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SELF-CARE BEHAVIOR OF PRIMIGRAVIDA AND MULTIGRAVIDA WOMEN'S CONCERNING MINOR DISCOMFORTS MANAGEMENT DURING PREGNANCY: A COMPARATIVE STUDY

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Abstract
Background: Self-care behavior is the capacity to carry out the requirements or needs for keeping one's health and well-being. The fast rising hormones during pregnancy alter the mother's body and may result in what are known as minor disorders. Pregnant women benefit from self-care behaviors about minor discomforts and behaviors throughout pregnancy; as a result, women's understanding of and adherence to self-care behaviors are critical for safeguarding their health. The purpose of this study was to assess the self-care practices of primigravida and multigravida women with regard to mild disorder management of pregnancy discomfort. Determine the relationship between the reproductive and demographic characteristics of primigravida and multigravida women and their self-care behavior for managing specific minor discomforts by contrasting their concerning behavior with that of self-care for managing particular minor discomforts.
Methods: The current investigation uses quantitative methods to conduct a descriptive study. A non-probability sample of 350 was used for three trimesters (127 primigravida and 223 multigravida). The primary healthcare facilities in Holy Karbala City served as the study's sites. As explained in the methods section, the questionnaire was designed with three sections.
Results: The results showed that housewives, nuclear families, bachelor degree holders, the bulk of the women in the study group, who were in their 20s and 30s. The results of the study showed that pregnant women also practiced moderate self-care for minor discomforts. Conclusion: There is a statistically meaningful association between the level of education, occupation, and family type of pregnant women and their overall self-care behaviors, with p-values of.001,.002, and.004 respectively. Furthermore, there is a significant correlation (p-values =.001,.002,.008,.050, and.011, respectively) between a pregnant woman's gravidity and her overall self-care behaviors, number of abortions, parity, and length of marriage. Recommendations: establishing a program to educate all expectant mothers about common discomforts and appropriate self-care techniques in an effort to broaden their understanding.
Keywords: Self-care behaviors, physical, Psychological, Spiritual, minor discomforts, pregnancy

Introduction

A woman's first pregnancy is a unique time in her life that is marked by quick changes in her physiology, psychology, and social interactions due to the effects of hormones and her body's adjusting to the process of pregnancy (Thatal et al., 2020). Though pregnancy is a special time when women may feel more motivated to alter their diets and physical activity levels and/or encounter new obstacles to changing, there is a lack of knowledge about the factors that influence diet and physical activity during pregnancy. behaviors (Eldousoky et al., 2023). Pregnancy hormones or the physical changes brought on by the gravid uterus might be the source of frequent pregnancy discomforts, which makes anatomical, physiological, and biochemical alterations related to pregnancy important. (Medforth et al., 2019). The daily changes that a pregnant woman's body goes through can occasionally be upsetting and intolerable, but they are rarely cause for concern because pregnant women can effectively manage these minor discomforts with the right health education and easy at-home remedies (Sowunmi et al., 2021). Pregnancy is a unique experience that alters every aspect of a person's social, psychological, and physical life. It is best to adjust to healthy changes in behavior during pregnancy. (Kazemi and others, 2018). Pregnant women benefit from self-care and Self-care for minor aches and pains during pregnancy; therefore, women's self-management practices are essential for protecting their health (Aziz & Maqsood,2016). Pregnant women may experience psychological, social, and behavioral distress due to the necessary adjustment, particularly if their quality of life is low (Olutola & Adejuwon, 2021). The effects of the hormones progesterone and estrogen take precedence over these modifications (Khalil, 2019). The primary objective of every pregnancy is to deliver a healthy child. Many expectant women look on nurses to provide them with courteous counsel and reliable information. Nurses must consider both the small discomforts and the self-care practices that can help to decrease them in order to give proper care. (Nguyen et al., 2022). When it comes to providing proactive guidance that encourages

women to take responsibility for their own self-care, nurses can be extremely important in dispelling myths and providing accurate information. Pregnant women must be taught to identify the risks to the threat to their safety that their surroundings, culture, society, and behavior lifestyle choices, and to recommend steps to lessen any negative consequences (Fatthy et al., 2021). Pregnant women should take care of their physical and mental health because the growing fetus depends entirely on the mother for all aspects of growth and development. This will ensure that the pregnancy develops beautifully. (Devkate and others, 2022). Nausea and vomiting are more common in pregnant women with high preconception AL Body Mass Index (BMI). The most common mild illness is morning sickness, which is most likely caused by a change in hormone levels. (Bagherzadeh et al., 2021) Whenever it comes to maternity care, self-care for pregnancy discomforts can help ease some of the anxiety and fears associated with having a healthy pregnancy that will ensure that the mother, child, and family are all kept safe both physically and psychologically. (Hassan et al., 2020). A 2008 National Institute for Care and Health Excellence (NICE) report states that between 50% and 80% of pregnant women report having mild discomforts. (Oluwatosin & ike, 2017). During the first and early second trimesters of early pregnancy (NVP), between 50% and 80% of women report feeling sick to their stomachs. In sixteen to twenty weeks, the symptoms disappear. NVP can be categorized as either moderate emesis gravidarum or hyper emesis gravidarum, the latter of which necessitates medical treatment or possibly hospitalization. While the exact reason is unknown, there are several risk factors that include dysregulated immune system, Helicobacter pylori infection, thyroid dysfunction, high levels of leptin, progesterone and estrogen, placental prostaglandins, serotonin, and dysmotility of the gastrointestinal tract. (Ayoub & Awed, 2018). Self-care practices for women with NVP include changing their diets to consume bland, foods that are low in fat and fiber, such as fruits, vegetables, breads, crackers, cereals, eggs, tofu, lean meat, peanut butter, and vegetables; foods that are high in protein and liquid content should be avoided. Additionally, medications and other alternative therapies may be used (Ahwinahwi et al,. 2016). The uterine counter is increased during pregnancy, which causes the abdominal muscles to weaken and stretch. Additionally, low back pain starts as a result of posture abnormalities including pelvic anteversion and increased lumbar lordosis brought on by gravity. These changes increase the strain on the lumbar spine and sacroiliac ligaments. Pregnancy-related low back pain is rarely treated (Khalil, 2019). No pharmacological interventions and women's self-care behaviors include increasing their intake of roughage, utilizing relaxation methods like deep breathing, scheduling regular bowel movements, consuming six to eight glasses of water every day, and participating in moderate activity (Ayoub & Awed, 2018) Maternity nurses are crucial in raising the standard of prenatal care by educating and supporting expectant mothers. Concurrently, the nurse offers medical and psychosocial services, including health promotion, education, counseling, nutrition, assessment of social services as well as the proper referral (Mendoza and Amsler, 2017).

In order to reduce the financial, psychological, and physical costs associated with Maternity nurses are essential in recognizing concerns related to mild discomforts encountered during pregnancy and arranging timely assistance for such difficulties, as well as in reducing maternal and neonatal morbidity and mortality. Thus, in order to offer comprehensive and all-encompassing nursing care to women having mild discomforts, nurses must pursue ongoing education and training. (Abd Elaa et al., 2022). Regarded as a branch of telehealth, telenursing is concerned with the delivery, administration, and synchronization of nursing care and services through the use of telecommunications technology. The most popular applications of telenursing are to offer opportunities for education to expectant mothers, teleconsultations with nurses, review of laboratory investigation results, and support in the (Fatthy et al., 2021).

Methodology:

Study Design A descriptive design has been carried out to fulfill the study's objectives. The research was carried out in five primary healthcare centers. which are (Al-Kawthar' Al-Nidal 'Al-Ghadeer 'Al-NasIr' hay AL-muzafine') in the Holy Kerbala City, Iraq. The study was conducted during period September 2023 and August 2024. Which data collection, analysis, and interpretation were having been done. Data were collected about four months from 16 /10 /2023 to 24 /2 /2024. Study Sample: A nonprobability Convenient sampling was used in this study to select 350 participants from five Primary Health Care Centers classified by region out of nineteen PHCCS in Karbala City whom were attending for antenatal care or medical checkup, during pregnancy. Sample was selected according to the following inclusion and exclusion criteria. Administrative Arrangements: The study's protocol and official approval to perform it were obtained by the University of Karbala's College of Nursing. After obtaining the title and the questionnaire, the College of Nursing's Ethics Committee evaluated the study instruments (questionnaire) and decided to move on with the research. obtaining the mother's consent as well during the interview Validity of the Current Study: To increase the instrument's validity, a panel of eighteen experts in the study's fields evaluated it. Experts reviewed the study's instruments and made additions and deletions. The instrument is valid after taking into account the advice and opinions of experts, and the experts are distributed based on the fields, Reliability of the study: The self-care behaviors scale has a very good Cronbach's alpha evaluation (0.851), indicating that the questionnaires' internal consistency and equivalency measurability were sufficient from December 21 to December 28, 2023,

The Study Instrument: The questionnaire is based on the investigators' experiences as well as an extensive review of previous research and relevant literature. (Torres Soto et al., 2021)

Section (1): Socio-Demographic Characteristics for pregnant woman: Features of the pregnant women under study, including age, family type, employment position, and place of residence

Section (2): Obstetric information: Gravidity, Abortion, Births, gestational age monitoring the present-day pregnancy, the initial follow-up time, The past of equality, kinship connection between the spouses

Section (3): Self-Care behavior concerning Minor Discomforts Management during pregnancy This section includes (3) parts of Self-Care behavior for Management them during pregnancy

Results

In order to analyze and interpret the current study's results, statistical procedures were used; the results were manipulated. Based on sample answers to the study questionnaire, those findings were produced.

Table 1: Women's distribution according to sociodemographic characteristics

List	Features		F	%
1	**Age (year) M±SD= 28 ± 6.6**	> 20	37	10.6
		20 – 29	164	46.9
		30 – 39	137	39.1
		40 ≤	12	3.4
		Total	***350***	***100***
2	**Level of education**	cannot write or read	35	10
		Read and write	39	11.1
		primary schooling	62	17.7
		Middle-school	39	11.1
		Secondary education	56	16
		Diploma	40	11.4
		Bachelor	66	18.9
		Postgraduate	13	3.7
		Total	***350***	***100***
3	**Occupation**	Housewife	198	56.6
		Employee	133	38
		Free work	19	5.4
		Total	***350***	***100***
4	**Residency**	Rural	62	17.7
		Urban	288	82.3
		Total	***350***	***100***
5	**Family type**	Nuclear	208	59.4
		Extended	107	30.6
		Largely extended	35	10
		Total	***350***	***100***

S: Standard deviation, M: Mean, %: Percentage, and f: Frequency

According to this Table (4-1) shows the mean age of woman's is 28±6.6 years, with 46.9% of them being in the 20–29 age range and 39.1% being in the 30–39 age range. In terms of educational attainment, the largest proportion relates to 18.9% of female bachelor's degree graduates and 17.7% of primary school graduates. In accordance to their occupational status, 38% of women work for the government and 56.6% of women are housewives. According to the residency, 82.3% of women live in cities and just 17.7% in rural areas. 59.4% of them reported having a nuclear family, while 30.6% reported having an extended family.

Table 2. Distribution of Women based on Features of Reproductive Health

List	Characteristics		F	%
1	**Gravidity**	Primigravida	127	36.3
		Multigravida	223	63.7
		Total	***350***	***100***
2	**Abortion**	None	199	56.9
		Once	84	24
		Twice	46	13.1
		More than two	21	6
		Total	***350***	***100***
3	**Parity**	None	75	21.4
		1	72	20.6

		2 – 3	113	32.3
		More than 3	90	25.7
		Total	***350***	***100***
4	**Gestational age**	First semester	17	4.8
		Second semester	1	.3
		Third semester	332	94.9
		Total	***350***	***100***
5	**Current pregnancy follow-up**	No	0	0
		Yes	350	100
		Total	***350***	***100***
6	**First follow-up**	First semester	307	87.7
		Second semester	30	8.6
		Third semester	13	3.7
		Total	***350***	***100***
7	**Lived children**	None	69	19.7
		1 – 3	222	63.4
		4 – 6	55	15.7
		7 ≤	4	1.1
		Total	***350***	***100***
8	**Lived birth**	None	84	24
		1 – 3	209	59.7
		4 – 6	53	15.1
		7 ≤	4	1.1
		Total	***350***	***100***
9	**Dead birth**	None	280	80
		1 – 3	68	19.4
		4 ≤	2	.6
		Total	***350***	***100***
10	**Duration of marriage M±SD= 7 ± 6**	1 – 5 years	186	53.1
		6 – 10 years	81	23.1
		11 – 15 year	35	10
		16 year ≤	48	13.7
		Total	***350***	***100***
11	**Kinship degree with husband**	Yes	205	58.6
		No	145	41.4
		Total	***350***	***100***

D: Standard deviation, M: Mean, f: Frequency, and %: Percentage

Based on this table, 36.3% of women are primigravida and 63.7% of women are multigravida. In terms of the quantity of abortions performed, 24% of women had one, and 13.1% had two. 32.3% of women with 2-3 parity and 25.7% of women with more than three parity have the highest percentage of parity. According to gestational age, 94.9% of pregnant women are in their third semester.

Whenever it comes to their current pregnancy, all of the women said they follow up 100% of the time. First semester was the first follow-up, according to 87.7% of pregnant women. In terms of 63.4% of women, the term "number of lived children" refers to one to three live children; in terms of 59.7% of women, it refers to one to three live births. There are only 1–3 dead births out of 19.4% of births. 53.1% of those who have been married for one to five years have been married for an average of seven and a half years. 58.6% of women report that their husbands have some degree of kinship with them, according to the kinship degree

Table 3. Considerable Variation in Self-Care Practices according to Gravity (N=350)

Gravidity / Behavior		M	SD	T	df	p≤ 0.05	Sig
Physiological discomfort	Primigravida	207.18	28.583	1.817	348	.040	**S**
	multigravida	201.39	28.753				
Psychological health	Primigravida	56.99	11.926	1.089	348	.277	**N.S**
	multigravida	55.62	10.945				
Spiritual health	Primigravida	32.61	5.783	.773	348	.440	**N.S**
	multigravida	31.61	5.782				

Overall self-care behavior	Primigravida	296.28	38.841	1.767	348	.048	**S**
	multigravida	288.61	39.110				

df: The amount of liberty, SD: Standard deviation, Sig: significance, M: mean, t: t-test,
p: Probability value, N.S: Not significant, S: Significant and H.S: High significant

The self-care behaviors related to primigravida as a whole show a significant difference (p-value =.048); additionally, the self-care behaviors related to the management of physiological minor discomfort show a significant difference (p-value =.040)

Table (4-14): Assessment of Self-Care Behavior Concerning Psychological Health during Pregnancy among Women

Self-care behavior	f	%	M	SD	Ass.
Poor	26	7.5	56.12	11.313	Moderate
Moderate	215	61.4			
Good	109	31.1			
Total	***350***	***100***			

M: Mean for total score, %: Percentage, f: Frequency, and SD: Standard Deviation for total score Ass: Evaluation Inadequate=17–39.66, Adequate=39.67–62.33, and Excellent=62.34–85

The table indicates that 61.4% of pregnant women (M±SD= 56.12±11.313) report having moderate self-care behaviors for their psychological health, while 311% report having good self-care behaviors.

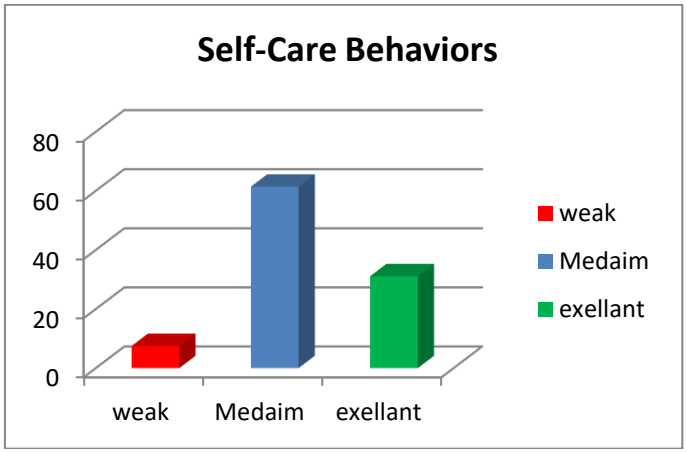

Figure (4-2) : Self-Care Behavior for Psychological Health among Women (N=350)

In response to this Figure (4-2) statistic, 61.4% of expectant mothers engage in modest self-care activities related to their mental health.

Table (4-16): Assessment of Self-Care Behavior Concerning Spiritual Health during Pregnancy among Women

Self-care behavior	f	%	M	SD	Ass.
Poor	16	4.6	31.79	5.779	Moderate
Moderate	195	55.7			
Good	139	39.7			
Total	***350***	***100***			

M: Mean for the overall score, SD: Standard Deviation for the total score, f: Frequency, %: Percentage, Ass: Assessment, Poor= 9 – 21, Moderate= 21.1 – 33, Good= 33.1 – 45

According to this table, pregnant women practice moderate to good self-care when it comes to their spiritual health, with 55.7% of them falling into the moderate self-care category (M±SD= 31.79±5.779) and 39.7% falling into the good self-care category.

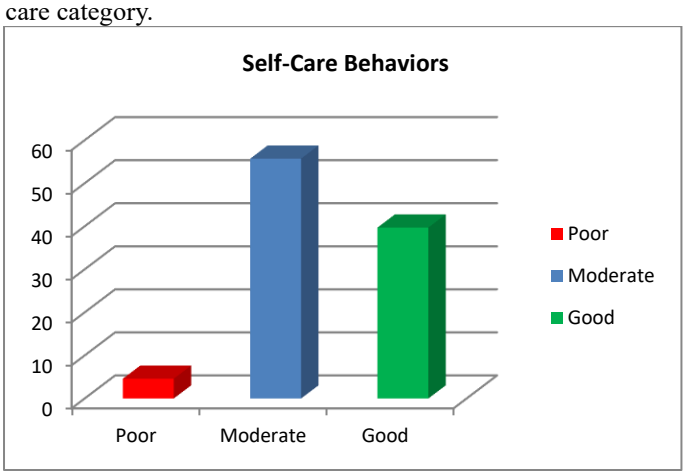

Figure (4-3): Self-Care Behavior for Spiritual Health among Women (N=350)

This statisticin the Table (4-17) shows that 55.7% of expectant mothers had moderate spiritual health self-care practices.

Table (4-18): Overall Assessment of Self-Care Behavior about Management of Women's Minor Discomforts During Pregnancy

Self-care behavior	f	%	M	SD	Ass.
Inadequate	16	4.6	291.39	39.131	Moderate
Moderate	307	87.7			
Excellent	27	7.7			
Total	***350***	***100***			

M: Mean for total score, %: Percentage, f: Frequency, and SD: Standard Deviation for total score Ass: Evaluation Inadequate = 95 – 221.66, moderate = 221.67 – 348.33, and Excellent = 348.34 – 475

As indicated by 87.7% of the pregnant women in this table (M±SD= 291.39±39.131), moderate self-care behavior is displayed on how to handle minor aches and pains throughout pregnancy.

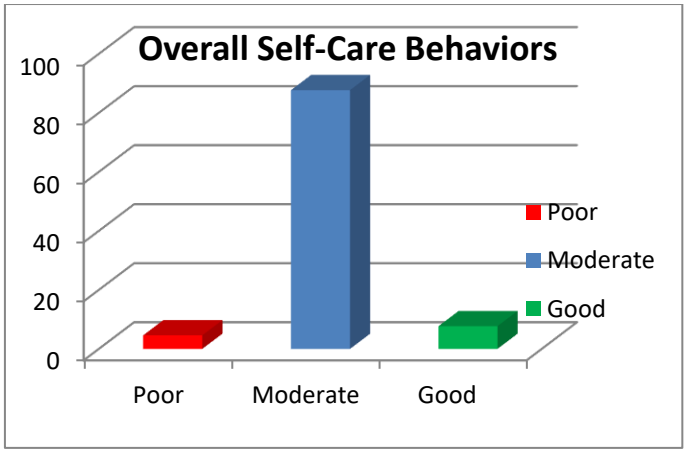

Figure (4-4): Overall Self-Care Behavior among Women (N=350)

According to this data in figure (4-4), 87.7% of expectant mothers engage in modest self-care activities.

Table 4. Relationship among Overall Self-Care Behaviors among Women and their Sociodemographic Variables (N=350)

Variables		Self-care behaviors				Association
		Poor	Moderate	Good	Total	
Age (year)	> 20	2	32	3	37	**r^s = .086** **P-value= .109** **Sig= N.S**
	20 – 29	7	138	19	164	
	30 – 39	5	127	5	137	
	40 ≤	2	10	0	12	
	Total	16	307	27	350	
Education level	Doesn't read & write	5	27	3	35	**r^s = .220** **P-value= .001** **Sig= H.S**
	Read and write	0	37	2	39	
	primary educational school	5	55	2	62	
	Intermediate school	1	37	1	39	
	Secondary school	3	49	4	56	
	Diploma	1	34	5	40	
	Bachelor	1	57	8	66	
	Postgraduate	0	11	2	13	
	Total	16	307	27	350	
Occupation	Housewife	12	177	9	198	**r^s = .162** **P-value= .002** **Sig= H.S**
	Employee	4	114	15	133	
	Free work	0	16	3	19	
	Total	16	307	27	350	
Residency	Rural	8	45	9	62	**r^*= 059** **P-value= .273** **Sig= N.S**
	Urban	8	262	18	288	
	Total	16	307	27	350	
Family type	Nuclear	3	188	17	208	**r^s = .153** **P-value= .004** **Sig= H.S**
	Extended	9	89	9	107	
	Largely extended	4	30	1	35	
	Total	16	307	27	350	

N.S: Not Significant, S: Significant, H.S: High Significant, rs: Spearman Correlation coefficient,
r*: Biserial correlation coefficient, P: Probability and Sig: Significance

The table presents a statistically significant association (p-values of.001,.002, and.004) between the family type, occupation, and education level of pregnant women and their total self-care practices.

Table 5. Relationship between Overall Self-Care Behaviors among Women and their Reproductive Health Variables (N=350)

Variables		Self-care behaviors				Association
		Poor	Moderate	Good	Total	
Gravidity	Primigravida	4	108	15	127	**r^*= .447 P-value= .001 Sig= H.S**
	Multigravida	12	199	12	223	
	Total	16	307	27	350	
Abortion	None	5	176	18	199	**r^s = .164 P-value= .002 Sig= H.S**
	Once	5	70	9	84	
	Twice	4	42	0	46	
	More than two	2	19	0	21	
	Total	16	307	27	350	
Parity	None	0	65	10	75	**r^s = .142 P-value= .008 Sig= S**
	1	3	66	3	72	
	2 – 3	9	95	9	113	
	More than 3	4	81	5	90	
	Total	16	307	27	350	
Gestational age	First semester	1	14	2	17	**r^s = .080 P-value= .134 Sig= N.S**
	Second semester	0	1	0	1	
	Third semester	15	292	25	332	
	Total	16	307	27	350	
First follow-up	First semester	14	266	27	307	**r^s = .130 P-value= .050 Sig= S**
	Second semester	1	29	0	30	
	Third semester	1	12	0	13	
	Total	16	307	27	350	
Duration of marriage	Between one and five years	3	163	20	186	**r^s = .135 the p-value = .011 Sig= S**
	Six to ten years	7	70	4	81	
	11 – 15 year	4	30	1	35	
	Sixteen year ≤	2	44	2	48	
	Overall	16	307	27	350	

Not Significant (N.S.), Significant (S). H.S.: Very Important rs: Spearman r*: Biserial correlation coefficient, correlation coefficient P: Chance and Sig: Importance

The total self-care behaviors of pregnant women are significantly correlated (p-values =.001,.002,.008,.050, and.011, respectively) with their gravidity, number of abortions, parity, and length of marriage, as shown in Table (4-21).

Table 6. Relationship among Self-Care Behaviors Domains among Women and their Socio-demographic Variables (N=350)

Variables		Self-Care Behaviors		
		Physiological health	Psychological health	Spiritual health
Age	The Correlation	.112*	.009	.004
	A Sig.	.037	.865	.941
Level of education	The Correlation	.237**	.119*	.053
	A Sig.	.001	.026	.324
Occupation	The Correlation	.151**	.154**	.001
	A Sig.	.005	.004	.991
Residency	The Correlation	.060	.045	.018
	A Sig.	.260	.399	.744
Family type	The Correlation	.149**	.127*	.062
	A Sig.	.005	.018	.350

* The correlation is significant at the two-tailed 0.05 level, and
** the correlation is significant at the two-tailed 0.01 level)

According to the table, there is a strong association between women's self-care behavior related to physiological health and their age, education level, occupation, and family type, with p-values of.037,.001,.005, and.005. Women's educational attainment, employment status, and family structure are significantly correlated with their self-care practices in relation to psychological health at p-values of.026,.004, and.018. There is no evidence of a There is a strong relationship between the demographic traits of women and their spiritual self-care habits.

Table 7. Relationship among Self-Care Behaviors Domains among Women and their Reproductive Health Variables (N=350)

Variables		Self-Care Behaviors		
		Physiological health	Psychological health	Spiritual health
Gravidity	The Correlation	.094	.049	.040
	A Sig.	.081	.363	.458
Abortion	The Correlation	.183**	.088	.031
	A Sig.	.001	.100	.563
Parity	The Correlation	.174**	.049	.050
	A Sig.	.001	.361	.354
Gestational age	The Correlation	.052	.107*	.012
	A Sig.	.328	.045	.826
First time follow up	The Correlation	.129*	.038	.110*
	A Sig.	.016	.483	.039
Marriage duration	The Correlation	.155**	.025	.079
	A Sig.	.004	.643	. 140

The correlation coefficient is significant at the 0.05 level (two-tailed).
* The correlation is significant at the two-tailed 0.01 level.

This table (4-23) shows the significant correlations between women's self-care practices and their physiological health as well as their abortion, parity, first-time follow-up, and length of marriage at p-values of 0.001, 0.001, 0.016, and 0.004. There is a substantial association (p-value=.045) between women's psychological health-related self-care practices and gestational age. The first follow-up and spiritual self-care behaviors are significantly correlated (p-value =.039).

Discussion

Evaluation of Women's Self-Care Practices Regarding the Handling of Physiological Minor Pains During Pregnancy Table (4-3) shows that 81.1% of pregnant women (M±SD = 203.49±28.786) reported managing physiological mild discomforts using moderate self-care strategies. From the perspective of the researcher, the sample consists of people with a moderate level of education, a large number of children, and a lack of cultural awareness regarding pregnancy planning, early marriage, and the constant search for pregnancy's drawbacks and inconveniences and how to deal with them (e.g., visiting the doctor at the first sign of discomfort and continuing treatment, rather than looking for ways to lessen these inconveniences and achieve a pregnancy without complications or difficulty). The results of this investigation disagree with those of the study conducted by (Ayoub& Awed, 2018).

According to this study, 56% of participants had little knowledge of common pregnancy discomforts. The current study's findings concur with that of the previous research (Kaur & Singh, 2018) According to the results of this study 01% of About how to treat minor ailments on their own while pregnant, the expectant women knew excellent, good, mediocre, below average, and poor about it, with 06% having good knowledge, 4% having poor knowledge, and 73% having average knowledge. The current study's findings are corroborated by research done in 2019 by Alageswari and Dash, which reveals that while 38% of moms had inadequate knowledge of minor illnesses, the majority of 62% of expectant women possessed a moderate level of expertise. Similar to this research ,(Karnati and Vanaja, 2015) studied Pregnancy-related mild discomforts and self-management techniques in Andhra Pradesh, India. They discovered that 26.67% of participants knew something well, 33.33% knew something mediocre, and 40% knew something bad. Furthermore, the results of this study disagree with those of Aldossary et al.'s (2018) investigation. The main finding shows that 32% of the moms had outstanding knowledge, 2% had low knowledge, and 59% of the mothers had good knowledge. Furthermore, the results of this study show that the primigravida women employed a good practice score of 47.0% for the total number of steps they did to reduce the discomforts associated with pregnancy. the current study's findings conflict with those of research by (Aziz & Maqsood, 2016). This study revealed that pregnant women had fair knowledge and poor self-management. The study's conclusions also showed that the ways in which expectant mothers handled small discomforts on their own were disgusting. The current study's findings differ from those of research by Samantha et al. (2020). According to the current study, primigravida women scored well (26.32%) and well (48.59%) on a knowledge scale for common minor pregnancy discomforts. Assessment of Self-Care Behavior Concerning Psychological Health during Pregnancy among Women

Table (4–14): This table demonstrates that while 311% of pregnant women exhibit excellent self-care behaviors, 61.4% of them report having moderate psychological health-related self-care behaviors (M±SD= 56.12±11.313). According to this table, pregnant women practice moderately good psychological self-care; the mean score for all items is moderate, with the exception of three that demonstrate good psychological self-care behaviors: (Usually Feel worry about pregnancy), (I think my emotions and mood are worth paying attention to), and (I try to be in a good mood). The current study's findings are not the same as those of the study conducted by (Kazemi et al., 2016).

That display Insufficient knowledge existed regarding adopting a healthy lifestyle, and the primary barriers to addressing health behaviors were time and the absence of a comprehensive approach within the healthcare system. Additionally, these results conflict with those of Umar and Adel's (2019) descriptive study assessing the health practices of expectant mothers. He found that they had poor sleep, bad habits with relaxation, medication, and medical care. Additionally, these results concur with the research done by Nurhasanah et al. (2020). The mean self-care behaviors of a pregnant woman are 156.5 (SD = 16.91), which is considered moderate.. Through the empowerment of self-care behaviors toward pregnancy-related problems, path analysis demonstrated the direct and indirect benefits of knowledge, self-efficacy, and social support. This result was different from the previous study's (Nguyenet al., 2022). Social support has only recently been found to strengthen the association between mental health and positive conduct. The indirect effect of social support was responsible for 11.9% of the overall effect and 13.5% of the direct effect. This study verified that risky behaviors could be decreased with the use of appraisal support. among pregnant women, and it also demonstrated the potential role of social support in improving their psychological wellbeing through mediating effects of health behaviors. This outcome was consistent with the earlier research (Kim & Dee, 2017). Approximately 43% of women were at risk for PPD. Among women with PPD, self-care skills, spirituality, and social support were all strongly correlated. Social support was a significant predictor of self-care ability for "Nutrition," "Psychological well-being," "Exercise," and "Responsible Health Practices" in rural Hispanic women at risk for PPD. This outcome contradicted the findings of the earlier study, which found that only 6.8% of the pregnant women studied had poor knowledge after the program, compared to approximately one-third (32.2%) who had good level knowledge prior to the program. Additionally, the current study showed that over two thirds (69.5%) of the women under investigation had good knowledge after the program, compared to 23.7% prior to the program. These findings were consistent with a Mukamana (2019) study. study that discovered the majority of expectant mothers received prenatal care aimed at enhancing post-test knowledge. Assessment of Self-Care Behavior about Spiritual Health among Pregnant Women able (4–17) This table shows that pregnant women practice moderate self-care when it comes to their spiritual health; the mean score is moderate for all items, with the exception of three that demonstrate good self-care practices: (I feel satisfied after meditating), (I turn to meditation to find inner peace and strength), and (I turn to meditation to find inner peace and strength). According to this table, pregnant women practice moderate to good self-care when it comes to their spiritual health, with 55.7% of them falling into the moderate self-care category (M±SD= 31.79±5.779) and 39.7% falling into the good self-care category. These results are consistent with the research done by Nurhasanah et al. (2020). The mean self-care behaviors of a pregnant woman are 156.5 (SD = 16.91), which is considered moderate. Through empowerment of self-care behaviors toward pregnancy-related complications, path analysis revealed the direct and indirect effects of knowledge, self-efficacy, and social support. This outcome was consistent with the earlier research (Kim & Dee, 2017). Approximately 43% of women were at risk for PPD. The ability to take care of oneself, spirituality, and social support were all highly correlated in PPD-afflicted women. In the rural Hispanic women at risk for PPD, social support was a significant predictor of self-care ability for "Nutrition," "Psychological well-being," "Exercise," and "Responsible Health Practices." The results of this study emphasize the significance of social support, spirituality, and religious beliefs and practices during pregnancy. This outcome was consistent with the earlier research that was carried out by (Rabiepoor and others, 2019) Pregnant women who scored highest on spiritual health (25.86 ± 4.7) indicated that childbearing was a profoundly transformative experience for them, leading to a higher sense of spirituality throughout the pregnancy and childbirth. First-time mothers scored higher on spiritual health and physical activity than multigravida women in the current study (Lin et al. 2009) It suggests that expectant mothers are typically driven to make changes to their lifestyle that will improve their health, especially if it is their first child. The fact that women who have children have less time to adopt a healthy lifestyle is another explanation.

Conclusions

conclusions showed that Self-care behaviors for minor discomforts among pregnant women were also moderate. The total self-care behaviors of pregnant women's are highly correlated with their family type, occupation, and educational attainment. Additionally, there is a strong correlation between a pregnant woman's general self-care practices and her gravidity, number of abortions, parity, first follow-up, and marital length. Overall Assessment of Self-Care Behavior about Management of Women's Minor Discomforts During Pregnancy show moderate level and Management of Physiological Women's Minor Discomforts During Pregnancy show moderate level, Psychological Health during Pregnancy among Women show moderate level. Self-Care Behavior Differ Significantly in Regards to Gravidity primigravida the significant difference is particularly reported in self-care behaviors regarding management of physiological minor discomfort. There is high significant relationship among overall pregnant women's self-care behavior and their level of education, occupation, and family type. there is significant relationship among overall self-care behaviors among pregnant women and their gravidity, number of abortion, parity, first follow-up, and duration of marriage.

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