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## **Effectiveness of Self Instructional Module (SIM) on Knowledge Regarding Selected Aspects of Safe Motherhood among Primigravida Women in Selected Hospitals, Bangalore Karnataka**

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### **ABSTRACT:**

*Pregnancy is a special event. The labor and birth process is an exciting, anxiety provoking situation for the woman and her family. Hence, a study was conducted to assess the effect of self-instructional module on knowledge regarding selected aspects of safe motherhood among primigravida women in selected hospitals, Bangalore Karnataka with the objective to assess the existing level of knowledge, assess the effect of SIM on safe motherhood among primigravida women and associate the pre-test level of knowledge with selected demographic variables. A quantitative evaluator approach and pre-experimental one group pre test- post test was used. Purposive sampling technique was done to select 50 primigravida women. To collect the data structured questionnaire was administered followed by administration of SIM. On the 7<sup>th</sup> day the effectiveness of the SIM assessed by conducting post test. The statistical analysis of the data shows that the self-instructional module was effective in improving knowledge as the 't' value is 20.12 which is significant at  $p < 0.01$ . After computation it depicts that the mean post test score is significantly higher than the mean pre-test score. So in the inference it reveals that the research hypothesis is accepted and null hypothesis is rejected. It signifies the association between the level of pre-test knowledge with selected demographic variables like education and occupation.*

**KEYWORDS:** *Safe motherhood; Self-instructional module.*

### **OBJECTIVES:**

- a. To assess the existing level of knowledge regarding selected aspects of safe motherhood among primigravida women.
- b. To evaluate the effect of SIM regarding safe motherhood in terms of gain in post-test knowledge scores of primigravida when compare to their pre test scores.
- c. To associate the level of knowledge with selected demographic variables among primigravida women regarding selected aspects of safe motherhood.

**Design:** The research design adopted for this study is pre experimental design, of which one group pre-test- post-test design.

**Settings:** The study was conducted at various hospitals in Bangalore Karnataka.

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**Samples:** In this study, the samples are the primigravida women who were admitted to the antenatal wards of selected hospitals, Bangalore Karnataka and also those who satisfy the inclusion criteria are included as samples in the study. The sample size was 50. The sampling technique used is Non-probability purposive sampling.

### **RESULT:**

The researcher found that there was a significant improvement in knowledge of primigravida women after the administration of self-instructional module on safe motherhood and there was significant association between levels of pre-test knowledge of primigravida women with selected demographic as educational status of the samples.

### **CONCLUSION:**

The present study shows that the most of the primigravida women had moderate knowledge. The difference between pre-test and post test score revealed that self-instructional module is very effective in improving knowledge of primigravida women. The pre-test knowledge of safe motherhood is significantly associated with variables like education and occupational status of primigravida women, but there is no significant association between the pre-test knowledge and age, family type, number of elder females in the family and age at marriage.

### **INTRODUCTION**

In every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women and families, and represent a time of intense vulnerability. Mothers and children constitute a major part of the total population. In India, women of the child bearing age (15-44 years) constitute 19% and children less than 15 years of age about 40% of the total population. Together they constitute nearly 59% of the total population [1].

Women are half of the nation and half of the power; their concerns must be addressed on priority basis. Women's autonomy, dignity, feelings, choices, and preferences must be respected, including their choice of companionship wherever possible. Childbirth can be a very frightening experience for many women, but it should be a joyous occasion—and every woman should feel valued, respected, and appreciated by all those who aid in her journey of bringing new life into the world [2].

Saving mother's life is a global aim as the health of mothers has long been considered as cornerstone of public health and attention. Safe motherhood encompasses a series of initiatives, practices, protocols and service delivery guidelines designed to ensure that women receive high-quality gynaecological, family planning, prenatal, delivery and postpartum care in order to achieve optimal health for the mother, fetus and infant during pregnancy, childbirth and postpartum. The ways to achieve safe motherhood include skilled attendance at all births, access to quality emergency obstetrical care, access to quality reproductive health care including family planning and safe post-abortion care [3].

The "safe motherhood" programme was launched in 1989. WHO reported that 5, 00,000 women continue to die globally each year due to pregnancy related issues. Nearly 99% of these deaths occur in developing countries. Maternal mortality is not only indicator of women's health, but also gives indication of access, integrity, effectiveness and health sector organizations. South-East Asia accounts for 40% of global deaths, which is highest in the world.

India has 1 out of 4 of the world's maternal deaths, or 1 every 6 minutes. The risk of maternal death has been calculated to be one in 64. Risk is unevenly distributed geographically. Risk is low in Kerala compared to Uttar Pradesh or Madhya Pradesh.

The concept of "safe motherhood" is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. Safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy, child birth and postnatal period. Safe motherhood includes antenatal care, intranasal care, postnatal care and neonatal care. Issues of gender equity and gender-based violence are also at the core of maternity care, so the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights.

Unsafe motherhood consists in maternal mortality or morbidity due to preventable pregnancy and childbirth-related causes. Maternal mortality is a major cause of death and disability among women of reproductive age.

500,000 women die every year from complications related to child bearing. Many more women are injured, some severely from childbirth complications. Maternal mortality and morbidity adversely affect the health and welfare of children, families and communities. Safe motherhood decreases maternal and infant mortality and morbidity. Although, most maternal and infant deaths can be prevented through safe motherhood practices, millions of women worldwide are affected by maternal mortality and morbidity from preventable causes.

In the *International statistical classification of diseases and related health problems*, 10th revision (ICD-10), WHO defines maternal death as: The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes [4].

Globally, the major causes of maternal deaths are severe bleeding (25%), infections (15%), unsafe abortions (13%), eclampsia (12%), obstructed labour (8%), and other direct causes (8%). In India major causes of maternal mortality are anaemia (19.4%), haemorrhage (11.8%), toxemia (15%), abortion (11.8%), puerperal sepsis (8.1%), and others (21.8%).

In India, the major causes of maternal deaths are haemorrhage (38%), sepsis (11%), hypertensive disorders (5%), obstructed labour (5%), abortion (8%) and other conditions (34%). India is among those countries which have a very high maternal mortality ratio, as per the Sample Registration System (SRS) report by Registrar General of India (RGI) for the last three years, As per the latest report of Special Bulletin on Maternal Mortality released by RGI, Maternal Mortality Ratio (MMR) of India reduced from 103 per 100,000 live births in 2017-19 to 97 per 100,000 live births in 2018-20. In the four southern states, Kerala and Tamil Nadu have already achieved the goal of a MMR 100 per 100,000 live births, but within

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the group, Karnataka lags behind with MMR 178, and at the current rate of decline, As per the Special Bulletin on MMR released by the Registrar General of India (RGI), the Maternal Mortality Ratio (MMR) of India has improved further by a spectacular 6 points and now stands at 97/ lakh live births. During the year 2023, women died of pregnancy related causes. It is mainly due to large number of deliveries conducted at home by untrained person. In addition, lack of adequate referral facilities to provide emergency obstetric care for complicated cases also contribute to high morbidity and mortality [5].

National Safe Motherhood Day is observed on 11 April every year. The theme for this year is “Every Woman Counts”. It aims at enforcing the strong voice that all women should have access to care and no maternal death is acceptable. Surviving childbirth is a basic right of every woman and each individual directly or indirectly associated with the issue has a social responsibility to ensure that every woman counts. The Millennium Development Goal (MDG) 5 has set a target for reducing maternal mortality to 109 per one lakh live births. Achieving MDG 5 is not only an important goal in itself, it is also central to the achievement of the other MDGs: reducing poverty, reducing child mortality, stopping new HIV infections, providing education and promoting gender equality.

Mother plays an important role within the family. Hence maternal deaths have very serious consequences within the family. The death of mother increases the risk to the survival of her young children. The road to maternal and infant death is a long one, but it is possible to escape the tragedy of its end at various points along the route. The challenge is to ensure that every woman has the chance of safe motherhood.

#### **NEED FOR THE STUDY:**

Addressing maternal health means ensuring that all women receive the care need for safe pregnancy and childbirth. Safe Motherhood includes antenatal care, delivery care and postnatal care, including care of baby and breastfeeding support. It encompasses social and cultural factors. Improving maternal health is one of the fifth millennium development goal and great efforts have been put forth to achieve this. Newborns have the highest risk of death among all children. Each day, about 8,000 babies die within the first 28 days of life. Most of them die at home. Prematurity/low birth weight, infection, asphyxia/birth traumas causes 77 percent of neonatal death. Every two minutes, the loss of a mother shatters a family and threatens the well-being of surviving children. Women in many areas still lack the power to make choices about their health and lives, with negative consequences for maternal health. They still have lots of traditional beliefs about the food and regarding medical seeking.

A survey was conducted to assess the obstetric morbidity among currently married women in selected states in India. This study uses the data from NFHS-3. According to NFHS-3, at the national level, 6% women were suffering from difficulty with vision, 9% had night blindness, 10% reported convulsion, 25% suffer from swelling in legs, body or face, 48% had excessive fatigue and four percent had vaginal bleeding during pregnancy. With regard to postpartum complications around 12% women had massive vaginal bleeding and 14% suffered from very high fever.

The above survey results also reveal that in Karnataka one third of the women reported symptoms of reproductive morbidity. Lack of education and economic status were emerged as significant factors affecting the women’s health. In Karnataka, the gynaecological

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morbidity is high among rural women, majority of women are suffering from one or more gynaecological morbidity. So there is an urgent need for suitable health education and awareness about reproductive diseases between both genders.

Ensuring that mothers have access to skilled attendant during labour can dramatically reduce the risk of death for the mother and newborn child. In almost all countries where health professionals attend more than 80% of deliveries, maternal mortality ratios are below 200 per 100,000 deliveries. Each day 800 women die worldwide from causes related to pregnancy and childbirth, while millions more suffer from post partum injuries. A woman is most vulnerable at the post-partum period. About 50-70% maternal death occur in the postpartum period of which 45% deaths occur in the first 24 hours after delivery and more than two-thirds during the first week. Between 11-17% of maternal deaths occur during child birth itself.

Illiteracy is the greatest barrier for any advances in the health condition. The investigator during the clinical posting had identified that most of the women were suffering from problems like excessive fatigue, swelling in leg and face, massive vaginal bleeding during their motherhood period. So the investigator felt the need for assessing the knowledge and find out the effectiveness of providing self instructional module. Mother's education level, even within the same socio-economic class is a key determinant of their children's health. To improve pregnancy outcomes, education, motivation and mobilization of pregnant women, including their families and communities on knowledge regarding safe motherhood should be provided [16] [17] [18].

The above depicted literature throws light to the increased prevalence of complications related to pregnancy, childbirth and postpartum among mothers. So the investigator felt the need to evaluate the effectiveness of SIM on knowledge of primigravida women regarding selected aspects of safe motherhood.

### **REVIEW OF LITERATURE:**

The literature review of the study has been organized and presented under the following headings:

- a. Literature related to knowledge on safe motherhood
- b. Literature related to knowledge on intranatal care
- c. Literature related to knowledge on postnatal care
- d. Literature related to knowledge on new born care

#### **Literature related to knowledge on safe motherhood:**

A descriptive study was conducted to assess the health worker's knowledge of safe motherhood services at selected primary health centres in Hassan District, Karnataka. A structured questionnaire was prepared and administered to 100 female health workers based on purposive random sampling. The mean knowledge percentage score was 67% and mean practice percentage score was 69%. The calculated Pearson's Correlation Co-efficient  $r = 0.62$  was greater than table value ( $r=0.388, p<0.05$ ) showing significant positive correlation between the mean knowledge and practice score[9].



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**Literature related to Intranatal care:**

A quasi-experimental study was conducted to assess the effectiveness of slow paced breathing on pain perception during first stage of labour among Primipara mothers at Kovai medical centre, Coimbatore. 40 mothers were selected 20 in experimental group and 20 in control group. The tools used for this study are pain intensity scale, facial pain scale and observational checklist for slow paced breathing exercises. Mother who practiced slow paced breathing reported significant reduction in pain[10].

**Literature related to postnatal care:**

A study was conducted to assess the effectiveness of SIM on knowledge of postnatal care among primigravida women in selected hospital, Thrissur. In this study, 50 Primigravidae women who were selected using non probability purposive sampling. Quantitative evaluative approach was used and the study design was pre experimental one group pre test post test design. To collect the data structured knowledge questionnaire was administered followed by administration of SIM. The statistical analysis of the data shows that the self instructional module was effective in improving knowledge as the 't' value is 20.909 which is greater than the table value at  $p < 0.05$ . The mean post test score is significantly higher than the mean pre-test score, so the hypothesis is accepted [11].

**Literature related to newborn care**

A study was conducted to evaluate the effectiveness of planned teaching program on knowledge of mothers on prevention of hypothermia among newborns. One group pre-test, post-test design (pre-experimental) was used. 30 postnatal mothers were selected by non-probability sampling and pre-test questionnaire was administered through structured interview schedule. 7 days after PTP post-test was conducted on same group. Results were analysed by 't' test. The results revealed that the overall knowledge improvement was found after PTP and the paired 't' 15.6 at  $p < 0.05$  level significance proved that the selected hypothesis H1 was accepted and there was statistically significant association between knowledge of mothers and age and religion ( $p < 0.05$ ). Thus it was inferred that PTP was the best teaching strategy as it enhance the knowledge on prevention of hypothermia [12].

**OBJECTIVES:**

- a. To assess the existing level of knowledge regarding selected aspects of safe motherhood among primigravida women.
- b. To evaluate the effect of SIM regarding safe motherhood in terms of gain in post test knowledge scores of primigravida when compare to their pre test scores.
- c. To associate the level of knowledge with selected demographic variables among primigravida women regarding selected aspects of safe motherhood.

**HYPOTHESIS**

**H1:** There will be a significant increase in the level of knowledge on safe motherhood after administration of self instructional module among primigravida women.

**H2:** There will be a significant association between the pre-test knowledge score and selected demographic variables.

### CONCEPTUAL FRAMEWORK

The conceptual model selected for this study is based on Daniel.L.Stufflebeam's context, input, process and product evaluation model (CIPP). [ 13]

### SAMPLE:

In this study the samples used are the 50 primigravida women at selected hospitals, **Bangalore Karnataka**. The sampling technique used is Non-probability purposive sampling.

#### Inclusive criteria for sampling:

- Primigravidae
- Primigravidae who fulfils 36 weeks of gestational age
- Mothers who can understand kannad and English
- Mothers who were willing to participate in the study

#### Exclusive criteria for sampling:

- Primigravida who were having high risk pregnancy (eclampsia, preeclampsia, mothers who had previous abortion and mothers suffering with mental illness.
- Primigravida who were in the second stage of labour

### RESEARCH DESIGN:

The research design adopted for this study is pre experimental design, of which one group pre-test- post test design.

Group	Pre-test	Treatment	Post test
Primigravida	O1	X	O2

O1= Pre-test to assess the knowledge of primigravida on safe motherhood.

X= Administration of Self instructional module on safe motherhood to a group of primigravida women.

O2= Post test to assess knowledge of primigravida on safe motherhood.

### TOOL DESCRIPTION:

In this study structured knowledge questionnaire was developed by the researcher to find out the level of knowledge of primigravida women on safe motherhood. The researcher adopted the following steps prior to development of the tool which includes extensive review of

research studies conducted in relation to postnatal care and its components, review of non research literature on postnatal care and also in discussion with the experts.

A blue print for the knowledge questionnaire was developed with 30 items pertaining to three domains of learning and covered the selected components of postnatal care. The data collection instrument consists of following sections:

**Section A: Demographic profile:**

A semi structured questionnaire was prepared by the researcher to assess the demographic variables. It comprised of 7 items such as age, religion, type of family, education, occupation, number of elder females in the family, information regarding safe motherhood, sources of information to assess the background data which included personal profile of the primigravida women.

**Section B: Structured knowledge questionnaire:**

Question includes:

Part I. Intranatal care

Part II. Postnatal care

Part III. Newborn care

All the questions were multiple choice questions. Four options were given for the questions and out of which only one is the correct answer.

**Scoring techniques:**

For the Section A the scoring key was prepared by coding the demographic variables to assess the background of the samples and assessment of association by statistical analysis.

For the section B, there were multiple choice questions and for that only one correct answers. There was 30 questions and each correct answer carries one score and incorrect / unanswered questions carry score 0. The maximum score of knowledge score was 30 and minimum score was zero. The obtained score was graded as follows:

Inadequate	Score between 0-14	<50%
Moderately	Score between 15-22	50-75%
Adequate	Score between 23-30	>75%

**Preparation of self instructional module:**

The self instructional module developed was based on the topic of the study. The SIM consists of the components of safe motherhood like intranatal care, postnatal care and newborn care.

**Data Collection Process:**

Data collection process is the gathering of information to address a research problem. After a brief introduction about the research study and its objectives, an informed consent was taken from the samples. Confidentiality was assured to all the samples to get their cooperation and data was collected directly by the researcher. Demographic data and knowledge on selected aspects of safe motherhood using structured questionnaire was administered to the



primigravida women during their visit. Samples were given 20- 30 minutes to fill the questionnaire. After pre test investigator distributed the self instructional module on safe motherhood which includes the selected aspects of safe motherhood. On the seventh day when the same samples returned for antenatal check up, the investigator administered the post test to assess the effectiveness of self instructional module using the same structured knowledge questionnaire. The samples were very co-operative during the course of the study and there were no drop outs. The researcher expressed her sincere gratitude to the samples for their cooperation.

**Plan for data analysis:**

Analysis is the systematic organization and synthesis of research data and the testing of research hypothesis using that data.

**CONCLUSION:**

The present study shows that the most of the primigravida women had moderate knowledge. The difference between pre test and post test score revealed that self instructional module is very effective in improving knowledge of primigravida women. The pre test knowledge of safe motherhood is significantly associated with variables like education and occupational status of primigravida women, but there is no significant association between the pre test knowledge and age, family type, number of elder females in the family and age at marriage.

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