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Safe motherhood practices-knowledge among pregnant women: A descriptive study

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Abstract
Background: Childbearing is an important event of a women's life. Childbirth is a multidimensional process with physical, psychological, emotional, social, and cultural dimensions. Childbirth education plays an important role in physical and psychosocial preparedness of the mother. Assessing the level of awareness about safe motherhood practices among pregnant women thus becomes necessary to plan interventions to further empower them to avail these services.
Objective: To assess the level of knowledge about the safe motherhood practices in pregnant women. To confirm the association between knowledge and socio-demographic variables.
Methodology: A descriptive design was used to confirm the knowledge of pregnant women regarding safe motherhood practices. 300 pregnant women were selected who attending antenatal OPD at a tertiary care hospital in Kharar, Punjab. Socio demographic data and details of knowledge about safe motherhood practices were collected using a predesigned questionnaire. Data was analyzed by using descriptive and inferential statistics.
Results: The results showed that out of 300 participants, 252 (84%) had average knowledge about safe motherhood practice, 33 participants(11%) had poor knowledge while only 15 participants (5%) had good knowledge about Safe Motherhood Practices. Statistically significant associations were observed between knowledge and education level, employment status and socio-economic class (p-value<0.05).
Conclusions: Among pregnant women knowledge about Safe Motherhood Practices was average and behaviour was poor. There is a necessity to increase the knowledge which will in turn bring about a good behaviour and empower women to use the safe motherhood services.

Keywords: Pregnancy, safe motherhood practices

Introduction

Safe motherhood is a set of practices that can reduce the risk of complications for both the mother and the baby during pregnancy and childbirth. Pregnancy and childbirth are essential for existence of the entire human race but the complications involved in pregnancies often have a negative impact on mothers mentally, physically and emotionally. If a woman dies during childbirth the risk of death for children under five year doubles or even triples as seen in studies conducted in developing countries [1].

To prevent maternal mortality, morbidity and related adverse con-sequences the International Health Community including the World Bank, WHO, United Nations Population Fund and agencies in 45 other countries launched the "Safe Motherhood Initiative" in 1987 at a conference held in Kenya [2]. This initiative enlisted four pillars of safe

Mother hood which included antenatal care, clean and safe delivery, essential obstetric care and post natal care including family planning [3].

The Safe Motherhood Initiative, jointly launched by the World Health Organization (WHO), the United Nations Children's Fund, the United Nations Population Fund, the World Bank, and other organizations, brought maternal and child health to the forefront of public health concerns. Among other goals, this initiative aims to reduce maternal mortality by 75% between 1990 and 2015 [4]. However, it has been widely documented that desired improvements in maternal health have not been achieved despite this increased attention and commitment to safe motherhood [5].

Globally 800 women still die every day of preventable causes related to pregnancy out of which 20% is contributed by India, currently esti-mated to be 212 per 1,00,000 live births [6]. Hence, in 2014 "Every Mother and Every Newborn" and in 2016, "The Global Strategy" were launched to implement the 2030 agenda of Sustainable Developmental Goal (SDG)-3

to ensure healthy lives and promote well-being for all at all ages [7].

Therefore it becomes necessary to assess the basic level of awareness about safe motherhood practices among pregnant women so that necessary interventions can be planned to increase their knowledge and empower them to avail these services. There is a dearth of literature regarding this aspect in the Indian population while no study has been conducted in the Kharar, Punjab. This study was therefore planned to assess the level of knowledge and behaviour about safe motherhood practices and factors influencing these practices in pregnant women.

Methods

A descriptive study was conducted among 300 pregnant women who attended the antenatal OPD at a tertiary care hospital, Kharar, Punjab from April 2024 to May 2024. Relevant permissions were obtained from the hospital authorities. Written informed consent was obtained from all the participants after briefing them about the study.

Data was collected by using pre-designed questionnaire. This questionnaire was divided into 2 parts namely "socio-demographic information", and questions related to knowledge about safe motherhood practices. The questionnaire consisted of 30 questions to assess knowledge. The scores were categorized as average knowledge, poor knowledge and good knowledge. One mark was awarded for every correct answer while the wrong answer was given 0 mark for knowledge questions. Ethical clearance from Institutional Ethics Committee was obtained for the study. Data entry and analysis was done by using the statistical package for social sciences (SPSS) software version 20 and Microsoft Excel. Frequency and percentage were used to analyze the level of knowledge. Chi square test was used to find associations.

Results

Table: 1 noted that half of the women (61.66%) were in the age group of 20-25 years, most of the subject (81.34%) were residing in rural area and more than half of them (64%) during their marriage were aged between 20 to25 years. Only 34% of the participants had completed their middle school, more than half (71%) of the participants were unemployed and half of the participants (51%) had low socio economic level. 62% mothers had with primigravid and more than half of the subject (63%) had 25 to 35 years of age during first child.

Table: 2 Indicate that out of 300 participants, 224 (74.6%) had average knowledge about safe motherhood, 54 participants (18%) had poor knowledge while only 22 participants (7.4%) had good knowledge about Safe Motherhood Practices.

Table 3 depict that knowledge score was assessed and statistically significant association was observed between the knowledge level of the participants, and socio-economic class of the participants. Age, residential area, education, employment, gravid, socio economic class and age at first child found non-significant at the level of $p<0.05$. Only age at marriage found to be significant. Thus this study concluded that the subjects were having average knowledge regarding safe motherhood practice.

Table 1: Socio demographic profile

(N=300)

Characteristics	Number (%)
Age (years)	
20-25	185 (61.66%)
25-30	090 (30.00%)
30-35	025 (08.34%)
Residential area	
Rural	244 (81.34%)
Urban	056 (18.66%)
Age at marriage (years)	
20-25	192 (64.00%)
26-30	067 (22.34%)
>30	041 (13.66%)
Education	
Illiterate	040 (13.34%)
Primary school	070 (23.33%)
Middle school	102 (34.00%)
Graduate	070 (23.33%)
Post Graduate	018 (06.00%)
Employment	
Employed	087 (29.00%)
Unemployed	213 (71.00%)
Socio economic class	
Lower	153 (51.00%)
Middle	113 (37.66%)
Upper	034 (11.34%)
Gravida	
Primi	186 (62.00%)
Multi	114 (38.00%)
Age at first child (years)	
20-25	086 (28.66%)
25-30	189 (63.00%)
30-35	022 (07.34%)
>35	003 (01.00%)

Table 2: Distribution of study participants according to their level of Knowledge

(N= 300)

Knowledge score groups	Number of participants & Percent (%)
Poor (<18)	054 (18.0%)
Average (18-36)	224 (74.6%)
Good (>36)	022 (07.4%)
Total	300 (100%)

Table 3: Association of knowledge with socio-demographic variables.

Socio-demographic Variables	Knowledge		
	Chi square value	df	p-value
Age (years)	02.23	3	$.52^{NS}$
Residential area	05.00	3	$.17^{NS}$
Age at marriage (years)	14.95	6	.02*
Education	18.80	12	$.09^{NS}$
Employment	01.49	3	$.68^{NS}$
Socio economic class	01.81	3	$.61^{NS}$
Gravida	02.55	3	$.46^{NS}$
Age at first child (years)	18.80	12	$.09^{NS}$

Discussion

In this study out of 300, more than half of the participants were in the age group of 20-25 years (61.6%) and more than three quarters of them resided in the rural areas (81.34%). In a similar study conducted in Belagavi (2021) on the knowledge of safe motherhood among women who came for regular checkup in hospital, the median age of the

participants was 25 years. Age at marriage also plays a vital role in reproductive health as well as in maintaining safe motherhood practices. In this study a large number of participants were married between the age of 20-25 years (64%). Education plays a major role to maintain safe motherhood practice. Data revealed that out of 300 participants 34% of the participants had only completed middle school while 13.34% of the participants were illiterate. The information reveals that participants did not have better education. The Belagavi study on knowledge of safe motherhood showed that half of the participants had received only 20.3% education.[8] Economic activity is one of the strong indicators of national development. Occupation is also related with the economic activities. In this regard out of 300 participants more than half of the participants 71% were unemployed and more than half of them 71% belonged to the lower socio-economic class. Similar findings are shown in a study conducted in Bangladesh about knowledge and behaviour on safe motherhood practices where 92% of the participants were unemployed [9].

In the present study maximum of the participants 224(74.6%) had average knowledge about safe motherhood practices. 54 participants (18%) had poor knowledge while only 22 participants out of 300 (7.4%) had good knowledge about Safe Motherhood Practices. These findings were similar to the study conducted within selected rural communities in northern Nigeria which showed generally poor knowledge about safe motherhood practices but among women who had recently delivered [10]. They were also corresponding with those of a study done in Tribal Women of Selected four Tribal Villages of Jambughoda Block, Panchmahal District, Gujarat showing that the overall knowledge regarding Safe Motherhood was low [11]. In this study it was seen that the knowledge regarding safe motherhood facilities was not associated with their level of education, employment and socio-economic class. This study was associated with age at marriage. This result goes hand with a safe mother hood knowledge study conducted in Nigeria which showed that knowledge of safe pregnancy practices among women in rural communities was strongly associated with, being employed and acquiring some level of education [12]. Many other studies also show that knowledge regarding different aspects of safe motherhood like ANC, PNC, breastfeeding, obstetric danger signs, breast feeding etc. is associated with education status of women. Educating and employing women will thus lead to increase in their knowledge about safe motherhood practices and empower these women to avail services which would translate into safer pregnancy outcomes and subsequently lead to lower maternal mortality across the developing world [13]. Knowledge of safe motherhood practices among women in rural communities in Nigeria was strongly associated with behaviour like attendance at antenatal clinics [14]. Also various studies conducted in Indonesia and Pune, India respectively showed that knowledge regarding contraception and ANC was associated with behaviour.

Conclusion

The participants had overall average to poor knowledge regarding safe motherhood practices and because of their lack of knowledge and awareness they are not able to avail the safe motherhood services. The knowledge of pregnant women regarding safe motherhood was not associated with their education level, employment status and socio-economic status. The knowledge was strongly associated with the age at marriage. If women are given higher education which will enable them to seek employment and have a better socio-economic status the knowledge regarding safe motherhood may also increase. Thus, if the knowledge increases it will lead to a better behaviour thus making pregnancy and delivery safer.

Conflict of Interest
Not available

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Not available

Reference

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