Research Article

A Study to Assess the Effectiveness of Midwife-Led Psychoeducation on Childbirth Fear and Childbirth Efficiency in Primigravida Mothers of Selected Hospital of Navi Mumbai

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Abstract

Aim: This study examines the effects of midwife-led psychoeducation on delivery fear and efficiency in primigravida moms in Navi Mumbai hospitals.

Method: The researcher used quantitative evaluator research. A quasi-experimental research approach was chosen for the investigation. Sample size for the study is 300. For this study, simple random sampling was performed. Results were presented using descriptive and inferential statistics. Demographic data, childbirth fear categorization, and efficacy were presented as frequency and percentage. T-test was used to compare pre- and post-test delivery fear and efficacy levels. Childbirth fear and efficacy were correlated with demographic characteristics using Chi-square testing.

Result: Pre-intervention primigravida mothers' delivery fear scores in the experimental and control groups. The experimental group contained 89 (59%) respondents with severe fear and 10 (7%) with low fear. 79 (53%) of the control group indicated high dread, whereas 8 (5% expressed low fear. Pre-interventional delivery efficacy scores for experimental and control primigravida moms. In the experimental group, 78 (52%) had average birthing efficacy, 63 (42%) with poor, and 9 (6% with good). Most of 72 (48%) control group members had low birth effectiveness scores, followed by 60 (40%) average and 18 (12%) good.

Conclusion: This study shows that midwife-led psychoeducation reduces primigravida moms' delivery fear and efficacy. Primigravida mothers' labor efficacy and fear scores improve.

Keywords: Childbirth efficiency, childbirth fear, mid-wife, primigravida, psychoeducation

Introduction

Human medicine defines "gravidity" as the number of pregnancies a woman has had, whether they were live births or abortions. In a patient's reproductive history, "gravidity" can indicate risk factors for pre-eclampsia, gestational diabetes, spontaneous abortion, premature birth, fetal development restriction, and more. Another name for a pregnant woman is "gravida".[1]

Birth occurs through vaginal or cesarean section in the final period of pregnancy. This is childbirth, or labor and delivery. Placenta and fetus exit the uterus through the vaginal canal during labor. During birth, fetal heart monitoring is usually performed to monitor the unborn. Cardiotocography measures contraction frequency and force. Monitoring and cervical checks let doctors determine the patient's labor stage and track its progression.[2]

Labor is a normal process, although complicating problems sometimes require therapy. To handle low-risk labor, nature must be allowed to run its course while avoiding complications.

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Cardiotocographic monitoring of uterine contractions and fetal heart rate is common during labor. Clinicians assess contractions and fetal distress to determine if intervention is needed.[3]

Birthing fear, or tokophobia, can delay birth. It classified as major or secondary. The biggest one is a woman's morbid dread of childbirth (FOC) after never being pregnant. A horrific obstetric experience in a previous pregnancy caused a pathological phobia of labor.[4]

Childbirth fear is not always explained. Anxiety is now considered a psychological state rather than a feature. Scandinavia, the UK, and Europe have focused on the FOC. A Western Australian survey found that 22% of women find their delivery expectations "horrifying" and "petrifying." Despite the lack of research in Australia, childbirth anxiety is a global concern. The Expectations and Experiences Questionnaire (WDEQ) was then administered to 400 pregnant women. 26% expressed severe delivery anxiety and almost 50% experienced moderate anxiety.[5,6]

Psychoeducational therapies combine counseling and education. People might receive psychoeducational therapy individually or in groups. Psychoeducational strategies that work better in pregnant women include exercises that improve laboring skills, psychological support, self-efficacy, and sensible options for transportation, delivery location, blood donors, birth partners, safe delivery materials, and other delivery-related issues.[7]

Psychological interventions were effective on most psychological, birth preparedness, and other outcomes in the included studies, but psychoeducational interventions were ineffective on some outcomes, including the mother's confidence to cope with motherhood, identification with a motherhood role, motherhood and infant care, and birth information, such as anxiety during active labor, duration. Other factors included maternal stress, normative beliefs, power and behavioral control perceptions, birth preferences, delivery technique choice, and birth experience. This lack of importance for psychoeducational intervention may be attributed to physiological, environmental, and cultural factors on multiple outcomes.[8]

Materials and Methods

Research approach

The researcher used the quantitative evaluator research approach for this study.

Research design

The selected research design for the study utilized the quasi-experimental research design.

The setting of study

The setting for the present study is the selected hospitals of Navi Mumbai.

Population of study

Population for the present study consisted of primigravida mothers of selected hospitals in Navi Mumbai.

Sample technique

For the present study, simple random sampling technique was used.

Sample size

The Sample size for the study was 300 Sample.

Description of tool

- Section A – It consists of Socio Demographical data of the participants under the study.
- Section B – It consists of Modified childbirth fear scale.
- Section C – It consists of Modified Childbirth self-efficacy inventory.

Statistics

Descriptive

Frequency and percentage distribution were used to analyze demographic data.

Inferential

T-test and Chi-square test were used to compare pre- and post-test scores of childbirth fear and efficacy and its associates with demographic characteristics.

Results

Section A: Frequency of and percentage of the demographic variables of experimental group and control group.

From Table 1, tn experimental group, 63 (42%) respondents are 19–25 years old and 10 (7%) are >35. The control group has 75 (50%) responders aged 26–30 and 5 (3%), aged >35. In the experimental group, 85 (57%) respondents were undergraduates and 8 (5%) were primary school graduates. Most control group members (66, 44%) finished high school, and 7 (4%), were illiterate. In the experimental group, 54% were private employees and 11% were businesspeople. In control group, 82 (55%) were private employees and 12 (8%) were businesspeople. Most 53 (35%) experimental group respondents have a family income of 15,001–20,000 Rs. With 22 (15%) having <10,000 Rs., most of 58 (38%) control group families earn 10,001–15,000 Rs. And 18 (12%) have <10,000 Rs. In experimental group, 70 (47%) are urban and 6 (4%) are rural. The control group has 68 (45%) urban residents and 23 (16%) slum residents.

Section B: Assessment of Pre-intervention childbirth fear score and childbirth efficiency score among primigravida mother of experimental group and control group.

Table 2 shows primigravida mothers' pre-intervention birthing fear scores in experimental and control groups. In the experimental group, 89 (59%) had strong fear, 51 (34%)

Table 1: Distribution of respondents in relation to selected demographic. *n*=300 (150+150)

S. No.	Demographic variables	Experimental group		Control group	
		frequency	percentage	Frequency	Percentage
1.	Age in years				
	a. 19–25 years	63	42	55	37
	b. 26–30 years	59	39	75	50
	c. 31–35 years	18	12	15	10
	d. >35 years	10	7	5	3
2.	Education status				
	a. Illiterate	10	7	07	4
	b. Primary	08	5	13	9
	c. Secondary	47	31	66	44
	d. Undergraduate and above	85	57	64	43
3.	Occupational status				
	a. Housewife	22	15	38	25
	b. Business	17	11	12	8
	c. Government employee	30	20	18	12
	d. Private employee	81	54	82	55
4.	Family Monthly income				
	a. <10,000 Rs.	22	15	18	12
	b. 10,001–15,000 Rs.	47	31	58	38
	c. 15,001–20,000 Rs.	53	35	22	15
	d. >20,001 Rs.	28	19	52	35
5.	Area of Residence				
	a. Urban	70	47	68	45
	b. Sub Urban	30	20	32	21
	c. Slum	44	29	23	16
	d. Rural	06	4	27	18

Table 2: Assessment of pre-intervention childbirth fear score among primigravida mother in experimental group and control group *n*=300 (150+150)

Pre-interventional childbirth fear score	Experimental group		Control group	
	Frequency	Percentage	Frequency	Percentage
No Fear (0–15)	00	00	00	00
Very Low fear (16–30)	10	7	8	5
Moderate fear (31–45)	51	34	63	42
High fear (46–60)	89	59	79	53

Table 3: Assessment of pre-intervention childbirth efficacy score among primigravida mothers in the experimental group and control group *n*=300 (150+150)

Pre-interventional childbirth efficacy score	Experimental group		Control group	
	Frequency	Percentage	Frequency	Percentage
Poor (0–16)	63	42	72	48
Average (17–32)	78	52	60	40
Good (33–48)	09	6	18	12

moderate fear, and 10 (7% extremely low fear). The control group had 79 (53%), 63 (42%), and 8 (5%) high, moderate, and very low fear.

Table 3 shows pre-interventional birthing efficacy score for primigravida mothers in experimental and control groups. In experimental group, 78 (52%) had average birthing efficacy, 63 (42%) had poor, and 9 (6%) had good. In the control group, 72 (48%) had poor birthing efficacy, 60 (40%) average, and 18 (12%) good.

Section C: Assessment of Post-intervention childbirth fear score and childbirth efficiency score among primigravida mother of experimental group and control group.

Table 4 shows post-intervention delivery fear scores for experimental and control primigravida mothers. In the experimental group, 97 (65%) had moderate fear, 28 (19) high fear, 23 (15%) very low fear, and 2 (1%) no fear. 76 (51%) of the control group had high fear, 65 (43%) moderate fear, and 9 (6%) extremely low fear.

Table 4: Assessment of post-intervention childbirth fear score among primigravida mother in experimental group and control group *n*=300 (150+150)

Post-interventional childbirth fear score	Experimental group		Control group	
	Frequency	Percentage	Frequency	Percentage
No Fear (0–15)	02	1	00	00
Very Low fear (16–30)	23	15	9	6
Moderate fear (31–45)	97	65	65	43
High fear (46–60)	28	19	76	51

Table 5: Assessment of post-intervention childbirth efficacy score among primigravida mother in experimental group and control group *n*=300 (150+150)

Post-interventional childbirth efficacy score	Experimental group		Control group	
	Frequency	Percentage	Frequency	Percentage
Poor (0–16)	31	21	72	48
Average (17–32)	99	66	59	39
Good (33–48)	20	13	19	13

Table 6: Effectiveness of midwife-led psychoeducation on childbirth fear in experimental group *n*=150

Test	Mean	SD	*t*-test	DF	*P*-value	Result
Pre-test	45.53	10.51	7.26	149	**<0.00001**	S
Post-test	37.18	9.36				Significant

Table 7: Effectiveness of midwife-led psychoeducation on childbirth fear in control group *n*=150

Test	Mean	SD	*t*-test	DF	*P*-value	Result
Pre-test	44.59	9.65	0.65	149	*P*<0.05	NS
Post-test	43.86	9.83			0.2575	Non-Significant

Table 5 shows post-intervention childbirth efficacy scores for primigravida mothers in experimental and control groups. In the experimental group, 99 (66%) had average birthing efficacy, 31 (21%) had bad, and 20 (13%) had good. Most 72 (48%) respondents in the control group had poor birthing efficacy scores, followed by 59 (39%) average and 19 (13%) good.

Section D: Assessment of impact of midwife-led psychoeducation on childbirth fear and childbirth efficiency in experimental group and control group.

Table 6 illustrates the effectiveness of midwife-led psychoeducation: Pre-test mean 45.33 and SD 10.51, post-test mean 37.18 and SD 9.36. The "t" test value was 7.26, df = 149, and $P < 0.00001$. The study found considerable efficacy ($P < 0.05$).

Table 7 indicates the effectiveness of midwife-led psychoeducation in the control group: pre-test mean 44.59 and SD 9.65, post-test mean 43.86 and SD 9.83. The "t" test value was 0.65172, df 149, and $P = 0.257542$. Results indicate non-significant efficacy ($P < 0.05$).

Table 8 indicates the effectiveness of midwife-led psychoeducation: pre-test mean 18.69 and SD 9.67, post-test mean 21.67 and SD 10.16. With df 149 and $P = 0.004876$, the "t" test value was 2.60. The study found considerable efficacy ($P < 0.05$).

Table 9 illustrates the efficiency of midwife-led psychoeducation in the control group: pre-test mean 19.23 and SD 11.46; post-test mean 19.31 and SD 11.56. The "t" test was 0.06017, df 149, and $P = 0.47603$. Results indicate non-significant efficacy ($P < 0.05$).

Table 8: Effectiveness of midwife-led psychoeducation on childbirth efficacy in experimental group *n*=150

Test	Mean	SD	*t*-test	DF	*P*-value	Result
Pre-test	18.69	9.67	2.60	149	0.004	S
Post-test	21.67	10.16			(*P*<0.05)	Significant

Table 9: Effectiveness of midwife-led psychoeducation on childbirth efficacy in control group *n*=150

Test	Mean	SD	*t*-test	DF	*P*-value	Result
Pre-test	19.23	11.46	0.06017	149	0.47603	NS
Post-test	19.31	11.56			*P*<0.05	Non-Significant

Section E: Determine the association between the pre-interventional childbirth fear score and childbirth efficiency score with the selected demographic variables in the experimental group and control group.

In Table 10, the Chi-square value of demographic variables such as age in year, educational status, occupation, family monthly income, and area of residence does not show a significant association with pre-test childbirth fear score at 0.05 level of significance. Hence, null hypothesis is accepted and alternative hypothesis is rejected.

Table 11 shows that chosen demographic characteristics in control group affect birthing fear score. At 0.05 significance level, the Chi-square value of demographic characteristics including educational status indicated a significant association with pre-test birthing fear score. The null hypothesis was rejected and the alternative hypothesis was accepted.

Table 10: Association between the pre-interventional childbirth fear score with the selected demographic variables in experimental group *n*=150

Sociodemographic variables	Total no of samples	Level of childbirth fear				Df	*P*-value	Chi-square value	Result
		No Fear 00	Very Low fear 10	Moderate fear 51	High fear 89				
1. Age in years						6	0.578	4.73	NS
19–25 years	63	0	5	25	33				
26–30 years	59	0	2	18	39				
31–35 years	18	0	2	4	12				
>35 years	10	0	1	4	5				
2. Education Status						6	0.479	5.520	NS
Illiterate	10	0	2	2	6				
Primary	08	0	1	2	5				
Secondary	47	0	1	17	29				
Undergraduate and above	85	0	6	30	49				
3. Occupational status						6	0.976	1.21	NS
Housewife	22	0	2	8	12				
Business	17	0	1	6	10				
Government Employee	30	0	2	8	20				
Private employee	81	0	5	29	47				
4. Family Monthly income						6	0.75	3.40	NS
<10,000 Rs.	22	0	3	7	12				
10,001–15,000 Rs.	47	0	3	14	30				
15,001–20,000 Rs.	53	0	2	21	30				
>20,001 Rs.	28	0	2	9	17				
5. Area of Residence						6	0.861	2.56	NS
Urban	70	0	4	27	39				
Suburban	30	0	2	10	18				
Slum	44	0	3	13	28				
Rural	06	0	1	1	4				

Table 11: Association between the pre-interventional childbirth fear score with the selected demographic variables in control group *n*=150

Sociodemographic Variables	Total no of Samples	Level of childbirth fear				Df	*P*-value	Chi-square value	Result
		No Fear	Very Low fear	Moderate fear	High fear				
1. Age in years						6	0.8678	2.50	NS
19–25 years	55	0	3	23	29				
26–30 years	75	0	3	32	40				
31–35 years	15	0	1	6	8				
>35 years	5	0	1	2	2				
2. Education Status						6	0.0052	18.40	S
Illiterate	07	0	2	2	3				
Primary	13	0	3	4	6				
Secondary	66	0	2	30	34				
Undergraduate and above	64	0	1	27	36				
3. Occupational status						6	0.9394	1.77	NS
Housewife	38	0	2	13	23				
Business	12	0	1	5	6				
Government Employee	18	0	1	8	9				
Private employee	82	0	4	26	52				
4. Family Monthly income						6	0.9794	1.14	NS
<10,000 Rs.	18	0	1	7	10				
10,001–15,000 Rs.	58	0	3	25	30				
15,001–20,000 Rs.	22	0	2	8	12				
>20,001 Rs.	52	0	2	23	27				
5. Area of Residence						6	0.5516	4.93	NS
Urban	68	0	2	32	34				
Suburban	32	0	1	13	18				
Slum	23	0	2	7	14				
Rural	27	0	3	11	13				

Table 12 shows that chosen demographic characteristics in experimental group affect childbirth efficacy score. The Chi-square value of demographic variables such occupational status indicated a significant correlation with pre-test childbirth efficacy score at 0.05. The null hypothesis was rejected and the alternative hypothesis was accepted.

Table 12: Association between the pre-interventional childbirth efficacy score with the selected demographic variables in Experimental group *n*=150

Sociodemographic Variables	Total no of Samples	Level of childbirth efficacy			Df	*P*-value	Chi-square value	Result
		Poor	Average	Good				
1. Age in years					6	0.098	10.69	NS
19–25 years	63	29	32	2				
26–30 years	59	22	35	2				
31–35 years	18	7	8	3				
>35 years	10	5	3	2				
2. Education Status					6	0.083	11.14	NS
Illiterate	10	6	2	2				
Primary	08	4	3	1				
Secondary	47	21	22	4				
Undergraduate and above	85	32	51	2				
3. Occupational status					6	0.037	13.39	S
Housewife	22	9	11	2				
Business	17	11	4	2				
Government Employee	30	12	14	4				
Private employee	81	31	49	1				
4. Family Monthly income					6	0.17	9.010	NS
<10,000 Rs.	22	10	11	1				
10,001–15,000 Rs.	47	23	21	3				
15,001–20,000 Rs.	53	25	26	2				
>20,001 Rs.	28	5	20	3				
5. Area of Residence					6	0.689	3.90	NS
Urban	70	34	32	4				
Suburban	30	10	18	2				
Slum	44	17	25	2				
Rural	06	2	3	1				

Table 13: Association between the pre-interventional childbirth efficacy score with the selected demographic variables in control group *n*=150

Socio-demographic Variables	Total no of Samples	Level of childbirth efficacy			Df	*P*-value	Chi-square value	Result
		Poor	Average	Good				
1. Age in years					6	0.861	2.55	NS
19–25 years	55	23	26	6				
26–30 years	75	40	26	9				
31–35 years	15	7	6	2				
>35 years	5	2	2	1				
2. Education Status					6	0.433	5.90	NS
Illiterate	07	3	2	2				
Primary	13	4	7	2				
Secondary	66	37	22	7				
Under graduate and above	64	28	29	7				
3. Occupational status					6	0.149	9.46	NS
Housewife	38	12	22	4				
Business	12	6	5	1				
Government Employee	18	7	8	3				
Private employee	82	47	25	10				
4. Family Monthly income					6	0.085	11.08	NS
<10,000 Rs.	18	9	5	4				
10,001–15,000 Rs.	58	24	29	5				
15,001–20,000 Rs.	22	7	11	4				
>20,001 Rs.	52	32	15	5				
5. Area of Residence					6	0.7181	3.69	NS
Urban	68	28	32	8				
Suburban	32	19	9	4				
Slum	23	11	9	3				
Rural	27	14	10	3				

Table 13 illustrates that association of level of childbirth efficacy score with selected demographic variables in control group, The Chi-square value of the demographic variables such as age in year, educational status, occupation, family monthly income, and area of residence does not show significant association with pre-test childbirth efficacy score at 0.05 level of significance, it depicted that there is a no association between childbirth efficacy score with selected demographic

variables. Hence, the null hypothesis is accepted and alternative hypothesis was rejected.

Discussion

A study by Çankaya and Şimşek (2020) examined the impact of antenatal education on dread of birth, depression, anxiety, childbirth self-efficacy, and method of delivery in primiparous pregnant women. A randomized controlled trial found that antenatal education reduced birth dread, sadness, anxiety, and stress symptoms and boosted childbirth self-efficacy compared to controls ($P < 0.05$). The antenatal education group showed considerably decreased postnatal birth dread, depression, anxiety, and stress symptoms compared to controls ($P < 0.001$). The prenatal education group had more vaginal births than controls ($P = 0.043$). Based on this evidence-based study, all pregnant women should obtain antenatal education, which has clinical benefits during and after pregnancy.[9]

The study by Sunay and Tuba (2022) examined the impact of childbirth education and birth plans on self-efficacy. A randomized controlled trial found that pregnant women's birth self-efficacy levels significantly increased in Group ED and Group ED&P after the intervention ($P < 0.05$), while the control group did not show a significant increase ($P > 0.05$). After the intervention, Group ED's birthing self-efficacy was higher than the control group's ($P > 0.05$). Pregnant women's childbearing self-efficacy is highest when they exclusively receive childbirth instruction.[10]

In Firouzan *et al*. (2020), the Gamble-based midwifery-led counseling study on delivery fear and self-efficacy in nulligravida women found that The intervention group had much lower birthing fear and higher self-efficacy than the control group. In addition, more intervention group women favored normal vaginal birth than control group women. The BELIEF treatment may help 1st-time pregnant women with delivery dread reduce their fear and increase their self-efficacy.[11]

Nooied *et al*. (2023) conducted the study on a nurse-led program to boost pregnant adolescents' self-efficacy and reduce childbirth fear: A randomized controlled trial found that following the intervention, the experimental group had a significantly higher mean score on childbirth self-efficacy and reduced delivery dread. After the program, the experimental group had significantly greater childbirth self-efficacy and lower fear of childbirth mean scores than the control group. In pregnant teenagers, a childbirth self-efficacy enhancement program increases self-efficacy and reduces delivery dread. Thus, it is a potential program for caring pregnant teenagers but needs to be tested with different samples before implementation.[12]

Stella (2018) conducted the study to examine pregnancy-related fear among primigravida moms at an Indore maternity clinic and found that they reported higher (53.3%) severe dread. Fear connected to pregnancy was higher in third-trimester mothers (60.6 ± 69.98) compared to second-trimester mothers (55.0 ± 64.95). Thus, the difference in pregnancy dread between second- and third-trimester primigravida mothers was real. A substantial correlation exists between age ($\chi^2 = 4.31187$ at df $P < 0.05$) and education ($\chi^2 = 3.9629$ at df $P < 0.05$). However, the χ^2 value for other variables, such as occupation and family type, was not significant at 0.05 level. Lack of understanding and expertise about forthcoming duties causes most primigravida mothers to fear pregnancy. The primigravida should be urged to reduce her fear to avoid obstetric complications.[13]

Conclusion

This study shows that midwife-led psychoeducation reduces primigravida moms' delivery fear and efficacy. Primigravida mothers' labor efficacy and fear scores improve.

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