborn are interconnected, and both can be marginalized in the process of childbirth and the ensuing months. If women and her partner are planning for a baby, they need to discuss things like affordability, timing and the spacing of future siblings, child care and work options. If a couple is planning for the first baby, they should discuss their parenting beliefs and possible support systems. They should also go for a medical check - up so that problems can be detected and treated early to avoid unnecessary stress and disappointment.<sup>6</sup> Focus on preventing maternal and newborn morbidity and mortality is not enough care during this period needs to encompass basic human rights, including the rights to respect, dignity, confidentiality, information and informed consent; the right to the highest attainable standard of health, and freedom from discrimination and from all forms of ill - treatment. A woman's autonomy should be recognized and respected, as should her emotional well - being, choices and preferences, including the right to have a companion of choice during labor and childbirth. Respect and recognition of the woman can benefit the newborn, who also has rights and requires respect and recognition. Together, the woman with her partner and family should be supported to care for and make the best decisions for their newborn.<sup>7</sup>

Antenatal period is the period which starts from the period of conception till delivery of baby, which needs special attention. During this period, family, society and health institutions play an important role for promoting health and preventing complication, during and after childbirth, so counselling should be provided regarding child birth preparedness.<sup>8</sup> Some people have basic questions about how pregnancy happens. Some may have questions about avoiding a pregnancy. Others are considering a pregnancy and have questions about pre - pregnancy health, or infertility. And some may wonder about options for an unintended pregnancy. Many women need information about pregnancy tests. Pregnant women may also have questions about prenatal care and the stages of pregnancy. And women who are concerned about pregnancy loss may have lots of questions about miscarriage or ectopic pregnancy. Only the person can decide if it is the right time to have a child. Motherhood is a lifelong commitment; Systemic supervision and advice of women during pregnancy are important. The supervision should be regular and the care should start from the beginning of pregnancy and end at delivery. The aims of care are to screen "high risk cases", to prevent or to treat complications at the earliest, to ensure continued medical surveillance and prophylaxis, to motivate the couple about the need of family planning and also provide appropriate advice to couples who are seeking Medical Termination of Pregnancy and preconception counselling.<sup>9</sup>

Pregnancy is a very sensitive period in which unexpected life - threatening complications may arise at any period, from conception to the postpartum period. Maternal and neonatal mortality is an ongoing major public health problem in developing countries. In 2015, the WHO estimates that ~830 women die every day from preventable causes related to pregnancy and childbirth, and 99% of all maternal deaths occur in developing countries.<sup>10</sup> Most maternal death is a consequence of complications during and following pregnancy and childbirth, most of which are preventable or treatable when births are assisted by skilled birth attendants. Although a safe motherhood program is successful in reducing maternal mortality, it does not mean high utilization of maternal health services. The problem may be due to the delays in seeking, reaching and receiving adequate care. One effective strategy to prevent maternal mortality is birth preparedness and complication readiness (BPCR), which will encourage pregnant women to make prompt decisions to seek care from skilled birth attendants.<sup>11</sup>

BPCR is a strategy to promote the timely use of skilled maternal and neonatal care, especially during childbirth. With this aim in mind, in 2001, The Maternal and Neonatal Health Program of John Hopkins Program for International Education in Gynaecology and Obstetrics (JHPIEGO) developed the BPCR matrix, which is a standard set of indicators that could be used across countries. BPCR matrix explains the roles of policymakers, facility managers, health care providers, communities, families and women in ensuring that women and newborns receive timely skilled maternal and neonatal care based on the theory that preparing for childbirth and being ready for complications reduce delays in seeking and obtaining appropriate care.<sup>12</sup> A report from Ethiopia showed that BPCR had a significant effect on skilled care use. Moreover, there is clear evidence from a meta - analysis of 14 randomized studies showing that BPCR interventions, with adequate population coverage, are effective in reducing maternal and neonatal mortality in low - resources setting.<sup>13</sup>

While pregnancy should be a time of immense hope and a positive experience for all women, it is tragically still a shockingly dangerous experience for millions around the world who lack access to high quality, respectful health care, ” said Dr Tedros Adhanom Ghebreyesus, Director - General of the World Health Organization (WHO). “These new statistics reveal the urgent need to ensure every woman and girl has access to critical health services before, during and after childbirth, and that they can fully exercise their reproductive rights. ” “For millions of families, the miracle of childbirth is marred by the tragedy of maternal deaths, ” said UNICEF Executive Director Catherine Russell. “No mother should have to fear for her life while bringing a baby into the world, especially when the knowledge and tools to treat common complications exist. Equity in healthcare gives every mother, no matter who they are or where they are, a fair chance at a safe delivery and a healthy future with their family. ” According to WHO The maternal mortality is unacceptably high. About 287 000 women died during and following pregnancy and childbirth in 2020. Almost 95% of all maternal deaths occurred in low and lower middle - income countries in 2020, and most could have been prevented.<sup>14</sup>

Sustainable Development Goal (SDG) target 3.1 is to reduce maternal mortality to less than 70 maternal deaths per 100 000 live births by 2030. The United Nations Maternal Mortality Estimation Inter - Agency Group (MMEIG) – comprising WHO, the United Nations Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank Group and the United Nations Department of Economic and Social Affairs, Population Division (UNDESA/Population Division) has collaborated with external technical experts on a new round of estimates covering 2000 to 2020. The estimates represent the most up to date, internationally - comparable MMEIG estimates of maternal mortality, using refined input data and methods from previous rounds. The report presents internationally comparable global, regional and country - level estimates and trends for maternal mortality between 2000 and 2020.<sup>15</sup>

### Objectives:

- 1) To assess the level of knowledge regarding birth preparedness among primigravida women in a selected Hospital Guwahati Assam.
- 2) To find out the association of knowledge regarding birth preparedness among primigravida mothers with demographic variables.
- 3) To develop an information booklet regarding primigravida mothers.

## 2. Review of Literature

### Section I: Studies Related to Birth Preparedness:

**Bhattacharya S, Dutta B, Mondal S C (2022)** conducted a cross sectional study on Knowledge and practice about birth preparedness and complication readiness among primi gravida women in antenatal clinic of Howrah District Hospital West. The study sample consists of 200 Primigravida mothers who were in third trimester of pregnancy attending the antenatal clinic. The data were collected by using Semi - structured questionnaire. The results shows that Out of 200 pregnant women, 169 (84.5%) have done higher secondary education and 176 (88%) were home makers. Majority (62.5%) were residing in urban area. Among participants, 138 (69%) primigravida mothers had inadequate levels of knowledge about BPACR and 140 (70%) had inadequate practice. The study concluded that Ideal BPACR given through education can help in healthy practice during antenatal and postnatal period.<sup>27</sup>

**Ademuyiwa, I Y, Oyediran O, Olowe A O, Emikpe A O, Oshinyemi T E, & Oladehinde T E (2022)** conducted a cross sectional study on Knowledge, practice of and factors influencing birth preparedness and complication readiness among pregnant women attending antenatal clinic in a tertiary institution in South - Western Nigeria. The study sample consists of 146 pregnant women. The Data were manually collected and analyzed electronically with the use of SPSS computer software version 23. The results shows that more than half of the respondents 74 (50.7%) had overall poor knowledge of BPCR while majority of the respondents 88 (60.3%) had good overall practice of BPCR. The findings revealed that factors influencing practice of BPCR were inadequate prenatal education (82.2%), knowledge of key danger signs (80.8%), poverty and place

of residents (80.1%), educational level (70.5%) and family size (60.3%). There was a significant relationship between the knowledge and practice of birth preparedness and complication readiness, with a p - value <0.05. The study concluded that Base on the results the study concluded that although the overall practice of BPCR is good while the overall knowledge is poor. There is a need to create an awareness and give adequate education on knowledge and practice of birth preparedness and complication readiness among pregnant women.<sup>28</sup>

### Section - II: Studies Related to Knowledge of Antenatal Care

**Ahmed A M, Nuh A M, Hassan H K (2023)** conducted a cross sectional study on Knowledge of Obstetric Danger Signs and Associated Factors among Pregnant Women Attending Antenatal Care in Hargeisa Town Health Institutions, Somaliland. A total of 222 pregnant women were taken as a sample by using Systematic random sampling. The data were collected by a pretested structured interviewer administered questionnaire. The results shows that only the mean ( $\pm$  SD) (Standard Deviation) of age was 28.52 ( $\pm$  6.88) years with the median age of 28.50 years. The age of all study population ranged from 18 to 48 years. The permanent address of the majority, 177 (79.7%) of the respondents, were Hargeisa. Concerning marital status, 190 women (85.6%) were married. The number of alive children the women had, ranged from 0 to 11, with mean of 3.39. The family size of respondents ranged from 2 to 16 with mean of 5.95. Pregnant women who had primary school accounted for 53 (23.9%), followed by Illiterate 52 (23.4%), Degree and above 42 (18.9%) and secondary 38 (17.1%). Regarding educational status of spouses of the women, 85 spouses of the women (38.3%) had degree followed by Secondary 42 (18.9%) and primary school 23 (10.4%). Almost three fourth of all women, 163 (73.4%), were house wives with no job, with only 49 (22.1%) employed. The study concluded that increasing knowledge or awareness of key obstetrics danger signs need to be given focus as it makes women and their families ready for prompt and appropriate decisions and measures if obstetrics dangers occur.<sup>44</sup>

**Bayisa D, Waltengus F, Lake, Wakuma B, Bayisa L, Chala M, Besho M, Mossisa G (2022)** conducted a cross - sectional study on Pregnant women's knowledge, attitudes, and associated factors toward physical exercise during pregnancy among those attending antenatal care at Bahir Dar city, Northwest Ethiopia. A total 475 pregnant women were taken as a sample by using sampling technique. The data were obtained through Interviewer - administered questionnaire. The study showed that 55.8% (95% CI: 48.45 - 59.12) of pregnant women were knowledgeable about benefits and contraindication of exercise during pregnancy; 53.3% (95% CI: 49.05 - 57.62) of them had positive attitudes toward exercise during pregnancy. Educational status adjusted odd ratio (AOR) = 3.95 (95% CI: 1.712 - 9.108), practicing physical exercise before becoming pregnant AOR = 3.64 (95% CI: 1.091 - 12.118), and women who heard about exercise during pregnancy AOR = 4.74 (95% CI: 2.563 - 8.756) were found to have statistically significant association with knowledge of women about exercise during pregnancy. Women who were



knowledgeable about exercise during pregnancy AOR = 4.45 (95% CI: 2.39 - 8.29) and women who heard about exercise during pregnancy AOR = 4.2 (95% CI: 2.19 - 8.08) were more likely to have a positive attitude toward benefits of exercise during pregnancy. The study concluded that Empowering women through health education about physical exercise during pregnancy should get due attention.<sup>45</sup>

### 3. Research Methodology

- **Research Approach:** Quantitative research approach
- **Research Design:** Descriptive survey research
- **Research Variables:** Knowledge
- **Demographic Variables:** Age, Education, Economic status, Occupation, No of antenatal visit, Types of family, Place of residency and Previous source of information.
- **Setting:** The setting was Guwahati Medical college and Hospital, Assam.
- **Population:** In this study, population consisted of Primigravida mothers.
- **Target Population:** In this study, the target population is referred to the primigravida mothers at Guwahati Medical College and Hospital, Assam.
- **Accessible Population:** In this study, the accessible population primigravida mothers attending antenatal OPD at Guwahati Medical College and Hospital, Assam.
- **Sample:** In this study, Primigravida mothers who come to the antenatal OPD of selected hospital, Guwahati Assam and who fulfill the inclusion criteria.

**Sample Size:** 110

**Sample Technique:** Non probability convenient sample technique.

**Sample Criteria:**

#### Inclusion Criteria:

The inclusion criteria in the study were: -

- Mothers who are 1<sup>st</sup> time pregnant.
- Mothers who are willing to participate.
- Mothers who are available during data collection period

#### Exclusion criteria:

The exclusion criteria in the study were

- Multigravida Mothers.
- Primigravida women who were critically ill at the time of data collection.

**Techniques:** Self - report

#### Content Validity:

**The prepared tool was validate by:** The tools were validated by experts comprising of 5 Nursing experts in the field of Obstetrics and Gynecology Nursing Department, Nursing experts in the field of Community Health Nursing department and 1 Medical experts in the field of Obstetrics and Gynecology Department. The expert were asked to provide their valuable suggestion in the remarks column of the content validity format. The items of the tools were

evaluated for relevancy, accuracy and appropriateness. Based on their suggestion the following modification were done on various sections of the tool.

**Reliability of Tool:** The reliability of the tool was done by split half method for knowledge and was found to be 0.72.

#### Pilot Study:

The study was conducted from 3<sup>rd</sup> September to 7<sup>th</sup> September, 2022 in Capital Dispensary, Lastgate, Guwahati, Assam. 17 samples were selected by using Non probability convenience sampling technique and study was found to be feasible.

**Main Study:** The main study was conducted for primi mothers in Antenatal OPD in Guwahati Medical College, Assam. The data collection began from 5<sup>th</sup> December to 15 December 2022.

### 4. Results

**Table 1:** Frequency and percentage distribution of demographic variables of primi mothers

Demographic variables	Frequency (f)	Percentage (%)
<b>Age Group (Years)</b>		
19 – 24 years	61	55.4
25 – 29 years	39	35.5
30 – 34 years	10	9.1
>35 years	-	-
<b>Education</b>		
Primary	17	15.5%
HSLC	49	44.5%
H. S	32	29.1%
Graduate	10	9.1%
No formal education	2	1.8%
<b>Monthly Family Income</b>		
≤9226	7	6.4%
9232 – 27648	67	60.9%
27654 – 46089	33	30.0%
46095 – 68965	3	2.7%
68957 – 92185	-	-
92191 - 184, 370	-	-
≥184, 376	-	-
<b>Occupation</b>		
Housewife	73	66.4%
Daily labour	19	17.3%
Work in Private sector	13	11.8%
Work in Govt. sector	5	4.5%
<b>No. of Antenatal Visit</b>		
1 <sup>st</sup> Visit	16	14.5%
2 <sup>nd</sup> Visit	40	36.4%
3 <sup>rd</sup> Visit	37	33.6%
4 <sup>th</sup> Visit	17	15.5%
<b>Types of Family</b>		
Nuclear	53	48.2%
Joint	54	49.1%
Extended	3	2.7%
<b>Place of Residence</b>		
Rural	56	50.9%
Urban	54	49.1%
<b>Previous Source of Information</b>		
Friends	11	10.0%
Relatives	48	43.6%
Health professionals	27	24.6%
Media/Newspaper	24	21.8%

Section II: Analysis of the of the Primi mothers according to their level of knowledge, Score, n =110

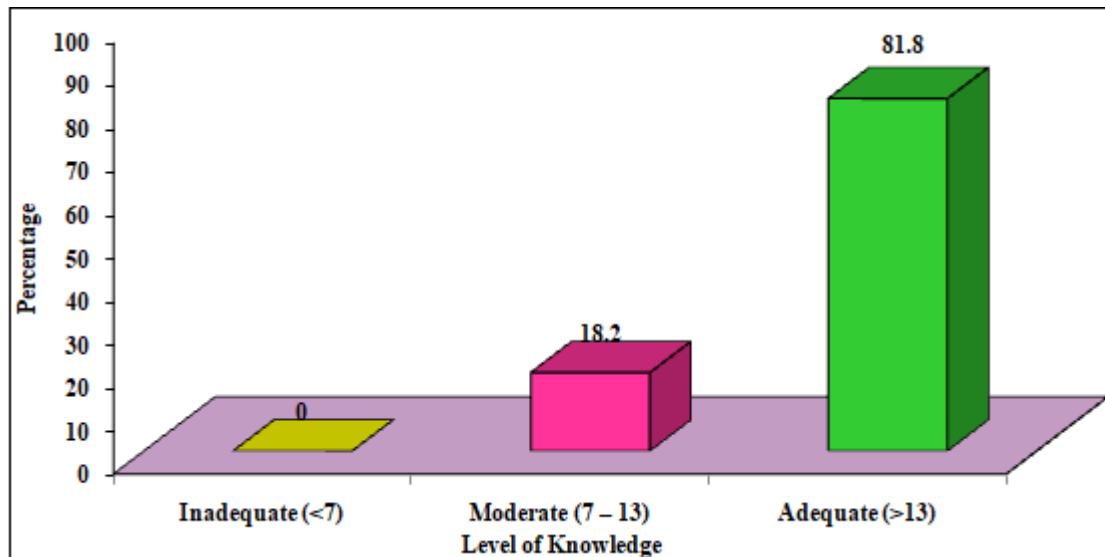


Figure 1: Percentage distribution of level of knowledge regarding birth preparedness among primi gravida mothers.

From Figure1, it has been observed as follows, that out the total sample (Primi mothers): Majority, 90 (81.8%) had adequate knowledge and 20 (18.2%) had moderately adequate knowledge on childbirth preparedness respectively.

Table 2: Association of level of knowledge regarding birth preparedness among primi gravida mothers with their selected demographic variables, n=110

Fisher exact test value showing the association of level of knowledge with the selected demographic variables at the significant level of 0.001 and 0.05, n= 110

Demographic Variables	Moderate		Adequate		Fisher Exact test p - value	Remarks
	f	%	f	%		
<b>1) Age (in years)</b>						
19 – 24 years	13	11.8	48	43.6	p=0.607	*NS
25 – 29 years	5	4.5	34	30.9		
30 – 34 years	2	1.8	8	7.3		
>35 years	-	-	-	-		
<b>2) Education</b>						
Primary	4	3.6	13	11.8	p=0.884	*NS
HSLC	10	9.1	39	35.5		
H. S	5	4.5	27	24.5		
Graduate	1	0.9	9	8.2		
No formal education	0	0	2	1.8		
<b>3) Monthly family income (in Rs.)</b>						
≤9226	4	3.6	3	2.7	p=0.005*	*S
9232 - 27648	11	10.0	56	50.9		
27654 - 46089	3	2.7	30	27.3		
46095 - 68965	2	1.8	1	0.9		
68957 - 92185	-	-	-	-		
92191 - 184, 370	-	-	-	-		
≥184, 376	-	-	-	-		
<b>4) Occupation</b>						
Housewife	16	14.5	57	51.8	p=0.638	NS
Daily labour	2	1.8	17	15.5		
Work in private sector	2	1.8	11	10.0		
Work in Govt. sector	0	0	5	4.5		
<b>5) No. of antenatal visit during pregnancy</b>						
1 <sup>st</sup> visit	4	3.6	12	10.9	p=0.164	NS
2 <sup>nd</sup> visit	5	4.5	35	31.8		
3 <sup>rd</sup> visit	5	4.5	32	29.1		
4 <sup>th</sup> visit	6	5.5	11	10.0		
<b>6) Types of family</b>						
Nuclear family	10	9.1	43	39.1	p=0.633	NS

Demographic Variables	Moderate		Adequate		Fisher Exact test p - value	Remarks	
	f	%	f	%			
Joint family	9	8.2	45	40.9	p=0.438	NS	
Extended family	1	0.9	2	1.8			
<b>7) Place of residence</b>						p=0.438	NS
Rural	11	10.0	45	40.9			
Urban	9	8.2	45	40.0			
<b>8) Previous source of information on birth preparedness</b>						p=0.363	NS
Friends	2	1.8	9	8.2			
Relatives	7	6.4	41	37.3			
Health professional	8	7.3	19	17.3			
Media / Newspaper	3	2.7	21	19.1			

The data presented in the above table 3 depicts that there was significant association of pre - test knowledge regarding childbirth preparedness. It was observed that the demographic variables Monthly family income (in Rs.) ( $p=0.005$ ) had statistically significant with level of knowledge at  $p<0.05$  level respectively.

The other demographic variables did not show statistically significant association with level of knowledge regarding childbirth preparedness among primigravida mothers. Age (in years),

Education, Occupation, No. of antenatal visit during pregnancy, Types of family, Place of residency, Previous source of information on birth preparedness.

## 5. Discussion

### Part A– Discussion of demographic characteristics:

The findings of the study revealed that out of 110 primigravida mothers in antenatal OPD, Majority i. e.61 (55.4%) of the primi mothers belonged to the age group between 19 - 24 years of age, 49 (44.5%) of the primi mothers had passed H. S. L. C, 67 (60.9%) of the primi mothers had family income of Rs.9232 - 2764, 73 (66.4%) of the primi mothers occupation were housewife, 40 (36.4%) of the primi mothers were 2<sup>nd</sup> Visit, 54 (49.1%) of the primi mothers belonged to joint family, 56 (50.9%) primi mothers belongs from rural area, 48 (43.6%) primi mothers previous source of information were from relatives.

### Part B - Discussion of knowledge regarding child birth preparedness:

The study also showed that out of 110 nurses, majority of the primi mothers i. e.90 (81.8%) had adequate knowledge and 20 (18.2%) respondents had moderately adequate knowledge.

These findings were supported by **Kiataphiwasu N, KaewkiattikunK (2018)** conducted a cross sectional study on birth preparedness and complication readiness among pregnant women attending antenatal care at the Faculty of Medicine Vajira Hospital, Thailand. The sample consist of 672 pregnant women. The data were collected by interviews using a structured questionnaire. The result shows that 528 (78.6%) pregnant women had good BPCR by fulfilling at least four BPCR indicators and remaining 144 (21.4%) showed poor. BPCR. Associated factors of good BPCR were adult pregnancy, married status, high education, employed,

high income, extended family, multiparity, first antenatal visit at  $\leq 12$  weeks and long - distance transportation. Predictive factors for good BPCR were high education, high income, multiparity and extended family.

This is comparable with study conducted by **Alex B elal. (2021)** conducted a community - based cross - sectional study on birth preparedness and complication readiness among pregnant women in rural Northern Ghana.549 samples were selected by using multistage sampling technique. Structured questionnaire was used to collect data from the participants. The data were analyzed both descriptively and analytically using the binary logistic regression. The results showed that less than half 4.7% of respondents had knowledge warning sign during pregnancy with respect to BPCR, only 46.5% of the mother were well prepared with respect to multiple analysis, respondents who had attended primary, secondary or tertiary education were associated with good birth preparedness and complication readiness. This study showed that poor knowledge of warning signs during pregnancy and inadequate BPCR among mothers. Providing adequate BPCR information and counseling, with emphasis on warning signs during pregnancy and delivery is essential.

## 6. Conclusion

The current study shown that primi mothers have adequate knowledge regarding child birth preparedness. Therefore, it is recommended to organize awareness programmes regarding birth preparedness among primi mothers to enhance their knowledge and will help primi mothers in better planning of pregnancy and childbirth in advance. The health care worker can conduct health education on child birth preparedness in clinical and community settings to update mothers knowledge.

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**Conflict of interest:** None

**Source of funding:** None

**Ethical Approval:** Approved

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