A COMPARATIVE STUDY TO ASSESS THE ANTEPARTUM STRESS, FAMILY SUPPORT, SELF ESTEEM AMONG PRIMI AND MULTI GRAVIDA MOTHERS IN SELECTED EMERGENCY OBSTETRICAL CARE CENTRES, CHENNAI.

SIGNATURE OF THE EXTERNAL EXAMINER

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Dissertation submitted to

THE TAMILNADU DR.M.G.R.MEDICAL UNIVERSITY

CHENNAI-600 032

In partial fulfillment of the requirement

for the degree of

MASTER OF SCIENCE IN NURSING

APRIL-2016

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Certified that this is the bonafide work of

Ms. Seematti.P
II Year M.Sc., Nursing
M.A.Chidambaram College of Nursing
V.H.S., T.T.T.I. Post, Adyar,
Chennai -600 113

Signature ----------

Prof. Dr. R. Sudha, R.N., R.M., M.Sc (N), Ph.D.
Principal and Professor in Nursing
M.A.Chidambaram College of Nursing
V.H.S., T.T.T.I. Post, Adyar,
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Approved by the Dissertation Committee in Feburary-2015

PROFESSOR IN NURSING RESEARCH
Prof. Dr. R. SUDHA, R.N., R.M., M.Sc.(N), Ph.D. _____
Principal and Professor in Nursing
M.A. Chidambaram College of Nursing
V.H.S., T.T.T.I. Post, Adyar,
Chennai - 600 113.

CLINICAL SPECIALITY EXPERT
Mrs. PREMA JANARDAN, R.N., R.M., M.Sc.(N). _____
Reader in Nursing
M.A.Chidambaram College of Nursing
V.H.S., T.T.T.I. Post, Adyar,
Chennai - 600 113.

MEDICAL EXPERT
Dr.MEENAKSHI ARVIND, M.B.B.S., DGO. _____
Medical Officer
Emergency Obstetrical Care Centre
Pulianthope
Chennai-600 012.

Dissertation submitted to
THE TAMILNADU DR.M.G.R MEDICAL UNIVERSITY
CHENNAI – 600 032

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COMPARATIVE STUDY TO ASSESS THE ANTEPARTUM STRESS, FAMILY SUPPORT AND SELF ESTEEM AMONG PRIMI AND MULTI GRAVIDA MOTHERS.

ABSTRACT

INTRODUCTION

Pregnancy is the privilege of experiencing God's miracles on earth Pregnancy is a time of many changes. The body, the emotion and the family life are changing. Feeling stressed is common during pregnancy, but too much of uncoped stress can make pregnancy uncomfortable for both the mother and fetus. It causes sleeping problems, headache, loss of appetite or over eating, high blood pressure, premature baby or a low birth weight baby etc. The support from the family members were found to be varying. Mothers with complications will be able to cope with the stress even when there wasn't much support from the family members if their self esteem was good. Presuming that family support and self esteem was good, the level of stress during antepartum period can be reduced.

STATEMENT

A comparative study to assess the antepartum stress, family support and self esteem among primi and multi gravida mothers in selected Emergency Obstetrical Care Centers, Chennai.

OBJECTIVES

- To assess and compare the antepartum stress, family support and self esteem among primi and multi gravida mothers with risk and without risk.
- To associate the antepartum stress, family support and self esteem with the demographic variables.

HYPOTHESIS

- H_0 - There is no statistically significant difference in antepartum stress, family support and self esteem between primi and multi gravida mothers with risk and without risk.

METHODOLOGY

The research design used was descriptive design. The setting of the study was Emergency Obstetrical Care Centres, Saidapet and Pulianthope, Chennai. Total of 240 samples 120 primi gravida and 120 multi gravida were (60 with risk and 60 without risk) selected using non probability purposive sampling technique.

MEASUREMENT AND TOOL

Data was obtained from the mothers regarding demographic variables, antepartum stress, family support and self esteem using structured questionnaire and rating scale. The data was analyzed using descriptive and inferential statistics.

RESULTS

The study findings revealed that primi gravida mothers without risk had mild antepartum stress, whereas primi mothers with risk had moderate antepartum stress, both primi gravida mothers with risk and without had high family support and high self esteem. Multi gravida mothers without risk had mild antepartum stress, high family support and high self esteem and mothers with risk had moderate antepartum stress, high family support and high self esteem. None of the mothers had severe antepartum stress, mild family support and low self esteem.

There was statistically significant difference between stress among primi and multi gravida mothers with and without risk at ($p= 0.001$) level. There was statistically significant difference between family support among primi and multi gravida mothers with risk and without risk at ($P <0.05$) level. There was statistically

significant difference between self esteem among primi and multi gravida mothers with risk and without risk at ($P < 0.05$) level. Also there was significant association between the antepartum stress with the gestational age, age of the mothers and type of the family, Family support with the age of the mothers, family monthly income and type of family and self esteem with the age of the mothers, educational status, family monthly income and type of the family. But there was no statistically significant association found with other demographic variables

DISCUSSION

From the study findings, it is evident that all the antenatal mothers had stress, high family support and high self esteem. None of the mothers had severe stress which could have been influenced by the family support and self esteem. Also there was significant association between the antepartum stress with the gestational age, age of the mothers and type of the family, Family support with the age of the mothers, family monthly income and type of the family and self esteem with the age of the mothers, educational status, family monthly income and type of the family.

CONCLUSION

The study concluded that the all the primi gravida and multi gravida mothers with risk and without risk had stress, but the level of antepartum stress varied between primi and multi gravida mothers which was influenced by the level of family support and the level of self esteem. The study proved that antepartum stress, family support and self esteem were related with each other. One can have the influence on other factors.

TABLES OF CONTENTS

APPENDICES

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER I

INTRODUCTION

Pregnancy is the privilege of experiencing God's miracles on earth. It is one of the stage of joyful anticipation which brings many changes in the body, the emotion and the family life. One can welcome these changes, but they can add new stress to the life which can have both beneficial and negative effects. Stress during pregnancy is common, but too much of uncoped stress can make the pregnancy risk for both the mother and the foetus. It causes sleeping problems, headache, lose of appetite or over eating, high blood pressure, premature fetus or a low birth weight baby etc.

The causes of stress are different for every woman, but there are some common causes during pregnancy like nausea, vomiting, constipation, being tired or having backache. Changing hormones can also cause mood changes. If pregnant women work, it can also lead to stress.

The ways to overcome the antepartum stress are by knowing the factors which are causing stress and talking about it to their partner, a friend or health care provider. Then by realizing that the discomforts of pregnancy are only temporary and taking steps to overcome or by handling those discomforts. Staying healthy and fit, eating nutritious foods, drinking plenty of water, sound sleep and exercise can help to reduce stress. Having good support network, including partner, family and friends asking their provider about resources in the community that may be able to help.

Family support helps the mother to overcome the stress before and during pregnancy. The help rendered by the family members like, supporting her during physical activities like cooking, washing, cleaning etc, promoting her psychological

well being by counseling her when feeling hope less, staying with her when she feels upset etc. Meeting her needs through financial support, proving adequate and necessary information to the mother. Likewise the family members can help the mothers to reduce her stress. However, studies have shown that for African American women, family support can decrease the risk for stress. Evidences suggest that the programs, creating social pregnancy-centered networks for pregnant women (like Centering Pregnancy) can reduce the risk of low birth weight among participants. (Oklahoma State Department of Health, 2009).

Self-esteem is an aspect of personality that are developed across the lifespan. Normally human beings should have high self esteem. Pregnancy may bring changes in their self-esteem because of physiological changes, body image and so on. That too in pregnancy, if a woman has grown up with a poor sense of self esteem, can add to stress, especially with the changes that occurs during pregnancy. Feeling stressed and incompetent can also lead to low self esteem during pregnancy (Zucker, J. 2014).

BACK GROUND OF THE STUDY

Women are twice as likely as men to have stress, depression, anxiety or panic attacks. The physical symptoms associated with stress such as increased heart rate, blood pressure and muscle tension. Even memory become dull during stress, thinking ability gets diminished and efficiency is retarded.

The prevalence of antenatal stress is rapidly increasing, which is associated with many maternal and fetal complications. Sandesh, P. et al. (2014) studied the prevalence of stress among pregnant women and found that 35 % of antenatal mothers were stressed during first trimester and 34.2% during third trimester. Excessive stress

in pregnancy can lead to potential problems in pregnancy and in their outcomes. Babies born to these mothers are preterm, low birth etc.

A descriptive survey by Roth, C. A. (2004) explored perceived social support of pregnant women was comprised of 60 pregnant women in their second and third trimester was assessed using Perceived social support self-report surveys. Research findings show that social support positively influences pregnancy outcomes.

Evidences suggest that the relationship between antepartum stress and depressive symptoms was partially mediated by higher levels of the internal resources of satisfaction with social support and self-esteem. Self-esteem had a greater influence on the relationship between antepartum stress and depressive symptoms than social support**.** (Jesse, E. D., Kim, H & Herndon, C. 2011).

NEED FOR THE STUDY

Stress is experienced by every human being irrespective of age, sex and nationality. Stress among the antenatal mother is reality. Stress can come from any situation or thought that makes frustration, angry or anxious. Pregnancy and stress often go hand-in-hand for many women. Aside from worrying about the actual labor and safety of the unborn baby, a lot of pregnant women also worry about the financial aspects of pregnancy. While some stress during pregnancy is to be expected, high level of stress is dangerous. It is also believed that it plays a major role in the miscarriage.

Pregnancy and stress can be a very dangerous combination. Finding ways to manage stress during this time is essential to the health of the unborn baby. Taking care of both the body and mind are the best things that women can do during their pregnancies.

Evidence suggests that pregnancy, labor and the postnatal period are times of tremendous stress, anxiety, emotional, turmoil and readjustment. Careful consideration must be given, therefore, to the exploration and identification of risk factors during the antenatal period. Fortunately, research is showing that lifestyle changes and stress-reduction techniques can help people learn to manage their stress. The study reports created an insight that there is more prevalence of stress among the primi mothers.

Studies during the last two decades have provided continuing and mounting evidence that negative maternal emotions during pregnancy are associated with an adverse pregnancy outcome. A meta-analysis of 29 studies on work related stress and adverse pregnancy outcome showed that occupational exposures significantly associated with preterm birth included physically demanding work, prolonged standing, shift and night work and a high cumulative work fatigue score. Physically demanding work was also related to pregnancy-induced hypertension and preeclampsia.

While the investigator was interacting with the antenatal mothers during her maternity posting, found that the antenatal mothers were stressed and the mothers shared that they feel more stressed due to physical and physiological changes, lack of sleep, labour pain, fear of getting abortions, sex of unborn fetus, workload, poor family support, existing medical problems etc. Also, mothers from nuclear family ventilated that, they were not able to carry out their routines at proper times because of these changes. The investigator found that the support from the family members was found to be varying. It was observed that the mothers with complications were able to cope with the stress even when there wasn't much support from the family members but their self esteem was good. So there might be some relationship between the

antepartum stress, family support and self esteem. It can be assumed that if the family support and self esteem is good, the level of stress during antepartum period can be reduced. So the investigator felt the need to assess the stress, family support and self esteem of the mother to identify the relationship that exists between the antepartum stress, family support and self esteem among antenatal mothers of all trimester.

STATEMENT OF THE PROBLEM

A comparative study to assess the antepartum stress, family support and self esteem among primi and multi gravida mothers in selected Emergency Obstetrical Care Centers, Chennai.

OBJECTIVES OF THE STUDY

- To assess the antepartum stress, family support and self esteem among primi and multi gravida mothers with risk and without risk.
- To compare the antepartum stress, family support and self esteem among primi and multi gravida mothers with risk and without risk.
- To associate the antepartum stress with the demographic variables.
- To associate the family support with the demographic variables.
- To associate the self esteem with the demographic variables.

OPERATIONAL DEFINITIONS

ASSESS

It is an act of gathering information regarding antepartum stress, family support and self esteem using rating scales and analyzing the data using statistical method.

ANTEPARTUM STRESS

It refers to physiological and behavioural manifestation of a pregnant woman in coping with the demands of pregnancy which will be assessed using rating scale.

FAMILY SUPPORT

It refers to physical, emotional, financial, and informational help rendered by the family members such as husband, parents, in laws or siblings to the antenatal mothers which will be assessed using rating scale.

SELF ESTEEM

It refers to the attitude of approval or disapproval towards oneself in pregnancy which will be assessed using rating scale.

PRIMI GRAVIDA

It refers to woman who has conceived for the first time.

MULTI GRAVIDA

It refers to woman who has conceived for more than one time.

EMERGENCY OBSTETRICAL CARE CENTRE

It refers to the centre which delivers 24 hours care to the mothers during antenatal, intranatal and postpartum period including newborn care.

HYPOTHESIS

H_0 - There is no statistically significant difference in antepartum stress, family support and self esteem between primi and multi gravida mothers with risk and without risk.

ASSUMPTIONS

- Mothers with risk will have more antepartum stress than mothers without risk.
- All mothers will have family support.
- Mothers with risk will have low self esteem than mothers without risk.
- Antepartum stress, family support and self esteem will be influenced by the demographic variables

DELIMITATIONS

The study is delimited to a period of four weeks of data collection.

PROJECTED OUTCOME

- The study will help to assess the antepartum stress, family support and self esteem of primi and multi gravida mothers.
- The study will help to compare the antepartum stress, family support and self esteem of primi and multi gravida mothers.

- The study will help to identify the influence of demographic variables on antepartum stress, family support and self esteem.
- The findings of the study will help the investigator to make recommendations to improve the family support and self esteem there by to reduce the antepartum stress.

CONCEPTUAL FRAME WORK

A conceptual frame work is made up of intellectual concept abstract. These concepts are assembled together to covey the association between them. It serves as a guide to identify systematically and precisely defined relationship among the variables. It gives an idea to view main and common theme of the research that is a visual diagram by which the researcher explain the area of interest.

Conceptual framework adopted for the study was based on Mercer's model of relationship between antepartum stress and family functioning.

THE EFFECT OF ANTEPARTUM STRESS ON THE FAMILY.

In antenatal care, there is a concern to provide support during pregnancy to reduce the effect of poor social support circumstances, lack of social support and self esteem among women (Chalmers et.al., 1981).

Mercer's research is concerned with a number of measures of the effect of antenatal stress relating to functioning of the family unit. Mercer and her colleagues have been seeking to understand the effect of antenatal stress on family functioning, as a whole on functioning of pairs of individuals in a family on health status.

Mercer et. al.,(1986) identified six variables from research and other literature that are related to the outcome variables of health status, dyadic relationship and family functioning .

- Antepartum stress
- Social support
- Self esteem
- Sense of mastery
- Anxiety

- Depression

ANTEPARTUM STRESS

It is described as resulting from a combination of negative life events and the level of risk associated with the pregnancy. Antepartum stress is defined as a complication of pregnancy or at risk condition (pregnancy risk) and negatively perceived life events (Mercer et. al., 1986).

FAMILY

It is defined as a dynamic system which includes sub system-individuals (mother, father, fetus/infant and dyads/ mother- father, mother- fetus, father- fetus) with in the overall family system.

Each of the independent variables, for example social support and self esteem is defined and the theoretical basis for each variable was given. Her study considered the effect of antepartum stress on family functioning within the model, it is suggested that variables have either negative or positive effects on family functioning, as indicated.

Stress from negative life events and pregnancy risk were predicted to have direct negative effects on self esteem and health status, self esteem and social support were predicted to have direct positive effects on sense of mastery, sense of mastery was predicted to have direct negative effects on family functioning (Mercer, et. al., 1988).

CHAPTER II

REVIEW OF LITERATURE

Review of literature is a key step in research process. It refers to an extensive, exhaustive and systematic examination of publications relevant to the research project. The extensive review of literature has been done and it is organized under following headings.

1. Studies related to stress of antenatal mothers.
2. Studies related to family support during antenatal period.
3. Studies related to self esteem during antenatal period.

STUDIES RELATED TO ANTENATAL STRESS

Gourounti, K., Karpathiotaki, N & Vaslamatzis, G. (2015) conducted a systematic review for the available evidence of the psychological stress, in terms of anxiety and depression of high-risk pregnancy. The review revealed that high-risk pregnant women had high levels of depression ranging from 18% to 58% and these rates decrease throughout the course of hospitalization and are similar between women hospitalized in a hospital/health centre and women bed-rested in home.

Pantha, S. et al, (2014) conducted a cross-sectional prospective observational study to assess the prevalence of antenatal stress among the pregnant women belonging the age group of 20-29 years attending Antenatal Checkup at the general Antenatal Clinic of Department of Obstetrics and Gynaecology of Patan Hospital. Data was collected by using General Health Questionnaire (GHQ-12) and 1 item Modified Life Events Inventory during the late first trimester and early third trimester. The study results showed that the prevalence of stress during pregnancy was 35% in the first trimester and 34.2% in the third trimester. The author concluded that there was high prevalence of stress among the women attending Antenatal care clinic at Patan Hospital.

Fernandes, M. et al, (2014) conducted a descriptive survey among working and non-working (30 each) antenatal mothers between the age group of 18-40 years in three local hospitals of Udupi district. Stress assessment scale was used to assess the stress, 63% of working antenatal mothers sometimes felt that they had lack of strength, 67% of working and 50% of non-working antenatal mothers sometimes complained of not getting adequate sleep at night, 50% of working antenatal mothers sometimes felt that they were lacking in socialization due to pregnancy. All antenatal mothers

participated in this study had mild stress and there was a significant difference between working and non-working antenatal mother's stress score. The researchers concluded that mothers are at more risk of developing stress during pregnancy.

Abeysena, C., Jayawardana, P. & Seneviratne, R. A., (2010) conducted a population-based prospective cohort study to determine the effect of psychosocial stress on maternal complications during pregnancy in Sri Lanka. The sample size was 774 pregnant women between 12^{th} and 28^{th} week of gestation. Psychosocial stress was assessed using the Modified Life Events Inventory and the General Health Questionnaire 30 (GHQ 30). The study concluded that psychosocial stress during the second trimester, BMI>26 kg/m^2, pre-pregnancy weight > 51 kg and low educational level were risk factors for maternal complications during pregnancy.

Woods,S M., Melville, J. L., Guo,Y., Fan, M & Gavin, A. (2009) performed cross sectional analysis on psychosocial stress during pregnancy among 1,522 women receiving prenatal care at a University Obstetrical Clinic from January 2004 through March 2008. The majority of participants reported antenatal psychosocial stress (78% low-moderate, 6% high). The study concluded that the antenatal psychosocial stress is common, and high levels of maternal factors known to contribute to poor pregnancy outcomes.

Wisborg, K., Barklin, A., Hedegaard, M. & Henriksen, T. B. (2008) conducted a study to assess the impact of psychological stress on the risk of stillbirth among 19,282 pregnant women at 30 weeks of gestation. The maternal stress was measured using a standard questionnaire on mental health. The result revealed that foetal death (after 28 weeks of gestation) occurred in 66 pregnancies (0.34% of all pregnancies).

This study observed that high levels of stress are associated with nearly twice the risk of stillbirth.

Leeners., Kuse, W., Stiller & Rath. (2007) investigated the correlation between emotional stress during pregnancy and the risk for hypertensive diseases in pregnancy (HDP). A self-administered questionnaire comprising obstetrical and psychosocial questions was completed by 725 patients and 880 controls matched for age, parity, nationality, and educational level. Emotional stress during pregnancy was associated with a 1.6-fold increased risk for HDP. The study found that psychosocial interventions to reduce emotional stress during pregnancy may help to decrease the risk to develop HDP.

Buitelaar, Huizink, Medina, M and Visser. (2003) studied the influence of maternal stress during pregnancy on the developing fetus, which resulting in delay of motor and cognitive development and impaired adaptation to stressful situations. Self-report data about daily hassles and pregnancy-specific anxiety and salivary cortisol levels were collected in nulliparous pregnant women. The study revealed that increased maternal stress during pregnancy seems to be one of the determinants of temperamental variation and delay of development of infants and may be a risk factor for developing psychopathology later in life.

STUDIES RELATED TO FAMILY SUPPORT DURING ANTENATAL PERIOD

Faramarz, M & Pasha, H. (2015). conducted a cross sectional study to determine the role of social support in prediction of stress during pregnancy among 210 pregnant women aging 18-40 years, who referred to two teaching hospitals of Babol in 2013. The subjects filled out demographic profile checklist, Pregnancy

Experience Scale (PES) and Social Support Questionnaire (SSQ) in the first, second and third trimesters of pregnancy. The results demonstrated that social support had a significant positive relationship with pleasant experiences and a significant negative relationship with unpleasant experiences and stress during pregnancy.

Haobijam, J., Sharma, U & David, S. (2010) conducted a study to explore family support and its effect on outcome of pregnancy in terms of maternal health during pregnancy and neonatal health. Purposive sampling method was used to collect the data from 80 postnatal mothers who were admitted in the postnatal unit of Christian Medical College and Hospital, Ludhiana. They were interviewed related to the four areas of support -emotional, informational, social and financial support during pregnancy with the structured questionnaire and observational checklist. The study revealed that the emotional support for the mothers during pregnancy was more as compared to the other areas. There was a significant positive relationship between family support and outcome of pregnancy.

Giurgescu C, Penckofer S., et al (2006) investigated whether prenatal coping strategies mediate the effects of uncertainty and social support on the psychological well being of high-risk pregnant women using a cross – sectional, descriptive, co relational design and convenience sampling technique. Hundred and five high risk pregnant women at the age group of 18-34 years with 24-36 weeks gestation was selected. Data analysis included descriptive statistics corelational techniques and path analysis. The findings of the study was that women who reported higher level of uncertainty also reported less social support, less psychological well being and more use of avoidance. The modified path analysis showed that social support had a significant direct effect on preparation for motherhood.

Elsenbruch. S. (2006) conducted a study to assess the effect of social support during pregnancy on maternal depressive symptoms, quality of life and pregnancy outcomes. Eight hundred ninety-six women were prospectively studied in the first trimester of pregnancy and following completion of the pregnancy. The sample was divided into quartiles yielding groups of low, medium and high social support based on perceived social support. Pregnant women with low support reported increased depressive symptoms and reduced quality of life. The study concluded that lack of social support constitutes an important risk factor for maternal well-being during pregnancy and has adverse effects on pregnancy outcomes.

Roth, C. A. (2004) conducted a descriptive survey to explore perceived social support of pregnant women. The sample was comprised of 60 pregnant women in their second and third trimester who resided in the Intermountain region. Perceived Social Support Self-report surveys (PRQ85- Part 2) were distributed and completed by women at two urban clinics and one hospital located in Montana. Research findings showed that social support positively influenced pregnancy outcomes.

Gjerdingen, D. K., Froberg, D. G & Fontaine, P. (1991) studied the effects of social support on women's health during pregnancy, labor and delivery, and the postpartum period. This review of the literature on social support and its relationship to maternal health indicated that emotional, tangible, and informational support are positively related to mothers' mental and physical health around the time of childbirth. The importance of various types of support changes with the changing needs of women as they move from pregnancy to labor and delivery, and then to the postpartum period. During pregnancy, emotional and tangible support was provided by the spouse In addition, informational support in the form of prenatal classes is related to

decreased maternal physical complications during labor and delivery, and to improved physical and mental health postpartum.

STUDIES RELATED TO SELF ESTEEM IN ANTENATAL PERIOD

Inanir, S. et al , (2015**)** conducted a study to examine the change in body image perception (BIP) and evaluated self-esteem levels during pregnancy which included 180 females having similar demographic features, i.e. 30 non-pregnant (control group) and 50 pregnant women from each trimester (first, second and third trimester groups) at an Obstetrics Outpatient Department of a university hospital. BIP and self-esteem scores have been compared among the groups. Data relating to all participants have been obtained by using socio-demographic data form, body image scale and Rosenberg Self-Esteem Scale (RSES). All demographic features have been found to be similar among the groups. The study concluded that BIP levels have declined during the pregnancy period and self-esteem has been observed at a higher level in the first trimester compared to the advanced trimesters of pregnancy.

Meireles, JFF. et al. (2013) conducted an integrative review on body dissatisfaction among pregnant women to analyze the literature relating to body image and body dissatisfaction among pregnant women. Research was based on articles extracted from the Scopus, PubMed, BVS and PsycINFO databases, by cross-referencing “pregnancy” with the keywords “body image” and “body dissatisfaction.” Once the inclusion and exclusion criteria had been adopted, forty studies were analyzed. These produced inconclusive data about body dissatisfaction during pregnancy. Symptoms of depression, low self-esteem, an inadequate approach towards healthy eating and weight gain above recommended limits have been associated with a

negative body image. The contradictory findings could be related to the different instruments used to measure body image. In view of the possible impact that a negative body image can have on maternal and infant health during pregnancy, it is recommended that further investigations were made, in particular related to the development of a specific tool to evaluate the body image of pregnant women.

Macola L., do Vale, I. N. & Carmona, E. V. (2010) conducted a descriptive, cross-sectional study to evaluate the self-esteem of 127 pregnant women seen in a prenatal care program in a public school hospital. Data collection was performed using the Rosenberg's Self-esteem Scale. Study results revealed that 60% of the pregnant women had low scores for self-esteem. As the socio demographic data, women with fewer years of education presented higher frequency of lower self-esteem scores, which disagrees with other studies. Pregnant women who reported having an unplanned pregnancy presented higher prevalence of low self-esteem than those who reported having planned pregnancy. The lack of support from the partner to look after the baby was also associated with the pregnant women's low self-esteem.

CHAPTER III

METHODOLOGY

This comparative study was undertaken to assess the antepartum stress, family support and self esteem among primi and multi gravida mothers in selected Emergency Obstetrical Care Centres, Chennai.

This chapter on methodology deals with the description of research approach and design, study setting, population, sample, criteria for sample selection, sampling technique, sample size, data collection instrument, description of tool, validity of tool, pilot study, reliability, data collection procedure and plan for data analysis.

SCHEMATIC REPRESENTATION OF METHODOLOGY

Figure 2. Schematic representation of methodology

RESEARCH APPROACH

The research approach is evaluative in nature.

RESEARCH DESIGN

A descriptive design is chosen for the study.

MAJOR VARIABLES OF THE STUDY

The major variables in the study are antepartum stress, family support and self esteem.

RESEARCH SETTING

The study was conducted in Emergency Obstetrical Care Centre at Pulianthope and Saidapet, Chennai.

POPULATION OF THE STUDY

Population for the study included all the primi and multi gravida mothers attending Antenatal Outpatient Department.

SAMPLE

The primi and multi gravida mothers who fulfilled the inclusion criteria were selected for the study.

CRITERIA FOR THE SELECTION OF SAMPLES

INCLUSION CRITERIA

1. Primi and multi gravida mothers who were willing to participate in the study.
2. Primi and multi gravida mothers of all trimester with risk and without risk.
3. Primi and multi gravida mothers who can understand Tamil & English.

EXCLUSION CRITERIA

1. Primi and multi gravid mothers who participated in the pilot study.
2. Single and widow mothers were excluded.

SAMPLE SIZE

From the population, a sample of 120 primi mothers (60 with risk and 60 without risk) and 120 multi gravida mothers (60 with risk and 60 without risk) were selected.

SAMPLING TECHNIQUE

Non Probability Purposive sampling technique was used to select the samples. Risk assessment was done and equal number of primi and multi gravida mothers with risk and without risk were selected from population.

	Primi gravida		**Multi gravida**	
	With risk	**Without risk**	**With risk**	**Without risk**
First trimester	20	20	20	20
Second trimester	20	20	20	20
Third trimester	20	20	20	20
Total	60	60	60	60

DESCRIPTION OF DATA COLLECTION TOOL, SCORING AND INTERPERTATION

It consisted of five parts.

PART I

It consisted of structured questionnaire to elicit the demographic variables of the antenatal mothers like gravida, gestational age, age in years, religion, family monthly income, educational status, occupation, number of members in the family and supporting members.

PART II - Tool to assess the risk status of primi and multi gravida mothers.

It consisted of reproductive history (age, parity, abortion, infertility, bleeding, hypertension, previous Lower Segmental Caesarean Section, Abnormal labour), Medical and surgical conditions (previous gyneacological surgery, chronic renal disease, gestational diabetes mellitus, cardiac disease others severe medical and surgical conditions) and present pregnancy like bleeding, anemia, post maturity, hypertension, premature rupture of membranes, polyhydramnios, oligohydramnias, multiple pregnancy, Rh isoimmunisation, breech and mal presentation.

The total scores were arbitrarily classified as

Without risk	0
With risk	1 and above

PART III - Tool to assess the antepartum stress of primi and multi gravida mothers.

Three point rating scale (Never, Sometimes and Always) was used to assess the antepartum stress. It consisted of 20 items like sleep disturbances, exhaustion,

headaches, palpitation, irritation, anxious, anger, depression, impatience, forgetfulness etc and each item was scored like

Scale legend	**Scores**
Never	0
Sometimes	1
Always	2

and the total scores was 40 which was arbitrarily classified as

Scores	**Interpretation**
1-13	Mild stress
14-26	Moderate stress
27-40	Severe stress

PART IV - Tool to assess the family support of primi and multi gravida mothers.

Three point rating scale (Always, Sometimes and Never) was used to assess the family support. It consisted of 20 items related to physical support by family members like washing, cooking cleaning, purchasing, providing sleep and rest and accompanying out, Emotional support like accepting anger, consoling when anxious and hopeless, understanding delay in work, Financial support like providing money for food, buys clothes, spending money for investigations and travel, savings for newborn and informational support like giving information to changes occurring in pregnancy, home remedies for minor disorders, danger signs of pregnancy and signs of onset of labour. And each item was scored like

Scale legend	**Scores**
Never	0
Sometimes	1
Always	2

and the total scores was 40 which was arbitrarily classified as

Scores	Interpretation
1-13	Mild support
14-26	Moderate support
27-40	High support

PART V - Tool to assess the self esteem of primi and multi gravida mothers.

Three point rating scale (Never, Sometimes, Always) was used to assess the self esteem of the mother. It consisted of 20 item like feeling worthful, useless, happy, proud, confident etc and each item was scored like

Scale legend	Positive statements	Negative statements
Never	0	2
Sometimes	1	1
Always	2	0

The total scores was 40 which was arbitrarily classified as

Score	Interpretation
1-13	Low self esteem
14-26	Moderate self esteem
27-40	High self esteem

VALIDITY OF THE TOOL

The tool was validated by five experts, two Obstetricians and three Obstetrics and Gynaecological Nursing experts. The suggestions given by the experts were incorporated in the tool.

RELIABILITY OF THE TOOL

The reliability of the tool was calculated by split half method. The reliability correlation coefficient values are 0.84 for antepartum stress, 0.77 for family support and 0.81 for self esteem.

HUMAN RIGHTS AND ETHICAL CONSIDERATION

The study was approved by the ethical committee constituted by the college. Permission was obtained from the Deputy Project Co-ordinator, District Family Welfare Bureau, Chennai to conduct the study. Informed consent was obtained from the participants who participated in the study.

PILOT STUDY

The study was conducted from 11.05.2015 to 16.05.2015 at Emergency Obstetrical Care Centres, Saidapet and Pulianthope, Chennai. After obtaining approval from the research committee in the college, permission was obtained from the concerned authority to conduct the study. Informed consent was obtained from the samples. Samples fulfilling the inclusion criteria were selected using non probability purposive sampling technique and were categorized as with risk and without risk group using the risk assessment scale. Data was obtained from the mothers regarding demographic variables, antepartum stress, family support and self esteem using structured questionnaire and rating scale. It took approximately 25 minutes to collect data from each sample.

PILOT STUDY RECOMMENDATIONS

There were no practical difficulties experienced in the sample selection. The tool was feasible and the main study was carried out without any modification in the tool used for pilot study.

DATA COLLECTION METHODS

The data for the main study was collected from 01.06.2015 to 27.06.2015 at Emergency Obstetrical Care Centres, Saidapet and Pulianthope, Chennai. After obtaining approval from the research committee in the college, permission was obtained from the concerned authority to conduct the study. Informed consent was obtained from the samples. Samples fulfilling the inclusion criteria were selected using non probability purposive sampling technique and were categorized as no risk and risks group using the risk assessment scale. Data was obtained from the mothers by interview method regarding demographic variables, antepartum stress, family support and self esteem using structured questionnaire and rating scale. It took approximately 25 minutes to collect data from each sample.

PLAN FOR DATA ANALYSIS

Data analysis was done using descriptive and inferential statistics

Descriptive statistics:

- Frequency and percentage distribution was used to describe the demographic variables.
- Frequency and percentage distribution was used to assess antepartum stress, family support and self esteem.

- Mean and standard deviation was used to assess the antepartum stress, family support and self esteem.

Inferential statistics:

- ANOVA was used to compare the mean scores of antepartum stress, family support and self esteem among primi and multi gravida mothers with risk and without risk.
- 't' test was used to compare the mean scores of antepartum stress, family support and self esteem between primi mothers with risk and without risk and multi gravida mothers with risk and without risk
- Chi square was used to find the association between antepartum stress with demographic variables.
- Chi square was used to find the association between family support with demographic variables.
- Chi square was used to find the association between self esteem with demographic variables.

CHAPTER – IV

DATA ANALYSIS AND INTERPRETATION

Data analysis and interpretation is the core step in the research process. The importance of analysis and interpretation of the collected data is to systematically organize, classify and summarize it so that the results can be interpreted and comprehended to give all the answers that trigged the research. In this chapter a detailed analysis of the collected data has been done as per the objectives stated earlier.

The data obtained were classified and is presented under the following sections.

SECTION I: Frequency and percentage distribution of the demographic variables of the mothers.

SECTION II: Assessment of the level of antepartum stress among primi and multi gravida mothers.

SECTION III: Assessment of the level of family support among primi and multi gravida mothers.

SECTION IV: Assessment of the level of self esteem among primi and multi gravida mothers.

SECTION V: Comparison of antepartum stress, family support and self esteem among primi and multi gravida mothers with risk and without risk.

SECTION IV: Association of antepartum stress, family support and self esteem with the demographic variables

SECTION I

TABLE. 1 FREQUENCY AND PERCENTAGE DISTRIBUTION OF DEMOGRAPHIC VARIABLES OF THE MOTHER

Table 1.1: Frequency and percentage distribution of the demographic variables of the mothers such as gravida status, gestational age, age in years and religion **N=240**

S.No	Demographic variables	Groups											
		Primi without risk		Primi with risk		Total Primi mothers		Multi without risk		Multi with risk		Total Multi gravida mothers	
		F	%	F	%	F	%	F	%	F	%	F	%
1.	**Gravida**												
	a) 1	60	100	60	100	120	100	-	-	-	-	-	-
	b) 2 and more	-	-	-	-	-	-	60	100	60	100	120	100
2.	**Gestational age**												
	a) Upto 12	20	33.3	20	33.3	40	33.3	20	33.3	20	33.3	40	33.3
	b) 13-24	20	33.3	20	33.3	40	33.3	20	33.3	20	33.3	40	33.3
	c) 25-40	20	33.3	20	33.3	40	33.3	20	33.3	20	33.3	40	33.3
3.	**Age in years**												
	a) 21-25 years	35	58.3	35	58.3	70	58.3	30	50	27	45	57	47.5
	b) 26-30 years	25	41.7	25	41.7	50	41.7	26	43.3	33	55	59	49.2
	c) >30 years	-	-	-	-	-	-	4	6.7	-	-	04	3.3
4.	**Religion**												
	a) Hindu	43	71.7	43	71.7	86	71.7	29	48.3	33	55	62	51.7
	b) Christian	06	10	06	10	12	10	17	28.3	11	18.3	28	23.3
	c) Muslim	11	18.3	11	18.3	22	18.3	14	23.3	16	26.7	30	25

Table 1.1 shows that equal numbers (120) were primi and multi gravida mothers. Equal number (40) of the primi and multi gravida mothers were in the gestational age upto 12 weeks, 13-24 weeks, 25-40weeks. Majority (58.3%) of the primi mothers were in the age group of 21-25 years whereas majority (59%) of the multi gravida mothers were in the age group of 26-30 years. None of the primi mothers were in the age >30 years. Majority (71.75%) of the primi mothers were Hindus whereas majority (51.7%) of the multi gravida mothers were Hindus.

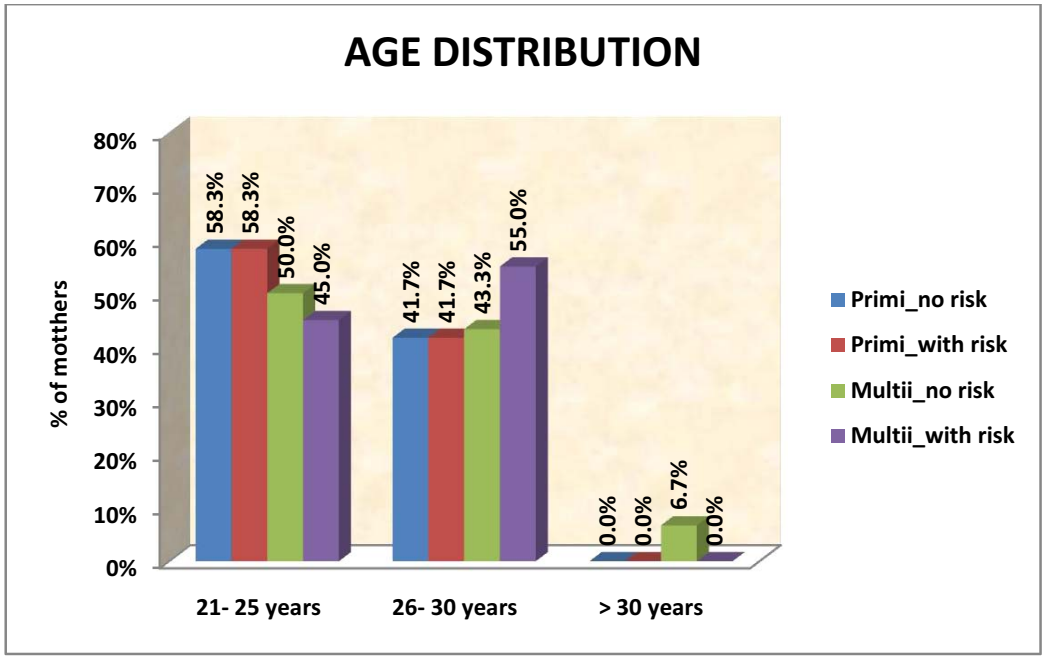

Figure 3: Percentage distribution of the age of the primi and multi gravida mothers.

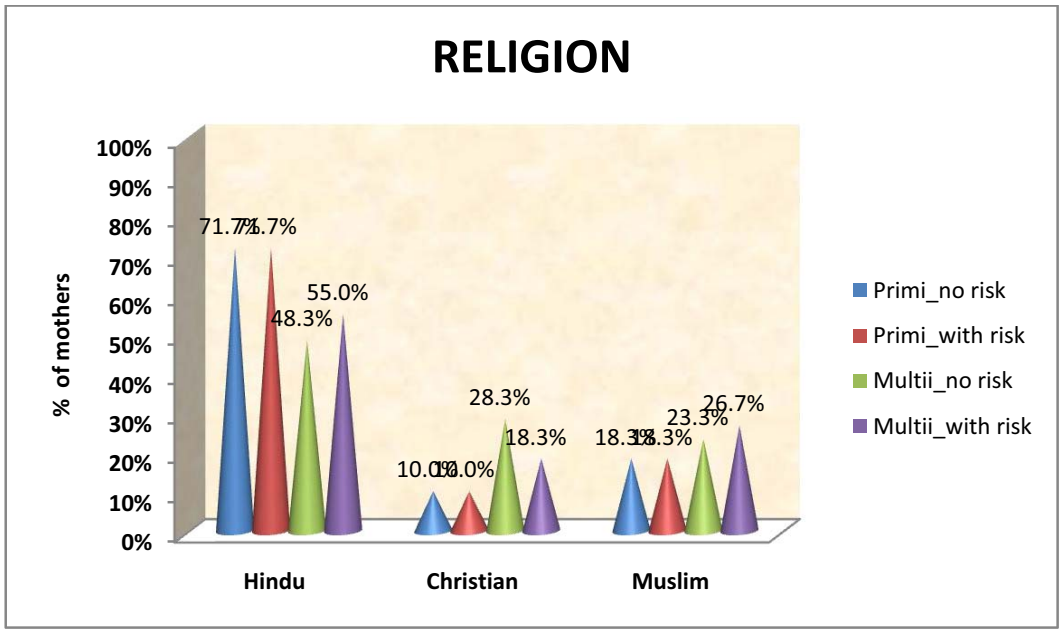

Figure 4: Percentage distribution of the religion of the primi and multi gravida mothers

Table1.2: Frequency and percentage distribution of the demographic variables of the mothers such as educational status, occupation and monthly family income. **N=240**

S.No	Demographic variables	Groups											
		Primi without risk		Primi with risk		Total Primi mothers		Multi without risk		Multi with risk		Total Multi gravida mothers	
		F	%	F	%	F	%	F	%	F	%	F	%
5.	**Educational status**												
	a) Primary school	17	28.3	17	28.3	34	28.3	16	26.7	19	31.7	35	29.1
	b) High school	19	31.7	19	31.7	38	31.7	19	31.7	28	46.7	47	39.2
	c) Higher secondary	14	23.3	14	23.3	28	23.3	09	15	10	16.7	19	15.8
	d) Degree	10	16.7	10	16.7	20	16.7	16	26.7	03	05	19	15.8
6.	**Occupation**												
	a) Unemployed	60	100	60	100	120	100	59	98.3	59	98.3	118	98.3
	b) Employed	-	-	-	-	-	-	01	1.7	01	1.7	02	1.7
7.	**Family monthly income**												
	a) Below Rs. 5000	03	05	04	6.7	07	5.9	06	10	08	13.3	14	11.7
	b) Rs 5001-10,000	09	15	09	15	18	15	06	10	14	23.3	20	16.7
	c) Rs 10,001- 15,000	18	30	17	28.3	35	29.1	24	40	18	30	42	35
	d) Above Rs. 15,001	30	50	30	50	60	50	24	40	20	33.3	44	36.6

Table. 2.2 shows that majority (31.7%) of the primi mothers and 39.2% of the multi gravida mothers had completed high school education. All the primi mothers were unemployed whereas (1.7%) of the multi gravida mothers with and without risk were employed. Majority (50%) of the primi mothers and 36.6% of the multi gravida mothers family monthly income was above Rs 15000.

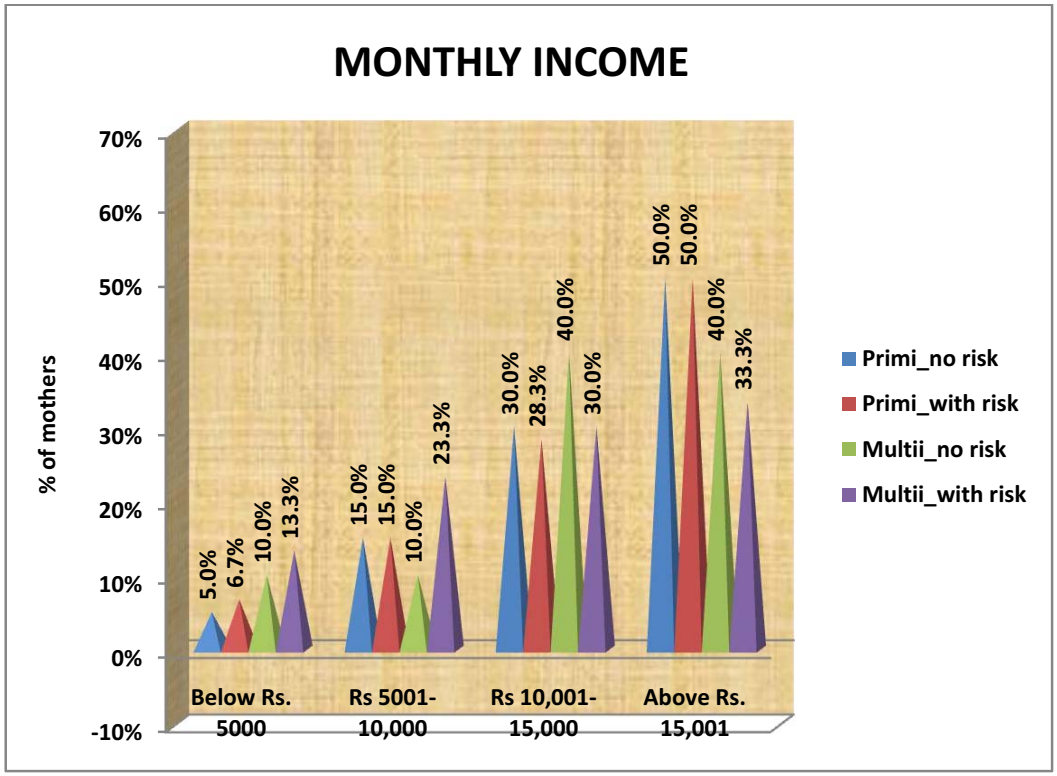

Figure 5: Percentage distribution of the family monthly income of the primi and multi gravida

Table 1.3: Frequency and percentage distribution of the demographic variables of the mothers such as type of family, number of members in the family and supporting members. N=240

S.No	Demographic variables	Groups											
		Primi without risk		Primi with risk		Total Primi mothers		Multi without risk		Multi with risk		Total Multi gravida mothers	
		F	%	F	%	F	%	F	%	F	%	F	%
8.	**Type of family**												
	a)Nuclear family	31	51.7	31	51.7	62	51.7	33	55	28	46.7	61	50.8
	b)Joint family	29	48.3	29	48.3	58	48.3	27	45	32	53.3	59	49.2
9.	**Number of members in the family**												
	a)Two	31	51.7	31	51.7	62	51.7	0	0.0	0	0.0	0	0.0
	b)Three	01	1.7	04	6.7	05	4.2	33	55	29	48.3	62	51.7
	c)> Three	28	46.6	25	41.6	53	44.1	27	45	31	51.7	58	48.3
10.	**Supporting members**												
	a)Husband & inlaws	10	16.7	10	16.7	20	16.7	16	26.7	10	16.7	26	21.7
	b)Husband & parents	17	28.3	17	28.3	34	28.3	13	21.7	13	21.7	26	21.7
	c)Husband & siblings	08	13.3	08	13.3	16	13.3	12	20	16	26.7	28	23.3
	d)Inlaws & parents	14	23.3	14	23.3	28	23.3	10	16.7	14	23.3	24	20
	e)Inlaws & siblings	08	13.3	08	13.3	16	13.3	06	10	02	3.3	08	6.7
	f)Parents & siblings	03	5.0	03	5.0	06	05	03	05	05	8.3	08	6.7

Table 1.3 shows that out of 60, equal number 31(51.7%) primi mothers with and without risk were from nuclear family whereas 33(55%) multi gravida mothers without risk were from nuclear family and 28(46.7%) of the multi gravida mothers with risk were from nuclear family. Majority (51.7%) of the primi mothers had two members in the family whereas (51.7%) of the multi gravida mothers had three members in the family. Majority (28.3%) of the primi gravida mothers with and without risk received support from husband and parents whereas (26.7%) of the multi gravida mothers without risk received support from their husband and inlaws and (23.3%) of the multi gravida with risk received support from their husband and siblings.

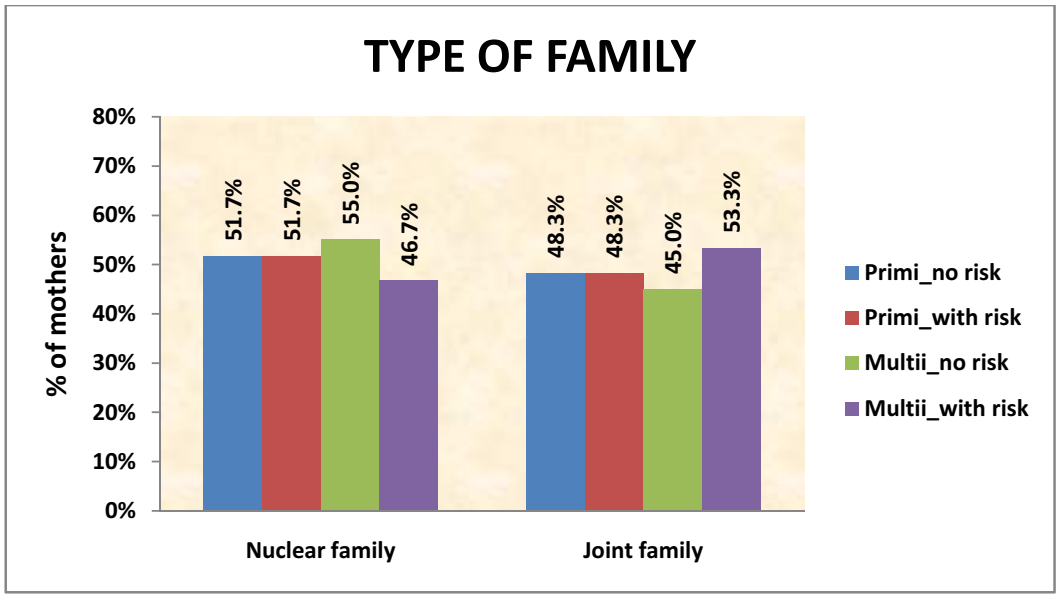

Figure 6: Percentage distribution of the type of family of the primi and multi gravida mothers.

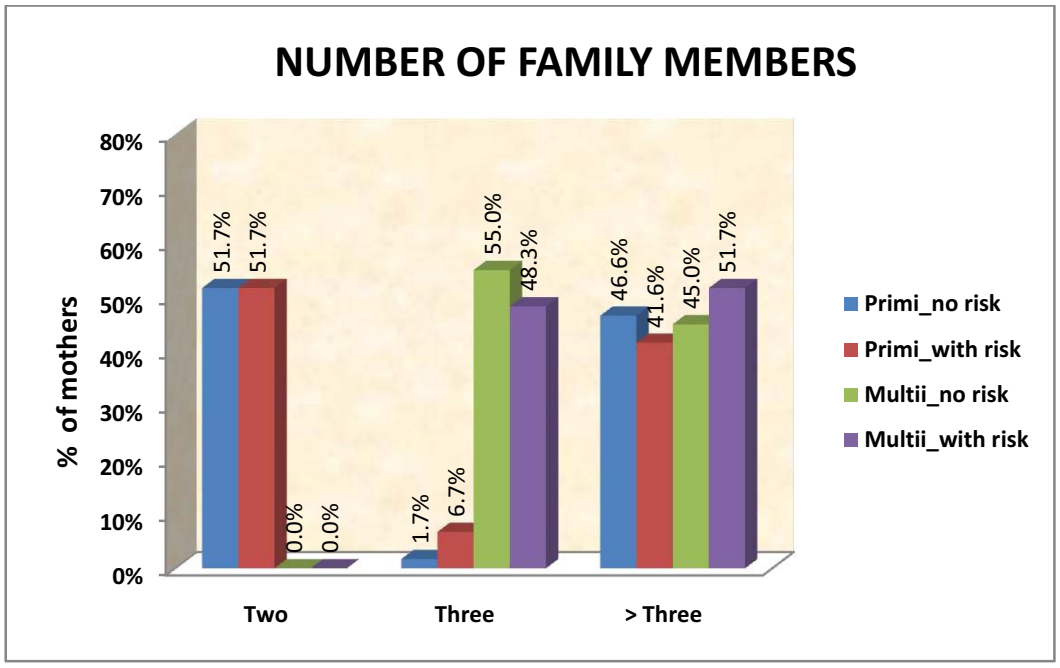

Figure 7: Percentage distribution of number of the family members of the primi and multi gravida mothers.

SECTION- II

ASSESSMENT OF ANTEPARTUM STRESS OF PRIMI AND MULTI GRAVIDA MOTHERS

Table 2: Frequency and percentage distribution of antepartum stress of the primi and multi gravida mothers with risk and without risk

N=240

Groups	Level of Antepartum stress					
	Mild		Moderate		Severe	
	F	%	F	%	F	%
Primi without risk	32	27.6	28	22.6	0	0.0
Primi with risk	21	18.1	39	31.5	0	0.0
Multi gravida without risk	37	31.9	23	18.5	0	0.0
Multi gravida with risk	26	22.4	34	27.4	0	0.0

Table 2 shows that out of 60 primi mothers without risk, majority (27.6%) of them had mild level of stress and 22.6% of them had moderate level stress whereas out of 60 multi gravida mothers without risk, majority (31.9%) of them had mild level of stress and 18.5% of them had moderate level of stress. Out of 60 primi mothers with risk, majority (31.5%) of them had moderate level of stress and 18.1% of them had mild level of stress whereas out of 60 multi gravida mothers with risk, majority (27.4%) of them had moderate level of stress and 22.4% of them had mild level of stress.

SECTION- III

ASSESSMENT OF FAMILY SUPPORT OF PRIMI AND MULTI GRAVIDA MOTHERS

Table3: Frequency and percentage distribution of family support of the primi and multi gravida mothers with risk and without risk

N=240

Groups	Level of family support					
	Mild		Moderate		Severe	
	F	%	F	%	F	%
Primi without risk	0	0.0	27	45	33	55
Primi with risk	0	0.0	15	25	45	75
Multi gravida without risk	0	0.0	28	46.7	32	53.3
Multi gravida with risk	0	0.0	17	28.3	43	71.7

Table 3 shows that out of 60 primi mothers without risk, majority (55%) of them had high level of family support and 45% of them had moderate level of family support whereas out of 60 multi gravida mothers without risk, majority (53.3%) of them had high level of family support and 46.7% of them had moderate level of family support. Out of 60 primi mothers with risk, majority (75%) of them had high level of family support and 25% of them had moderate level of family support whereas out of 60 multi gravida mothers with risk, majority (71.7%) of them had high level of family support and 28.3% of them had moderate level of family support.

SECTION –IV

ASSESSMENT OF SELF ESTEEM OF PRIMI AND MULTI GRAVIDA MOTHERS

Table 4: Frequency and percentage distribution of self esteem of primi and multi gravida mothers with risk and without risk

N=240

Groups	Level of self esteem					
	Mild		Moderate		Severe	
	F	%	F	%	F	%
Primi without risk	0	0.0	8	13.3	52	86.7
Primi with risk	0	0.0	16	26.6	44	73.4
Multi gravida without risk	0	0.0	9	15	51	85
Multi gravida with risk	0	0.0	14	23.3	46	76.7

Table 4 shows that out of 60 primi mothers without risk, majority (86.7%) of them had high level of self esteem and 13.3% of them had moderate level of self esteem whereas out of 60 multi gravida mothers without risk, majority (85%) of them had high level of self esteem and 9% of them had moderate level of self esteem. Out of 60 primi mothers with risk, majority (73.4%) of them had high level of self esteem and 26.6% of them had moderate level of self esteem whereas out of 60 multi gravida mothers with risk, majority (76.7%) of them had high level of self esteem and 23.3% of them had moderate level of self esteem.

SECTION- V

TABLE 5: COMPARISON OF ANTEPARTUM STRESS, FAMILY SUPPORT AND SELF ESTEEM AMONG PRIMI AND MULTI GRAVIDA MOTHERS WITH RISK AND WITHOUT RISK.

Table 5.1: Comparison of antepartum stress, family support and self esteem among primi gravida mothers with risk and without risk.

N=120

	Primi without risk		Primi with risk		Difference	Student independent t-test
	Mean	SD	Mean	SD		
Antepartum stress	13.30	5.61	15.50	6.04	2.20	t=2.04 p=0.04* S
Family support	27.15	4.55	28.83	4.81	1.68	t=2.32 p=0.02* S
Self esteem	33.32	2.12	32.42	2.98	0.90	t=1.96 p=0.05* S

***p<0.05 S – Significant**

Table 5.1 shows that the primi mothers without risk had the mean stress score of 13.30 with the SD of 5.61, the mean family support score of 27.15 with the SD of 4.55 and mean self esteem score of 33.32 with the SD of 2.12 whereas the primi mother with risk had the mean stress score of 15.50 with the SD of 2.20, mean family support score of 28.83 with the SD of 1.68 and mean self esteem score of 32.42 with the SD of 0.90. Also there was a statistically significant difference in stress between primi mothers with risk and without risk at p = 0.04 level. There was a statistically significant difference in family support between primi mothers with risk and without risk at p = 0.02 level. There was a statistically significant difference in self esteem between primi mothers with risk and without risk at p = 0.05 level.

Table 5.2: Comparison of antepartum stress, family support and self esteem among multi gravida mothers with risk and without risk

N=120

	Multi without risk		Multi with risk		Difference	Student independent t-test
	Mean	**SD**	**Mean**	**SD**		
Antepartum stress	12.32	2.53	15.12	4.43	2.80	t=4.2p=0.001***S
Family support	27.10	3.50	28.30	3.28	1.20	t=1.96 p=0.05 *S
Self esteem	33.23	1.96	32.00	2.45	1.23	t=1.96 p=0.05 *S

*****p<0.001**, ***p<0.05 S – Significant**

Table 5.2 shows that the multi gravida mothers without risk had the mean stress score of 12.32 with the SD of 2.53, the mean family support score of 27.10 with the SD of 3.50 and mean self esteem score of 33.23 with the SD of 1.96 whereas the multi gravida mothers with risk had the mean stress score of 15.12 with the SD of 4.43, mean family support score of 28.30 with the SD of 3.28 and mean self esteem score of 32.00 with the SD of 2.45. Also there was a statistically significant difference in stress between multi gravida mothers with and without risk at p = 0.001 level. There was a statistically significant difference in family support between multi gravida mothers with and without risk at p = 0.05 level. There was a statistically significant difference in self esteem between multi gravida mothers with and without risk at p = 0.05 level.

Table 5.3: Comparison of antepartum stress, family support and self esteem among primi and multi gravida mothers.

N=240

	Groups								One way ANOVA F-test
	Primi without risk		Primi with risk		Multi without risk		Multi with risk		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Antepartum stress	13.30	5.61	15.50	6.04	12.32	2.53	15.12	4.43	F=5.79, P=0.001**S
Family support	27.15	4.55	28.83	4.81	27.10	3.50	28.30	3.28	F=2.64, P=0.01** S
Self esteem	33.32	2.12	32.42	2.98	33.23	1.96	32.00	2.45	F=4.23, P=0.01** S

****p<0.01 S – Significant**

Table 5.3 shows that irrespective of the gravida status mothers with risk had high mean stress value than the mothers without risk. Irrespective of the gravida status and risk status, all the mothers had almost more or less same mean family support and self esteem value. This showed that there was a statistically significant difference between stress among primi and multi gravida mothers with and without risk at p = 0.001 level. There was a statistically significant difference between family support among primi and multi gravida mothers with risk and without risk at p <0.05 level. There was a statistically significant difference between self esteem among primi and multi gravida mothers with risk and without risk at p <0.05 level.

SECTION VI

TABLE 6: ASSOCIATION OF ANTEPARTUM STRESS, FAMILY SUPPORT AND SELF ESTEEM WITH SELECTED DEMOGRAPHIC VARIABLES

Table 6.1a: Association between level of antepartum stress with the demographic variables such as gestational age, age, type of family among primi mothers without risk.

N=60

Demographic variables	Level of stress				Total	Chi square test
	Mild		Moderate			
	F	%	F	%		
Gestational age						
a) Upto 12 weeks	4	20	16	80	20	χ^2=13.79
b) 13-24 weeks	15	75	5	25	20	p=0.01**S
c) 25-40 weeks	13	65	7	35	20	
Age						
a) 21-25 years	23	65.7	12	34.3	35	χ^2=5.17
b) 26-30 years	9	36	16	64	25	p=0.02**S
Type of family						
a) Nuclear family	21	67.7	10	32.3	31	χ^2=5.34
b) Joint family	11	37.9	18	62.1	29	p=0.02**S

****p<0.01 S – Significant**

Table 6.1a shows that there was a statistically significant association between level of stress with gestational age at p=0.01 level age at p=0.02 and type of family at p=0.02 level among primi mothers without risk.

Table 6.1b: Association between level of stress with the demographic variables such as gestational age and age among primi mothers with risk

N=60

Demographic variables	Level of stress				Total	Chi square test
	Mild		Moderate			
	F	%	F	%		
Gestational age						
a) Upto 12 weeks	2	10	18	90	20	χ^2=8.35
b) 13-24 weeks	10	50	10	50	20	p=0.01**S
c) 25-40 weeks	9	45	11	55	20	
Age						
a) 21-25 years	16	45.7	19	54.3	35	χ^2=4.23
b) 26-30 years	5	20.0	20	80	25	p=0.05**S

****p<0.01 S – Significant**

Table 6.1b shows that there was a statistically significant association between level of stress with gestational age at p=0.01 level, age at p=0.02 level among primi mothers with risk.

Table 6.1c: Association between level of stress with the demographic variables such as age and educational status among multi gravida mothers without risk

N=60

Demographic variables	Level of stress				Total	Chi square test
	Mild		Moderate			
	F	%	F	%		
Age						
a) 21-25 years	24	80	6	20	30	χ^2=8.63
b) 26-30 years	11	42.3	15	57.7	26	p=0.01**S
c) > 30 years	2	50	2	50	4	
Educational status						
a) Primary school	6	37.5	10	62.5	16	
b) High school	11	57.9	8	42.1	19	χ^2=7.67
c) Higher secondary	7	77.8	2	22.2	9	p=0.05*S
d) Degree	13	81.3	3	18.7	16	

****p<0.01, *p<0.05 S – Significant**

Table 6.1c shows that there was a statistically significant association between level of stress with age at p=0.01 level, education status at p=0.05 level among multi gravida mothers without risk.

Table 6.1d: Association between level of stress with the demographic variables such as gestational age and type of family among multi gravida mothers with risk

N=60

Demographic variables	Level of stress				Total	Chi square test
	Mild		Moderate			
	F	%	F	%		
Gestational age						
a) Upto 12weeks	13	65	7	35	20	χ^2=6.65
b) 13-24weeks	8	40	12	60	20	p=0.04**S
c) 25-40 weeks	5	25	15	75	20	
Type of family						
a) Nuclear family	17	60.7	11	39.3	28	χ^2=6.45
b) Joint family	9	28.1	23	71.9	32	p=0.01**S

****p<0.01 S – Significant**

Table 6.1d shows that there was a statistically significant association between level of stress with gestational age at p=0.04 level and type of family at p=0.01 level among multi gravida mothers with risk.

Table 6.2a: Association between level of family support with the demographic variables such as age and type of family among primi mothers without risk

N=60

Demographic variables	Level of family support				Total	Chi square Test
	Mild		Moderate			
	F	%	F	%		
Age						
a) 21-25 years	20	57.1	15	42.9	35	χ^2=8.63
b) 26-30 years	7	28	18	72	25	p=0.02*S
Type of family						
a) Nuclear family	18	58.1	13	41.9	31	χ^2=6.45
b) Joint family	9	31	20	69	29	p=0.03*S

***p<0.05 S – Significant**

Table 6.2a shows that there was statistically significant association between level of family support with age at p=0.02 level and type of family at p=0.03 level among primi mothers without risk

Table 6.2b Association between level of family support with the demographic variables such as age and type of family among primi mothers with risk.

N=60

Demographic variables	Level of family support				Total	Chi square test
	Mild		Moderate			
	F	%	F	%		
Age						
a) 21-25 years	13	37.1	22	62.9	35	χ^2=8.63
b) 26-30 years	2	8	23	92	25	p=0.05*S
Type of family						
a) Nuclear family	11	35.4	20	64.6	31	χ^2=6.45
b) Joint family	4	13.8	25	86.2	29	p=0.05*S

***p<0.05 S – Significant**

Table 6.2b shows that there was statistically significant association between level of family support with age at p=0.05 level and type of family at p=0.05 level among primi mothers with risk.

Table 6.2c Association between level of family support with the demographic variables such as age and family monthly income among multi gravida without risk.

N=60

Demographic variables	Level of family support				Total	Chi square test
	Mild		Moderate			
	F	%	F	%		
Age						
a) 21-25 years	19	63.3	11	39.7	30	χ^2=6.74
b) 26-30 years	8	30.7	18	69.3	26	p=0.03*S
c) > 30 years	1	25	3	75	4	
Family monthly income						
a) < Rs 5000	5	83.3	1	16.7	6	χ^2=10.62
b) Rs 5001-Rs 10,000	4	66.7	2	33.3	6	p=0.01*S
c) Rs10,001-Rs 15,000	12	50	12	50	24	
d) > Rs 15,001	5	20.8	19	79.2	24	

***p<0.05 S – Significant**

Table 6.2c shows there was a statistically significant association between level of family support with age at p=0.03 level and family monthly income at p=0.01 level among multi gravida mothers without risk.

Table 6.2d: Association between level of family support with the demographic variables such as age and type of family among multi gravida mothers with risk.

N=60

Demographic variables	Level of family support				Total	Chi square test
	Mild		Moderate			
	F	%	F	%		
Age						
a) 21-25 years	11	40.7	16	59.8	27	χ^2=3.48
b) 26-30 years	6	18.2	27	81.8	33	p=0.05*S
Type of family						
a) Nuclear family	12	42.8	16	57.2	28	χ^2=5.12
b) Joint family	5	15.6	26	84.4	32	p=0.02*S

***p<0.05 S – Significant**

Table 6.2d shows that there was statistically significant association between level of family support with age at p=0.05 level and the type of family at p=0.02 level among multi gravida mothers with risk.

Table 6.3a Association between level of self esteem with the demographic variables such as age and family monthly income among primi mothers without risk.

N=60

Demographic variables	Level of family support				Total	Chi square Test
	Mild		Moderate			
	F	%	F	%		
Age						
a) 21-25 years	7	20	23	80	35	χ^2=3.84
b) 26-30 years	1	4	24	96	25	p=0.05*S
Family monthly income						
a) < Rs 5000	2	66.7	1	33.3	3	χ^2=10.76
b) Rs 5001-Rs 10,000	2	22.3	7	77.8	9	p=0.05*S
c) Rs10,001-Rs 15,000	3	16.7	15	83.2	18	
d) Rs 15,001	1	3.3	29	96.7	30	

***p<0.05 S – Significant**

Table 6.3a shows that there was a statistically significant association between level of self esteem with age at p=0.05 level and family monthly income at p=0.05 level among primi mothers without risk.

Table 6.3b Association between level of self esteem with the demographic variables such as gestational age and age among primi mothers with risk.

N=60

Demographic variables	Level of stress				Total	Chi square test
	Mild		Moderate			
	F	%	F	%		
Gestational age						
d) Upto 12 weeks	11	55	9	45	20	χ^2=8.35
e) 13-24 weeks	3	15	17	85	20	p=0.01**S
f) 25-40 weeks	2	10	18	90	20	
Age						
c) 21-25 years	13	37.1	22	62.9	35	χ^2=4.23
d) 26-30 years	3	12	22	88	25	p=0.05*S

****p<0.01, *p<0.05 S – Significant**

Table 6.3b shows that there was a statistically significant association between level of self esteem with gestational age at p=0.01 level and age at p=0.05 level among primi mothers with risk.

Table 6.3c Association between level of self esteem with the demographic variables such as educational status and family monthly income among multi gravida mothers without risk.

N=60

Demographic variables	Level of stress				Total	Chi square test
	Mild		Moderate			
	F	%	F	%		
Educational status						
a) Primary school	5	31.3	11	68.7	16	χ^2=6.25 p=0.03*S
b) High school	3	15.8	16	84.2	19	
c) Higher secondary	1	11.1	8	88.9	9	
d) Degree	0	0.0	16	87.5	16	
Family monthly income						
a) < Rs 5000	3	50	3	50	6	χ^2=11.32 p=0.01*S
b) Rs 5001-Rs 10,000	2	33.3	4	66.7	6	
c) Rs10,001-Rs 15,000	2	8.3	22	91.7	24	
d) > Rs 15,001	1	4.2	23	95.8	24	

***p<0.05 S – Significant**

Table 6.3c shows that there was a statistically significant association between level of self esteem with educational status at p=0.03 level and family monthly income at p=0.01 level among multi gravida mothers without risk.

Table 6.3d Association between level of self esteem with the demographic variables such as age and type of family among multi gravida mothers with risk.

N=60

Demographic variables	Level of family support				Total	Chi square Test
	Mild		Moderate			
	F	%	F	%		
Age						
a) 21-25 years	10	37	17	63	27	χ^2= 5.15
b) 26-30 years	4	12.1	29	87.9	33	p=0.02*S
Type of family						
a) Nuclear family	10	37	18	64.3	28	χ^2=4.49
b) Joint family	4	12.5	28	87.5	32	p=0.3*S

***p<0.05 S – Significant**

Table 6.3d shows that there was statistically significant association between level of self esteem with age at p=0.02 level and type of family at p=0.03 level among multi gravida mothers with risk

CHAPTER V

DISCUSSION

The aim of the present study was to assess the antepartum stress, family support and self esteem among primi and multi gravida mothers in selected Emergency Obstetrical Care Centres, Chennai.

A total of 240 samples were selected by non probability purposive sampling method (120 primi gravida and 120 multi gravida mothers). Data on demographic variables, antepartum stress, family support and self esteem were collected by using structured interview schedule.. The collected data were tabulated and analyzed using descriptive and inferential statistics and results were interpreted. The discussion is based on the objectives specified in the study.

The significant findings of the study were as follows

In relation to demographic variables

- Equal numbers (120) were primi and multi gravida mothers.
- Equal number (40) of the primi and multi gravida mothers were in the gestational age upto 12 weeks, 13-24 weeks, 25-40weeks.
- Majority (58.3%) of the primi mothers were in the age group of 21-25 years whereas majority (59%) of the multi gravida mothers were in the age group of 26-30 years. None of the primi mothers were in the age >30 years whereas out of 60, 4 (6.7%) of the multi gravida mothers were in the age >30 years.
- Majority (71.75%) of the primi mothers were Hindus whereas majority (51.7%) of the multi gravida mothers were Hindus

- Majority (31.7%) of the primi mothers and 39.2% of the multi gravida mothers had completed high school education.
- All the primi mothers are unemployed whereas 1.7% of the multi gravida mothers with and without risk were employed.
- Majority (50%) of the primi mothers and 36.6% of the multi gravida mothers family monthly income were above Rs 15000.
- Out of 60, equal number 31(51.7%) of the primi mothers with and without risk were from nuclear family whereas 33(55%) of the multi gravida mothers without risk were from nuclear family and 28(46.7%) of the multi gravida mothers with risk were from nuclear family.
- Majority (51.7%) of the primi mothers had two members in the family whereas 51.7% of the multi gravida mothers had three members in the family.
- Majority (28.3%) of the primi gravida mothers with and without risk received support from husband and parents whereas 26.7% of the multi gravida mothers without risk received support from their husband and inlaws and 23.3% of the multi gravida with risk received support from their husband and siblings.

The findings of the study based on the objectives were,

- **The first objective was to assess the antepartum stress, family support and self esteem among primi and multi gravida mothers with risk and without risk.**

Antepartum stress

Out of 60 primi mothers without risk, majority (27.6%) of them had mild level of stress and 22.6% of them had moderate level of stress whereas out of 60 multi gravida mothers without risk, majority (31.9%) of them had mild level of stress and 18.5% of them had moderate level of stress. Out of 60 primi mothers with risk, majority (31.5%) of them had moderate level of stress and 18.1% of them had mild level of stress whereas out of 60 multi gravida mothers with risk, majority (27.4%) of them had moderate level of stress and 22.4% of them had mild level of stress. None of the mothers had severe antepartum stress (Table2.1). So we can infer that irrespective of the gravida status all the mothers had stress. On comparison, both primi and multi gravida mothers with risk had moderate stress whereas mothers without risk had only mild stress. Also the primi mothers with risk had more stress than the multi gravida mothers with risk.

The above finding was supported by the study conducted by Pantha,S et al, (2014) which showed that there was high prevalence of stress among the women attending antenatal clinic at Patan Hospital.

Hence the assumption stated earlier that mothers with risk will have more antepartum stress than mothers without risk was supported by the study findings.

Family Support

Table 2.1 showed that out of 60 primi mothers without risk, majority (55%) of them had high level of family support and 45% of them had moderate level of family support whereas out of 60 multi gravida mothers without risk, majority (53.3%) of them had high level of family support and 46.7% of them had moderate level of family support. Out of 60 primi mothers with risk, majority (75%) of them had high level of family support and 25% of them had moderate level of family support whereas out of 60 multi gravida mothers with risk, majority (71.7%) of them had high level of family support and 28.3% of them had moderate level of family support.

We can infer from the above findings of the study that primi and multi gravida mothers with risk had high family support than the primi and multi gravida mothers without risk

Hence the assumption stated earlier that all mothers will have family support was supported by the above findings.

Self esteem

Table 4 showed that out of 60 primi mothers without risk, majority (86.7%) of them had high level of self esteem and 13.3% of them had moderate level of self esteem whereas out of 60 multi gravida mothers without risk, majority (85%) of them had high level of self esteem and 9% of them had moderate level of self esteem. Out of 60 primi mothers with risk, majority (73.4%) of them had high level of self esteem and 26.6% of them had moderate level of self esteem whereas out of 60 multi gravida mothers with risk, majority (76.7%) of them had high level of self esteem and 23.3% of them had moderate level of self esteem.

From the above findings, primi gravida mothers without risk had high self esteem than the multi gravida mothers without risk. Regard to risk, primi gravida and multi gravida mothers with risk had higher self esteem than the mothers without risk.

Hence the assumption stated earlier that the mothers with risk will have low self esteem than mothers without risk was not supported by the study findings.

The second objective is to compare the antepartum stress, family support and self esteem among primi and multi gravida mothers with and without risk.

Table 5.1 showed that the primi mothers without risk had the mean stress score of 13.30 with the SD of 5.61, the mean family support score of 27.15 with the SD of 4.55 and mean self esteem score of 33.32 with the SD of 2.12 whereas the primi mother with risk had the mean stress score of 15.50 with the SD of 2.20, mean family support score of 28.83 with the SD of 1.68 and mean self esteem score of 32.42 with the SD of 0.90. Also there was a statistically significant difference in stress between primi mothers with risk and without risk at p= 0.04 level. There was a statistically significant difference in family support between primi mothers with risk and without risk at p = 0.02 level. There was a statistically significant difference in self esteem between primi mothers with risk and without risk at (p = 0.05) level.

Table 5.2 showed that the multi gravida mothers without risk had the mean stress score of 12.32 with the SD of 2.53, the mean family support score of 27.10 with the SD of 3.50 and mean self esteem score of 33.23 with the SD of 1.96 whereas the multi gravida mothers with risk had the mean stress score of 15.12 with the SD of 4.43, mean family support score of 28.30 with the SD of 3.28 and mean self esteem score of 32.00 with the SD of 2.45. Also there was a statistically significant difference in stress between multi gravida mothers with and without risk at p = 0.001 level. There

was a statistically significant difference in family support between multi gravida mothers with and without risk at p= 0.05 level. There was a statistically significant difference in self esteem between multi gravida mothers with and without risk at p = 0.05 level.

Table 5.3 showed that there was a statistically significant difference between stress among primi and multi gravida mothers with and without risk at p = 0.001 level. There was a statistically significant difference between family support among primi and multi gravida mothers with risk and without risk at p <0.05 level. There was a statistically significant difference between self esteem among primi and multi gravida mothers with risk and without risk at p <0.05 level.

From the above finding we can infer that majority of the mothers had high family support and high self esteem irrespective of the gravida and risk status.

Irrespective of high family support and high self esteem primi and multi gravida mothers with risk had more stress than the mothers without risk. This showed when there is risk, the level of stress will be increased.

Hence the null hypothesis stated earlier that there was no statistically significance difference in antepartum stress, family support and self esteem among primi and multi gravida mothers with risk and without risk was rejected.

The third objective is to associate the antepartum stress with the demographic variables.

There was a statistically significant association between level of stress with gestational age at p=0.01 level, age at p=0.02 level and type of family at p=0.02 level among primi gravida mothers without risk (Table 6.1a). From the above findings we

can infer that the gestational age, age of the mother and type of family influenced the stress among primi gravida mothers without risk.

There was a statistically significant association between the level of stress with gestational age at p=0.01 level and age at p=0.05 level among primi gravida mothers with risk (Table.6.1b). From the above findings we can infer that the level of stress was influenced by the period of gestation and age of the mothers among primi gravida mothers with risk

There was a statistically significant association between the level of stress with age at p=0.01 level and educational status at p=0.05 level among multi gravida mothers without risk. (Table. 6.1c) The findings revealed that the age of the mother and educational status influenced the stress among multi gravida mothers without risk.

There was a statistically significant association between the level of stress with gestational age at p=0.04 level and type of family at p=0.01 level among multi gravida with risk. (Table.6.1d). It is evident that period of gestation and type of the family influenced the stress.

Hence the assumption stated earlier that antepartum stress will be influenced by the demographic variables was supported by the study findings.

The fourth objective is to associate the family support with the demographic variables.

There was a statistically significant association between level of family support with age at p=0.02 level and type of family at p=0.03 level among primi gravida mothers without risk (Table.6.2a). From the above findings we can infer that age of the

mothers and type of family influenced the family support among primi gravida mothers without risk.

There was a statistically significant association between the level of family support with the age of the mother at p=0.05 level and type of family at p=0.05 among primi gravida mothers with risk (Table.6.2b). It was evident that the age of the mothers and type of family influenced the family support among primi gravida mothers with risk

There was a statistically significant association between the level of family support with age at p=0.03 level and monthly income at p=0.01 among multi gravida mothers without risk (Table 6.2c). It was evident that the age of the mothers and family monthly income influenced the family support among multi gravida mothers without risk.

There was a statistically significant association between the level of family support with age at p=0.05 level and type of family at p=0.02 level among multi gravida mothers with risk (Table 6.2d) It was evident that the age of the mothers and type of family influenced the family support among multi gravida mothers with risk.

Hence the assumption stated that earlier family support will be influenced by the demographic variables was supported by the study findings

The fifth objective was to associate the self esteem with the demographic variables.

There was a statistically significant association between level of self esteem with age at p=0.05 level and family monthly income at p=0.05 level among primi gravida mothers without risk (Table.6.3a) From the above finding it was evident that

the self esteem was influenced by the age of the mother and family monthly income among primi gravida mothers without risk

There was a statistically significant association between the level of self esteem with the gestational age at p=0.01 level and age of the mother at p=0.05 level among primi gravida mothers with risk (Table.6.3b). From the above finding it was evident that the self esteem was influenced by the period of gestation and age of the mother among primi gravida mothers with risk.

There was a statistically significant association between the level of self esteem with educational status at p=0.03 level and family monthly income at p= 0.01 level among multi gravida mothers without risk (Table 6.3c). From the above finding it was evident that the self esteem was influenced by the educational status and family monthly income among multi gravida mothers without risk.

There was a statistically significant association between the level of self esteem with age at p=0.02 level and type of family at p=0.03 level among multi gravida mothers with risk (Table.6.3d). From the above finding it was evident that the self esteem was influenced by the age of the mother and type of family among multi gravida mothers with risk

Hence the assumption stated earlier that self esteem will be influenced by the demographic variables was supported by the study findings

CHAPTER VI

SUMMARY, CONCLUSION, IMPLICATION AND RECOMMENDATIONS

SUMMARY

Pregnancy is the privilege of experiencing God's miracles on earth. Feeling stressed is common during pregnancy, but too much of uncoped stress can make pregnancy uncomfortable for both the mother and fetus. Mothers with complications were able to cope with the stress even when there wasn't much support from the family members but their self esteem was good. Presuming that family support and self esteem was good, the level of stress during antepartum period can be reduced. The investigator felt the need to assess the stress, family support and self esteem of the mother .

The objectives of the study were

1. to assess the antepartum stress, family support and self esteem among primi and multi gravida mothers with risk and without risk,
2. to compare the antepartum stress, family support and self esteem among primi and multi gravida mothers
3. to associate the antepartum stress, family support and self esteem with the demographic variables.

HYPOTHESIS

H_0 - There is no statistically significant difference in antepartum stress, family support and self esteem between primi and multi gravida mothers with risk and without risk.

Review of literature provided a base to construct the tool and methodology. The conceptual frame work was based on Mercer's effect of antepartum stress on family. Descriptive design was chosen for the study. The tool was developed and validated by five experts, two Obstetricians and three Obstetrics and Gynaecological Nursing experts. The reliability was determined by split half method. Feasibility was analyzed by conducting the pilot study. The main study was conducted from 01.06.2015 to 27.06.2015 at Emergency Obstetrical Care Centres, Saidapet and Pulianthope, Chennai. Samples fulfilling the inclusion criteria were selected using non probability purposive sampling technique and were categorized as mothers with risk and without risk group using the risk assessment scale.

Data was obtained from the mothers regarding demographic variables, antepartum stress, family support and self esteem using structured questionnaire and rating scale. The data was analyzed using descriptive and inferential statistics and the results were interpreted. The study findings revealed that primi gravida mothers without risk had mild antepartum stress, high family support and high self esteem and mothers with risk had moderate antepartum stress high family support and high self esteem and multi gravida mothers without risk had mild antepartum stress, high family support and high self esteem and mothers with risk had moderate antepartum stress, high family support and high self esteem. None of the mothers had severe antepartum stress, mild family support and low self esteem. There was a significant relationship

between antepartum stress family support and self esteem of primi gravida and multi gravida mothers with risk and without risk. Also there was significant association between the antepartum stress with the gestational age, age of the mothers and type of the family, Family support with the age of the mothers, family monthly income and type of the family and self esteem with the age of the mothers, educational status, family monthly income and type of the family.

CONCLUSION

The study concluded that the all the primi gravida and multi gravida mothers with risk and without risk had stress, but the level of antepartum stress was influenced by the level of family support and the level of self esteem The study proved that antepartum stress, family support and self esteem were related with each other. One can have the influence on other factors.

NURSING IMPLICATIONS

The study findings are relevant to nursing field. The implication can be discussed mainly in the area of nursing services, nursing education, nursing administration and nursing research.

NURSING SERVICE

- Stress assessment must be done as a routine procedure for the antenatal mothers visiting the outpatient department which helps the nurses to identify stress level and plan intervention to overcome.

- Health teaching regarding importance of family support and methods to improve the self esteem has to be conducted in maternity units to the mother and family members.
- Midwives should include the family members while providing care to the mothers.
- Counselling sessions can be arranged for the mothers with moderate to severe stress.
- Doctor/ Nurses can educate the mother about antepartum stress and its effect on the un born fetus and its preventive measures
- The staff nurse must explain preventive aspects of antepartum stress like yoga, time management, breathing techniques etc when the mothers come for the visits.
- The community programmes about prevention of antepartum stress, importance of family support and ways to improve self esteem can be taught.

NURSING EDUCATION

- Curriculum should include about antepartum stress, its effect on the mother during and after pregnancy and also on the unborn fetus.
- Seminars, conferences panel discussion should be held to the students to create awareness regarding the stress, its impact and ways to prevent
- Students should be encouraged to include stress management related topics in their health teachings to the antenatal mothers.
- Nurse educator can conduct staff development programme to the staff nurses about the importance of family support and self esteem on antepartum stress and its preventive measures.

NURSING ADMINISTRATION

- Nurse administrator should make standard protocol for stress assessment, management and referral forms need to made for their hospitals
- Nurse administrator can plan and organise in service education for the staff nurses to reinforce the importance of family support and self esteem for antenatal mothers.

NURSING RESEARCH.

- Disseminate the finding of the research through conferences, seminars and publishing in nursing journal.
- Results to be confirmed by conducting more studies in this area.
- Data collection tools can be standardised.
- More researches can be done as there was only few researches done in this area

RECOMMENDATIONS

Keeping the findings of the present study in view, the following recommendations were made.

- Similar study can be conducted at private setting.
- Longitudinal studies can be done to see the outcome of the mother as well as the fetus.
- Recommended to educate mothers and family on prevention of antepartum stress and the ways to improve self esteem.
- The study can be conducted with multi variables which will influence the antepartum stress.

- A comparative study can be conducted among rural and urban mothers.
- The study can be conducted to assess the prenatal stress and antenatal stress
- The study can be conducted to find the different factors which influence the antepartum stress among the antenatal mothers
- Research can be done to identify the consequences of antepartum stress for the mother and the fetus

LIMITATIONS

There were no limitations faced by the investigator during the study.

REFERENCES

1. Abeysena, C., Jayawardana, P & Seneviratne, R.A. (2008) *Psychosocial stress on maternal complications during pregnancy*. International Journal of Collaborative Research on Internal Medicine & Public Health 2010 Dec;1(2):436-48.
2. Pilliteri, A. (2004) *Maternal and Child health nursing*, 4th edition, William and Wilkins publications; Philadelphia.
3. Basavanthappa, B. T. (2008). *Nursing Research*. Jaypee Medical Publications. New Delhi.
4. Bea R.H. Van den Bergh. (2004). *Antenatal maternal anxiety and stress and the neurobehavioural development of the fetus and child: links and possible mechanisms*. A review. Retrieved from www.elsevier.com/locate/neubiorev.
5. Bryar, NR. (2012). *Theory for midwifery practice*. 1st edition, Macmillan publication. London
6. Cormack, D. (2001). *The Research Process in Nursing*. 4th edition. Black well Science.
7. Madhavanprabhakaran, G. K. (2015). *Prevalence of pregnancy anxiety and associated factors*. Retrieved from www.sciencedirect.com/science/article/pii/S2214139115000141
8. Giurgescu, C & Penckofer, S. et al (2006). *Impact of uncertainty, social support and prenatal coping on the psychological well being of high-risk pregnant women*., sep-oct;55(5):356-65.
9. Gurumani, N. (2005). *An Introduction to Biostatistics*. 2nd edition MJP Publishers. Chennai

10. Hodnett, E. D. & Fredericks, S. (2007). Support during pregnancy for women at increased risk of low birth weight babies (Review). *The Cochrane Collaboration.* Published by John Wiley & Sons, Ltd.
11. Janet, A. (2012). *Maternal stress in pregnancy: Considerations for fetal development*. Journal of Adolescent Health. 51(2 Suppl): S3–S8. doi: 10.1016/j.jadohealth.2012.04.008.
12. Haobijam, J. Sharma, U & David, S. (2010). An exploratory study to assess the Family support and its effect on Outcome of Pregnancy in terms of Maternal and Neonatal health in a selected Hospital, Ludhiana Punjab. *Nursing and Midwifery Research Journal, Vol-6, No. 4, October 2010*
13. Shaikh, K et al. (2013). *The Relationship between Prenatal Stress, Depression, Cortisol and Preterm Birth: A Review*. Retrieved from (http://www.scirp.org/journal/ojd) http://dx.doi.org/10.4236/ojd.2013.23006
14. Fernandes, M et. Al. (2014) Comparative study to assess the stress among working and non-working antenatal mothers in selected hospitals of udupi district. *Nitte University Journal of Health Science*. Vol. 4, No.3, September 2014, ISSN 2249-7110.
15. Maternal & Child Health Service. Oklahoma State Department of Health. *Stressors, social support and pregnancy outcomes among African American and white mothers*, Oklahoma Pregnancy risk assessment monitoring system vol 13 no 2 spring 2009.
16. Mulder, EJH. Robles, PG & Huizink, AC. (2002) *Prenatal maternal stress: effects on pregnancy and the (unborn) child*. Early Human Development ; 70:3–14.

17. Broom, N. (1999). *Maternal and child health nursing*, 9th edition, Mosby publications, Missouri.

18. Pantha, S et al., (2014). *Prevalence of Stress among Pregnant Women Attending Antenatal Care in a Tertiary Maternity Hospital in Kathmandu*. Retrived from http://dx.doi.org/10.4172/2167-0420.1000183.

19. Polit, F. D., Hungler and Bernadette, P. (2001). *Essentials of Nursing Research, Methods, Appraisals And Utilisation*. J B Lippincott Publishers.

20. Reader & Marttin., *Maternity Nursing*, 18th edition, Lippincott, Philadelphia.

21. Shrish N. Daftary. (2007). *Manual of Obstetrics*. 2nd edition. Elsevier Publications Pvt. Limited.

22. *Stress in pregnancy*. retrieved from: URL:http://www.healthberth.com/2010/04/how-to-manage-stress-during-pregnancy.html

23. Sundar Rao, P.S. (2002). *A Introduction to Biostatistics*. 3rd edition, Prentice-Hall of India Pvt Limited.New Delhi.

24. Glover,V (2010). *Stress and Pregnancy (prenatal and perinatal)*, Retrieved from www.child-encyclopedia.com.

25. Wisborg K. Barklin A Hedegaard M & Henriksen T.B. (2008) *Psychological stress during pregnancy and stillbirth: prospective study*. BJOG;115(7):882-1.

26. Woods SM., Melville JL., Guo Y., Fan MY & Gavin A., (2010). *Psychosocial stress during pregnancy*. Am J Obstet Gynecol, Jan;202(1):611-7.

27. Streubert. Helen. J, Dona Rinaldi Carpenter. *Qualitative Research In Nursing*. 4th edition. Lippincott Williams & wilkins. Philadelphia.

28. Gunter J Harris (2006). *Self-Esteem, Family Support, Peer Support, and Depressive Symptomatology: A Correlational Descriptive Study of Pregnant*

Adolescents Dissertation, Georgia State University, http://scholarworks.gsu.edu/nursing_diss/5

29. Inanir, S et.al (2015). *Body Image Perception and Self-esteem During Pregnancy.* International Journal of Women's Health and Reproduction Sciences Vol. 3, No. 4, October 2015, 196–200
30. Meireles JFF (2013). *Body dissatisfaction among pregnant women: an integrative review of the literature* DOI: 10.1590/1413-81232015207.05502014
31. Maçola L do., Vale IN & Carmona EV.(2010). *Assessment of self-esteem in pregnant women using Rosenberg's Self-Esteem Scale,* Rev Esc Enferm USP Sep;44(3):570-7.
32. Faramarzi, M & Pasha, H (2015).*The role of social support in prediction of stress during pregnancy*. Available from: https://www.researchgate.net/publication/285470163

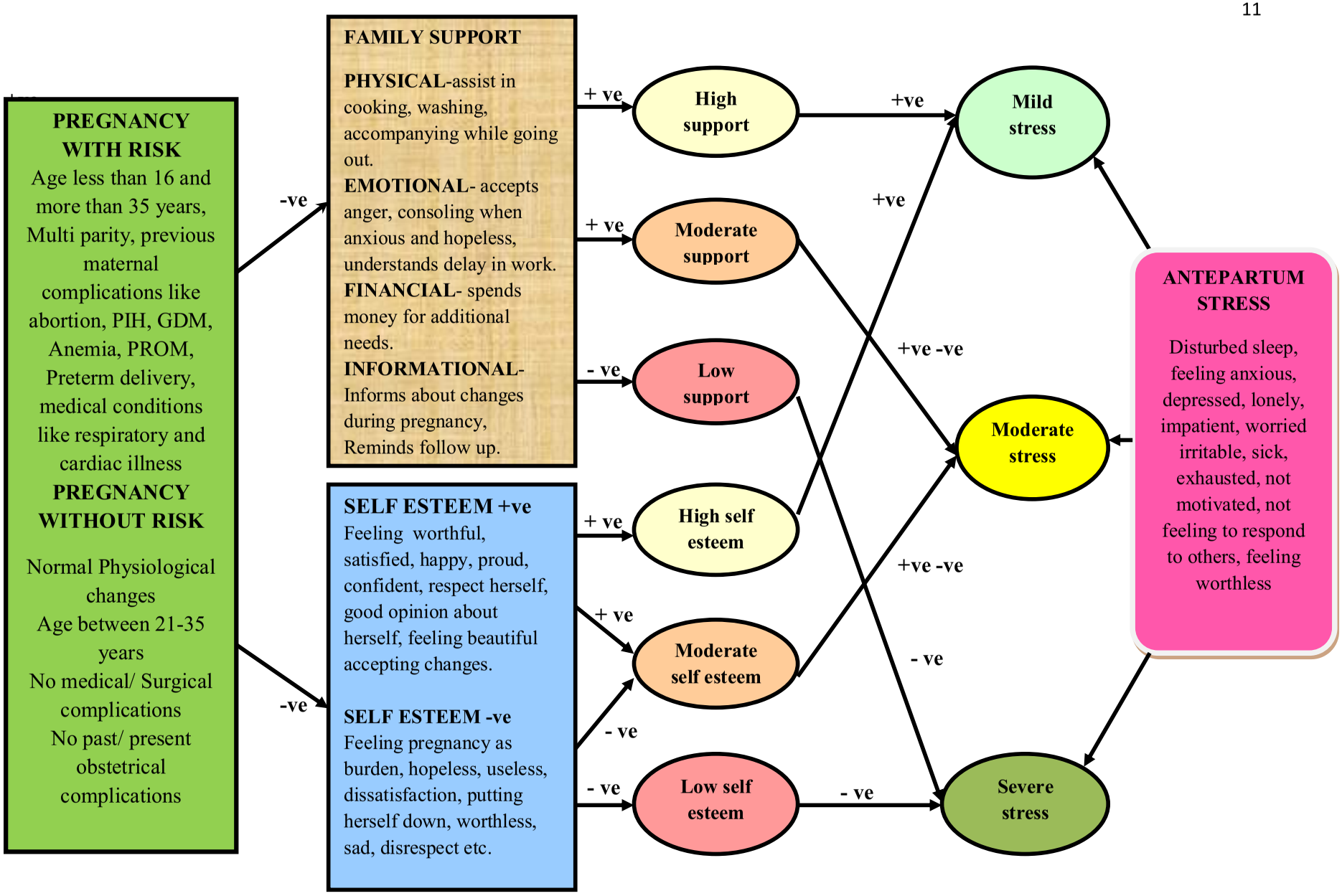

Figure: 1 Modified Mercer's model of relationship between antepartum stress and family functioning (1986).

Figure: 1 Modified Mercer's model of relationship between antepartum stress and family functioning (1986).

APPENDICES

INFORMED CONSENT FORM

I have been informed about the purposes of the study being conducted by Ms. Seematti P., M.Sc (Nursing) student of M.A.Chidambaram College of Nursing, Adyar, Chennai and I have no objection in participating in the study. I also give my full consent for the use of this data for the purpose of any presentation or publication.

Signature:

Name:

Date:

TOOL FOR DATA COLLECTION
PART –I
DEMOGRAPHIC DATA

1) Gravida
   a) 1
   b) 2 and more

2) Gestational age (in weeks)
   a) upto 12
   b) 13 – 24
   c) 25-40

3) Age in years
   a) Upto 20 years
   b) 21- 25 years
   c) 26- 30 years
   d) Above 35 years

4) Religion
   a) Hindu
   b) Christian
   c) Muslim
   d) Others (specify)

5) Educational status
   a) Primary school
   b) High school
   c) Higher secondary
   d) Degree

6) Occupation
   a) Unemployed
   b) Employed (Specify)

7) Family monthly income
   a) Below Rs <5000
   b) Rs 5001-10,000
   c) Rs 10,001- 15,000
   d) Above Rs 15,001

8) Type of family
   a) Nuclear family
   b) Joint family
   c) Extended family

9) Number of members in the family
    a) 2
    b) 3
    c) more than 3

10) Supporting members
    a) husband
    b) inlaws
    c) parents
    d) siblings

PART II

TOOL FOR ASSESSING HIGH RISK STATUS OF PREGNANT MOTHERS

REPRODUCTIVE HISTORY	**SCORE**	
Age <16 years	1	
16-35 years	0	
35 years	2	
Parity		
0	1	
1-3	0	
>3	2	
2 or more abortion or h/o infertility	1	
Postpartum bleeding or manual removal	1	
Toxemic hypertension	2	
Previous LSCS	2	
Abnormal / difficulty labour	2	
	Total	
MEDICAL AND SURGICAL CONDITIONS		
Previous gynaecologic surgery	1	
Chronic renal disease	1	
Gestational DM		
Class a	1	
Class b	3	

Cardiac disease	3	
Others		
Medical or Surgical (according to severity)	1-3	
	Total	
PRESENT PREGNANCY		
Bleeding <20 weeks	1	
Bleeding >20weeks	3	
Anaemia <10 gms%	1	
Post maturity	1	
Hypertension	2	
Premature rupture of membrane	2	
Polyhydramnias	2	
Oligohydramnias	3	
Multiple pregnancy	3	
Breech / malpresentation	3	
Rh isoimmunisation	3	
	Total	

Total score ---------- (sum of three scores)

No risk = 0 **risk = more than 1**

PART- III

TOOL TO ASSESS STRESS AMONG PRIMI AND MULTI GRAVIDA MOTHERS

INSTRUCTIONS : CHOOSE THE COLUMN WHICH IS CLOSE TO YOUR OPINION

SL.NO	ITEMS	NEVER	SOME TIMES	ALWAYS
1.	Sleep is disturbed			
2.	Feeling exhausted			
3.	Having reduced appetite			
4.	Feeling sick			
5.	Having headaches			
6.	Having palpitation			
7.	Feeling irritable			
8.	Feeling worried			
9.	Feeling anxious			
10.	Feeling angry			
11.	Feeling depressed			
12.	Feeling impatient			
13.	Having forgetfulness			
14.	Unable to concentrate on daily activities			

15.	Feeling upset			
16.	Feeling not motivated in routine			
17.	Having unknown fears			
18.	Want to be alone			
19.	Feeling not to respond to others			
20.	Feeling worthless			

It consist of 20 items, each item will be scored like

	Scores
Never	0
Sometimes	1
Always	2

And the total scores were arbitrarily classified as

Scores	**Category**
1-13	Mild stress
14-26	Moderate stress
27-40	Severe stress

PART IV

TOOL TO ASSESS THE LEVEL OF FAMILY SUPPORT FOR PRIMI AND MULTI GRAVID MOTHERS.

INSTRUCTIONS : CHOOSE THE COLUMN WHICH IS CLOSE TO YOUR OPINION

SL.NO	ITEMS	NEVER	SOME TIMES	ALWAYS
	PHYSICAL SUPPORT			
1.	Assists in cooking and washing			
2.	Assist in cleaning the house			
3.	Takes care of outside works(purchasing)			
4.	Provides time adequate sleep and rest			
5.	Accompanying while going out			
	EMOTIONAL SUPPORT			
6.	Accepts my anger			
7.	Consoles me when anxious			
8.	Understands delay in my work			
9.	Consoles me when feeling hopeless			
10.	Stay with me when upset about minor disorder			
	FINANCIAL SUPPORT			
11.	Provides money for additional food			
12.	Buys clothing			
13.	Spends money for investigation			

14.	Provides money for travel expenses			
15.	Saves money for new born needs			
	INFORMATIONAL SUPPORT			
16.	Informs about changes that occur during pregnancy			
17.	Reminds about follow ups			
18.	Tells about the home remedies for minor disorders			
19.	Informs about danger signs of pregnancy			
20.	Tells me about the symptoms of signs of onset of labour			

It consist of 20 items each item will be scored like

	Scores
Never	0
Sometimes	1
Always	2

And the total scores were arbitrarily classified as

Scores	**Interpretation**
1-13	Mild support
14-26	Moderate support
27-40	High support

PART –V

TOOL TO ASSESS THE SELF ESTEEM DURING PREGNANCY FOR PRIMI AND MULTI GRAVIDA MOTHERS

INSTRUCTIONS : CHOOSE THE COLUMN WHICH IS CLOSE TO YOUR OPINION AFTER YOU HAVE BECOME PREGNANT

Sl no	Items	Never	Some times	Always
1.	I feel worthful after pregnancy			
2.	I know my strength and weakness			
3.	I feel i am useless			
4.	I am satisfied with my pregnancy			
5.	I feel happy being pregnancy			
6.	I feel proud being pregnant			
7.	I respect myself			
8.	I feel pregnancy is a burden for me			
9.	I appreciate myself after being pregnant			
10.	I can do things successfully			
11.	I have good opinion about myself			
12.	I look beautiful after pregnancy			
13.	I do what I like self esteem			
14.	I feel confident			
15.	I know my needs			
16.	I can overcome the minor problems of pregnancy			
17.	I don’t put myself down			

18.	I focus on self improvement			
19.	I accept the bodily changes that occur during pregnancy			
20.	I am sincere in my work			

It consist of twenty items, each item will be scored like

	Scores for Positive statements	Scores for negative statements
Never	0	2
Sometimes	1	1
Always	2	0

The total scores were arbitrarily classified as

Score	**Interpretation**
1-13	Low self esteem
14-26	Moderate self esteem
26-40	High self esteem

¾¸Åø §º¸Ã¢ôÒ ÀÊÅõ

§¿÷¸¡½ø ¨¸§ÂÎ

À̾¢ - I

¾É¢¿À÷ Å¢ÅÃí¸û:

1. À¢ÃºÅ ¿¢¨Ä
   «) 1
   ¬) 2 ÁüÚõ «¾üÌõ §Áø

2. ¸Õ ÅÇ÷ìº¢ì ¸¡Äõ
   «) 12 Å¡Ãí¸û
   ¬) 13 - 24 Å¡Ãí¸û
   þ) 25 - 40 Å¡Ãí¸û

3. ÅÂÐ
   «) 20 ÅÂÐ Å¨Ã
   ¬) 21 ÅÂÐ Ó¾ø 25 ÅÂÐ Å¨Ã
   þ) 26 ÅÂÐ Ó¾ø 30 ÅÂÐ Å¨Ã
   ®) 35 ÅÂÐ «øÄÐ «¾üÌ §Áø

4. Á¾õ
   «) þóÐ
   ¬) ¸¢ÕŠÐÅ÷
   þ) þŠÄ¡Á¢Â÷
   ®) ÁüÈÅ÷ (ÌÈ¢ôÀ¢Î¸)

5. ¸øÅ¢ò ¾Ì¾¢
   «) ¬ÃõÀì¸øÅ¢
   ¬) ¿Î¿¢¨Äì¸øÅ¢
   þ) §Áø¿¢¨Äì ¸øÅ¢
   ®) Àð¼ôÀÊôÒ

6. ¡¾¡Æ¢ø

«) À½¢ÒÃ¢Â¡¾Å÷

¬) À½¢ÒÃ¢ÀÅ÷ (ÌÈ¢ôÀ¢¼×õ)

7. ÌÎõÀ Á¡¾ ÅÕÁ¡Éõ

«) å.5000/- ÁüÚõ «¾üÌõ ¸£ú

¬) å.5001/- Ó¾ø å.10,000 Å¨Ã

þ) å.10,000/- Ó¾ø å.15,000 Å¨Ã

®) å.15,000/-ìÌõ §Áø

8. ÌÎõÀò¾¢ý Å¨¸

«) ¾É¢ìÌÎõÀõ

¬) ÜðÎìÌÎõÀõ

þ) Å¢Ã¢Å¡É ÌÎõÀõ

9. ÌÎõÀò¾¢ø ¯ûÇ ¿À÷¸Ç¢ý ±ñ½¢ì¨¸

«) 2

¬) 3

þ) 3ìÌõ §Áø

10. ¯¾×õ ¿À÷¸û

«) ¸½Å÷

¬) ¦¸¡í¨º/¸½ÅÃ¢ý þÃò¾ Å¨¸Â¢ø º¡÷ó¾ ÌÎõÀ ¿À÷¸û

þ) ¦Àü§È¡÷¸û

®) ¯¼ý À¢Èó¾Å÷¸û

ÀÌ¾¢ - III

´ýÚ ÁüÚõ þÃñÊüÌõ §ÁüÀð¼ À¢ÃºÅ ¿¢¨ÄÂ¢ÖûÇ ¾¡öÁ¡÷¸Ç¢ý ÁÉ «Øò¾ò¨¾ «È¢Å¾ü¸¡É ¾¸Åø ÀÊÅõ

«È¢ï¨¸: ¯í¸û ¸Õò¾¢üÌ ´ýÈ¢ô§À¡Ìõ Àò¾¢¨Âò §¾÷× ¦ºöÂ×õ.

Å. ±ñ.	**¾¸Åø**	**´Õ §À¡Ðõ þø¨Ä**	**«ùÅô§À¡Ð**	**±ô§À¡Ðõ**
1	àì¸õ ¸¨Ä¸¢ýÈÐ.			
2	¸¨ÇòÐô §À¡¸¢ý§Èý.			
3	Ì¨ÈÅ¡¸ô À°¢ì¸¢ýÈÐ.			
4	§¿¡ÔüÈÐ §À¡ø ¯½÷¸¢§Èý.			
5	¾¨Ä ÅÄ¢Â¡¸ þÕì¸¢ýÈÐ.			
6	À¼À¼ôÀ¡¸ ¯½÷¸¢ý§Èý.			
7	±Ç¢¾¢ø ±Ã¢ïºø «¨¼¸¢ý§Èý.			
8	¸Å¨ÄÂ¡¸ ¯û§Çý.			
9	ÀÂÁ¡¸ þÕì¸¢ýÈÐ.			
10	§¸¡Àõ ÅÕ¸¢ýÈÐ.			
11	ÁÉ ¯¨Çïº§Ç¡Î þÕì¸¢ý§Èý.			
12	¦À¡Ú¨Á þÆó¾¨¾ ¯½÷¸¢ý§Èý			
13	ÁÈ¾¢Â¡¸ ¯ûÇÐ.			
14	«ýÈ¡¼ §Å¨Ä¸Ç¢ø ¸ÅÉõ ¦ºÖò¾ÓÊÂÅ¢ø¨Ä.			
15	¸Äì¸Á¡¸ þÕôÀÐ §À¡ø ¯½÷¸¢ý§Èý.			
16	¦ºÂø àñÎ¾ø þø¨Ä.			
17	«È¢Â¡¾ «ïºõ ¯ûÇÐ.			
18	¾É¢¨Á¨Â Å¢ÕõÒ¸¢ý§Èý.			
19	ÁüÈÅ÷¸ÙìÌ À¾¢ÄÇ¢ì¸ §¾¡ýÈ Å¢ø¨Ä.			
20	Á¾¢ôÀüÈÐ §À¡ø ¯½÷¸¢ý§Èý.			

Á¾¢ôÀ£Î:

´Õ §À¡Ðõ þø¨Ä - 0

«ùÅô§À¡Ð - 1

±ô§À¡Ðõ - 2

Á¾¢ôÀ£Î	À¢Ã¢×
1-13	Ì¨ÈÅ¡É ÁÉ «Øò¾õ
14-26	Á¢¾Á¡É ÁÉ «Øò¾õ
27-40	«¾¢¸Á¡É ÁÉ «Øò¾õ

ÀÌ¾¢ - IV

´ýÚ ÁüÚõ þÃñÊüÌõ §ÁüÀð¼ À¢ÃºÅ ¿¢¨ÄÂ¢ÖûÇ ¾¡öÁ¡÷¸Ç¢ý ÌÎõÀ ´òÐ¨Æô¨À «È¢Å¾ü¸¡É ¾¸Åø ÀÊÅõ

«È¢ï¨¸: ¯í¸û ¸Õò¾¢üÌ ´ýÈ¢ô§À¡Ìõ Àò¾¢¨Âò §¾÷× ¦ºöÂ×õ.

Å. ±ñ.	**¾¸Åø**	**´Õ §À¡Ðõ þø¨Ä**	**«ùÅô §À¡Ð**	**±ô§À¡Ðõ**
	¯¼ø Ã£¾¢Â¡É ´òÐ¨ÆôÒ			
1	º¨ÁôÀ¾üÌõ, Ð½¢ Ð¨ÅôÀ¾üÌõ À¡ò¾¢ÃíÁ¸û ¸Ø×Å¾üÌõ ¯¾× Å¡÷¸û			
2	Å£ð¨¼ àö¨ÁôÀÎòÐÅ¾üÌ ¯¾Å¢ ÒÃ¢Å¡÷¸û.			
3	Å£ðÊüÌò §¾¨ÅÂ¡É¨Å¸¨Ç ¦ÅÇ¢Â¢ø ¦ºýÚ Å¡í¸¢ ÅÕÅ¡÷¸û.			
4	§À¡ÐÁ¡É «Ç× àì¸Óõ µö×õ ÅÆíÌ Å¡÷¸û.			
5	¦ÅÇ¢Â¢ø ¦ºøÖõ §À¡Ð Ð¨½ìÌ ÅÕÅ¡÷¸û.			
	ÁÉ Ã£ò¢Â¡É ´òÐ¨ÆôÒ			
6	±ý §¸¡Àò¨¾ ²üÚì ¦¸¡ûÅ¡÷¸û.			
7	¿¡ý ÀÂôÀÎõ §À¡Ð ¬Ú¾ø «Ç¢ôÀ¡÷¸û.			
8	±ý §Å¨Ä¸Ç¢ø ¾¡Á¾õ ²üÀð¼¡ø «¨¾ ²üÀ¡÷¸û.			
9	¿õÀ¢ì¨¸ þÆó¾ ¾Õ½í¸Ç¢ø ¬¾Ã× «Ç¢ôÀ¡÷¸û.			
10	¸Äì¸Á¡¸ þÕìÌõ §¿Ãò¾¢ø Ð¨½ þÕôÀ¡÷¸û.			
	¦À¡ÕÇ¡¾¡Ã ºõÀó¾Á¡É ´òÐ¨ÆôÒ			
11	±ý §¾¨ÅìÌ ²üÈÅ¡Ú ¯ñÀ¾üÌô À½õ ¾ÕÅ¡÷¸û.			
12	¬¨¼¸û Å¡í¸¢ò ¾ÕÅ¡÷¸û.			
13	ÀÃ¢§º¡¾¨É ¦ºöÅ¾üÌô À½õ ¦ºÄÅ¢ÎÅ¡÷¸û.			
14	ÀÂ½õ ¦ºöÅ¾ü¸¡É ¦ºÄ×ò ¦¾¡¨¸¨Âò ¾ÕÅ¡÷¸û.			
15	À¢ÈìÌõ ÌÆó¨¾ì¸¡¸ §ºÁ¢òÐ ¨Åì¸¢È¡÷¸û.			
	¾¸Åø Ã£¾¢Â¡É ´òÐ¨ÆôÒ			

Å. ±ñ.	¾¸Åø	´Õ §À¡Ðõ þø¨Ä	«ùÅô §À¡Ð	±ô§À¡Ðõ
16	¸÷À ¸¡Äò¾¢ø ²üÀÎõ Á¡üÈí¸û ÌÈ¢òÐ ±ÎòÐ¨Ãò¾¢Õì¸¢È¡÷¸û.			
17	«ýÈ¡¼ ÀÃ¢§º¡¾¨ÉìÌî ¦ºøÅ¾üÌ ¦ºøÅ¨¾ô ÀüÈ¢ Å¢Æ¢ôÒ½÷× ¾ÕÅ¡÷¸û.			
18	º¢ýÉ ¯À¡¨¾¸ÙìÌ Å£ðÎ ¿¢Å¡Ã½õ ÀüÈ¢ ±ÎòÐ ¯¨Ãò¾¢Õì¸¢È¡÷¸û.			
19	¸÷À ¸¡Äò¾¢ø º¡ôÀ¢Îõ ¯½× Ó¨È¸¨Ç ÀüÈ¢ ±ÎòÐ ¯¨ÃôÀ¡÷¸û.			
20	À¢ÃºÅõ ÐÅíÌÅ¾üÌ ÓýÉ¾¡¸ ¯ûÇ «È¢ÌÈ¢¸¨Ç ±ÎòÐ¨Ãò¾¢Õì¸¢È¡÷¸û.			

<u>Á¾¢ôÀ£Î:</u>

´Õ §À¡Ðõ þø¨Ä - 0

«ùÅô§À¡Ð - 1

±ô§À¡Ðõ - 2

Á¾¢ôÀ£Î	À¢Ã¢×
1-13	Ì¨ÈÅ¡É ´òÐ¨ÆôÒ
14-26	Á¢¾Á¡É ´òÐ¨ÆôÒ
27-40	«¾¢¸Á¡É ´òÐ¨ÆôÒ

´ýÚ ÁüÚõ þÃñÊüÌõ §ÁüÀð¼ À¢ÃºÅ ¿¢¨ÄÂ¢ÖûÇ ¾¡öÁ¡÷¸Ç¢ý ÍÂ Á¾¢ôÀ£ð¨¼ «È¢Å¾ü¸¡É ¾¸Åø ÀÊÅõ

«È¢ï¨¸: ¯í¸û ¸Õò¾¢üÌ ´ýÈ¢ô§À¡Ìõ Àò¾¢¨Âò §¾÷× ¦ºöÂ×õ.

Å. ±ñ.	**¾¸Åø**	**´Õ §À¡Ðõ þø¨Ä**	**«ùÅô §À¡Ð**	**±ô§À¡Ðõ**
1	¸÷Àõ ¾Ã¢ò¾ À¢ÈÌ Á¾¢ôÒ¼ý ¯½÷¸¢ý§Èý.			
2	±ýÀÄÓõ, ÀÄÅ£ÉÓõ ±ÉìÌò ¦³¾Ã¢Ôõ.			
3	¿¡ý ´ýÈ¢üÌõ ¯¾Å¡¾Åû §À¡ø ¯½÷¸¢ý§Èý.			
4	±ý ¸÷ôÀõ ±ÉìÌ ¾¢Õô¾¢ «Ç¢ì¸¢ýÈÐ.			
5	¿¡ý ¸÷ôÀÁ¡¸ þÕôÀ¨¾ ±ñ½¢ ºó§¾¡„Á¨¼¸¢ý§Èý.			
6	¿¡ý ¸÷ôÀÁ¡¸ þÕôÀ¨¾ ±ñ½¢ ¦ÀÕÁ¢¾õ ¦¸¡û¸¢ý§Èý.			
7	¿¡ý ±ý¨É Á¾¢ì¸¢ý§Èý.			
8	¸÷ôÀõ ±ÉìÌ ´Õ Í¨ÁÂ¡¸ þÕôÀÐ §À¡ø ¯½÷¸¢ý§Èý.			
9	¸÷ôÀõ ¾Ã¢ò¾¨¾ ±ñ½¢ ¿¡ý ±ý¨É À¡Ã¡ðÊì ¦¸¡û¸¢ý§Èý.			
10	±ýÉ¡ø ±øÄ¡ ¸¡Ã¢Âí¸¨ÇÔõ º¢ÈôÀ¡¸ ¦ºöÐ ÓÊì¸ ÓÊÔõ.			
11	±ý¨Éì ÌÈ¢òÐ ±ÉìÌ ¿øÄ «À¢ôÀ¢Ã¡Âõ ¯ûÇÐ.			
12	¸÷ôÀõ ¾Ã¢ò¾ À¢ÈÐ ¿¡ý «Æ¸¡¸ ¦³¾Ã¢¸¢ý§Èý.			
13	±ÉìÌ Å¢ÕôÀõ ¯ûÇ¨¾ ¿¡ý ¦ºö¸¢ý§Èý.			
14	±ÉìÌ «º¡¾¡Ã½ ¿õÀ¢ì¨¸ ¯ûÇÐ.			
15	±ý §¾¨Å¸û ±ÉìÌò ¦³¾Ã¢Ôõ.			
16	¸÷ôÀ¸¡Äò¾¢ø ÅÕõ º¢ýÉ À¢ÃîºÉ ¸Ç¢ø þÕóÐ ±ýÉ¡ø Á£ñÎ ÅÃ ÓÊÔõ.			
17	¿¡ý ±ý¨É§Â ¿¡ý ¾¡úò¾ Á¡ð§¼ý.			
18	¿¡ý ±ýÛ¨¼Â ÍÂ Óý§ÉüÈò¨¾ §¿¡ì¸¢ ¦ºø¸¢ý§Èý.			
19	¸÷ôÀ ¸¡Äò¾¢ø ²üÀÎõ ¯¼ø Ã£¾¢Â¡É Á¡üÈí¸¨Ç ¿¡ý ²üÚì ¦¸¡û¸¢ý§Èý.			
20	±ý §Å¨Ä¸Ç¢ø ¿¡ý §¿÷¨ÁÂ¡¸ þÕì¸¢ý§Èý.			

<u>Á¾¢ôÀ£Î:</u>

´Õ §À¡Ðõ þø¨Ä - 0

«ùÅô§À¡Ð - 1

±ô§À¡Ðõ - 2

Á¾¢ôÀ£Î	À¢Ã¢×
1-13	Ì¨ÈÅ¡É ÍÂ Á¾¢ôÀ£Î
14-26	Á¢¾Á¡É ÍÂ Á¾¢ôÀ£Î
27-40	«¾¢¸Á¡É ÍÂ Á¾¢ôÀ£Î

´ôÒ¾ø ÀÊÅõ

«¨¼Â¡Ú ±õ.².º¢¾õÀÃõ ¦ºÅ¢Ä¢Â÷ ¸øæÃ¢Â¢ø ±õ.±Š….¢ ¿÷º¢í ÀÂ¢Öõ ¦ºøÅ¢ **º£Á¡ðÊ.¦À** ±ýÀÅÃ¡ø §Áü¦¸¡ûÇôÀÎõ ¬ö¨ÅôÀüÈ¢ ±ÉìÌ Å¢ÅÃÁ¡¸ ÜÈôÀð¼¾¡ø þó¾ ¬öÅ¢ø Àí§¸üÀ¾¢ø ±ó¾ Å¢¾ ¬ð§ºÀ¨ÉÔõ þø¨Ä. §ÁÖõ ±ýÛ¨¼Â Å¢ÅÃí¸¨Ç «îº¢§ÄüÈ×õ ÓØ ´ôÒ¾ø «Ç¢ì¸¢ý§Èý.

¨¸¦Â¡ôÀõ :

¦ÀÂ÷ :

§¾¾¢ :

þ¼õ :