I. INTRODUCTION

Pregnancy is the gestation period that begins with conception, continues through the foetus's development, and ends with birth. A typical woman's gestation duration is nine months, forty weeks, or 280 days. Pregnancy occurs when the female gamete, or oocyte, merges with the male gamete, spermatozoon, in a process known in medical science as "fertilization," or more generally as "conception." After fertilization, it is referred as a fertilised egg with the fusion of male and female gametes and is normally achieved by sexual intercourse, resulting in spontaneous pregnancy. It is a crucial phase for all women's life because of numerous Psycho-physiological and socio-emotional changes when they undergo complicated birth, spontaneous miscarriage, stillbirth, or an abortion. So, pregnancy phase will be considered very important for every woman due to various challenges all might face in a different way. The typical gestation time is divided into three trimesters: the first has conception and the highest risk of miscarriage, the second has the baby's movement and growth of his various bodily parts, and the third or at last trimester is meant for the baby's delivery (Wylie, 2005).

1.1 CONCEPTION AND GESTATION

"Conception occurs when an egg from the female is fertilized by a sperm from the male. In humans, the conception process begins with ovulation, when an ovum, or egg (the largest cell in the human body), which has been stored in one of the female's two ovaries, matures and is released into the fallopian tube"- Charles Stangor & Jennifer Walinga, 2014.

"Gestation is the period between conception and birth when a baby grows and develops inside the mother's womb. Because it is impossible to know exactly when conception occurs, gestational age is measured from the first day of the mother's last menstrual cycle to the current date. It is measured in weeks" -National Library of Medicine, 2023.

The prenatal period typically lasts for about ten lunar months of twenty-eight days each or around nine calendar months, but its length can vary significantly, ranging from the days of 180 to 334. Research shows that there is about three times count as many premature births as post-term births. Studies by Meredith indicate that the average duration of the prenatal period ranges about 38 weeks or 266 days. However, majority i.e 70% of infants are born between 36 to 40 weeks (252 to 280 days), while 98% fall within the range of 34 to 42 weeks (238 to 294 days) (Hurlock, 1980).

Around the middle of the menstrual cycle, which happens approximately every 28 days, women go through ovulation: A process where an egg cell matures, exits the ovary, and travels all the way through the fallopian tube to reach to the uterus. Normally, the matured egg deteriorates and leaves the body during menstruation. However, if a woman engages in sexual intercourse with a fertile man around the ovulation period, the roughly 300 million sperm cells in his semen move in various directions, resembling tadpoles. Out of the hundreds to thousands of sperm that manage to survive the lengthy, 6-hour journey to the fallopian tubes, one might successfully fertilize the egg as it descends from the ovary. When this single sperm cell penetrates the egg, a biochemical process is triggered, preventing other sperm from entering the fertilized egg. This moment marks the beginning of life, as the genetic material from both the sperm and the egg combine to form a zygote (Singleman & Rider, 2013).

Pregnancy is defined as 'at term' upon the gestation reaching 37 full weeks but remaining below 42 weeks (from 259 to 294 days since LMP). Occurrences prior to reaching 37 weeks (259 days) are considered pre-term, while those after 42 weeks (294 days) are seen as post-term. If a pregnancy goes beyond 42 weeks (294 days), there is a notable increase in complications for both mother and the infant. Hence, in a straightforward pregnancy, obstetricians typically opt to induce labour sometime between 41 and 42 weeks (Vijayalakshmi & Subhasini, 2013).

1.2 DEFINITION OF PREGNANCY

"A condition of carrying a developing fetus in the uterus" (Salhan, 2016).

Pregnancy refers to events that occur from the time of fertilization (conception) until the infant is born (Marieb & Hoehn, 2007).

Pregnancy or gestation that occurs by sexual intercourse or by assisted reproductive technology is a state during which women carries a foetus in uterus (NICHD, 2013).

Pregnancy is one of the most critical and unique periods in a women's life cycle. Due to higher nutritional requirement this group is considered too vulnerable and critical in life span (Singh et al., 2009).

Pregnancy seems designed to prepare us for life as a mother. We start making sacrifices nine months before the child is born, so by the time they put in an appearance we are used to giving things up for them. – Brett Kiellerop-Morris, (n.d).

Pregnancy can be defined in the psycho-analytic literature as "a period of crisis involving profound psychological as well as somatic changes" (Bibring, 1959).

Pregnancy, especially the first one, bonds a woman more strongly than previously to the repercussions of her prior choice of spouse, decision to marry, and temporary abandonment of occupational aspirations. One price she must pay for having a child is increased responsibility and a loss of much of her previous freedom; while the consequences of such decisions are not entirely irreversible, the arrival of a child is one of the Rubicons on life's journey that, once crossed, cannot be recrossed. (Vyas, 1994).

1.3 SIGNS AND SYMPTOMS OF PREGNANCY

During pregnancy various physiological and anatomical changes bring about different sign and symptoms per trimester (Sharma et al., 2014). First trimester woman experience fatigue, breast tenderness, nausea and vomiting, and mood liability. Second trimester is comparatively better as the shape of the body starts to show pregnancy and increases excitement. Along with-it complications of first trimester also lessen down. Third trimester is related with physical discomfort in many pregnant women. It may include dyspnoea, weight gain, heart murmur and heart burn because of profound changes in all the body systems- cardio vascular, renal, pulmonary, gastrointestinal, and endocrine (Sadock et al., 2015).

Stretch marks, often known as reddish streaks, are caused by hormonal changes and physical strain on the skin of a pregnant woman's thighs, breasts, and belly. Due to the pressure of their uterus on large blood vessels, they may have mild to severe swelling in their legs, ankles, and feet in addition to varicose veins in their legs. Haemorrhoids, or enlarged veins in the rectum, may also develop.

During third trimester, the baby is completely formed, his/her major internal systems are maturing and eyelashes, finger nails, and hair, are in place. The symptoms of pregnancy will not be noticed until the missed period, or a week or two later. However, women may experience some of the symptoms below even though they have not had a period for a while.

According to Sharma et al., (2014) pregnancy diagnosis is categorized into some signs:

1.3.(a) Amenorrhea or missed period

Cessation of menstruation. It is considered as the first most symptom of pregnancy. Amenorrhea can occur due to several reasons like some medications, emotional disturbances, lactation, after oral contraceptive discontinuation etc.

1.3.(b) Tenderness & swollen breasts

Breasts that are sensitive and painful due to increased hormone levels are one of the first signs of pregnancy. The discomfort might resemble an exacerbated version of what a woman's breasts feel like just before her menstruation. The sensation of breast fullness and tenderness is a symptom that most primigravidas encounter. It generally happens between weeks six and eight of pregnancy.

1.3.(c) Fatigue

Women complain of common and early symptoms of pregnancy like fatigue, tiredness, disinclination toward any work or sleepiness due to elevated levels of progesterone hormone and also stress. A women's body undergoes as it adapts to pregnancy and can make them feel tired/exhausted. However, pregnant women sometimes feel more energetic once they enter into second trimester, however fatigue usually returns again in the third trimester.

1.3.(d) Bleeding during implantation

About 11- or 12-days following conception, some women have mild vaginal bleeding. Nobody is certain, but it's possible that the fertilized egg may have bled because it burrows into the uterine lining, which is rich in blood, starting as soon as six days after fertilization. The bleeding is quite little, lasting just one or two days, and manifests a red spotting or pink or brownish-red stains.

1.3.(e) Nausea or Vomiting

Pregnancy-related sickness, nausea and vomiting are uncomfortable symptoms for every woman. The exact cause of nausea is uncertain, although the most frequently mentioned likely explanation is hormonal fluctuations at the time of pregnancy (Cisek & Bucholc, 2015; Lagiou, 2003). Nausea begins at fourth week of pregnancy and sometimes can linger throughout pregnancy, but it usually subsides by week twelve. It is also known as "morning sickness" and it may be mild, moderate, or severe, but it can progress to severe type of hyperemesis gravidarum (Almond et al., 2016; Miller, 2002).

1.3.(f) Increased sensitivity to odors

The odour of a meat, egg or a cup of coffee repels pregnant women, and certain fragrances stimulate their gag reflex, which might be an unintended consequence of their body's fast-growing oestrogen levels.

1.3.(g) Aversions to foods

While some women insist on craving particular meals during the pregnancy, food aversions are far more prevalent. They might discover that meals they like are now entirely distasteful to them. These feelings might come and go or will remain throughout the pregnancy.

1.3.(h) Urination occurs often

Increased frequency of urination occurs in pregnancy; there may be several reasons as elevated levels of progesterone, increase in vascularity, and pressure of uterus on the bladder. During every pregnancy, the amount of blood and other fluids in a woman's body rises, resulting in added fluid being processed by her kidneys and may end up in her bladder. This sensation can appear a bit early as six weeks into the first trimester and may persist or worsen as the pregnancy develops and the expanding baby puts additional strain on the bladder.

1.3.(i) Changes in salivation

It is an early symptom and happens in certain pregnancies. Scientific studies have shown that the human body can produce an average of 2 litres of saliva per day. For women during pregnancy, saliva may be secreted more than usual in the first months of pregnancy, accompanied by other symptoms such as phlegm, nausea, fatigue, irritability and so on.

1.3.(j) Increased sweating

It occurs due to alteration in cutaneous circulation, increased hormone and blood flow causing rise in body temperature.

1.4. STAGES OF PREGNANCY

The prenatal development is divided into three periods:

1.4. (a) First Trimester

The first stage, known as first trimester (1-13 weeks) and starts when the mother may either feel happy or surprised about her positive symptoms of pregnancy. During the second week of its life, the embryo grows to 1.5 millimetres in length, and its major body axis begins to develop. As it elongates, a primitive streak forms, very similar in appearance

to the primitive streak of the chick. Cells migrating through the primitive form the mesoderm, establishing the three-layered embryo. The dorsal part of the body can be seen to be divided into somite. During the third week, the embryo develops to 2.3 millimeters in length and the majority of its major organ systems begin to develop. The neural groove reflects the development of central nervous system (Spinal cord and the brain), which is the first organ system to develop. With twenty-two days, the very rudimentary heart, which may still only a tube which begins to flutter and then pulse. From this moment onward, the heart will continue to beat 100,000 times every day until the individual's death. Soon, the eyeballs begin to develop (Viyas, 1994).

By the end of the first month, the embryo is 5 millimetres in length and has increased its mass 7,000 times. The neural grove has closed, and the embryo is now C-shaped. At this stage, it can be clearly seen that the tissues lateral to the notochord are arranged in paired somites. Each embryo has 40 pairs of somites, from which muscles, bones, and connective tissues will develop. The heart, even as it beats, develops from a simple set paired, contracting tubes to a four chambered vessel (Viyas, 1994).

Also, by this time, about 100 cells have been set aside (in the yolk sac) as germ cells, from which the egg or sperm cells of the individual will eventually develop. These cells begin to crawl, amoeba-like, toward the site at which the reproductive organs will develop. By the end of the first month, the embryo is 5 millimetres in length and has increased its mass 7,000 times. The neural groove has closed, and the embryo is now C-shaped. At this stage, it can be clearly seen that the tissues lateral to the notochord are arranged in paired somites. Each embryo has 40 pairs of somites, from which muscles, bones, and connective tissues will develop. The heart develops from a simple set of paired, contracting tubes to a four-chambered vessel.

By 38 days, the germ cells reach their destination, the developing gonads. Although the rudimentary gonads have begun to form by this time, male and female embryos are still morphologically identical. Whether or not the infant develops as a male is determined by the influence of some as yet unknown chemical whose production is directed by a gene or genes situated on the Y chromosome.

Gall bladder and pancreas are present at this stage, and there is clear differentiation of the divisions of the intestinal tract. The liver now constitutes about 10 percent of the body of the embryo and is its main blood forming organ. Arms, legs, elbows, knees, fingers, and toes are all forming during this time.

After the second month, the major steps in organ development are more or less complete, and the embryo, despite its very small size (3 centimetres), is almost human-looking and from this time on it is commonly known as a foetus. Its head is still relatively large, because of the early and rapid development of the brain, but the size of the head in proportion to the body will continue to decrease throughout gestation. The foetus begins to move its arms and kick its legs, and the mother may become aware of its movements. Reflexes, such as the startle reflex (by the end of the third month) and sucking first appear at this time. Its face becomes expressive; the foetus can squint, frown, or look surprised. Its respiratory organs are fairly well formed and the external sexual organs begin to develop.

By the third month, the foetus is about 9 centimetres long from the top of its head to its buttocks and weighs about 15 grams. It can suck and swallow and occasionally does consume a portion of the fluid that surrounds it in the amniotic sac.

1.4.(b) Second Trimester

The period identified as the second trimester, ranging from 14 to 28 weeks of gestation, starts with the sensation of foetal movements, also called quickening, and the auditory identification of the foetal heartbeat. During the fourth month, movements of the foetus become obvious to the mother. The baby's bony skeleton may form and also can be seen through ultrasound or x-rays. The baby's body will be covered with a protective cheese like coating called 'Vernix Caseosa' which is a protective coating for the skin. Then, the four-month-old foetus is about 14 centimetres long and weighs about 115 grams.

By the end of the fifth month, the placenta covers about 50 per cent of the uterus. The foetus has grown to almost 20 centimetres and now wight 250 grams. It has acquired hair on its head, and its body will be covered with a fuzzy, thin, soft hair called 'Lanugo' – a Latin word for down. Heart beats between 120 and 160 times per minute. During the sixth months, the foetus may have a sitting height of 30-36 centimetres and weighs about 680 grams. At the end of 6^{th} months, it may perhaps survive outside the mother's body, although probably only with respiratory assistance in an incubator. Its skin is red and wrinkled, and although teeth are only rarely visible at birth, they are already forming dentine. The cheese body covering, which helps protect the foetus against abrasions, is now abundant reflexes are more vigorous. In the intestines is a pasty green mass of dead cells and bile, known as meconium, which will remain there until after birth (Viyas, 1994).

As the pregnancy advances, the pregnant woman becomes increasingly aware that she carries life. In the second trimester of pregnancy, various undesired physical symptoms are reduced or eliminated, thereby defining this period as one marked by calmness and contentment During this critical phase, one of the main obligations for a mother is to foster an emotional attachment with the foetus. Numerous behaviours pertaining to attachment have been understood, such as conversing with the foetus or using a nickname to interact with the foetus (Leifer, 1977). However, pregnant women may become more social during this period (Stotland & Stewart, 2008).

1.4.(c) Third Trimester

The third trimester (29-38 weeks) is considered the final psychological stage of pregnancy, and it begins when physical discomforts begin and the woman senses that her unborn child is still alive. The foetus expands in size and weight. During this time, many neural tracts arise and the number of brain cells grows at a rapid pace. By the seventh month, brain waves from the foetal cortex may be monitored via the mother's belly. Infants weighing fewer than 2,000 grams at birth have a significant chance of dying or suffering serious brain damage.

At the time of last month of pregnancy, the baby typically acquires antibodies from his/her mother. Within one to two months after birth, the maternal antibodies will be gradually replaced by antibodies manufactured by the baby's own immune system. Weight at birth is the major factor in infant mortality. Low-weight infants (under 2,500 grams) are 40 times as likely to die within a month of birth, and two thirds of all babies who die are low weight. During this last month, the growth of the baby in the mother's womb slows down and the placental tissue begins a process of breakdown, leading to a conversion into a solid and fibrous structure.

At the final stage of pregnancy, maternal and foetal attachment is at its highest, leading to "nesting behaviour." Pregnant women frequently direct their focus towards bodily perceptions and physical appearance, potentially resulting in a heightened preoccupation. The primary anxieties of pregnant women encompass issues such as disrupted sleep patterns, discomfort in the back and legs, heightened apprehension regarding childbirth, concerns about the well-being of the foetus, sensations of pain, and the sense of relinquishing control during the birthing process (Stotland & Stewart, 2008). Based on the pregnancy signs and symptoms, expectant mother may experience psychological discomfort if not well treated, which will inevitably impair women's psychological well-

being. It is critical to recognize that the experience in this stage differs from woman to woman, but there are certain similar symptoms connected with all women in these stages that may impair their well-being. As a result, if appropriate care is not provided throughout any stage of pregnancy, both the mother and the unborn baby's psychological well-being may suffer.

1.5 HAZARDS DURING PREGNANCY

(i)The Physiological common complaints during pregnancy: The Physiological common complaints are backaches, constipation, depression, fatigue, and laziness etc, frequent urination, leg cramp, excessive salivation, food nausea, heartburn, nasal problem, headaches, varicose veins, vomiting.

(ii) The Psychological common complaints during pregnancy are depression, anxiety, and stress.

Depression: Prenatal depression refers to severe and mild phases of depression that begin during gestation and extend for six months to a year afterward. Women suffering from prenatal depression may be predisposed to changes in hormone levels, which induce the onset of symptoms (Gaynes et al., 2005).

Stress: Stress is the sensation of tension and pressure. It describes a wide spectrum of bodily responses that occur as a direct result of a stressor disrupting the body's homeostasis (The free medical dictionary by Farlex, 2003).

Anxiety: Anxiety is an undesirable emotional condition that varies from minor worry to terrifying fear (The free medical dictionary by Farlex, 2003).

1.6 COMPLICATIONS DURING PREGNANCY

Pregnant women with pre-existing medical condition or illness had a higher risk of having complications during pregnancy. Pregnant women with complications are at high risk and need regular checkups and monitoring. (Yadav & Yadav, 2019). According to their research, some of the most common complications include:

1.6.(a) Preterm delivery

Differences in stress level during second and third trimesters of pregnancy have been linked to an increased risk of premature delivery (Cole-Lewis et al., 2014; Qu et al., 2016) and foetal development (Dipietro, 2012; Alder, 2007). These outcomes are among the

primary causes of newborn mortality and health issues, which can last not just throughout infancy but also into adulthood (Lobel et al., 2008).

1.6.(b) Miscarriage

Miscarriage is among the most prevalent difficulties of early pregnancy (Poulose et al., 2006). Miscarriage is predicted to occur in 20% of clinically recognized pregnancies (Zinaman et al., 1996) and up to 50% of all pregnancies (Hure et al., 2012). It has been distinctly associated with increased levels of anxiety, sorrow, and depression (Toffol et al., 2013). Anxiety and depression can sometimes last for up to a year following a miscarriage (Lok et al., 2010). Moreover, studies revealed that the adverse psychological and emotional effects of previous miscarriages continue even after the loss and during future pregnancies (Geller et al., 2004; Bergner et al., 2008).

1.6.(c) Preeclampsia

It is a high-risk pregnancy condition that can arise in the middle of pregnancy or even up to two months following delivery. Preeclampsia can cause high blood pressure and, ultimately, significant damage to the brain, liver, and kidneys. Insufficient blood circulation due to preeclampsia towards the uterus may result in hindered growth, decreased amniotic fluid, and placental abruption. Signs and symptoms could involve feelings of intense headaches, nausea, vomiting, low eyesight, swelling limbs etc (Bishnoi et al., 2020).

1.6.(d) Reduced amniotic fluid

The amniotic sac holds amniotic fluid, providing protection and nourishment to the foetus. It is a protective layer, maintaining the temperature and pressure around the umbilical cord. Usually amniotic fluid increases during pregnancy, but starts to decrease in the final trimester (Bishnoi et al., 2020).

1.6.(e) Ectopic Pregnancy

An ectopic pregnancy occurs when a fertilized egg implants in the fallopian tube rather than the uterus. This situation arises when the fallopian tube experiences partial blockage during the implantation process. These pregnancies are commonly referred to as tubal pregnancies. Nevertheless, in such cases, implantation does not occur, leading to the eventual termination of these pregnancies (Bishnoi et al., 2020).

1.6.f) Gestational diabetes

Gestational diabetes is the most frequent pregnancy-related health issue. Even a woman who was not diabetic before pregnancy can acquire gestational diabetes. It is caused by a rise in blood sugar levels during pregnancy and can be restored to normal after birth.

Women with a history of gestational diabetes are at a higher risk of acquiring type 2 diabetes after birth (Bishnoi et al., 2020).

1.6.(g) Placenta previa

The placenta is situated at the lower part of the uterus, either in proximity to or covering the cervix. If it persists in the same position, the condition may be dangerous, causing bleeding and other issues. C-sections are commonly used in certain circumstances. It happens at a delivery rate of 1:200 (Bishnoi et al., 2020).

1.6. (h) Pregnancy-related infections

Preterm birth infection with any bacterium, parasite, virus, or vaginal infection can pose serious health concerns to both mother and baby (Bishnoi et al., 2020).

1.6.(i) Hypertensive pregnancy disorders

Previously, hypertensive pregnancy problems were thought to have no long-term influence on a woman's cardiovascular health; nevertheless, research has indicated that high blood pressure during pregnancy is a significant risk factor for heart disease in later life. Heart rate increases by 40% in pregnancy as a result of an increase in stroke volume. The third trimester results in a 10-beat-per-minute increase in heart rate. In the second stage of pregnancy, blood resistance decreases due to the decrease in blood pressure (Vyas, 1994).

1.6.(j) Cardiovascular illnesses

Valvular heart disease is the most prevalent cause of pregnancy complications (Vyas, 1994).

1.6.(k) Mitral Stenosis

It is more likely to result in death while pregnant. Increased blood pressure and cardiac output during pregnancy may result in pulmonary oedema. Pregnancy and mitral valve disease for a long time can be caused by diabetes. If hypovolemia is not treated, it can lead to sudden death. HR control during labour reduces the impact of tachycardia and ventricular filling on cardiac function (Vyas, 1994).

1.6.(l) Tuberculosis

There is not much doubt that untreated tuberculosis (TB) puts a pregnant woman and her foetus at higher risk than adequate illness treatment. Pregnant women who are multidrug-resistant have an increased risk of pulmonary problems and mortality. HIV patients may become reinfected with a resistant isolate following effective treatment of a

drug-sensitive pathogen. The problem of medication resistance presents a quandary for the obstetrician, who is also constrained by the possible prenatal toxicity of antitubercular treatment (Vyas, 1994).

1.6.(m) Epilepsy during pregnancy

Epilepsy is linked with a increased levels premature delivery, vaginal bleeding, eclampsia, and caesarean delivery. The pregnancy can be damaged by seizures caused by miscarriage, foetal damage, or placental abruption. Spontaneous abortion can occur as a result of intracranial bleeding inhibition of the foetal heart and neonatal haemorrhage, especially if the mother has not received Vitamin K (Vyas, 1994).

1.6.(n) Pregnancy & depression

There are multiple causes for the highest occurrence of depression during pregnancy. Biological changes that occur during pregnancy have a direct impact on mood (Oates, 2003). Women who have a history of chronic depression were found to recover in 68% cases when they stopped taking antidepressants during pregnancy, compared to 26% for those who continued using them without prevention (Cohen et al. 2006; Dayan et al., 2002).

1.6.(o) Obsessive-compulsive-disorder

According to epidemiological research, females are more likely to develop OCD than males. These findings suggest that reproductive events including pregnancy and delivery may be linked to OCD in females. These ladies often describe preoccupation with cleaning and washing. The emergence of such thoughts and behaviour can have a significant impact on maternal-child bonding and the mother's capacity to care for her infant (Brandes et al., 2010).

1.6.(p) Panic-disorder

The course of panic disorder during pregnancy is largely unknown. Pregnancy has been shown to induce an abrupt aggravation in women with past severe symptoms, although women with lesser panic symptoms may enjoy asymptomatic improvement (Klonoff-Cohen et al., 1996).

1.6. (q) Schizophrenia

Antenatal exposure to influenza and rubella, particularly during the second trimester, respiratory infections, hypoxia-related obstetric problems, low birth weight, and intrauterine growth retardation (in males only) are among the variables known to be somewhat linked

with this disease. Antenatal stress and inadequate nutrition are two remotely linked factors (Cannon et al., 2002).

1.6.(r) Eating-disorders

According to one research, women with eating disorders are more likely to have a caesarean section and postpartum depression (Franko et al., 2001). Women who binge eat during pregnancy should be evaluated for eating disorders.

1.6.(s) Bipolar mood disorders

Bipolar disorders are more common in women aged 12 to 30 (Kennedy et al., 2005) and are more prevalent during pregnancy and postpartum (reproductive age group). The majority of studies reveal significant recurrence rates throughout pregnancy, whereas some demonstrate exceptional stability (Viguera et al., 2002). Some experience fewer or shorter recurrences during pregnancy than during the prenatal period.

1.7 PHYSICAL DISCOMFORTS IN PREGNANCY

Common discomforts during pregnancy are as follows:

1.7. (a) Vaginal discharge

The increased vaginal discharge that most pregnant women experience is normally natural. The cervical glands produce more mucus in response to oestrogen. Monilia may be cultivated from the vagina of around 25% of pregnant women, and trichomonas vaginalis in up to 20% (Pritchard et al., 1985). Routine hygiene and prevention of douching are suggested (Biringer, 1988).

1.7. (b) Hyperemesis Gravidarum

Differs from nausea and vomiting as it involves severe complications as ketosis, dehydration, and acidosis and weight loss. Vomiting is severe, frequent, chronic and persistent than nausea and vomiting (Sadock & Ruiz, 2015).

1.7.(c) Constipation

Constipation is highly prevalent during pregnancy, and it can be caused by a variety of circumstances. These include lower motility due to smooth muscle relaxation (from increased progesterone and decreased motilin levels), mechanical blockage by the uterus, and increased water resorption from the colon (Pritchard et al., 1985). Constipation is frequently aggravated by the habitual use of iron-containing prenatal vitamins. The conventional treatment options include fibre ingestion, increased hydration intake, and exercise (Biringer, 1988).

1.7.(d) Backache

Low back discomfort is a prevalent ailment. Pregnant women have low back discomfort to varying degrees (Bewyer et al., 2009; Oswald & Assimakopouos, 2013). These problems occur before or after the fifth month of pregnancy (Bewyer et al., 2009). The cause of prenatal backaches is due to the history of trauma and back pain prior to pregnancy period (Bewyer et al., 2009). Back pain during pregnancy is the leading cause of sick leave (Malmqvix et al., 2015). However, prevention is effective option to overcome backpain during this phase (Gibson, 2017).

1.7.(e) Varicosities

Varicose veins, which are characterized by dilated and convoluted superficial veins caused by valve damage, can develop because of venous abnormalities (Heller & Evans, 2015). Typically, varicose vein is found in the lower extremities, but they can occur elsewhere in the body (Smith et al., 2008). During pregnancy, the woman's body undergoes various changes, including alterations to her vasculature, particularly venous changes. Venous changes during pregnancy are caused by both hormonal and mechanical events (Cronenwett et al., 2014). At the third-trimester, the enlarged uterus puts more pressure on the inferior vena cava and pelvic muscles, resulting in hypotension and lower cardiac output due to diminished venous return to the heart (Catchpole, 2013). However, later in pregnancy, this pressure can cause accumulation of blood in the lower extremities resulting in varicosities of the legs and vulva, as well as other conditions like dependent oedema and haemorrhoids (Ball et al., 2015).

1.7.(f) Headache

Headaches are a typical early pregnancy discomfort. There is usually no obvious cause, and most headaches subside or disappear by mid-pregnancy. Treatment should be symptomatic, with acetaminophen used only as needed. Later in pregnancy, headaches may indicate toxaemia (Biringer, 1988).

1.7.(g) Dizziness and fainting

Pregnant women often experience dizziness or syncope, especially when standing for extended periods or in warm weather. This is due to a decrease in cardiac output due to lowered venous return and peripheral vessel dilation. To prevent supine hypotension, pregnant women should avoid prolonged standing and lying flat on the back. When fainting, they should sit down or lie on their left side to reduce pressure on the inferior vena cava (Biringer, 1988).

1.7.(h) Bleeding gum

During pregnancy, the gums become hyperaemic and mushy due to oestrogen. There is no conclusive evidence that pregnancy causes tooth decay, but women should maintain routine dental treatment while pregnant. Pregnancy epulis is a localized vascular swelling of the gums that resolves spontaneously after delivery (Pritchard et al., 1985).

1.7.(i) Shortness of breath

Even early in pregnancy, 60%-70% of women report a heightened awareness of the desire to breathe. This greater respiratory effort is likely produced by a combination of variables, including higher progesterone, lower PaCO2 levels, and awareness of pregnancy's increased tidal volume (Pritchard et al., 1985). Later in pregnancy, when residual volume declines and weight grows, shortness of breath may become more intense. Sitting up upright and sleeping with pillows might assist to some extent.

1.7.(j) Pica

The term 'pica' describes the obsessive desire for the consumption of non-food objects. Pica is defined as an individual's desire, mouthing, or ingestion of essentially nonnutritive substances. Although most substances are harmless, there is still a chance of them containing hazardous elements such as paint, graphite from pencils, cigarette butts, adhesive sharp objects, sand, clay, stones, soil, soap, glass, waste material, hair, paper, ice, drywall, metal, starch, buttons, and chalk (Upadhyaya & Sharma, 2012). Pregnant women and children are the most common populations affected by pica (Lumish et al., 2014). There is evidence linking pica during pregnancy to both psychological and physiological problems. Pica has been linked to physiological abnormalities, such as deficiencies in iron, calcium, zinc, vitamin C, and thiamine (Upadhyaya& Sharma, 2012). Pregnancy makes these inadequacies worse to meet the demands of the developing foetus. The substance that a person is deficient in is frequently found in the element that they ingest. Apart from inadequate nutrition, psychological issues including cultural background or taught behaviour, stress or trauma, poor socioeconomic status, hunger or malnourishment, and underlying metabolic problems might also be involved (Jyothi, 2015).

1.7.(k) Heartburn

The most common symptom among pregnant women is heartburn, which is caused by the reflux of gastric fluids in the lower region of the oesophagus. It is caused by uterine expansion, which exerts pressure on the stomach, resulting in compression and displacement, as well as relaxation of the lower oesophageal sphincter. Small, frequent

meals, avoiding fatty or spicy foods, and raising the head of the bed may help (Atlay et al., 1978).

1.7.(l) Haemorrhoids

Haemorrhoids form or worsen during pregnancy because of increased pressure in the haemorrhoidal veins induced by the gravid uterus' blockage of venous return and the pregnancy's inclination to constipation. Stool softening, Sitz baths, and, on occasion, topical medications are used to treat the condition. External haemorrhoids that are thrombosed must be surgically removed. However, because most haemorrhoids become asymptomatic after delivery, additional surgical treatment is unnecessary (Biringer, 1988).

1.7.(m) Leg cramps

The exact cause of leg cramps during pregnancy remains unknown, but various factors may contribute to their occurrence. These factors include increased weight gain, pressure on pelvic nerves, changes in blood circulation, and blood vessels from the growing foetus, inadequate intake of minerals like magnesium and calcium, and dehydration. Recognizing these contributing factors could assist in formulating methods to alleviate leg cramps (Hensley, 2009; Ricci et al., 2013).

1.8 PSYCHOLOGICAL WELLBEING

Well-being is a complex structure that requires consideration of living and functioning at an optimal level, encompassing various facets. Previous studies explored the concept of well-being highlighted two key perspectives from which it is understood: firstly, a hedonic approach that emphasizes happiness, pleasure-seeking, and the avoidance of pain; secondly, a eudemonism approach that defines well-being as the pursuit of self-realization and fulfilment at a full-functionality level (Ryan & Deci, 2001; Keyes et al., 2002). Psychological well-being is a subjective term that holds different meanings for different individuals, reflecting the diverse nature of human experiences. While individuals may face times of mental and emotional challenges, experiencing a positive state of psychological well-being indicates effective coping mechanisms. This state not only impacts mental health but also influences physical well-being. Indicators of psychological well-being assess of their mental and emotional states and traditionally, two psychological approaches have been used to explore well-being: hedonic and eudemonic perspectives (Ryan & Deci 2001; Ryff 1989).

Psychological or mental well-being encompasses the way individuals evaluate their lives in terms of emotions, cognition, and feelings. It reflects the frequency and intensity of

either positive or negative emotions and attitudes, which can have diverse consequences. Furthermore, psychological well-being involves an individual's overall evaluation of their life (Diener, 2000). This dynamic concept includes subjective, social, and psychological dimensions and health-related behaviours. Another perspective on psychological well-being considers it as a social construct, emphasizing the satisfaction of human needs, meaningful action towards goals, and overall quality of life (Ryff, 1995).

Psychological well-being is realizing an individual's full potential and abilities, emphasizing a multidimensional nature. It comprises purpose in life, environmental mastery, autonomy, self-acceptance, personal growth, and positive relations with others (Winefield et al., 2012). Additionally, psychological well-being is conceptualized across six dimensions: positive relations with others, self-acceptance, purpose in life, environmental mastery, autonomy, and personal growth. These factors collectively form the foundation of psychological well-being, with strength in each area indicating good psychological well-being and struggles reflecting lower levels of well-being (Ryff, 2008).

During pregnancy, women experience profound changes in their mental and physical health, which can affect their psychological well-being on a variety of levels (O'Leary, 2015). Researchers suggest that pregnancy can disrupt psychological well-being and mental health, leading to stress, anxiety, and depression (O'Leary, 2015, Liu et al., 2013). Additionally, these challenges may increase the risk of future emotional disorders in both the child and the mother, potentially impacting early childhood behavioural issues (Liu et al., 2013).

1.9 IMPORTANCE OF PSYCHOLOGICAL WELL-BEING DURING PREGNANCY

Pregnancy is a unique and specific period in a woman's life that involves a myriad of physical and psychological changes that she undergoes (Bjelica et al., 2018; Isaacs & Andipatin, 2020). This stage is crucial as the expectant mother prepares herself for the upcoming role of motherhood, experiencing a mix of excitement and joy along with common occurrences of stress and negative feelings. Recent years have seen a rise in studies examining the impact of stress during prenatal period on both the mother-to-be and the development of the baby (Lindsay, 2019).

The process of pregnancy is a natural process that typically brings about a feeling of satisfaction and anticipation. However, some women may encounter psychological challenges like anxiety, depression, and stress during this period. Psychological aspects of

pregnancy have been a focal point in research due to their potential impact on pregnancy progression, labour, delivery, child development, and the mental well-being of the mother (Erickson, 1976). Pregnancy can be viewed as a transitional phase in a woman's life that intertwines with her emotional and psychological well-being. Poor mental health during pregnancy can have lasting effects on a woman's overall health and the well-being of her offspring and family. Expectant parents often harbour hopes and worries about their future child, with stress being particularly heightened in the case of first-time parents due to the unknowns associated with pregnancy. Concerns about various aspects of pregnancy such as the baby's health, the delivery process, financial implications, and relationship dynamics can collectively impact the psychological well-being of parents (Ilska & Przybyła, 2017; Biehle & Mickelson, 2011).

Despite women generally viewing pregnancy as a positive experience, the changes and demands during this period, coupled with societal influences, can elevate feelings of anxiety and stress among pregnant women (Guardino & Schetter, 2014). The sources of anxiety and stress vary and may include worries about the baby's well-being, the impending childbirth, and the responsibilities of future parenthood (Lobel et al., 2008). Studies have indicated that factors such as being a younger woman, a single mother, residing in a disadvantaged area, experiencing an unplanned pregnancy, and having pre-existing physical or mental health issues are linked to prenatal anxiety (Henderson & Redshaw, 2013). Pregnancy is a state that brings about physiological, familial, occupational, and emotional challenges necessitating adaptation; for women with limited financial resources, these challenges may be perceived as even more daunting (Norbeck & Anderson, 1989; Ritter et al., 2000). While having a child in the family is stressful, in some cases (such as a high-risk pregnancy), stress becomes more severe (Kemp & Hatmaker, 1989). A high-risk pregnancy is defined as any condition that has a detrimental impact on the mother's or foetal health and well-being (Cunningham et al., 1997).

The concept of perinatal well-being is multidimensional and multifaceted. However, well-being in this phase entails "the time interval between pre and post labouring, in terms of physical, psychological, social, spiritual, economic, and environmental aspects, a subjective cognitive and/or affective self-evaluation of one's personal life" (Allan et al., 2013). The perinatal time is a transitional era, and mothers' perinatal well-being is critical not only for their personal wellbeing, but also for the welfare of their newborn and family (Jomeen & Martin, 2018). Pregnant women's psychological well-being

impacts their emotional state, which is crucial for foetal development, delivery, and post-partum adaption (Ilska & Przybyła-Basista, 2017).

Social support is linked to higher psychological and physical well-being during and after pregnancy. Women who report more effective family support during pregnancy have less anxiety (Rini et al., 2006). Depression lessens when social support increases (Virit et al., 2008). Supportive spousal connections during pregnancy contribute significantly to the mother's and baby's post-natal well-being (Stapleton et al., 2012). Women with both high-risk and risk-free pregnancies who get support, mostly from their partners, may exhibit positive pregnancy behaviour (Gumusdas et al. 2014). Women with high-risk pregnancies benefit from high levels of social support, which improves their preparedness for parenthood and increases their positive perception of their situation. Aside from that, praying was shown to be the most commonly employed coping mechanism during high-risk pregnancy. Similarly, more optimistic women report less anxiety because they believe their pregnancy is readily controllable (Lobel et al., 2002).

During the period pregnancy, the placenta transmits emotional and physiological surroundings of the women to the developing child. As a complex neuroendocrine organ, the placenta plays varying roles, such as providing nutrients and oxygen to the foetus (Beijers et al., 2014). Placental blood flow disruptions that impact foetal nutrition and oxygen supply trigger a stress response. (Cole Lewis et al., 2014). Placental blood flow can be disturbed by maternal anxiety, sadness and stress that hinder foetal growth and development (Arabin & Baschat, 2017). Increased placental weight at birth indicates a compromised intrauterine environment, indicating compensatory development of the placenta in an attempt to protect the developing foetus from many maternal risk factors such as stress (Tegethoff et al. 2011).

Psychological well-being during pregnancy is critical for both the mother and her child. The impact of the mother's psyche on the foetus begins at conception. Many studies have focused on the postnatal element rather than the prenatal. According to the WHO report (2022), around 10% of pregnant women and 13% of postnatal mothers suffer from a mental condition, the most frequent of which is depression or anxiety. The examination of psychological condition, as well as physical and physiological evaluation, must begin immediately after pregnancy registration at a health care facility. Psychosocial evaluation of all pregnant women is an essential component of quality prenatal treatment (Austin, 2003). Pregnancy and childbirth provide an amazing opportunity for both parents to learn a variety

of topics about new life and care. During the prenatal time, both parents prepare physically and psychologically for parenthood (Prabhuswami, 2016).

1.10 FACTORS AFFECTING PSYCHOLOGICAL STATUS OF PREGNANT WOMEN

1.10.(a) Age

In relation to age, a study found that psychological distress decreased with advancing age over the age range of 20 to 64 years (Tesfaye et al. 2023). Most mental illnesses appear early in life, including psychological disturbance during pregnancy (Jorm et al., 1997). According to certain research, women aged 14-19 are 72% more likely to experience prenatal depression than women aged 20-29 (Ayele et al., 2016). Similarly, young pregnant women are more vulnerable to antenatal depression (Marcus et al., 2003).

1.10.(b) Education

Lack of formal education is linked with emotional distress. Higher education levels appear to contribute to decreased levels of mental stress later in life (Tesfaye et al. 2023). Education enhances psychological wellness. This might be because educated individuals have more options, resulting in more control over their life and better safety (Miech et al., 2007).

1.10.(c) History of abortion

Abortion history has a connection to mental distress during pregnancy (Tesfaye et al. 2023). Even though the relationship between abortion and mental illness is controversial most women felt more regret, grief, and anger about the abortion than about the pregnancy (Reardon, 2018).

1.10.(d) Spouse's Physical and Sexual Violence

The presence of physical and sexual abuse of spouse and anxiety related to pregnancy are remarkable risk factors for prenatal depression (Sheeba et al., 2019). Facing abusive behaviour at home increases the risk of depression in pregnancy (Gazmararian, et al., 2000). Intimate partner violence (IPV) also likely to develop mental problems, episodic mood distortion and psychological consequences (Tesfaye et al., 2023; Groves et al., 2012).

1.10.(e) Social support

Poor social support is also a predictor of pregnancy-related psychological distress (Tesfaye et al., 2023). Perceived social support tends to reduce pregnancy anxiety (van

Heyningen et al., 2017). Many studies showed that support from the family members as well as members from the society act as a determining factor for mental health status of pregnant women. Social support is a voluntary demonstration from one individual that is given to another, which evokes an immediate or delayed positive response in the recipient. Perception of social support is an essential predictor of mental health in the prenatal period. Studies revealed that one of the significant risk factors for depression during pregnancy is poor social support from the family and society (Leigh & Milgrom, 2008).

1.10.(f) Occupation

Housewives are 2.5 times as likely to have prenatal depression than government employees. Traders and everyday workers have 3.4 times the odds as government employees (Ayele et al., 2016). Housewives are 4.2 times more likely to develop prenatal depression than private workers (Mossie et al., 2017).

1.10.(g) Maternal Anxiety

Several research investigated the relationship between parental anxiety and depression (Records & Rice, 2007; Armstrong, 2004). Depression and anxiety are inextricably linked; approximately 60% of those with severe depression also diagnoses with the symptoms for anxiety disorder (Kessler et al., 2003). Anxiety during pregnancy has been linked with moderate-to-high levels of depression.

1.10.(h) Personality

Pregnancy is frequently viewed as a period of adaptation to transitions, both mentally and physically. These modifications could be impacted by their behaviour and attitudes. Several studies have found a significant frequency of neuroticism among pregnant women (Kitamura et al., 1996).

1.10.(i) Quality of Marital Relationship

Mental health of pregnant women often depends on their quality of marital relationship. Pregnancy is the time when all women need support from husband, requires quality of time from husband, talking and sharing opinions with her partner. Good relationship with spouse/partner can act as protective factor against any mental health problems including depression (Rosand et al., 2014).

1.10.(j) Socio-economic status

Maternal health outcomes are profoundly influence by socio-economic determinants, posing significance challenges to achieving equitable care for pregnant

women worldwide (S.J. & S.P., 2024). Health diet also supports optimal health and mother's overall wellbeing (Marshall et al., 2022).

1.10.(k) Psychological resilience

Oz & Bahadır-Yılmaz (2009) define resilience as adapting to harsh environments. Pregnant women's prenatal discomfort decreases as their sleep quality improves (Li et al., 2016). Pregnant women with high psychological resilience cope with the risk of preterm birth more actively, have a more hopeful outlook, and experience less depression (Nie et al., 2017). Women with low psychological resilience are more likely to have preterm births (Bhatia et al., 2015).

1.11 CARE DURING PREGNANCY

Pregnancy care is critical to the baby's normal growth and development, it can help decrease or avoid poor pregnancy outcomes. Poor pregnancy care causes neonatal mortality, preterm and low birth weight babies, difficulty in delivery, and so on. It also helps to reduce maternal morbidity, which is caused by poor health, an unsanitary environment, malnutrition, and a lack of medical services. Prenatal care should focus on the following elements to provide the best pregnancy possible:

1.11.(a) Nutrition and diet

Nutrition studies all nutrients and other compounds found in food that are required for appropriate growth, development, and bodily maintenance. All foods that provide vital nutrients for body development are part of a proper or balanced diet, which provides important nutrients for the body's growth and development. During gestation, a pregnant woman needs an increased intake of all nutrients such as calcium, iron, vitamins, protein, and folic acid (Bishnoi et al., 2020).

1.11.(b) Foods to consume during pregnancy

During the period of pregnancy, foods like whole grains, fruits, vegetables, low-fat protein, and dairy products should be consumed in enough amounts. All of these foods contribute to a well-balanced diet growth and development. The consumption of caffeine and fish is not recommended during pregnancy as it can harm the developing foetus and result in miscarriage or premature delivery. Some foods, such as raw meat, fish with high mercury levels, unpasteurized meals, alcohol and so on, should be absolutely avoided. Pregnant women should consume an additional diet rich in all food categories to fulfil the demands of their developing foetus (Bishnoi et al., 2020).

1.11.(c) Clothing

A healthy and safe pregnancy is ensured through the use of maternal wear. A woman should dress appropriately for her developing baby as the body undergoes rapid changes. The use of smooth fabrics is recommended for women who are pregnant and have a body that is sensitive to hormonal and psychological changes, which can lead to skin allergies or rashes. Most pregnant women feel too hot in summer and too cold in winter, so they should wear cotton clothes in summer to absorb sweat and keep the body cool, and woollen clothes in winter to warm the body. Wearing tight or fitting clothing may cause trouble breathing, heartburn, indigestion, nausea, and vomiting. Wearing loose and comfortable clothing at night improves peaceful sleep and helps the body prepare for normal delivery in the third trimester (Bishnoi et al., 2020).

1.11.(d) Immunization

Immunization is essential for the protection of the mother and foetus from various infections and diseases during pregnancy. Influenza vaccination is essential for pregnant women, as it reduces influenza morbidity by 63% in infants up to 6 months. Tdap vaccinations are recommended for pregnant women around 27-36 weeks of gestation to prevent severe pneumonia and brain inflammation. The vaccine also protects the unborn baby from liver diseases caused by food and water contamination, which can cause fever, nausea, and fatigue. Rare cases may lead to premature birth and infection, potentially leading to liver cancer and death. Pregnant women with this disease can pass the infection to their baby during delivery, making vaccination a recommended practice (Bishnoi et al., 2020).

1.11.(e) Personal hygiene

Personal hygiene is crucial during pregnancy, including hand washing and distance from dirty areas. However, unhygienic conditions increase the risk of microorganisms and infections, making both mother and baby more susceptible to infections (Bishnoi et al., 2020).

(i) Skin and hair hygiene

Pregnancy is a sensitive period for skin and hair, with oil glands secreting more oil, potentially causing infections. Proper washing and natural cosmetics should be used to maintain cleanliness and prevent reactions.

(ii) Oral hygiene

It is crucial to maintain dental hygiene since eating habits of pregnant women impact the growing foetus. Deviations in estrogenic levels cause dental sensitivity and gum swelling; in this instance, a doctor's counsel is required. Pregnant ladies should wash their teeth twice a day.

(iii) Hygienic Clothing

Clothing is the most significant thing that comes into close touch with the mother. When selecting maternity clothes, women should look for those that have antibacterial characteristics and can be readily washed with detergent.

(iv) Breast Care

As a parent, a woman must keep her infant near to her breast when feeding after birth, maintain her breasts clean, and wash them well with water.

(v) Vaginal hygiene

During pregnancy changing hormones can cause vaginal discharge in higher amount. This will be usually yellowish but harmless and may cause foul smell, itching or infection. Washing vaginal area with normal water after using washroom is suggestible without using harsh chemicals/soaps on it.

1.11.(f) Physical exercise

Pregnancy is an important period for physical exercise since it enhances the body’s well-being, prepares it for labour and delivery, increases stamina, muscular tone, and strength, decreases leg and back pain, promotes excellent blood circulation, and relieves stress. Moderate-intensity exercise is advised even if it was not previously practiced.

According to research, physical exercise is extremely important during pregnancy. Water workouts or exercise during pregnancy resulted in a shorter labour duration for women (Rodriguez-Blanque et al., 2019). Pregnant women’s attitudes and performance improved significantly after participating in fitness education sessions (Rezaee et al., 2016). Exercise during pregnancy is also beneficial to babies. Physical activity also positively reduces the risk of hypertension during gestation (Gao et al., 2020).

1.12 RESEARCH GAP

Pregnancy is a time of excitement and joy; however, stress is a common experience for pregnant women and other people may feel symptoms such as anxiety and depression (Lindsay et al., 2019), which can lead to unfavourable obstetric complications like foetal death or anomalies. This may also be associated with shorter gestation period, low birth weight, premature birth and increased uterine vascular resistance (Hosseini et al., 2009).

Pregnant women, on the other hand can use prenatal music for stimulation to bring relaxation, improve labour outcomes, and considerably reduce discomfort, anxiety, and misery during labour (Liu et al., 2010; Carolan et al., 2012). According to literatures, meditation and music therapies significantly lowered tension, fear, and anxiety while also boosting psychological status through course of pregnancy. According to research meditation, mindful eating, deep breathing, pranayama and yoga can significantly enhance mental and psychological wellness (Shi & MacBeth, 2017). It alleviates sadness and anxiety symptoms, improves sleep quality, and decreases cortisol stress levels (Ventura et al., 2012). Various studies have demonstrated that music can alleviate anxiety in both mother and unborn child while also decreasing the release of stress-inducing hormone cortisol, which decreases blood pressure, leading to feelings of calmness and relaxation (Helsing et al., 2016).

Therefore, music and meditation interventions have proven to enhance the emotional wellbeing of pregnant women, benefiting both the women and their baby's psychological health. Presently, there is limited research on the effects of mindfulness-based interventions on self-reported and physiological stress markers among pregnant mothers in India. Additionally, there are lack of records or publications that utilize music and meditation intervention to assess the psychological status of pregnant women in the chosen study area. Consequently, the researcher opted to conduct a study to examine the psychological status of pregnant women and implement music and meditation interventions to enhance their psychological health.

1.13 SCOPE OF THE STUDY

- The present study focuses on influence of music and meditation to bring positive mindset and wellbeing of pregnant women.
- Studies indicate that engaging in meditation practices and incorporating music interventions are intricately connected with beneficial health outcomes, a general sense of well-being, and adjunctive treatment for diseases, since emotions and experiences of pregnant women negatively influence the development of the growing fetus and it can have detrimental effects on children for the rest of their lives.

- The incorporation of music and meditation fosters the development of mindfulness and self-compassion, enhancing the ability to withstand stress and confront discomfort during pregnancy and helps to manage pregnancy related stress, anxiety and happiness, family relationships, physical health and one's body image which intern benefit pregnant women's psychological wellbeing.
- Considering the importance of psychological wellbeing and health of the pregnant mother and lack of necessary research in this area in our country especially in Assam, Lakhimpur district, the researcher decides to conduct this study to evaluate maternal psychological wellbeing and aimed to provide music and mediation intervention throughout the pregnancy to see its effectiveness on pregnant women.

1.14 NOVELTY OF THE STUDY

- ❑ The study has developed a tool to assess the psychological status of pregnant women which was not available in India. Lot of researches have been undertaken to assess the stress and anxiety levels among pregnant women in which they used the tools we use for other age groups. However, the tool is designed to support community facilitators and healthcare practitioners in providing assured treatment/counselling to pregnant women in order to improve their well-being. No standardized tools based on pregnancy psychological status are available in India to assess the same, under several areas which fills that gap, aiding pregnant women in self-assessment and helping them to choose intervention packages as per their choice.
- ❑ The study was carried out in Lakhimpur District of Assam where there was no such records or publications been found based on meditation and music therapy applied among pregnant women.
- ❑ The study's samples were chosen from the first trimester to the third trimester and intervention was carried out throughout.

1.15 STATEMENT OF THE PROBLEM

Pregnancy related stress, anxiety impacts overall psychological status. In Lakhimpur district of assam, the clinical practice of music and meditation has not been conducted, and no such records have been found. While there is fairly substantial literature on maternal psychological wellbeing and role of different interventions during pregnancy in this area. So, the researcher made an effort to promote such interventions in specialized areas to enhance the psychological status and satisfaction of pregnant women. Thus, the researcher has chosen the topic **"Effectiveness of Music and Meditation on Psychological Status of Pregnant Women in Lakhimpur District, Assam"** and to implement music and meditation intervention for them.

1.16 AIM AND OBJECTIVES OF THE STUDY

The aim of the present study is to design, implement and evaluate the effectiveness of the following two strategies on psychological status of pregnant women.

a. Music intervention
b. Meditation intervention.

The primary and secondary objectives of the present study are as follows:

Primary Objective:

- To measure the effectiveness of Music and Meditation on psychological status of pregnant women in two different samples

Secondary objectives:

- To study the socio-demographic profile of the selected pregnant women
- To construct and validate Pregnancy Psychological Status Scale
- To assess psychological status and its dimensions of pregnant women based on socio-demographic profile
- To plan music and meditation interventions for selected pregnant women
- To explore the effectiveness of intervention module on selected pregnant women
- To compare the effectiveness of interventions on pregnant women's psychological status

1.17. HYPOTHESES

$H0_1$: There would be no significant difference in the psychological status and its dimensions among pregnant women based sociodemographic variables.

$H0_2$: There might be no significant difference in psychological status of pregnant women in Pre, Mid and Post test under music intervention group.

$H0_3$: There may be no significant difference in psychological status of pregnant women in Pre, Mid and Post test under meditation intervention group.

$H0_4$: There would be no significant difference found in effectiveness of music and meditation intervention among pregnant women.

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