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Effectiveness of Structured Teaching Programme on self assessment of fetal well- being among Primigravida Mothers.

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Abstract: *Quasi experimental one group pre test and post test design was used to assess the effectiveness of structured teaching programme. The sample size was 60 were selected by using convenience sampling technique. Pretested structured interview schedule on knowledge questionnaire was used for data collection. Analysis was done SPSS package 21 version. The study findings in the pre-test revealed that the majority 58.3% (35) had poor knowledge whereas 16.7% (10) had average knowledge and least 25% (15) had good knowledge on self assessment of fetal well-being. In post-test knowledge scores on self assessment of fetal well-being among primi mothers. It reveals the majority 68.3% (41) had fair knowledge whereas least 6.7% (4) had average knowledge on self assessment of fetal well-being. Study finding imply that such a teaching programme contribute to increased knowledge on self assessment of fetal well being among primigravida mothers.*

Key Words: *Assess, effect, structured teaching programme, fetal well-being primimother*

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I. Introduction

Pregnancy is considered as a very precious event in every woman's life. It is filled with happiness, joy and surprises. Every parent hopes for a healthy baby but may sometimes become sorrowful when danger sets in either to the mother or to the fetus.

Pregnancy links mother and fetus together and the basis for regenerating the generation. Most pregnancies will work for a live baby to a healthy mother. In high pregnancies the mother may sometimes escape death but fetus often becomes the victim.

Mother's education is not a luxury but a necessity if mothers are to receive the maximum benefit from today's knowledge of the possible treatment, prevention and control of disease. Reedmen says that the process of teaching and learning often begins when division identifies a need for knowing or gaining an ability to do something.

Fetal well-being is a term which describes the fetus whose growth is appropriate for length of gestation and who has normal form and structure. Fetal well being depends on a satisfactory maternal health throughout the pregnancy.

Assessment of maternal and fetal well being is the focus of prenatal care .Fetal monitoring in a wide sense means fetal surveillance but practically it is an indirect way to measure fetal well-being or the adequacy of fetal oxygenation and as such it is an integral part of the concept of "the fetus as a patient."Antepartum fetal surveillance technique allows detection of high risk pregnancy before damage occurs. It is used to assess the well-being of the fetus at risk of adverse prenatal outcome associated with utero – placental insufficiency. Pregnancies that are at risk with hypoxia and still-birth can be protected providing early identification and intervention for fetal compromise.

The primary goal of antenatal evaluation is to identify fetus at risk for intrauterine injury and risk so that intervention and timely delivery can prevent progression to still-birth. Movements of the fetus are unique for every fetus as also the mother's experiences of those movements. The frequency of movements increases from 24 weeks of pregnancy until 32 weeks. From 32 weeks onwards the frequency of fetal movements tends to plateau until the onset of labour.

Fetal movement counting by mother is a method used to assess the fetal well- being and this unstructured screening helps the mother to be assured of the health of the fetus.[8] More than 99% of women who have given birth to a healthy baby say that it is so important for them to feel the baby's movements every day. In women with decreased fetal movements, there is the risk of complications such as fetal growth restriction and still-birth. More women notice the changes in fetal movement, its intensity and frequency.

Normal fetal movements can be defined as 10 or more movements in 2 hours, felt by a woman when she is lying on her side and focusing on the movement which may be perceived as any discrete kick, flutter, swish or roll. Fetal movements provide reassurance of the integrity of the central nervous and musculoskeletal systems.

Many women associate one or more of their pregnancies with the development of obesity. Obesity has long been recognized as a risk factor for the development of a variety of diseases such as diabetes mellitus and cardiovascular disease. In particular, among women of child bearing age, obesity predisposes towards impaired glucose tolerance and gestational diabetes mellitus. The mother may be more than usually accepting the change or weight gain that would benefit the health of her unborn child. The benefits of weight management in pregnancy are numerous. Normal pregnancy has been implicated in the development of obesity in women having healthy weight.

Numerous adverse effects of obesity during pregnancy have been reported. Associations include an increased risk of miscarriage, congenital malformations, hypertension, gestational diabetes, preeclampsia, anesthetic complications, instrumental delivery, macrosomia and maternal death.

Gestational weight gain recommendations aim to optimize outcomes for the woman and the infant. In 2009, the Institute of Medicine (IOM) published revised gestational weight gain guidelines that are based on pre-pregnancy body mass index (BMI) ranges for underweight, normal weight, overweight, and obese women recommended by the World Health Organization and are independent of age, parity, smoking history, race, and ethnic background. Other changes include the removal of the previous recommendations for special populations and the addition of weight gain guidelines for women with twin gestations. For twin pregnancy, the IOM recommends a gestational weight gain of 16.8–24.5 kg (37–54 lb) for women of normal weight, 14.1–22.7 kg (31–50 lb) for overweight women, and 11.3–19.1 kg (25–42 lb) for obese women. The IOM guidelines recognize that data are insufficient to determine the amount of weight women with multifetal (triplet and higher order) gestations should gain Excessive gestational weight gain (GWG) is prevalent in obstetric populations Worldwide. Excessive GWG has the potential to have negative impact on maternal and fetal health, causing a range of poor obstetric and neonatal outcomes. Adverse obstetric outcomes include increased risk of maternal complications such as gestational diabetes, postpartum weight retention, and development of long-term obesity. Fetal exposure to maternal obesity, diabetes, and excessive GWG can increase their risk of childhood obesity and chronic diseases later in life.

The fundal height measurement is a widely used tool to aid in the detection of fetal growth abnormalities during the second and third trimesters of pregnancy. While it is an appealing intervention given the fact that it is inexpensive, relatively it is non- invasive and easy to perform. Since the early part of the twentieth century measurement of the fundal height with a tape or pelvimetry caliper has been advocated (Engstrom, 1993). Traditionally, fetal growth has been assessed by comparing the height of the uterine fundus to landmarks on the maternal abdomen. Indeed**,** this technique is still widely used by midwives in Great Britain. Observant clinicians as early as Sutugin in1875 (Engstrom, 1993) noted significant variation in the distance between maternal abdominal landmarks and recommended more formal measurement. He found that the measurement between the maternal symphysis pubis to the umbilicus could vary from 15 cm to 22cm.

A healthy fetus is the goal of every expectant mother and her physician. Yet for every 1000 live births the perinatal mortality is 37.7, varying from 24.8 in Kerala to75.5/1000 in Orissa. It is higher in rural (54.4) and lower in urban areas. It is estimated that 7.3 million perinatal deaths occur annually in the world and most of these occurs in the developing countries. W orldwide 36 deaths among 1000 live births in rural areas and 22 fetal deaths among 1000 live births in urban areas are recorded. In India 9 fetal deaths among 1000 live births in rural areas and 8 deaths among 1000 births in urban areas are recorded. In Andhra Pradesh 4.48 fetal deaths among 1000 live births; in Tirupathi 1 in100 live births and in India about 8, 90,000 perinatal deaths occurs annually . Currently the main focus of maternal and child health is towards the evaluation of fetal health that is to assess the fetal well-being. Because majority (80%) of fetal deaths occur in the antepartum period due to various causes which include chronic fetal hypoxia, intrauterine growth retardation, maternal complications - diabetes, hypertension, infection and fetal congenital malformations.

Perinatal mortality and morbidity is a problem or a serious dimension in all countries. Numerous factors are responsible for fetal death which may involve one or more complications in the mother during pregnancy or labour. The incidence of perinatal mortality accounts for about 90% of all fetal and infant mortality in the developed countries.

In India, still- births are seldom registered. The SRS estimates for perinatal mortality rate in India for the year 2006 as about 37/1000 total births, with about 41 from rural areas and 24 from urban areas. In Karnataka total perinatal mortality rate is estimated to be about 34/1000 total births, with about 42 of rural areas and 21 from the urban areas.

According to Aida Abd El-Razek (2016) conducted a study on the impact of increased knowledge and awareness among staff nurses towards assessment of methods of fetal well-being to early

identification of pregnancy outcomes and the frequency of interventions during delivery. A quasi-experimental design was used in carrying out the study on knowledge and awareness assessment regarding methods of fetal well-being among staff nurses. The study was conducted at Obstetric & Gynecological Department in Jarsh Governorate Hospitals & Prince Hussein Bin Abdullah Hospitals.

The study sample consisted of all staff nurses working at Obstetrics & Gynecological Department in Jarsh Governorate Hospital & Prince Hussein Bin Abdullah Hospitals who had agreed to participate in the study. The current study included 150 staff selected as convenient sample. The main findings of the study showed that there was a highly statistical significant difference between pre-test and post-test in all answers regarding knowledge about methods of fetal well-being assessment. Nurses have a major role to prevent the complications for the fetus and mother during pregnancy. Nurses coming in contact with the antenatal mothers should take initiative to provide necessary information to the women and the relatives on different methods used for the assessment of fetal wellbeing, so as to improve the quality of life among the pregnant women. For that they should have adequate knowledge about all the aspects of fetal well-being, so that they could prevent the complications.

Objectives:

1. To assess the pretest knowledge of primi mothers regarding self assessment of the fetal well-being.
2. To assess the effectiveness of structured teaching programme on knowledge of primi mothers regarding self assessment of fetal well-being.
3. To assess the significant relationship between pre-test knowledge and demographic variables of primi mothers regarding self assessment of fetal well-being.

HYPOTHESES:

H1: There will be effect of structured teaching programme on knowledge of primi mothers regarding self assessment of fetal well-being.

H2: There will be significant association between the knowledge scores of primi mothers on self assessment of fetal well-being and their selected demographic variables.

II. Methodology

The research approach adopted was pre-experimental one group pre-test, post-test design. Study was conducted in MCH Centre, Tirupati, chittoor district, Andrapradesh. Sample size was 60 primigravida mothers pre validated interview schedule and questionnaire was adopted to collect the data on knowledge of the mothers towards on self assessment of fetal well being among primi mothers. Formal permission was obtained from medical officer MCH centre. Pre-test was collected followed by structured teaching programme was given, post-test was collected and analysed with help of SPSS 21 version package.

III. Results

Demographic profile of primi gravida mothers

Majority 55% (33) of the mothers were 19-21 years of age, in religion majority of the mothers 78.3%% (47) were Hindus; regarding education majority 41.7% (25) were graduates; regarding the occupation of the primi mothers, majority 40% (24) were others types of occupation; regarding the education of the husband, majority 50% (30) studied upto 10^{th}class; regarding the occupation of the husband, majority 45% (27) were private employees; regarding the total family income per month in rupees, majority 51.7% (31) were in the income range of Rs.5001–10000; regarding duration of marital life in years, majority 65% (39) were having1–2 years; regarding the exposure to mass media, majority 40% (24) gained knowledge from health workers; regarding the gestational age in years, majority 36.7% (22) were having the period 20- 24 weeks and 25–28 weeks; regarding consanguinity, majority 60% (36) were having non-consanguineous marriages; regarding the weight of the mother in kgs, majority 53.3% (32) were having 51 – 60 kgs weight; regarding the number of times TT injection received, majority 71.3% (43) received 2 doses; Regarding the use of contraceptives, majority 78.3% (47) did not use contraceptives; regarding the habits of the mothers, majority 53.3% (32) were watching T.V; regarding the presence of medical illnesses, majority 71.7% (43) had no history of medical illnesses; regarding the use of other drugs, majority 76.7% (46) were not using any other drugs.

Table 1 Pre-test and post-test knowledge of primi gravida mothers

Table- 1 Paired t- test values between pre and post test knowledge on self assessment of fetal well being.

		Mean	N	Std. Deviation	Std. Error Mean	t-value	Sig.
Pair 1	Post	23.15	60	1.929	.249	20.281**	0.000
	Pretest	14.33	60	3.413	.441		

**significant at 0.01 level.

Table 1 shows that the effectiveness of structure teaching programme on self assessment of fetal well-being among primi mothers which was significant at 0.01 level.

Table 2 Association of pre-test knowledge scores regarding self assessment of fetal well- being with demographic variables of the primi mothers.

n= 60

S.No	Demographic Variables	Assessment of fetal well-being among primi mothers						Chi-square
		Inadequate <50%		Moderate 51-75 %		Adequate > 75 %		
1.	**Age in years**							
	Below 19	7	20.0	0	0.0	0	0.0	$\chi2$=13.297*; (p= 0.039 df= 6;
	19 – 21	22	62.9	5	50.0	6	40.0	
	22 – 25	4	11.4	4	40.0	6	40.0	
	Above 25	2	5.7	1	10.0	3	20.0	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
2	**Religion**							
	Hindu	28	80.0	9	90.0	10	66.7	$\chi2$ =14.256*; (p = 0.027); df= 6;
	Muslim	5	14.3	1	10.0	0	0.0	
	Christian	1	2.9	0	0.0	5	33.3	
	Others	1	2.9	0	0.0	0	0.0	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
3	**Education of the Mothers**							
	Upto 10th class	13	37.1	3	30.0	2	13.3	$\chi2$ =17.429*; (p = 0.008); df= 6;
	Intermediate	11	31.4	2	20.0	1	6.7	
	Graduate	10	28.6	3	30.0	12	80.0	
	Post graduate	1	2.9	2	20.0	0	0.0	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
4.	**Education of the Husband**							
	Upto 10th class	20	57.1	7	70.0	3	20.0	$\chi2$=9.905*; (p = 0.042); df= 6;
	Intermediate	11	31.4	2	20.0	11	73.3	
	Graduate	4	11.4	1	10.0	1	6.7	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	

6	**Occupation of the Husband**							
	Coolie	18	51.4	0	0.0	5	33.3	$\chi 2$ =12.619*; (p = 0.049); df= 4;
	Private employee	11	31.4	9	90.0	7	46.7	
	Govt Employee	2	5.7	0	0.0	1	6.7	
	Others	4	11.4	1	10.0	2	13.3	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
7	**Family Income per month in rupees**							
	5001 – 1000	21	60.0	6	60.0	4	26.7	$\chi 2$ =16.575*; (p = 0.002); df= 4;
	10001 – 15000	12	34.3	3	30.0	3	20.0	
	Above 15000	2	5.7	1	10.0	8	53.3	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
8.	**Duration of the marital life in years**							
	Below 1	11	31.4	3	30.0	5	33.3	$\chi 2$ = 1.521; (p = 0.958); df= 6;
	1 – 2	22	62.9	7	70.0	10	66.7	
	3 – 4	1	2.9	0	0.0	0	0.0	
	Above 4	1	2.9	0	0.0	0	0.0	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
9.	**Exposure to Mass Media**							
	Television	18	51.4	4	40.0	1	6.7	$\chi 2$ = 26.197**; (p = 0.000); df= 4;
	Health worker	16	45.7	4	40.0	4	26.7	
	Internet	1	2.9	2	20.0	10	66.7	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
10.	**Gestational age in Weeks**							
	20 – 24	13	37.1	4	40.0	5	33.3	$\chi 2$ = 3.280; (p = 0.773); df= 6;
	25 – 28	13	37.1	4	40.0	5	33.3	
	29 -32	9	25.7	2	20.0	4	26.7	
	Above 32	0	0.0	0	0.0	1	6.7	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
11.	**Consanguinity**							
	No	20	57.1	7	70.0	9	60.0	$\chi 2$ = 0.536; (p = 0.765); df= 2;
	Yes	15	42.9	3	30.0	6	40.0	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
12	**Weight of the mother in kgs**							
	Below40 – 40	3	8.6	0	0.0	0	0.0	$\chi 2$ = 7.977; (p = 0.240); df= 6;
	41 – 50	11	31.4	5	50.0	2	13.3	
	51 - 60	18	51.4	3	30.0	11	73.3	
	Above 60	3	8.6	2	20.0	2	13.3	
	Total	35	100.0	10	100.0	15	100.0	

13	**Number of times TT injection received**							$\chi 2$ = 0.692; (p = 0.708); df= 2;
	1 time	11	31.4	3	30.0	3	20.0	
	2 times	24	68.6	7	70.0	12	80.0	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
14.	**Use of Contraceptives**							
	Yes	11	31.4	1	10.0	1	6.7	$\chi 2$ =4.756; (p =0.093); df= 2;
	No	24	68.6	9	90.0	14	93.3	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
15.	**Habits**							
	Watching TV	17	48.6	6	60.0	9	60.0	$\chi 2$ =2.408; (p =0.661); df= 4;
	Reading books	10	28.6	3	30.0	5	33.3	
	Others	8	22.9	1	10.0	1	6.7	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
17.	**Presence of Medical illnesses**							
	Yes	9	25.7	2	20.0	6	40.0	$\chi 2$ =1.466; (p =0.481); df= 2;
	No	26	74.3	8	80.0	9	60.0	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	
18. .	**Use of other drugs**							
	Yes	8	22.9	1	10.0	5	33.3	$\chi 2$ =1.837; (p =0.399); df= 2;
	NO	27	77.1	9	90.0	10	66.7	
	Total	**35**	**100.0**	**10**	**100.0**	**15**	**100.0**	

Table – 2 shows that there was significant association between age in years, religion, education of the mothers and husband, occupation of the mothers and husband, family income per month in rupees, source of information and knowledge on self assessment of fetal well-being at p <0.05 and the other variables duration of marital life, gestational age in weeks, consanguinity, weight of the mother in kgs, number of times TT injection received, use of contraceptives, habits, presence of medical illnesses and use of other drugs which had no significant association with the knowledge on self assessment of fetal well-being.

Table 3 Association of Post – test knowledge scores on self assessment of fetal well-being with demographic variables of primi mothers

n= 60

S.No	**Demographic Variables**	**Assessment of fetal well-being among primi mmmmothersmothers**						**Chi- square**
		Inadequate <50%		**Moderate 51-75 %**		**Adequate > 75 %**		
1.	**Age in years**							
	Below 19	2	50.0	3	20.0	2	4.9	$\chi 2$ =13.117*; (p =0.041); df= 6;
	19 – 21	2	50.0	5	33.3	26	63.4	
	22 – 25	0	0.0	6	40.0	8	19.5	
	Above 25	0	0.0	1	6.7	5	12.2	

	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
2	**Religion**							
	Hindu	2	50.0	12	80.0	33	80.5	$\chi 2$ =6.976; (p = 0.323); df= 6;
	Muslim	1	25.0	3	20.0	2	4.9	
	Christian	1	25.0	0	0.0	5	12.2	
	Others	0	0.0	0	0.0	1	2.4	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
3	**Education of the mothers**							
	Upto 10^{th} class	3	75.0	8	53.3	7	17.1	$\chi 2$ =12.858*; (p =0.045); df= 4;
	Intermediate	1	25.0	3	20.0	10	24.4	
	Graduate	0	0.0	3	20.0	22	53.7	
	Post graduate	0	0.0	1	6.7	2	4.9	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
4.	**Education of the Husband**							
	Upto 10^{th} class	2	50.0	10	66.7	18	43.9	$\chi 2$ =11.057*; (p =0.026); df= 4;
	Intermediate	0	0.0	4	26.7	20	48.8	
	Graduate	2	50.0	1	6.7	3	7.3	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
5	**Occupation of the mothers**							
	Home maker	2	50.0	5	33.3	9	22.0	$\chi 2$ =3.953; (p =0.412); df= 4;
	Employee	2	50.0	5	33.3	13	31.7	
	Others	0	0.0	5	33.3	19	46.3	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
6	**Occupation of husband**							
	Coolie	2	50.0	1	6.7	20	48.8	$\chi 2$ =13.774*; (p =0.032); df= 6;
	Private employee	1	25.0	8	53.3	18	43.9	
	Govt Employee	0	0.0	2	13.3	1	2.4	
	Others	1	25.0	4	26.7	2	4.9	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
7	**Family income per month in rupees**							
	Below 5001 – 10000	4	100.0	11	73.3	16	39.0	$\chi 2$ =9.972*; (p = 0.042);df= 4;
	10001 – 15000	0	0.0	2	13.3	16	39.0	
	Above 15000	0	0.0	2	13.3	9	22.0	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
8.	**Duration of marital life in Years**							
	Below 1	1	25.0	5	33.3	13	31.7	$\chi 2$ = 1.080; (p = 0.982); df= 6;
	1 – 2	3	75.0	10	66.7	26	63.4	
	3- 4	0	0.0	0	0.0	1	2.4	

	Above 4	0	0.0	0	0.0	1	2.4	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
9.	**Exposure to Mass media**							
	Television	1	25.0	3	20.0	19	46.3	$\chi2 = 9.708$; ($p = 0.046$); df= 4;
	Health worker	3	75.0	10	66.7	11	26.8	
	Internet	0	0.0	2	13.3	11	26.8	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
10.	**Gestational age in weeks**							
	20 – 24	1	25.0	2	13.3	19	46.3	$\chi2 = 13.099$*; ($p = 0.041$); df= 6;
	25 – 28	2	50.0	10	66.7	10	24.4	
	29 -32	1	25.0	2	13.3	12	29.3	
	Above 32	0	0.0	1	6.7	0	0.0	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
11.	**Consanguinity**							
	No	1	25.0	11	73.3	24	58.5	$\chi2 = 3.189$; ($p = 0.203$); df= 2;
	Yes	3	75.0	4	26.7	17	41.5	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
12	**Weight of the mother in kgs**							
	Below 40-40	0	0.0	2	13.3	1	2.4	$\chi2 = 15.298$; ($p = 0.018$);df= 6;
	41 – 50	1	25.0	5	33.3	12	29.3	
	51 - 60	3	75.0	3	20.0	26	63.4	
	Above 60	0	0.0	5	33.3	2	4.9	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
13	**No. of times TT injection Received**							$\chi2 = 2.817$; ($p = 0.245$); df= 2;
	1	2	50.0	2	13.3	13	31.7	
	2	2	50.0	13	86.7	28	68.3	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
14	**Use of Contraceptives**							$\chi2 = 4.491$; ($p = 0.106$); df= 2;
	Yes	0	0.0	1	6.7	12	29.3	
	No	4	100.0	14	93.3	29	70.7	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
15	**Habits**							
	Watching TV	0	0.0	12	80.0	20	48.8	$\chi2 = 9.687$; ($p = 0.046$); df= 4;
	Reading books	3	75.0	2	13.3	13	31.7	
	Others	1	25.0	1	6.7	8	19.5	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
16.	**Presence of medical illnesses**							
	Yes	2	50.0	3	20.0	12	29.3	$\chi2 = 1.455$; ($p = 0.483$); df= 2;
	No	2	50.0	12	80.0	29	70.7	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	
17.	**Use of other drugs**							
	Yes	3	75.0	3	20.0	8	19.5	$\chi2 = 6.397$; ($p = 0.041$); df= 2;
	No	1	25.0	12	80.0	33	80.5	
	Total	**4**	**100.0**	**15**	**100.0**	**41**	**100.0**	

Table 3 shows that there was significant association between post-test knowledge on self assessment of fetal well-being among primi mothers and their demographic variables on age in years, education of the mothers and husband, occupation of the husband, family income per month in rupees, gestational age in weeks at P< 0.05 and the other variables religion, occupation of the mothers, duration of marital life in years, exposure to mass media, consanguinity, weight of the mothers in kgs and number of times TT injection received which had no significant association with the post-test knowledge on self assessment of fetal well-being.

IV. Discussion

It revealed that the pre-test revealed that the majority 58.3% (35) had poor knowledge whereas 16.7% (10) had average knowledge and least 25% (15) had good knowledge on self assessment of fetal well-being. In post-test knowledge scores on self assessment of fetal well-being among primi mothers. It reveals the majority 68.3% (41) had fair knowledge whereas least 6.7% (4) had average knowledge on self assessment of fetal well-being. Study finding imply that such a teaching programme contribute to increased knowledge on self assessment of fetal well being among primigravida mothers.

The present study was supported by other studies:The findings of the study were supported by earlier study Gomez LM, Vega GDL, Padilla, Bautista F C who made a descriptive study in Sweden where 1914 women were asked to count the fetal movements for 15 minutes every evening from 28^{th} week of pregnancy until delivery. An individual lowest limit for number of fetal movements were calculated from the first five counts. The women were instructed to contact the maternity ward for fetal evaluation as soon as their count fell below the lowest limit on two consecutive evenings. 79% of the women made a record of fetal movements, the proportion of those who did so being significantly high in nulliparae and women 20-35 years older than in multiparae, teenagers and women older than 35 years. The mean duration of registration period was 11.4(SD 3.2) weeks and the median interval from the end of registration period to delivery was 0.32weeks. Nearly 31% of women with an alarm signal on the Fetal Movement Chart never reported the decrease in fetal movement count. Nearly 30% of the women who did report a reduction in the number of fetal movements did so despite the absence of an alarm signal. Therefore, the researchers thus concluded that most pregnant women were willing and able to count fetal movements but they had difficulty in following the instructions concerning when to report a decrease in the number of fetal movements.

Lt col Singh G, Maj Sindhu K (2008) conducted a prospective study in military hospital at Amirtsar. Sample were 500 of 9^{th} month pregnant women. Among them no fetus was lost in 250 cases who were given DFMC chart anddelivered with no perinatal mortality. Five intrauterine deaths occurred in the ninth month in control group (2% perinatal mortality). The result of intrauterine deaths was statistically analyzed using chi square test and the difference was found to be significant at the value of P < 0.025. The findings of the study showed that fetal deaths reduced from 20.4 per 1000 live births to nil in the study group.

ETHICAL APPROVAL: - Research Committee College of nursing SVIMS approved the study. Informed consent was obtained from participants.

CONFLICT OF INTREST: - Nill

SOURSE OF FUNDING: - Nill

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