

CHAPTER - II

REVIEW OF LITERATURE

This chapter deals with the review of published and unpublished research studies and non-research literature related to the present study.

A review of related literature is an essential and important step for the scientific research projects. It helps the investigator to develop a deeper insight into the problem and gain intonation on what has been done before in the field and illuminates about the significance of the new studies.²⁴

According to Abdellah and Levine (1979),²⁴ "A review of literature provides basis for the investigations. It justifies the need for replication and throws light on the feasibility of the study, indicates constraints of data collection, and helps to relate the findings from one study to another".

Best (1986)²⁵ stated that "a review of literature helps the researcher in many ways. It helps him / her to assess what is already known, what is still unknown and untested justify the need for its replication, throw some light on the feasibility of the study and the problems that may be encountered by her. It also helps her to uncover promising methodological tools, which shed light on the ways to improve the efficiency of the data collection and obtaining useful information on how to increase the effectiveness of data analysis".

"A review of related literature is an essential aspect of scientific research. It broadens the understanding of the researcher and helps to gain an insight necessary for the development of a broad conceptual context into which the problem fits" as stated by Polit and Hungler (1999)³⁷

Literature review involves a systematic identification, location, scrutiny and summary of the written materials that contain information on a research problem. An attempt has been made by the investigator to follow these steps in the review of related research and non research literature to broaden the understanding and to gain an insight into the selected problem under study. Investigator has done manual as well as MEDLARS, PUBMED, DELNET search for the review of related literature. The purpose of this study was to examine the effect of video assisted childbirth education programme on knowledge, intra partum behaviour, maternal and fetal outcome among primigravida women.

This chapter integrates the related research and non-research literature into the following sections:

- 1. Literature related to childbirth education**
- 2. Literature related to the knowledge of pregnant women regarding labour and childbirth preparedness**
- 3. Literature related to prenatal care and variables that influence childbirth**
- 4. Literature related to the effectiveness of child birth education**
- 5. Literature related to the effectiveness of structured video assisted education/teaching programme**

1. LITERATURE RELATED TO CHILDBIRTH EDUCATION

Childbirth education prepares the mother and usually her partner for labor and birth. It may also include information on cesarean birth, breastfeeding, maternal postpartum issues, and neonatal care. Special classes may be available for adolescent

mothers, vaginal birth after cesarean birth, siblings, and grandparents. Classes may consist of lectures, slides, videos, demonstration, and practice.⁴⁰

Childbirth education has influenced the practice of obstetrics remarkably during the past 50 years. In the early 20th century, most women gave birth in the comfort and familiarity of their own homes, but there also were high rates of maternal and infant mortality. Advances in obstetric technology and maternal-fetal medicine shifted birth from the home to the hospital. The likelihood for medical intervention during pregnancy and childbirth has subsequently increased, requiring more consumer education and preparation. As perinatal morbidity and mortality have declined, the expectations for a perfect outcome have increased. Women have become more knowledgeable, self-confident, and participatory in their childbirth experiences, shifting the focus to more family-centered maternity care. Women began to question the safety and necessity of obstetric interventions, anesthetics and analgesics, and routine hospital procedures. Women currently are demanding more knowledge about, and control over, their childbirth experience. In addition, women are having fewer children and consequently are spending more time and effort in preparation for parenting through attendance at various childbirth education classes. Information about reproduction and birth formerly obtained through the extended family now is based on scientific study and is obtained through formal childbirth education programs.³⁹

In the 1930s, a British obstetrician, Dr. Grantley Dick-Read (find ref.), recognized the need to assist women through childbirth without the use of medication. He observed that women

who anticipated the pain of childbirth were more fearful. He surmised that their resulting tension interfered with the labour process and ultimately increased their pain. Dick-Read described his fear-tension-pain syndrome in his book, *Childbirth without Fear*, published in 1944. He strongly advocated education and emotional support to reduce fear and break the fear-tension-pain cycle. His teaching included total body relaxation, as well as female anatomy and physiology, nutrition, hygiene, and breathing techniques. Unfortunately, Dick-Read was sharply criticized by his colleagues for his lack of scientific evidence and the spiritual nature of his writings. However, his work had a significant impact on current childbirth practices because it was the beginning of a more humanistic approach to women during childbearing.⁴⁴

Childbirth education should be designed to assist expectant mothers and their families through pregnancy with preconception planning and continue in an organized fashion throughout pregnancy based on the physical and emotional changes occurring during each trimester. Accurate information concerning conception, nutrition, physiologic changes of pregnancy, labor and birth, and newborn care should be included. This information should be provided in the physician's office by written materials and through discussion during prenatal visits. Reinforcement and expansion of childbirth education also can be provided by the various classes available in the community.⁴⁵

Content of childbirth education classes:

The educational requirements for individual women clearly vary with their educational level and motivation for self-study.

The content of childbirth education should include minimum basic information, with additional information available through community programs or supplemental materials in the physician's office. An outline of the content follows. It is not intended to be all inclusive but serves as an example of information that would be included during the course of routine prenatal care.^{46,47,48}

Preconception

- Reproductive anatomy and physiology
- Nutritional evaluation and information
- Genetic risk evaluation and counselling
- Medical conditions: immunity status, medications, acute and chronic illness
- Risk factors associated with pregnancy risk: smoking, alcohol, recreational and over-the-counter drugs
- Environmental/work hazards
- Counselling regarding safe sex, pregnancy planning, spacing of children, and contraception

First Trimester

- Content and timing of prenatal visits
- Reproductive anatomy and physiology, calculation of estimated date of confinement
- Nutritional needs of pregnant women, vitamins, iron supplements
- Genetic counselling/referral
- Physiologic and psychological changes of pregnancy
- Body changes: breast growth, acne, weight gain

- Common discomforts: nausea/vomiting, fatigue, constipation, headache, indigestion, faintness
- Self-help remedies for discomforts
- Fetal growth and development
- Laboratory and ultrasound testing/screening: standard and optional testing, advantages and disadvantages
- Smoking, drugs, alcohol, caffeine and other food additives, avoidance of teratogens and infectious disease
- Pregnancy risks, Individual risk factors and management
- Travel guidelines
- Health habits: hygiene, exercise, Seat belt use, dental care, rest and sleep
- Sexual relations, safe sex
- Warning signs of the first trimester: bleeding, cramping, fever, severe vomiting

Second Trimester

- Physiologic and psychological changes
- Body changes: abdominal growth, striae gravidarum, chloasma
- Common discomforts: backache, constipation, hemorrhoids, indigestion, ligament pain, vaginal discharge
- Mood swings
- Self-help remedies for discomforts
- Fetal growth and development, quickening
- Laboratory and ultrasound testing and screening: standard and optional testing
- Weight gain
- Travel restrictions (if any)
- Sexual relations, safe sex

- Promotion of breast-feeding
- Warning signs of the second trimester: premature labor, vaginal bleeding, or fluid loss
- Introduction to outside resources
- Childbirth education classes
- Social services: Supplemental Food Program, housing support, financial support
- Substance abuse referral to treatment center
- Mental health treatment referral

Third Trimester

- Physiologic and psychological changes
- Body changes
- Common discomforts: constipation, shortness of breath, edema, heartburn, backache
- Fetal growth and development, tests for fetal wellness
- Ultrasonography
- Nonstress testing, contraction stress tests
- Fetal movement counts
- Laboratory and ultrasound testing: standard and optional testing
- Continuation of second-trimester instructions
- Signs of labor: contractions, rupture of membranes, bloody show
- Analgesia and anesthesia for labor and birth
- Discussion of birth plan: routine procedures for labor and birth
- Contacting the physician or midwife for labor, where to go
- Family roles and adjustment

- Warning signs of the third trimester: severe edema, headache, visual disturbances, abdominal pain, vaginal bleeding, premature labor, premature rupture of membranes

Postpartum

- Warning signs for immediate postpartum period
- Physiologic and psychological changes
- Body changes: weight loss, return of menses, resumption of intercourse
- Psychosocial adaptation to parenthood
- Family planning
- Child spacing
- Contraception
- Postpartum depression screening
- Nutrition, weight loss
- Health habits: hygiene, rest, exercise
- Health maintenance: breast self-examination, annual gynecological examination, immunizations
- Return to work

Method of Childbirth Education:

The Russians experimented with hypnosis in the early 1900s but with limited success. They then began to explore the application of Pavlovian principles of behavior modification to the childbirth experience. Negative and painful responses to childbirth stimuli were deconditioned and replaced with other responses, such as breathing techniques and attention focusing. Introduced as the psychoprophylactic method of childbirth by the Russian Velvovsky, it was observed by Dr. Fernand Lamaze, a French obstetrician visiting the Soviet Union for a professional

conference in 1951. Lamaze returned to France and adapted the psycho prophylactic method for use in his clinic, the Maternité.T de Metallurgiste. In his book, Painless Childbirth, Lamaze introduced a method that included teaching female anatomy, physiology of pregnancy, labour and birth, breathing techniques, and other exercises. Psychoprophylaxis as a method for childbirth spread rapidly throughout Europe and China and was introduced to the United States through the efforts of Karmel and Bing and referred to as the Lamaze Method. A few years later, the American Society for Psychoprophylaxis was founded. This organization set up official teacher training programs for the psychoprophylactic method. Classes include reproductive anatomy and physiology, nutrition, the process of labour and birth, anesthesia and analgesia, and cesarean birth.^{49,50,51} The philosophy of Lamaze International includes:

- Birth is normal, natural and healthy.
- The experience of birth profoundly affects women and their families.
- Women's inner wisdom guides them through birth.
- Women's confidence and ability to give birth is either enhanced or diminished by the care provider and place of birth.
- Women have the right to give birth free from routine medical interventions.
- Birth can safely take place in homes, birth centers and hospitals.
- Childbirth education empowers women to make informed choices in health care, to assume responsibility for their health and to trust their inner wisdom.

Another method of childbirth originated in the late 1940s, conceived by an American obstetrician, Dr. Robert Bradley. The Bradley Method was based on his observations of the natural instinctual behaviour of all mammals bearing their young and emphasizes a truly natural childbirth. Use of analgesia or anesthesia is strongly opposed, as is most routine obstetric interventions, such as intravenous fluids, continuous electronic monitoring, amniotomy, and episiotomy. Deep relaxation and a natural diaphragmatic breathing are taught for coping with labour, as well as female anatomy and physiology, exercise, nutrition, process of labour and birth, breast-feeding, and child care. Instructors are trained and certified by the American Academy of Husband-Coached Childbirth. Couples are usually extremely well prepared for the birth, understanding and anticipating common variations of labour and possible management. A birth plan is designed and presented to the physician or midwife weeks before the birth so that any conflicts can be worked through. Although some professionals find the Bradley method antagonistic to the medical profession, it is well known for its very consumer-oriented classes.³⁹

Educational activities aimed at preparing women for labor by providing information and practising physical exercise, breathing and relaxation techniques promote women's self-control and may contribute for a satisfactory birthing experience. However, it has been reported that a large amount of information given over a short period of time may be ineffective; and that the lack of opportunities to discuss the information transmitted and to practise pain relief techniques may hamper the benefits of antenatal education. There is evidence of the need to reinforce the information during labor to ensure a better effect, since the stress generated during labor and delivery may

influence a woman's memory, compromising the information received during pregnancy. Women's ability to maintain self control during labour has been seen as fundamental for a good birthing experience. Participation in antenatal education activities is associated with women having more realistic expectations and consequently more positive experiences of labour.⁷⁴

A study conducted by MARY L. NOLAN in 2009 on Information giving and education in pregnancy: a review of qualitative studies, where findings confirm women's preference for a small-group learning environment in which they can talk to each other as well as the educator and can relate information to their individual circumstances.⁴²

Childbirth education was an important social movement in the 20th century but has lost its way in recent years. We describe the reasons for the dwindling importance of childbirth education and offer a proposal for reform that will align childbirth education with the needs of today's birthing mothers. Our plan will create "Centers for the Childbearing Year" (CCBYs) and a new model of childbirth educator, which we call the "birth coach." The CCBY is the place for women to go to for information and support related to fertility, pregnancy, childbirth, and newborn care; the birth coach combines the role of childbirth educator, doula, and postpartum caregiver. In creating a fresh model of childbirth education, we not only honor our pioneers but also rediscover the wisdom in community and relationship that childbirth offers us, and we learn in new ways to journey alongside each other to create new possibilities for birthing families.⁷⁷

Prenatal education classes in British Columbia, Canada, are offered by health-care professionals and childbirth educators. Classes differ in length, content, and affiliations. Some are associated with particular hospitals, and others are offered through community-based organizations. For example, BC Women's Hospital in British Columbia has the largest volume of births in the province and offers two types of prenatal classes: a 1-day intensive (7 hr) course or a 6-week course (16 hr of instruction). Both formats include education about psychological and physical changes associated with late pregnancy, how to know when labor has started, events in labor and birth and their variations, characteristics of the newborn in the first hours, breastfeeding promotion, a tour of the maternity ward, and an optional 2-hr breastfeeding class.⁷⁹

In a representative survey ($n = 1,573$) of American women aged 18-45 years old who gave birth to a singleton in a hospital in 2005, 25% of respondents (56% of nulliparas and 9% of multiparas) reported taking childbirth education classes. Locations of classes varied, but 87% of women attended classes in a clinical setting (hospitals and clinics). When the American women in this survey were asked why they attended childbirth education classes, 82% reported that they wanted to learn about labor and birth, and 37% specifically indicated they were interested in achieving a natural labor and birth. In relation to the impact of their childbirth education classes, 88% of the women indicated they had become more aware of maternity care options after taking classes, 78% felt more confident in their ability to give birth, and 70% described better communication with their maternity care providers. The women in the survey reported greater trust in their hospitals (60%) and care

providers (54%) and less fear about medical interventions (58%) after attending childbirth education classes.⁸¹

Information is still scarce on the birthing experience of women who participate in antenatal systematic education programs. The objective of the study was to report the experience of labor as described by nulliparous women who participated and who did not in a systematic Birth Preparation Program (BPP). A qualitative study was conducted with eleven women who participated in a BPP and ten women attending routine prenatal care selected through purposeful sampling. The BPP consisted of systematized antenatal group meetings structured to provide physical exercise and information on pain prevention during pregnancy, the role of the pelvic floor muscles, the physiology of labor, and pain relief techniques. A single, semi-structured interview was conducted with each participant. All interviews were recorded, transcribed verbatim and thematic analyses performed. The relevant themes were organized in the following categories of analysis: control of labor, positions adopted during labor, and satisfaction with labor. Women who participated in the systematic educational activities of the BPP reported they maintained self-control during labor and used breathing exercises, exercises on the ball, massage, baths and vertical positions to control pain. Also they reported satisfaction with their birthing experience. Women who did not participate in systematic educational activities referred to difficulties in maintaining control during labor and almost half of them reported lack of control. Also they were more likely to report dissatisfaction with labor.⁸⁷

2. LITERATURE RELATED TO THE KNOWLEDGE OF PREGNANT WOMEN REGARDING LABOUR AND CHILDBIRTH PREPAREDNESS

A survey was conducted in a teaching hospital, New Delhi, to know the views of women in labour on awareness, information and care during their labour. One hundred women including 43 primigravidae and 57 multigravidae were included in this study. Results showed that a total of 36 were not aware of the events of labour and none had any knowledge of pain relief in labour and overall 59% found labour room to be unsatisfactory.⁶⁹

A retrospective, descriptive survey done by Sylvia T Brown, et al examined which non-pharmacologic pain-relief techniques are used most often by labouring women and the effectiveness of the chosen techniques. Of the 10 non pharmacological strategies rated by the sample (N=46), breathing techniques, relaxation, acupuncture, and massage were found to be the most effective. However, no specific technique or techniques were helpful for all participants. The results provide directions for childbirth educators in designing and implementing an effective childbirth education curriculum that assists women to have empowered birth experiences.^[46]

Childbirth information received by mothers during antenatal period influences their satisfaction with the care during perinatal period. It is important for the midwives to know the type of information that satisfies their clients. This study found that the childbirth information that mothers received during antenatal period did not satisfy them. On the other hand, although some of the information received at home was useful, some information had potential to cause fear, anxiety and ill health on the mothers. The

information needs of the clients were taken into account when designing a childbirth program for Malawi. The specific objective of the study was to identify childbirth information needs of Malawian women as perceived by Malawian mothers and midwives in order to design a childbirth education program. An exploratory, descriptive qualitative design was used to determine Malawian women's childbirth information needs. A total of 150 first time mothers who attended antenatal clinics at selected central, district and mission hospitals were interviewed. Four focus group discussions were conducted with four different types of midwives to identify their perceptions of the childbirth information needs of Malawian women. These discussions were complimented by individual interviews with experienced midwives who held key positions in government and non - governmental health organizations. The content of the childbirth education program for pregnant mothers should include; care during pregnancy, danger signs during pregnancy, labour and after birth, the labour process and the postnatal care for the mother and the baby. Regarding cultural beliefs and taboos of childbirth, it was recommended that they should not be presented as a stand alone topic but be incorporated in other topics such as self care. Cultural beliefs and taboos vary with regions and tribes hence rather than generalizing, midwives should address specific issues prevalent in their work areas. The training manual should be translated into the vernacular language in view of the high illiteracy rate in the country. The education program should address self-care during pregnancy, nutrition during pregnancy, common discomforts of pregnancy, danger signs of pregnancy, sexually transmitted diseases and preparation for delivery. The program should also address the labour process, possible complications during labour and birth, caesarean birth and non pharmaceutical

pain relief measures in labour. It was also evident that the program should deal with self-care during postnatal period, exclusive breast feeding, care of the newborn baby, danger signs of puerperium, care of the newborn baby and family planning.⁷⁵

The possible influence of the expectant mother's knowledge of childbirth on the outcome and experience of pregnancy and labour was investigated by means of a postpartum questionnaire in 1238 primiparae. The mothers were divided into two groups according to their basic childbirth knowledge. At birth, the conditions of newborns were equal in both groups when judged by Apgar scores. The low knowledge level group had small-for-gestational-age babies more frequently and these babies were also treated in the paediatric ward more frequently than those in the high knowledge group. The latter group was significantly more critical towards the staff of the delivery room and the postnatal ward; the fathers of this group were also present at delivery significantly more frequently. The low knowledge level group was significantly more unwilling to have another pregnancy in the near future or ever. The results indicate that low childbirth knowledge is associated with a poorer pregnancy outcome. It is a message to antenatal care staff of the need for support, supplementary education and careful obstetric surveillance. Low childbirth knowledge may imply a set of problems, including those in inter-parental relationship, socio-economic situation and need for close surveillance and improved education.⁷⁶

The aim of this study was to describe pregnant Finnish women's perceptions of a good childbirth. Data were collected through semi structured interviews in maternity health care

clinics and maternity hospitals. Data interpretation was based on content analysis. A purposive sample of 24 pregnant women aged 19 to 45, half of them expecting their first child, were interviewed. Five main issues were seen by informants as important in the course of childbirth: 1) unhurried atmosphere, 2) normality, 3) reasonable duration of labour, 4) security, and 5) control. Participants did not expect much from their birth companions, although some mentioned various tasks for them. The three main issues considered important for the role of staff were the professionals' 1) personal characteristics, 2) attitudes toward the childbearing woman, and 3) way they acted. The question about the physical environment was found quite irrelevant by some women, and only a few had special wishes related to the birthing environment. None of the participants voiced opposition to obstetric interventions, but some were willing to avoid them if possible. Informed consent for interventions was seen as very important. These results suggest that health care providers are challenged to provide individualized education and care regarding labour and childbirth for every woman.⁸²

To investigate first-time mothers' views about antenatal childbirth and parenthood education and their contact with other class participants after birth, and to compare participants and non-participants with respect to the use of pain relief, experience of pain, mode of delivery, childbirth overall, duration of breastfeeding, and assessment of parental skills. A national cohort of 1197 Swedish-speaking women completed three questionnaires: during early pregnancy, 2 months, and 1 year after giving birth. Seventy-four percent of first-time mothers stated that antenatal education helped prepare them for childbirth, and 40% for early parenthood. One year after giving birth, 58% of the mothers had met with other

class participants. These outcomes were associated with the number of class sessions. When controlling for the selection of women into participants and non-participants, no statistical differences were found concerning memory of labour pain, mode of delivery, overall birth experience, duration of breastfeeding, and assessment of parental skills. Mothers who were young, single, with low level of education, living in a small city, and smokers were less likely to find the classes helpful. Participation in childbirth and parenthood education classes did seem to affect first-time mothers' experience of childbirth and assessment of parental skills, but expanded their social network of new parents. The higher epidural rate suggests that participation in classes made women more aware of pain relief techniques available, rather than improving their own coping with pain. More research should focus on current forms of antenatal education, with special focus on women of low socioeconomic status.⁹¹

3. LITERATURE RELATED TO THE PRENATAL CARE AND VARIABLES THAT INFLUENCE CHILDBIRTH

There is a general consensus regarding the value of prenatal care and its impact on the mother, the growing fetus and childbirth. Supporting this is available, ample of text and research literature. However, the approach to prenatal care and childbirth varies depending upon the policies of the health care delivery system. In India the consistent message relayed by health care providers is that, early and adequate prenatal care is of vital importance to both mother and baby. Seemingly, health indices and research studies done among women across the nation and world are sluggishly responding to this message.

The WHO indicators derived from a survey in 2005/06 showed that approximately 76% of women who gave at least a live birth

received ANC, and 74% did so from a skilled provider. Also women's wealth status is one of the determinants of receiving skilled care. ^[19,20,21]

Supporting this data, In a prospective longitudinal study conducted by Khatib N and et al in central Maharashtra among 274 pregnant women to study the predictors for antenatal services and pregnancy outcome in a rural area in Wardha district, Maharashtra state showed that the antenatal services, in spite of being essential to the care of pregnant women, are being poorly delivered. It revealed that mean age at marriage was 19.8 ± 3.6 years and average age at 1st pregnancy was 21.6 ± 4.5 years. Of the 274, 156 women were pregnant for the first time. The author had also recommended that antenatal care services need to be delivered more practically, as it is the single most important intervention that can reduce the maternal and infant morbidity and mortality in developing countries. ^[17]

C. S. Metgud et al conducted a longitudinal study for one year in a rural village population. Among all the pregnant women during the study period to know the profile of antenatal care received and the factors influencing the utilization Patterns of Antenatal Services among 130 pregnant women in Rural Area of North Karnataka. The study concluded early and wide spread use of antenatal care, but it also revealed that the antenatal visits occur late in the pregnancy. Few women did not take ANC care reasoning that preparation is a natural phenomenon which didn't need any special care. The impression about ANC provider, from this study, is that care from private sources is considered far superior to that from government services. It was also seen that the literacy of women had a significant bearing on utilization of antenatal care by the pregnant women. ^[52]

A cross sectional study done by R. R. Venkatesh et al to assess the factors influencing the extent of utilisation of health services in the antenatal, intra natal and postnatal period on 510 PNC mothers in 27 urban slums of Davangere city showed that educated mothers had better awareness of health promotion, and availability of existing health services lead to its better utilization. A significant difference was found in level of utilization of ANC services by housewives compared to working women. The research also observed that there are socio- cultural and behavioural barriers like female literacy, occupation, poverty, low status of women, parity, age of the women, and type of family, which has influenced the utilization of the same by the expectant mothers. It was seen that utilization of services by woman in joint families could be attributed to increased awareness created, the concern and support showed by other members in the family and also their affordability to avail the services because there is no economic pressure on them as seen contrary to women from nuclear families. It was also observed that the awareness and the benefit of these services are yet to be understood by the maternal community. ^[53]

A cross-sectional survey conducted in 2005 by Nomita Chandhiok et al to analyze the possible factors contributing to women obtaining antenatal care services and to determine whether these services influence their decision regarding the place of delivery, among 7005 pregnant women, carried out in the sampled areas of 28 districts in 14 states of India concluded that there is a need for improving community awareness on maternal health and childbirth preparedness for motivating women to utilize maternal care services. ^[54]

Wanda K. Nicholson et al conducted a cross-sectional survey of 102 African- American women in 2003 at a University

affiliated urban health centre, to ascertain the priority of prenatal support services from the perspective of patients, their relationship between patients' needs, and both knowledge of and intent to use services, and to assess factors associated with the intent to use available support services. The study revealed that psychosocial or personal factors in addition to knowledge effect urban women's decisions to use prenatal support services. Only a small portion of women were previously aware of health education sources of information. The relation between need for information on other clinical services at the centre and intent to use health educational services reflect the role of women in health education decision making. The authors concluded that Physicians should ensure prenatal patients' knowledge of support services at healthcare centers. ^[55]

A descriptive study done on 30 primigravida by Ibach et al in Cape Town of South Africa explored previous painful experiences, knowledge of labour, expectation and attitudes towards labour pains and knowledge of analgesia. The study revealed that the patients were poorly informed about the process and pain of labour, most of them had no concept of the severity/duration of the pain and knew very little concerning methods available for pain relief in labour. It concluded that primigravida woman at Cape Town were poorly prepared for the experience of delivery and recommended patients centered ANC education with regard to expectation of comfort and involvement in labour. ^[9]

In a retrospective, descriptive, qualitative analysis done on the basis of data collected by the IIPS 1998-99 and NFHS-3 2000, the researcher had studied determinants of RCH services in 32393 birth data 3 years preceding the survey, the study revealed that socio-economic status, education, urban residence,

age, parity and religion are the determinants of availing of delivery care services.^[56]

A cross sectional descriptive study conducted in rural population of Rewa district on 2022 respondents which included pregnant and recently delivered women showed that there is lack of specialist manpower in CHCs for the provision of CEMOC services in all the 9 CHCs. Knowledge and competency for diagnosis and management of complication was not up to the set bench mark in health care providers. Birth preparedness index was found to be 47.5. BP/CR index was significantly high in APL families, high educational level and in-service business group.^[18]

A descriptive cross sectional study done to evaluate Birth Preparedness and Complication Readiness (BP & CR) among ANC client done in 394 ANC women attending Keyatta National Hospital, Nairobi in 2006 concluded that education and counselling on different aspects of birth preparedness was not given to all respondents. The respondents' knowledge of danger signs was low and many did not know about birth preparedness. A large proportion of clients were not prepared for obstetric emergencies.^[16]

In the NFHS survey analysis conducted in 4 states to study the role of existing ANC services in promoting institutional deliveries, the researchers found that the mothers who receive ANC check up once have more chances of giving birth in a medical institution than one who did not receive any ANC care. Among other predictor variables, the mothers' education, age have a positive effect on odds of institutional delivery but child's birth order has a negative effort. Chances of institutional delivery are higher for mothers who are regularly exposed to electronic mass media and mothers in high household standard of living.^[57]

The latest data from DHS 2008 reveals that women at poorest situation had approximately 5 times less access to skilled care compared to their richest counterparts. By women's wealth quintile a 1.9 fold difference was found in the perinatal mortality rate between women in the richest and the poorest socio-economic groups. At national level the latest survey indicated that approx. 4% women aged 15-19 years were reported to be currently pregnant with their first child. By age highest rate of teenage pregnancy was found in the age group of 18-19 years. [58]

A six months survey done to find out the difference contributed by ANC services to safe deliveries in 336 poor-middle income households in urban Varanasi concluded that the ANC services need to be placed with in a context acceptable to women and their families. It also recommends that further research should be undertaken to include and assessment of aspects of ANC care, knowledge regarding labour and birth preparedness which are usually ignored in both research and practice, such as patient education. [59]

A randomized single group pre and post test trial done on 100 women at an Iranian social security hospital to study the uptakes and evidence based practices in the improvement of quality of maternity care, showed that translation of appropriate evidence into practice appears to have had an important and positive impact on maternity care. The authors state that this study may also provide food for thought for health care policy makers and care providers who are looking for better strategies to bring about evidence based patient centered care. [60]

It is inferred from the above data that optimum antenatal care and prenatal services have a direct relationship with the age, socio economic strata, education and area of residence viz

rural/ urban. It deductive from the literature that private hospitals render better prenatal support services and there is lack of patient centered care in evidence based practice especially in the area of patient education.

4. LITERATURE RELATED TO THE EFFECTIVENESS OF CHILD BIRTH EDUCATION

A study done by Malata, Ellen Chirwa (2011) on Assessment of the effectiveness of childbirth education in Malawi where a sequential quasi-experimental design was used to assess the structured childbirth education programme that was subsequently launched. Healthy pregnant women of at least 30 weeks gestation were recruited and the final sample sizes were 104 and 105 for the control and intervention groups. The control group attended the normal antenatal clinic and the intervention group enrolled in a childbirth education programme in addition to the antenatal clinic education. Using a semi-structured questionnaire, the mean pre-test and post-test scores for the control group across the three domains were not significantly different from each other ($P>0.05$). For the intervention group there were significant differences ($P<0.05$) in the mean pre-test and post-test scores across the three domains. The results show that the childbirth education programme imparted knowledge to the intervention group who received more effective childbirth education.⁷⁰

In September 2009 Study conducted on Evaluation of the effect of childbirth education class: a mixed-method study where the researchers choose the random sample of 40 Chinese women was invited to complete a questionnaire after attending a childbirth education class. The questionnaire was focused on their satisfaction with specific aspects of the class.

Descriptive statistics were performed to summarize participants' response. In Phase Two, six of the original 40 women were purposively selected for a semi-structured interview pertaining to the perceived effect of the childbirth education class on their labour experience. Thematic analysis was conducted on the interview data. The participants expressed overall satisfaction with the class. The area that satisfied them the most was the performance of the midwife. The areas that satisfied them the least were the date, length, size and time of the class. Three themes emerged from the interview data, namely, 'learning about labour', 'contributing to a smooth labour process' and 'coping with uncertainty and handling anxiety. This study supports using a mixed-method approach to evaluate client education activity, and highlights the importance of cultivating positive coping measures among the Chinese women after attending childbirth education class when facing childbirth-related anxiety.⁷¹

In September 1995 a study on Do Childbirth Classes Influence Decision Making about Labor and Postpartum Issues investigated the role of childbirth education for women attending the Royal Women's Hospital Family Birth Center, Melbourne, Australia, in relation to making decisions about breastfeeding, pain medication, and length of hospital stay. Fifty-nine primiparous women completed a questionnaire after delivery about the influence of childbirth education classes on their decisions during pregnancy, birth, and the postnatal period. The results indicated that although the women enjoyed childbirth education classes, the information they received had minimal effect on their decision to breastfeed and the appropriateness of a 24-hour stay. Information gained about

the use of pain medication in labor was clearly helpful when women made decisions about pain relief. Educational strategies have failed to address the tendency of nulliparous women to postpone making decisions about the postnatal period such as early discharge, and further investigation on this aspect of a childbirth education program is suggested.⁷³

The objective of this study was to examine the associations between attendance at childbirth education classes and maternal characteristics (age, income, educational level, single parent status), maternal psychological states (fear of birth, anxiety), rates of obstetric interventions, and breastfeeding initiation. Between women's 35th and 39th weeks of gestation, we collected survey data about their childbirth fear, anxiety, attendance at childbirth education classes, choice of health-care provider, and expectations for interventions; we then linked women's responses ($n = 624$) to their intrapartum records obtained through Perinatal Services British Columbia. Older, more educated, and nulliparous women were more likely to attend childbirth education classes than younger, less educated, and multiparous women. Attending prenatal education classes was associated with higher rates of vaginal births among women in the study sample. Rates of labor induction and augmentation and use of epidural anesthesia were not significantly associated with attendance at childbirth education classes. Future studies might explore the effect of specialized education programs on rates of interventions during labor and mode of birth.⁷⁸

Benefits of prenatal education classes have included increased confidence for labor and birth among women who attended prenatal classes, higher likelihood of breastfeeding, improved communication between childbearing women and their

maternity care providers, decreased need for analgesic medication in labor, and increased satisfaction with birth. In a large representative survey of childbearing women in Canada ($n = 6,421$), about one third (32.7%, 95% confidence interval [CI]: 31.7–33.7) of women reported attending childbirth education classes. Nulliparas attended classes more frequently (65.6%) than multiparas (6.0%). Women between the ages of 15 and 19 years old were more likely to attend classes compared to all other age groups. Women with low incomes were significantly less likely to attend classes, compared with women with a family income above the low-income cutoff. Of the women who attended childbirth education classes, 35% attended classes at a hospital, 25% at a health clinic, 21% at a community center, 12% in private settings, and 6% at unspecified locations.⁸⁰

Lawrence Z Freedman et al. investigated the variations in remembrance of the physiological events and affective responses related to childbirth. The mothers were assisted in using abdominal breathing and other techniques for relaxation, and not infrequently performing such services as back massage. During the second stage, she was encouraged to change position, to control her breathing and to exert muscular effort. The study showed that objective factors were remembered better than those with a high subjective affective component. The mother tended to rate herself as having suffered somewhat less anxiety and discomfort & as having offered more cooperation than the staff had observed. [62]

For first-time mothers, the fear of the unknown (i.e., pain of delivery) can be especially intense. More recent evidences have indicated the use of alternative pain management methods such as meditation, yoga, mental healing and visual imagery are on the rise among pregnant women. Specifically, acupuncture,

hypnosis and massage have been documented as successful methods of reducing childbirth pain among women abroad. Literature from abroad suggests that it helps enormously if women know what to expect and understand what occurs during labour and delivery. This reduces the anxiety and pain and enables mothers to participate in the decisions made during labour. ^[63]

In a retrospective survey done by Gagnon AJ, and Sandall J, to assess the effects of antenatal education for childbirth or parenthood, or both, on knowledge acquisition, anxiety, sense of control, pain, labour and birth support, breastfeeding, infant-care abilities, and psychological and social adjustment. The result showed that the effects of general antenatal education for childbirth or parenthood, or both, remain largely significant. It was noticed that Individualized prenatal education directed toward child birth and child care had significantly reduce duration of labour and use of pain relieving drugs ^[64]

Skilled care during and immediately after delivery has been identified as one of the key strategies in reducing maternal mortality. However, recent estimates show that the status of skilled care during delivery remained very low in Ethiopia. Birth preparedness and complication readiness has been implemented as comprehensive strategy to fill this gap. However, its effectiveness in improving skilled care use hasn't been well studied. The objective of this study was to determine the effect of birth preparedness and complication readiness on skilled care use in Southwest Ethiopia. A prospective follow-up study was conducted from September 2012-April 2013 in Southwest Ethiopia among randomly selected 3472 mothers. Data were collected by using pre-tested interviewer administered questionnaires and analyzed by using SPSS for windows V.20.0 and STATA 13. Mixed-effects multilevel logistic regression model was used to look at

the relation between birth preparedness and complication readiness plan and skilled care use and identify other determinant factors. The status of skilled care use was 17.5% (95% CI: 16.2%, 18.8%). Factors affecting skilled care use existed both at the community as well as individual levels. Planning to use skilled care during pregnancy was found to increase actual use significantly (OR=2.24; 95%CI: 1.60, 3.15). Place of residence, access to basic emergency obstetric care, maternal education, husband's occupation, wealth quintiles, number of pregnancy, inter-birth interval, knowledge of key danger signs during labour and ANC use were identified as factors affecting skilled care use. The status of skilled care use was found to be low in the study area. Birth preparedness and complication readiness had significant effect on skilled care use. Socio-demographic, economic, access to health facility, maternal obstetric factors and antenatal care were identified as determinant factors for skilled care use. Designing appropriate interventions to improve information, education and communication, antenatal care use, family planning and knowledge of key danger signs are recommended.⁸³

A systematic review conducted by Lally JE, Murtagh MJ, Macphail S and Thomson R using various research databases, examined experience and expectations of pain, and its relief in labour, Appraisal revealed four key themes: the level and type of pain, pain relief, involvement in decision-making and control. Studies predominantly showed that women underestimated the pain they would experience and hope for a labour free of pain relief. Women expected to take control in labour in a number of ways, but their degree of reported control was less than hoped for. Women may have ideal hopes of what they would like to happen with respect to pain relief, control and engagement in decision-making, but experience is often very

different from expectations. Antenatal educators need to ensure that pregnant women are appropriately prepared for what might actually happen to limit this expectation- experience gap and potentially support greater satisfaction with labour. [65]

A non randomized control trial conducted for 8 months to determine the effect of breathing techniques and nurse-administered massage on the pain perception of pregnant Turkish woman during labour. Study results demonstrated that nursing support and patient-directed education concerning labour and non-pharmacological pain control methods (e.g., breathing and cutaneous stimulation techniques) were effective in reducing the perception of pain by pregnant women (when provided in the latent labour phase before delivery), leading to a more satisfactory birth experience and labour outcomes. [66]

A national survey was conducted in 1583 mothers in US who have given birth to single babies to study the mother's perceptions of their child bearing experiences information about maternity preparation and outcome to understand the dimensions of experience of child bearing in the US. It is seen that women used a variety of drug-free methods to increase comfort and relieve pain. 88% used at least 1 non- pharmacologic method of pain relief. 61% used breathing technique, 60% used positioning and movements, 32% used massage, effleurage and 30% used mental strength such as relaxation and visualizations. [67]

A randomised controlled trial conducted to study the effect of deep breathing and relaxation exercises on behavioural outcome of 20 primigravida mothers in a selected tertiary level hospital of Pune revealed that the prenatal teaching regarding breathing exercises was very effective during labour to cope with the pain and thus there is improvement in the labour outcomes. [68]

Maternal mortality is a global burden, with more than 500,000 women dying each year due to pregnancy and childbirth-related complications. Birth-preparedness and complication readiness is a comprehensive strategy to improve the use of skilled providers at birth, the key intervention to decrease maternal mortality. Birth-preparedness and complication readiness include many elements, including: (a) knowledge of danger signs; (b) plan for where to give birth; (c) plan for a birth attendant; (d) plan for transportation; and (e) plan for saving money. The 2003 Burkina Faso Demographic and Health Survey indicated that only 38.5% of women gave birth with the assistance of a skilled provider. The Maternal and Neonatal Health Program of JHPIEGO implemented a district-based model service-delivery system in Koupéla, Burkina Faso, during 2001-2004, to increase the use of skilled providers during pregnancy and childbirth. In 2004, a cross-sectional survey with a random sample of respondents was conducted to measure the impact of birth-preparedness and complication readiness on the use of skilled providers at birth. Of the 180 women who had given birth within 12 months of the survey, 46.1% had a plan for transportation, and 83.3% had a plan to save money. Women with these plans were more likely to give birth with the assistance of a skilled provider ($p=0.07$ and $p=0.03$ respectively). Controlling for education, parity, average distance to health facility, and the number of antenatal care visits, planning to save money was associated with giving birth with the assistance of a skilled provider ($p=0.05$). Qualitative interviews with women who had given birth within 12 months of the survey ($n=30$) support these findings. Most women saved money for delivery, but had less concrete plans for transportation. These findings highlight how birth-preparedness and complication readiness may

be useful in increasing the intra-partum coping behaviour and thus improving maternal outcome.⁸⁴

Birth preparedness is a comprehensive strategy to improve the use of skilled providers at birth and the key intervention to decrease maternal mortality. Birth preparedness and complication readiness (BP/CR) is the process of planning for normal birth and anticipating actions needed in case of emergency. It encourages women, households, and communities to make arrangements such as identifying or establishing available transport, setting aside money to pay for service fees and transport, and identifying blood donor in order to facilitate swift decision-making and reduce delays in reaching care once a problem arises. Responsibilities for BP/CR must be shared among all safe motherhood stakeholders, since coordinated effort is needed to reduce the delays that contribute to maternal and newborn deaths.⁸⁵

The birth-preparedness package (BPP) promotes active preparation and decision-making for births, including pregnancy/postpartum periods, by pregnant women and their families. This paper describes a district-wide field trial of the BPP implemented through the government health system in Siraha, Nepal, during 2003-2004. The aim of the field trial was to determine the effectiveness of the BPP to positively influence planning for births, household-level behaviours that affect the health of pregnant and postpartum women and their newborns, and their use of selected health services for maternal and newborn care. Community health workers promoted desired behaviours through inter-personal counselling with individuals and groups. Content of messages included maternal and newborn-danger signs and encouraged the use of healthcare services and

preparation for emergencies. Thirty-cluster baseline and endline household surveys of mothers of infants aged less than one year were used for estimating the change in key outcome indicators. Fifty-four percent of respondents (n=162) were directly exposed to BPP materials while pregnant. A composite index of seven indicators that measure knowledge of respondents, use of health services, and preparation for emergencies increased from 33% at baseline to 54% at endline (p=0.001). Five key newborn practices increased by 19 to 29 percentage points from baseline to endline (p values ranged from 0.000 to 0.06). Certain key maternal health indicators, such as skilled birth attendance and use of emergency obstetric care, did not change. The BPP can positively influence knowledge and intermediate health outcomes, such as household practices and use of some health services. The BPP can be implemented at any health care delivery area and should be an integrated part of safe motherhood programme.⁸⁶

Globally, an estimated 287 000 maternal deaths occurred in 2010 annually as a result of complications of pregnancy and childbirth. Sub-Saharan Africa and Southern Asia were accounted for 85% of the global burden (245 000 maternal deaths) including Ethiopia. Obstetric related complications cannot be reliably predicted. Hence, insignificant decline of maternal mortality ratio might be due to the non use of birth preparedness and complication readiness strategies. Therefore, this paper aimed to assess knowledge and practices towards birth preparedness and complication readiness and associated factors among women of reproductive age group (15-49) in Robe Woreda, Arsi Zone, Oromia Region, Ethiopia. Community-based cross-sectional study supplemented by qualitative design was conducted in January, 2012. A total of 575 women from 5 kebeles were selected after proportionally allocated to population size and interviewed

using structured and semi-structured, pre-tested questionnaires. Univariate and bivariate analysis was performed. Multiple logistic regression analysis was also done to control for possible confounding variables. Taking into account place of delivery identification, means of transportation, skilled attendant identification and saving money, about 16.5% of the respondents were prepared for birth and its complications. Preparation for birth and its complication was higher among educated mothers (AOR=6.23, 95% CI=1.5, 25.87). Monthly income of >716 Ethiopian birr (AOR=1.94, 95% CI=1.01, 3.87), ANC visit (AOR=5.68, 95% CI=1.27, 25.4), knowledge of obstetric complications (AOR=2.94, 95% CI=1.61, 5.37) and those who had given birth at health facility before their last delivery (AOR=3.9, 95% CI=2.04, 7.46) were also significantly associated with birth preparedness and complication readiness. The study identified very low magnitude of birth preparedness and complication readiness in the study area and poor knowledge and practices of preparation for birth and its complication. Community education about preparation for birth and its complication and empowerment of women through expansion of educational opportunities are important steps in improving birth preparedness. In all health facilities during antenatal care emphasis should given to preparation for birth and its complication and provide information and education to all pregnant women.⁸⁸

To undertake a structured review of the literature to determine the effect of antenatal education on labour and birth, particularly normal birth. Ovid Medline, CINAHL, Cochrane and Web of Knowledge databases were searched to identify research articles published in English from 2000 to 2012, using specified search terms in a variety of combinations. All articles included

in this structured review were assessed using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). The labour and birthing effects on women attending antenatal education may include less false labour admissions, more partner involvement, less anxiety but more labour interventions. This literature review has identified that antenatal education may have some positive effects on women's labour and birth including less false labour admissions, less anxiety and more partner involvement. There may also be some negative effects. Several studies found increased labour and birth interventions such as induction of labour and epidural use. There is contradictory evidence on the effect of antenatal education on mode of birth. More research is required to explore the impact of antenatal education on women's birthing outcomes.⁸⁹

This paper is a report of a study to develop and evaluate a childbirth educational programme for Malawian women. Providing parent education is integral to the midwife's role. Malawian midwives face a challenge in fulfilling this role, with no existing childbirth education programme to facilitate this process. A mixed method approach was used for this three-phase study. In Phase 1, childbirth information needs of Malawian women were determined from literature and interviews with midwives. In Phase 2, a structured childbirth education programme was developed. In Phase 3, a quasi-experimental design using sequential sampling was conducted to evaluate the education programme. Participants were pregnant women who attended antenatal clinics in 2002, with 104 in the control group and 105 in the intervention group. Changes in childbirth knowledge were determined over a 6-week period. The childbirth education programme included information, teaching

strategies and a schedule for implementation for content relevant to the antenatal, labour and birth and postnatal time periods. Results revealed no significant difference in knowledge in the control group between pre-test and post-test scores. For the intervention group, however, an overall significant increase in knowledge across all time periods was demonstrated ($P < 0.01$). A childbirth education programme, developed for the Malawian context, was associated with important increases in maternal knowledge about antenatal, labour and birth and postnatal topics. The findings have implications for midwives in other developing countries and offer an example of a midwifery-led initiative to provide formal childbirth education to these vulnerable women.⁹⁰

A quasi-experimental study was conducted to determine the effectiveness of childbirth preparation class in terms of behavioural responses during first stage of labour and outcome of labour in terms of maternal and neonatal outcome among 60 primigravida women in selected hospitals of Udupi district, Karnataka. Non-equivalent post-test only design was used. Thirty primigravida participated in the childbirth preparation class and another 30 made up the control group. The effectiveness was assessed by means of student 't' test and chi-square test. Statistically significant differences between the groups were found in behavioural responses in first stage of labour, nature of delivery, and neonatal outcome. Statistically significant differences in the duration of labour were not observed. The mean behavioural responses scores in the experimental group (31.882) were higher than that of the control group (18.82). The standard deviation in the experimental group was 4.765 while in the control group was 3.7. The 't' value computed for

behavioural responses of the experimental and control group was significantly higher ($t_{58}=11.858$, $P<0.05$). Therefore, regular childbirth preparation classes in the antenatal wards and clinics are effective in bringing about positive behavioural responses and helps the parturients to cope up with labour pains. The information provided also reduces women's fear of unknown and they are able to participate positively in the process of labour. ⁹⁵

5. LITERATURE RELATED TO THE EFFECTIVENESS OF STRUCTURED VIDEO ASSISTED EDUCATION/TEACHING PROGRAMME

Online CBT training is in its infancy. The initial studies have varied program characteristics and trainee groups, but results appear promising. At this stage, there is a need to evaluate programs with different characteristics to determine which are useful, and which are not. This paper reports a preliminary evaluation of an online CBT training package, OCTC Online, which is distinguished from other online programs by its particularly strong focus on video presentations by trainers, accompanying PowerPoint slides, and video demonstrations of key clinical techniques. Participants ($N = 94$) completed online rating scales and questionnaires assessing (a) their satisfaction with the training; (b) their self-rated knowledge and confidence about the topics discussed (pre- and post-training); and (c) a multiple choice questionnaire (MCQ) objective test of knowledge (also pre- and post-training). Results showed that on average students were highly satisfied with the online training modules, their self-rated confidence increased significantly, and so did their scores on the MCQ. The study has significant limitations but nevertheless contributes to the growing body of evidence that computer based learning and

training may have a useful part to play in enhancing therapists' knowledge of CBT theory and techniques, and their confidence in using the techniques.⁹²

A randomized controlled trial was conducted on evaluating the effects of an Internet education programme on newborn care in Taiwan. A total of 118 women receiving prenatal care in a hospital clinic. The changes in newborn-care knowledge were 7.21 for the experimental group, compared with 1.95 for the control group; the difference between the least-squares means computed by ancova was 5.73. The changes in maternal confidence were 8.46 for the experimental group and 3.05 for the control group; the difference between the least-squares means computed by ancova was 5.94. Results suggest that Internet education about newborn care may contribute to greater care knowledge and maternal confidence. Internet newborn-care education programmes can achieve success in promoting newborn care and provide health professionals with evidence-based intervention.⁹³

A study was conducted to evaluate a video-based breastfeeding education programme provided to primigravida in the third trimester of pregnancy with the aim of deepening breastfeeding knowledge and enhancing skills of 60 mothers in Taiwan. Results suggest that the rate after the intervention has significantly increased from 32% to 44% at 1 week of age and from 18% to 28% at 9 months of age. Video-based breastfeeding education may contribute to breastfeeding knowledge and attitude and improved breastfeeding rate. Video-based breastfeeding education programme can achieve success in promoting breastfeeding and provide health professionals with an evidence-based intervention.¹¹²

A study was conducted to assess the effectiveness of video assisted nursing intervention on lumbo-sacral pain and activities of daily living among antenatal primi mothers. The study was conducted on 60 primi mothers and the post test knowledge of the mothers regarding pain and daily living activities are higher than the pre test scores before video assisted teaching programme. The findings indicate that 65.45% has good knowledge, while 15.45% had average knowledge and 19.09% had poor knowledge after the video assisted program. The study concluded that video assisted teaching programme will improve the knowledge of the mother and it helps in regaining their activity level than those who were not participated in the study. ⁹⁴

A pre-experimental study with one group pre-test post-test design was conducted to assess the effectiveness of video assisted teaching on knowledge & practice of breast feeding technique among the primipara mothers. Purposive sampling technique was used to select 60 primipara mothers from selected hospitals, Bangalore. The overall pre test mean was 53.88% (21.55±5.85) where as in post test it improved to a level of 79.29% (31.22±3.22) of the total score, depicting an overall difference of 47.18%. While considering the breast feeding practice, the mean% obtained during the pre test was 46.42% (9.28±2.37), whereas during post test it increased to a level of 78.92% (15,78±1.56) with an improvement of 70.02%. The overall findings of the study revealed that there is a very highly significant increase in the knowledge and practice of primipara mothers regarding breast feeding technique. Hence it is concluded that the video assisted teaching on breast feeding technique was highly effective in improving the knowledge and practice of primipara mothers. ¹¹¹

Another pre-experimental study with one group pretest posttest design was conducted to assess the effectiveness of video assisted teaching programme on knowledge regarding newborn care among primipara mothers in selected hospitals, Mangalore. 60 samples were recruited for the study. Before the administration of video assisted teaching programme the level of knowledge was less i.e. 59.30% as compared to the level of knowledge after the video assisted teaching programme i.e. 84.53% revealing the difference of 25.23%, thus depicting the effectiveness of video assisted teaching programme.¹¹³

A quantitative study with Quasi Experimental - Pre test and Post test control design design was conducted to assess the effectiveness of video teaching Programme on physical care of newborn among Primigravida mothers admitted in urban health Maternity centres, Coimbatore, Tamilnadu. The sample size for the study was 30. Distribution of experimental group according to their level of pre and post test knowledge regarding physical care shows in post test all of them had excellent knowledge. Whereas in pre test it shows 40% of mothers had very poor knowledge and remaining 60% had poor knowledge on physical care aspects. It shows that most of the mothers had poor knowledge on physical care aspects before implementing the video teaching programme. The study can be concluded by saying that experimental group mothers gained excellent knowledge and completely adoptive practice on physical care aspects after implementation of video teaching programme. There was highly significant difference was found between pre and post test knowledge scores in experimental group as compared to control group.¹⁰⁸

The purpose of this pre-experimental study conducted by Sreelekha Rajesh, et, al., is to assess effectiveness of video assisted teaching program on knowledge regarding non pharmacological pain relieving intervention for children in selected hospital. A structured questionnaire is used to assess the knowledge of the staff nurse regarding non pharmacological pain relieving interventions for children in selected hospitals. In the pre-test more than half (53.3%) of the staff nurses had average knowledge, 40% of them had poor knowledge and 6.7% had good knowledge regarding non-pharmacological pain relieving interventions before the video assisted teaching program, but in the post test there was significant improvement in the knowledge scores 80 % of nurses had good knowledge. None of the demographic variables was found to have significant association with knowledge of the staff nurses. Hence the video assisted teaching regarding non pharmacological pain relieving interventions for children is effective in rendering knowledge and bringing awareness.¹¹⁴

SUMMARY

Ample evidence in literature is available which mentions certain variables that influence childbirth behaviours and outcomes. These characteristics include anxiety, pain, self efficacy, perceived childbirth knowledge, non pharmacologic support measures, prenatal care, childbirth education classes and level of labour support from the birth partner. The review of the literature indicated that findings from previous studies support the importance of non pharmacological methods of pain relief; prenatal education and nursing support help a parturient in coping with labour pain and overcome the stress and fear of

unknown. However, previous studies had been conducted in culturally diverse areas and so the content and the structure of the childbirth classes provided, also widely varied accordingly. Therefore it calls to develop a tailor-made childbirth education programme which is more culturally appropriate for use in India. Pregnant women should be well informed about the total labour process, labour pain and the advantages and disadvantages of a variety of techniques to relieve the pain of labour. As women approach labour, they may benefit from childbirth education classes by incorporating information on a wide range of expectant intra-partum behaviour. The review of the literature also indicated that Video assisted teaching programme was effective to improve the knowledge and practice in various areas of health care. Hence the researcher felt the need to develop a video assisted child birth education programme of labour process and childbirth preparedness which is culturally and scientifically congruent to the needs of primigravida mothers of the selected study settings.