

Effectiveness of a Structured Educational Intervention on Managing Minor Disorders of Pregnancy Through Home Remedies Among Antenatal Women in Urban and Rural Kuppam

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Abstract

Pregnancy is a physiological process often accompanied by minor disorders such as nausea, vomiting, backache, heartburn, and fatigue, which can affect the well-being of expectant mothers. Appropriate knowledge and timely management using simple home remedies can significantly reduce discomfort and improve maternal health. This study aimed to evaluate the effectiveness of a structured educational intervention on the management of minor disorders of pregnancy through home remedies among antenatal women in urban and rural areas of Kuppam. A quasi-experimental comparative research design was adopted, involving antenatal mothers attending selected urban and rural health clinics. Participants were assessed for their baseline knowledge regarding minor pregnancy disorders and their home-based management using a structured questionnaire. Following the pretest, a structured educational programme was administered, covering common minor ailments and safe, evidence-based home remedies. A posttest was conducted after the intervention to evaluate changes in knowledge levels. The findings revealed a significant improvement in posttest knowledge scores among participants in both urban and rural groups, indicating the effectiveness of the educational intervention. Furthermore, a comparative analysis showed variations in baseline knowledge between the two groups, with rural participants demonstrating relatively lower initial awareness. However, both groups exhibited substantial gains following the intervention. The study highlights the importance of structured teaching programmes in empowering antenatal mothers with practical, cost-effective strategies to manage minor pregnancy-related discomforts safely at home. Incorporating such educational initiatives into routine antenatal care services can enhance maternal self-care practices and overall pregnancy experience.

Keywords: Structured educational intervention, minor disorders of pregnancy, home remedies, antenatal mothers, maternal health education

INTRODUCTION

Pregnancy is a natural and significant phase in a woman's life, characterized by various physiological, psychological, and hormonal changes. Although it is generally a normal process, many women experience a range of minor disorders, such as nausea and vomiting, backache, constipation, heartburn, fatigue, leg cramps, and edema. These discomforts, while not life-threatening, can negatively affect the daily activities, emotional well-being, and overall quality of life of antenatal mothers. Effective and timely management of these minor ailments is essential to ensure a healthy and comfortable pregnancy [1].

In many cases, minor pregnancy disorders can be safely managed through simple, non-

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pharmacological measures and home remedies. These approaches are often cost-effective, easily accessible, and culturally acceptable, particularly in resource-limited settings. However, a lack of awareness and inadequate knowledge among pregnant women may lead to improper practices and unnecessary medical interventions. Therefore, educating antenatal mothers about safe and appropriate home management strategies is crucial to prevent these complications [2].

Structured educational interventions play a vital role in improving knowledge, shaping positive attitudes, and promoting healthy practices among pregnant women. These programs provide systematic and evidence-based information, enabling women to recognize common pregnancy-related discomforts and manage them effectively at home. Moreover, disparities in access to healthcare information between urban and rural populations may influence the level of awareness and self-care practices among pregnant women [3].

Kuppam, located in Andhra Pradesh, has a diverse population with both urban and rural communities, making it an ideal setting to compare knowledge levels and assess the impact of educational interventions. Understanding these differences is important for designing targeted maternal health education programs.

Hence, this study aimed to evaluate the effectiveness of a structured educational intervention on managing minor disorders of pregnancy through home remedies among antenatal women in urban and rural Kuppam and to compare the outcomes between these groups [4].

Minor disorders may occur due to hormonal, accommodation, metabolic, and postural changes. Everybody's system is affected by pregnancy. Minor disorders during pregnancy include:

1st Trimester

- Nausea
- Vomiting
- Fatigue
- Frequency of micturition
- Pica

2nd Trimester

- Heart burn
- Constipation
- Vaginal discharge
- Backache

3rd Trimester

- Hemorrhoids
- Leg cramps
- Edema
- Varicosities

If minor disorders are not treated, they may have deleterious effects on the health of the mother and baby. Therefore, the treatment of minor disorders is very important to minimize these minor disorders and to provide comfort to the mother [5].

Need for Study

According to a World Health Organization Report (2012), approximately 57% of pregnant women experience minor pregnancy disorders. The commonly experienced ailments are nausea, vomiting, leg cramps, constipation, and heartburn [6].

Sixty percent of antenatal mothers have a history of common discomforts during pregnancy, such as nausea (47%), vomiting (87%), fatigue (7%), heart burn (55%), and back pain (80%). According to the worldwide incidence (2011), there are nearly 1.6 billion women between the ages of 15 and 44 who are childbearing, and in the United States alone, there are about 62 million. Among these women, 50% of antenatal mothers suffer from minor disorders [7].

Ngozi PO (2018) conducted a study to determine the prevalence of pica during pregnancy in urban and rural areas of Nairobi, Kenya. A cross-sectional descriptive design was used; the sample included in the study was the pregnant women in urban and rural areas of Nairobi, Kenya. The results revealed a high prevalence of pica in pregnant women in urban areas compared to rural areas [8].

The above-mentioned statistical prevalence indicates the need for effective education in the management of minor disorders of pregnancy among antenatal mothers, as a large number of antenatal mothers were affected by one or the other minor disorders due to their ignorance of home remedies for minor disorders of pregnancy. Therefore, the investigator is interested in conducting this study to determine the effect of a structured teaching programme on minor disorders and their home remedies to enhance the knowledge of antenatal mothers [9, 10].

Objectives

- To evaluate the knowledge levels regarding minor disorders of pregnancy and their home-based management among urban antenatal mothers attending the antenatal clinic at Government Area Hospital, Kuppam, before and after the implementation of a structured teaching program.
- To determine the knowledge levels related to minor pregnancy ailments and their home remedies among rural antenatal mothers attending the antenatal clinic at Community Health Center, V. Kota, before and after the structured teaching intervention.
- To compare the post-intervention knowledge scores of urban and rural antenatal mothers from the Government Area Hospital, Kuppam, and Community Health Center, V. Kota, regarding minor pregnancy-related discomforts and their simple home management strategies.
- To examine the relationship between posttest knowledge scores and selected sociodemographic variables, such as age, religion, education, occupation, income, age at marriage, duration of married life, gravida, and gestational age, among antenatal mothers in both urban and rural settings.

Hypothesis

H_0 (*null hypothesis*): There is no statistically significant difference in posttest knowledge scores regarding minor disorders of pregnancy and their home remedies between antenatal mothers from urban and rural areas.

H_1 (*research hypothesis*): There is a statistically significant relationship between posttest knowledge scores on minor pregnancy disorders and their home-based management and the selected sociodemographic variables among antenatal mothers in both urban and rural settings.

METHODOLOGY

The data for this study were collected over four weeks. Prior to initiating the study, formal permission was obtained from the Medical Officer of the Government Area Hospital, Kuppam, Andhra Pradesh, and the Medical Officer of the Community Health Center, Andhra Pradesh. A total of 100 antenatal mothers were selected as samples, comprising 50 participants from the urban group and 50 from the rural group. Participants were chosen using a simple random sampling technique through the lottery method based on the inclusion criteria.

Before data collection, the researcher introduced the study to the participants, explained its purpose, and obtained their verbal consent. The confidentiality of the participants' responses was strictly maintained. A pretest was conducted using a structured knowledge questionnaire among antenatal mothers at both the Government Area Hospital, Kuppam, and the Community Health Center. Approximately 30 minutes were required to collect the data from each participant.

Following the pretest, a structured teaching program on minor pregnancy disorders and their home remedies was administered on the same day. Subsequently, a posttest was conducted using the same structured questionnaire to assess changes in knowledge levels.

The research instrument was validated by experts in nursing and medicine, confirming its suitability and relevance to the study. The tool consisted of the following components.

- *Part A:* Consists of demographic data such as age, religion, occupation, age at marriage, marital life, gravida, and gestational age.
- *Part B:* Consists of 25 multiple-choice questions regarding minor disorders of pregnancy and their home remedies. The data were analyzed using descriptive and inferential statistics, and the findings were interpreted.

RESULTS

The results obtained from the study are presented as follows.

DISCUSSION

The discussion of the study is based on the objective of the study.

Figure 1 shows a comparison between the posttest knowledge scores of urban and rural antenatal mothers. 0% of urban and rural antenatal mothers had poor knowledge. 0% of urban and rural antenatal mothers had inadequate knowledge. 0% of the urban antenatal mothers had moderate knowledge, and 10% of the rural antenatal mothers had moderate knowledge. 8% of urban antenatal mothers had adequate knowledge, and 90% of rural antenatal mothers had adequate knowledge. Among the urban antenatal mothers, 92% had good knowledge, and 0% of the rural antenatal mothers had good knowledge.

Table 1 presents the frequency and percentage distribution of urban and rural antenatal mothers (N=100) based on the selected demographic variables. The findings showed variations between the two groups across different characteristics. In terms of age, the majority of urban mothers were in the 21–30 years group (34%), while rural mothers were predominantly in the same age group (42%). Regarding religion, most urban participants were Hindu (70%), whereas rural participants had a higher proportion of Muslims (54%).

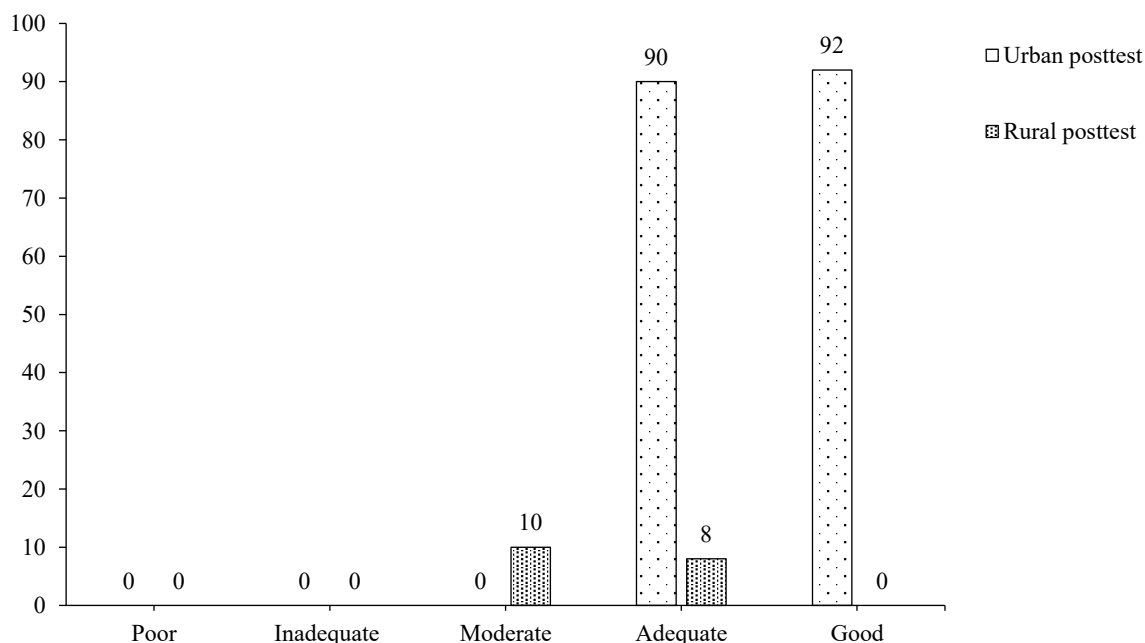


Figure 1. Comparison between pretest and posttest knowledge scores.

Table 1. Frequency and percentage distribution of urban and rural antenatal mothers based on their demographic variables (N=100).

| S.N. | Demographic variable | Frequency | | Percentage | |
|------|----------------------------|-----------|-------|------------|-------|
| | | Urban | Rural | Urban | Rural |
| 1. | Age | | | | |
| | Below 20 years | 24 | 19 | 48% | 38% |
| | 21–30 years | 17 | 21 | 34% | 42% |
| | Above 30 years | 9 | 10 | 18% | 20% |
| 2. | Religion | | | | |
| | Hindu | 35 | 18 | 70% | 36% |
| | Muslim | 15 | 27 | 30% | 54% |
| | Christian | 00 | 5 | 00% | 10% |
| | Others | 00 | 00 | 00% | 00% |
| 3. | Educational status | | | | |
| | Primary | 8 | 19 | 16% | 38% |
| | Secondary | 32 | 27 | 24% | 54% |
| | Higher secondary | 10 | 4 | 20% | 8% |
| | Graduation and above | 00 | 00 | 00% | 00% |
| 4. | Occupational status | | | | |
| | Housewife | 39 | 32 | 78% | 6% |
| | Daily wages | 11 | 18 | 22% | 36% |
| | Government | 00 | 00 | 00% | 00% |
| 5. | Monthly income | | | | |
| | Below 1000 | 11 | 26 | 22% | 52% |
| | 1001–5000 | 25 | 20 | 50% | 40% |
| | 5001–10000 | 14 | 4 | 28% | 8% |
| | Above 10000 | 00 | 00 | 00% | 00% |
| 6. | Age at marriage | | | | |
| | Less than 20 years | 15 | 23 | 30% | 46% |
| | 21–28 years | 25 | 18 | 50% | 36% |
| | 29–40 years | 10 | 9 | 20% | 18% |
| | Above 40 years | 00 | 00 | 00% | 00% |
| 7. | Marital life | | | | |
| | 1 year | 17 | 22 | 34% | 44% |
| | 2 years | 24 | 15 | 48% | 30% |
| | 3 years | 9 | 13 | 18% | 26% |
| | Above 5 years | 00 | 00 | 00% | 00% |
| 8. | Gravida | | | | |
| | Urban | | | | |
| | Primigravida | 28 | 26 | 56% | 52% |
| | multigravida | 22 | 24 | 44% | 48% |
| 9. | Gestational age | | | | |
| | Less than 14 weeks | 8 | 14 | 16% | 24% |
| | 15–28 weeks | 23 | 17 | 46% | 34% |
| | 29–33 weeks | 12 | 15 | 24% | 30% |
| | Above 34 weeks | 7 | 4 | 14% | 8% |

With respect to educational status, most urban mothers had secondary education (32%), while rural mothers were mainly in secondary (54%) and primary (38%) education levels. Regarding occupational

status, the majority of urban mothers were housewives (78%), while rural mothers included a higher proportion of daily wage workers (36%).

Overall, Table 1 highlights notable demographic differences between urban and rural antenatal mothers that may influence their knowledge and health practices.

Table 2 presents the mean and standard deviation of pretest and posttest knowledge scores among urban antenatal mothers (N=50) regarding minor disorders of pregnancy and their home remedies. The findings indicate that the mean pretest score was 13.2, with a standard deviation of 3.4, whereas the mean posttest score increased to 20.1, with a standard deviation of 2.3. This notable increase in the mean score suggests a considerable improvement in knowledge following the structured teaching programme. Furthermore, the calculated t-value of 12.6 demonstrates that the difference between the pretest and posttest scores is statistically significant. Hence, it can be inferred that the structured teaching programme was highly effective in enhancing the knowledge of urban antenatal mothers (Table 2).

Table 3 shows that the mean posttest knowledge scores (20.1) of urban antenatal mothers were higher than the mean posttest knowledge score (18.7) of rural antenatal mothers. The calculated t-value of urban antenatal mothers was greater than the table value (i.e., $t=2.01$ at 0.05, $df=49$). The calculated t-value of rural antenatal mothers was greater than the table value (i.e., $t=2.01$ at 0.05, $df=49$). The null hypothesis (H_0), which stated that there would be no significant difference between pretest and posttest knowledge scores regarding minor disorders of pregnancy and their home remedies among urban and rural antenatal mothers, was rejected. This indicates that the structured teaching programme had a positive impact and was effective in improving knowledge.

The analysis of Tables 4, 5, and 6 revealed a significant association between posttest knowledge scores and certain sociodemographic variables. Among urban antenatal mothers, factors such as gravida and gestational age showed a significant relationship, while among rural antenatal mothers, gestational age was significantly associated with knowledge. These findings suggest that posttest knowledge levels are influenced by selected demographic variables, leading to the acceptance of the alternative hypothesis (H_1).

These findings are supported by similar studies. A single-blind clinical trial conducted in Isfahan in 2012 examined the effectiveness of ginger in managing nausea and vomiting during pregnancy. The study involved 67 pregnant women who were randomly divided into experimental and control groups. The experimental group received 250 mg ginger capsules for four days, while the control group received a placebo. The results showed a significantly higher improvement rate in the ginger group than in the placebo group (85% vs. 56%, $p < 0.01$), demonstrating that ginger is an effective herbal remedy for reducing nausea and vomiting during pregnancy.

Table 2. Mean and standard deviation of pretest and posttest knowledge scores of antenatal mothers of urban (N=50).

| S.N. | Effectiveness of structured teaching programme on minor disorders of pregnancy and their home remedies among antenatal mothers of urban areas. | Mean | SD | t-value |
|------|--|------|-----|---------|
| 1 | Pretest | 13.2 | 3.4 | 12.6 |
| 2 | Posttest | 20.1 | 2.3 | |

Table 3. Mean and standard deviation of pretest and posttest knowledge scores of antenatal mothers of rural (N=50).

| S.N. | Effectiveness of structured teaching programme on minor disorders of pregnancy and their home remedies among antenatal mothers of rural areas. | Mean | SD | t-value |
|------|--|------|-----|---------|
| 1 | Pretest | 11.6 | 3.8 | 11.2 |
| 2 | Posttest | 18.7 | 2.9 | |

Table 4. Association of the posttest knowledge scores of urban antenatal women with their selected demographic variables (N=50).

| S.N. | Demographic variables | Knowledge scores | | | | | | | | | | |
|------|----------------------------|------------------|---|------------|---|----------|---|----------|---|------|----|------|
| | | Poor | | Inadequate | | Moderate | | Adequate | | Good | | |
| | | F | % | F | % | F | % | F | % | F | % | |
| 1. | Age | | | | | | | | | | | |
| | Below 20 years | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4 | 22 | 44 | 894 |
| | 21–30 years | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 16 | 32 | NS |
| | Above 30 years | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 8 | 16 | |
| 2. | Religion | | | | | | | | | | | |
| | Hindu | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 6 | 32 | 64 | 654 |
| | Muslim | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 14 | 28 | NS |
| | Christian | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| | Others | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 3. | Educational status | | | | | | | | | | | |
| | Primary | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 7 | 14 | 785 |
| | Secondary | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 6 | 29 | 58 | NS |
| | Higher secondary | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 20 | |
| | Graduation and above | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 4. | Occupational status | | | | | | | | | | | |
| | Housewife | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 6 | 36 | 72 | 1.00 |
| | Daily wages | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 10 | 20 | NS |
| | Government | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 5. | Monthly income | | | | | | | | | | | |
| | Below 1000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 | 22 | 799 |
| | 1001–5000 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 6 | 22 | 44 | NS |
| | 5001–10000 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 13 | 26 | |
| | Above 10000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 6. | Age at marriage | | | | | | | | | | | |
| | Less than 20 years | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 14 | 28 | 1.00 |
| | 21–28 years | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4 | 23 | 46 | NS |
| | 29–40 years | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 9 | 18 | |
| | Above 40 years | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 7. | Marital life | | | | | | | | | | | |
| | 1 year | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 16 | 32 | 427 |
| | 2 years | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 4 | 23 | 46 | NS |
| | 3 years | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 7 | 15 | |
| | Above 5 years | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 8. | Gravida | | | | | | | | | | | |
| | Primigravida | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 27 | 54 | 0.04 |
| | multigravida | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 6 | 19 | 38 | S |
| 9. | Gestational age | | | | | | | | | | | |
| | Less than 14 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 18 | 0.01 |
| | 15–28 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 8 | 25 | 50 | S |
| | 29–33 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 | 24 | |
| | Above 34 weeks | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

Table 5. Association of the posttest knowledge scores of rural antenatal mothers with their selected demographic variables (N=50).

| S.N. | Demographic variables | Knowledge scores | | | | | | | | | | |
|------|----------------------------|------------------|---|------------|---|----------|----|----------|----|------|---|-------|
| | | Poor | | Inadequate | | Moderate | | Adequate | | Good | | |
| | | F | % | F | % | F | % | F | % | F | % | |
| 1. | Age | | | | | | | | | | | |
| | Below 20 years | 0 | 0 | 0 | 0 | 3 | 6 | 16 | 32 | 0 | 0 | 604 |
| | 21–30 years | 0 | 0 | 0 | 0 | 2 | 4 | 19 | 38 | 0 | 0 | NS |
| | Above 30 years | 0 | 0 | 0 | 0 | 0 | 0 | 10 | 20 | 0 | 0 | |
| 2. | Religion | | | | | | | | | | | |
| | Hindu | 0 | 0 | 0 | 0 | 2 | 4 | 16 | 32 | 0 | 0 | 449 |
| | Muslim | 0 | 0 | 0 | 0 | 3 | 6 | 24 | 48 | 0 | 0 | NS |
| | Christian | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 10 | 0 | 0 | |
| | Others | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 3. | Educational status | | | | | | | | | | | |
| | Primary | 0 | 0 | 0 | 0 | 1 | 2 | 16 | 32 | 0 | 0 | 765 |
| | Secondary | 0 | 0 | 0 | 0 | 4 | 8 | 25 | 50 | 0 | 0 | NS |
| | Higher secondary | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 8 | 0 | 0 | |
| | Graduation and above | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 4. | Occupational status | | | | | | | | | | | |
| | Housewife | 0 | 0 | 0 | 0 | 4 | 8 | 31 | 62 | 0 | 0 | 524 |
| | Daily wages | 0 | 0 | 0 | 0 | 1 | 2 | 14 | 28 | 0 | 0 | NS |
| | Government | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 5. | Monthly income | | | | | | | | | | | |
| | Below 1000 | 0 | 0 | 0 | 0 | 2 | 4 | 24 | 48 | 0 | 0 | 767 |
| | 1001–5000 | 0 | 0 | 0 | 0 | 3 | 6 | 17 | 34 | 0 | 0 | NS |
| | 5001–10000 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 8 | 0 | 0 | |
| | Above 10000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 6. | Age at marriage | | | | | | | | | | | |
| | Less than 20 years | 0 | 0 | 0 | 0 | 2 | 4 | 21 | 2 | 0 | 0 | 1.00 |
| | 21–28 years | 0 | 0 | 0 | 0 | 2 | 4 | 16 | 32 | 0 | 0 | NS |
| | 29–40 years | 0 | 0 | 0 | 0 | 1 | 2 | 8 | 16 | 0 | 0 | |
| | Above 40 years | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 7. | Marital life | | | | | | | | | | | |
| | 1 year | 0 | 0 | 0 | 0 | 2 | 4 | 20 | 40 | 0 | 0 | 596 |
| | 2 years | 0 | 0 | 0 | 0 | 2 | 4 | 13 | 26 | 0 | 0 | NS |
| | 3 years | 0 | 0 | 0 | 0 | 1 | 0 | 12 | 24 | 0 | 0 | |
| | Above 5 years | 0 | 0 | 0 | 0 | 0 | 20 | 0 | 0 | 0 | 0 | |
| 8. | Gravida | | | | | | | | | | | |
| | Primigravida | 0 | 0 | 0 | 0 | 3 | 6 | 23 | 43 | 0 | 0 | 539 |
| | Multigravida | 0 | 0 | 0 | 0 | 2 | 4 | 22 | 44 | 0 | 0 | NS |
| 9. | Gestational age | | | | | | | | | | | |
| | Less than 14 weeks | 0 | 0 | 0 | 0 | 1 | 2 | 13 | 26 | 0 | 0 | 0.001 |
| | 15–28 weeks | 0 | 0 | 0 | 0 | 2 | 4 | 15 | 30 | 0 | 0 | S |
| | 29–33 weeks | 0 | 0 | 0 | 0 | 1 | 2 | 14 | 28 | 0 | 0 | |
| | Above 34 weeks | 0 | 0 | 0 | 0 | 1 | 2 | 3 | 6 | 0 | 0 | |

Table 6. Association between chi-square values in posttest knowledge scores among urban and rural antenatal mothers regarding minor disorders of pregnancy and their home remedies with their selected demographic variables.

| S.N. | Variables | P-value | | Significance |
|------|---------------------|--------------|--------------|--------------------------------|
| | | <i>Urban</i> | <i>Rural</i> | |
| 1. | Age | 894 | 604 | Not significant |
| 2. | Religion | 654 | 449 | Not significant |
| 3. | Educational status | 785 | 765 | Not significant |
| 4. | Occupational status | 1.00 | 524 | Not significant |
| 5. | Monthly income | 799 | 767 | Not significant |
| 6. | Age at marriage | 1.00 | 1.00 | Not significant |
| 7. | Marital status | 427 | 596 | Not significant |
| 8. | Gravida | 0.04 | 539 | Significant in urban |
| 9. | Gestational age | 0.01 | 0.001 | Significant in urban and rural |

Recommendations

- This study can be replicated with a larger sample size to enhance the generalizability of the results.
- It may also be carried out across diverse settings to broaden its relevance.
- A comparative approach, including a control group, could be undertaken for more robust findings.
- Further studies should explore the association between antenatal mothers' knowledge, practices, and attitudes.

CONCLUSION

The structured teaching programme on minor pregnancy-related disorders and their home remedies was effective in improving the knowledge levels of antenatal mothers, with a greater impact observed among those in urban areas compared to their rural counterparts.

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