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Social Capital: Handling Obstacles by Doctors and Midwives to Minimize Fetal Paralysis Due to Fear of Pregnant Women

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Abstract: This study aims to analyze the obstacles faced by doctors and midwives in minimizing the risk of fetal paralysis due to pregnant women's fear. The fear experienced by pregnant women can influence medical decisions made by doctors and midwives, leading to complications during pregnancy and childbirth. The research involves qualitative analysis from the perspectives of practitioners in various healthcare facilities. Findings reveal various relationships between factors and levels of maternal fear. Firstly, there is no significant relationship between the age of pregnant women and their fear levels. Secondly, maternal education significantly impacts fear levels, with highly educated pregnant women exhibiting lower fear levels, while those with lower education experience higher fear levels. Thirdly, maternal employment status is significantly related to anxiety levels, indicating that working pregnant women may experience higher levels of fear than non-working counterparts. Qualitative analysis indicates that nulliparous women tend to have greater fear of labor pain and pre-delivery concerns. BMI has a significant relationship with anxiety levels, suggesting that pregnant women with higher BMI may experience higher fear levels. Lastly, spousal support plays a crucial role in anxiety levels, with pregnant women receiving greater support from their husbands tending to have lower levels of fear.

Keywords: Doctor; Fear; Fetal Paralysis; Midwife; Pregnant Woman

Introduction

Pregnant women are a group that is vulnerable to mental health problems because of the changes they experience at various stages that affect their mental health. Nearly one in five pregnant women is affected by mental health problems during the pre-natal and postpartum periods (Farshbaf-Khalili et al., 2020). Therefore, in this article we will explain mental health in pregnant and postpartum women. Influencing factors and some examples of affected populations in several countries. Pregnancy is the process in which a woman carries and grows a fetus in her womb (Kendal, 2020). This process begins when the egg cell that has been fertilized by sperm attaches to the uterine wall. Pregnancy lasts for about 9 months or 270 days. During pregnancy, the fetus will experience very rapid development and vital organs such as the brain, liver, heart, kidneys, bones, hands or arms, legs and other body organs begin to form and continue to develop (Grzeszczak et al., 2020).

The first period of human life, from conception of the fetus until 2 years of age, is called the first thousand days of life (1000 HPK). At this stage, brain cells grow rapidly as does the growth of nerve fibers and branches, thus forming a complex nerve and brain network. Brain development is almost perfect, reaching 80%, so it really determines a person's quality in the future (Schmiedhofer et al., 2021). Pregnant women have an increased tendency to worry, which can lead to psychological disorders including anxiety, stress, insomnia, depression, or post-traumatic stress disorder. Mental health disorders during pregnancy increase the risk to the fetus in the form of poor fetal growth and premature birth (Chamberlain et al., 2019). The underlying factors are limited access to health services, lack of social support from various parties, and concerns about the health of themselves and their fetus if they contract a disease. Social support helps pregnant women deal with their life stressors.

According to data from the Ministry of Health of the Republic of Indonesia in 2015, out of 100,000 live

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births in Indonesia, 305 of them ended in the death of the mother. This figure is relatively high compared to other countries in Southeast Asia. This problem is a serious concern for the Indonesian government and the general public. According to (Collier & Molina, 2019), that maternal deaths generally occur due to complications during and after pregnancy. Data from the Ministry of Health of the Republic of Indonesia (Kemenkes) in 2015 shows that out of 100,000 live births in Indonesia, 305 of them ended in the death of the mother. The high maternal mortality rate in Indonesia is caused by several factors, starting from the pre-pregnancy phase, namely the condition of fertile women who experience anemia, until the labor and postpartum phases. Several other factors that influence MMR in Indonesia are lack of access to health services, lack of knowledge about reproductive health, and lack of support from family and community (Damayanti et al., 2023).

The Indonesian government has made various efforts to reduce maternal mortality. One way is to include the MMR reduction target in the 2014-2019 National Medium Term Development Plan (RPJMN). However, reducing MMR is not an easy matter because this problem is multidimensional. The Ministry of Health together with related parties are coordinating to improve health system services in order to reduce maternal and infant mortality rates, including during the COVID-19 pandemic. Currently, the Ministry of Health continues to strengthen the capacity and capability of health facilities so that they are able to handle the problems faced by patients as quickly as possible. FKTP is also encouraged to be able to carry out early detection of potential disorders or abnormalities in the health of pregnant women, strengthen preventive promotive efforts, and help empower the community (Melchiorre et al., 2020; Nigussie et al., 2020).

The MMR problem in Indonesia is an issue that is often raised because maternal death is the death of a mother during pregnancy or within 42 days after termination of pregnancy (Cholishotin, 2023); (Sutrisno Sutrisno, Md PhD Og (Rei), 2022). This problem greatly affects the survival of families and communities. Therefore, there needs to be support from all parties to reduce the maternal mortality rate in Indonesia. The problem of AKI during pregnancy is caused by various factors that result in mental damage to the mother, which has an impact on the fetus being conceived. First, depression is the most common mental health disorder during pregnancy. This often triggers mental health problems, even after giving birth. Symptoms of depression in pregnant women include feelings of sadness or emptiness, loss of interest in usual activities, changes in appetite, and changes in sleep patterns

A study in China described that 5.3% of pregnant women experienced symptoms of depression, 6.8% experienced anxiety, 2.4% experienced physical discomfort, 2.6% experienced insomnia, and 0.9% experienced Post-Traumatic Stress Disorder (PTSD). Compared with non-pregnant women, pregnant women may have more opportunities for contact with health workers, although this remains very limited during this pandemic (Zhou et al., 2020). The period of pregnancy and childbirth in women places them in a condition that is vulnerable to psychological disorders, even though postpartum blues and depression have existed long before the pandemic. A person who is depressed displays feelings of helplessness and loss of hope, accompanied by feelings of sadness, loss of interest and joy. This can affect the mental health of pregnant women and fetuses (Alipour et al., 2018). However, that depression in pregnant women is not something that rarely occurs during the pregnancy phase. A person who is depressed displays feelings of helplessness and loss of hope, accompanied by feelings of sadness, loss of interest and joy. This can affect the mental health of pregnant women and fetuses.

Second, anxiety. Pregnant women tend to experience increased anxiety which can result in psychological disorders including anxiety, stress, insomnia. Anxiety in pregnant women can be caused by various factors such as hormonal changes, physical changes, and concerns about the health of the fetus. A study found that the majority of third trimester pregnant women who visited community health centers reported experiencing anxiety (up to 15 respondents (100%) (Douglas Wilson et al., 2021). This shows that anxiety in pregnant women is not a rare thing. Pregnant women who experience Anxiety also means feeling worried about the development of the fetus and fear of health problems (Hildingsson & Larsson, 2021); (McCarthy et al., 2021). Pregnant women who have entered the third trimester of pregnancy usually often experience sleep disturbances due to anxiety before the birth process. As in research, pregnant women in the third trimester who experienced anxiety while facing childbirth during the Covid-19 pandemic in the Tersono Community Health Center working area, namely 85.5% of pregnant women experienced mild anxiety during the last pandemic. This shows that the Covid-19 pandemic can also trigger anxiety in pregnant women.

Third, Changes in eating and sleeping habits during pregnancy. Changing sleeping and eating habits is a common phenomenon that occurs in many pregnant women. When a woman is pregnant, her body experiences significant hormonal changes, which can affect her sleep and appetite. Elevated hormones such as progesterone can cause excessive daytime sleepiness and interfere with a good night's sleep (Shivalingaiah et al., 2021). In the first trimester, morning sickness and nausea can also affect sleep patterns. In the second trimester, the increasing size of the stomach can cause discomfort in finding a comfortable sleeping position.

Meanwhile, in the third trimester, pregnant women often have difficulty sleeping because they want to urinate more, leg cramps, restlessness due to anxiety about giving birth. (Sūdžiūtė et al., 2020). Nausea and vomiting that often occur in the first trimester can also cause loss of appetite or aversion to certain foods in pregnant women. Apart from that, changes in the digestive system and increased nutritional needs of the fetus can also affect the appetite of pregnant women (Marshall et al., 2022); (Clarke et al., 2024).

Of the many factors above that will affect pregnant women themselves, it is paralysis. Paralysis is a medical condition in which a person loses the ability to move all or part of their body. Paralysis can occur in various parts of the body, such as the legs, hands, face, or the whole body. Paralysis can be temporary or permanent, depending on the cause. Some causes of paralysis include autoimmune diseases, brain tumors, Guillain-Barré syndrome, and sleep paralysis. Sleep paralysis is a condition where a person experiences temporary paralysis while sleeping or when waking up. Paralysis in pregnant women can affect fetal blood flow, fetal movement, fetal oxygenation, mental health of pregnant women, and the ability to do household work, and caring for babies after pregnant women give birth (Sun et al., 2023).

Paralysis in pregnant women can affect the health of the fetus in several ways. First, if a pregnant woman experiences paralysis in certain parts of the body, such as the legs or pelvis, then blood flow to the fetus can be disrupted. This can cause fetal distress or fetal distress, which indicates that the fetus lacks oxygen during pregnancy or during delivery (Aghajani et al., 2022). If a pregnant woman experiences paralysis in parts of the body used for breathing, such as the chest or neck, this can affect fetal oxygenation. Second, paralysis in pregnant women can also affect fetal movements. Pregnant women who experience paralysis in certain parts of the body may not be able to feel fetal movements clearly (Quintero & De Jaegher, 2020). Reduced or drastically changing fetal movements can be a sign of fetal distress. Third, paralysis in pregnant women can cause stress and anxiety which can affect the health of the fetus. Pregnant women who experience paralysis may experience depression or anxiety which can affect the health of the fetus.

In addition, if a pregnant woman experiences paralysis in parts of the body used to lift or carry heavy objects, such as the arms or back, then this can affect the pregnant woman's ability to carry out household tasks and care for the baby after birth. This can also affect the pregnant woman's ability to lift or move the baby after birth. Paralysis in pregnant women can also cause discomfort and pain which can affect the quality of pregnant women's sleep (Swain & Pattnaik, 2021). This can affect the health of the fetus because adequate sleep is important for fetal growth and development.

The research presented in this article seeks to address the mental health challenges faced by pregnant and postpartum women, a vulnerable group susceptible to various psychological disorders. Approximately one in five pregnant women experiences mental health issues during the prenatal and postpartum periods, which can have significant implications for both maternal and fetal well-being. One of the critical outcomes under investigation is paralysis in pregnant women. Paralysis, whether temporary or permanent, can have profound effects on fetal blood flow, movement, and oxygenation. It can also impact the mental health of pregnant women, hindering their ability to perform daily tasks and care for their newborns. Additionally, the discomfort and pain associated with paralysis can disrupt the quality of sleep, influencing fetal growth and development. In summary, this research aims to shed light on the mental health challenges faced by pregnant and postpartum women, considering various contributing factors and their implications for both maternal and fetal well-being. The ultimate goal is to contribute to a better understanding of these issues and pave the way for effective interventions to improve the mental health outcomes of pregnant women and reduce the associated risks to fetal health.

Method

The primary focus of this research is to delve into the factors contributing to fear in pregnant women leading to fetal palsy. An exhaustive analysis will be conducted, categorizing internal factors such as the pregnant mother's age, gravida, education, employment, economic status, history of prenatal examinations, history of previous pregnancy complications, and husband's support. The research's primary objective is to identify these factors and their association with the occurrence of fear in pregnant women, ultimately leading to fetal palsy. The research hypotheses generated from the study are as follows:

H1: Pregnant women's age, gravida, education, employment, economic status, history of prenatal check-ups, history of previous pregnancy complications, and husband's support pose as risk factors for fear in pregnant women. H0: Pregnant women's age, gravida, education, employment, economic status, history of prenatal check-ups, history of previous pregnancy complications, and husband's support do not serve as risk factors for fear in pregnant women.

This research adopts a mixed methods approach, combining qualitative and quantitative research strategies. Following Creswell's mixed research definition, the sequential mixed methods strategy is

employed, allowing the integration of data obtained through interviews and surveys. The research employs different sequential strategies, such as the sequential explanatory strategy, sequential exploratory strategy, and sequential transformative strategy, each offering a unique approach to combining qualitative and quantitative data.

Data collection involves primary data from direct sources, encompassing individuals and groups, acquired through survey methods and observation. The survey method employs oral and written questions, with interviews conducted with medical professionals. Observations at hospitals and delivery rooms supplement this primary data collection. This process includes survey responses gathered through questionnaires distributed directly and via Google Form, along with secondary data sourced from medical records of pregnant women patients.

The data analysis process comprises editing, coding, transferring, and tabulating. Editing ensures data accuracy and completeness, followed by coding to transform textual data into numerical form for easier processing. Transferring involves organizing coded data, and tabulating presents data in tables for clarity. The analysis, conducted to test research hypotheses, includes univariate analysis, providing descriptive insights into independent and dependent variables, and bivariate analysis, examining the relationship between these variables using the chi-square test with Statistical for Social Science (SPSS 25) application.

Result and Discussion

Research Analysis Results

The study, employed SPSS V.25.0 to meticulously compile and analyze data, adopting a methodological approach that involved the transformation of continuous variables into categorical variables. This categorization was guided by a thorough review of the literature and aligned with the specific research objectives. The presentation of categorical variables was articulated in counts and percentages, providing a comprehensive overview of the dataset. The analytical framework encompassed both univariate and multivariate analyses. In the univariate analysis, the $\chi 2$ or Fisher test was instrumental in scrutinizing the relationships among factors contributing to variations in the fear levels experienced by pregnant women. (Xu et al., 2023) states, that moving beyond univariate exploration, the study employed multivariate binary logistic regression with Odds Ratios (OR) to delve into the nuanced factors influencing prenatal depressive symptoms.

Notably, depressive symptoms served as the dependent variables, while those factors exhibiting statistical significance ($p<0.05$) in the univariate analysis were designated as independent variables. These included age categories (≤24, 25–29, ≥30), pre-BMI classifications (underweight, normal, overweight), relationship quality with the husband (poor, adequate, good), gestational age (1st trimester, 2nd trimester, 3rd trimester), and the number of pregnancies (nullipara, primipara, multipara). It is imperative to underscore that all statistical tests employed in this study adhered to a two-sided approach, ensuring a comprehensive and robust analysis of the intricate factors influencing the fear and depressive symptoms experienced by pregnant women.

Table 1. Frequency of Pregnant Woman's Age

		Frequency	Percent%	Valid Percent%	Cumulative Percent$
Valid	< 25 years	14	14	14	14
	25 - 30 years	47	47	47	61
	> 30 years	39	39	39	100
	Total	100	100	100	

Derived from the data presented in Table 1, the breakdown of age demographics among the surveyed pregnant women is evident. Specifically, 14% of respondents fall within the age bracket of less than 25 years, while a predominant 47% are aged between 25 and 30 years. Additionally, 39% of participants are categorized as being over 30 years old.

Table 2. Frequency of education of pregnant women

		Frequency	Percent%	Valid Percent%	Cumulative Percent%
Valid	Senior High School	24	24	24	24
	S1	59	59	59	83
	S2	17	17	17	100
	Total	100	100	100	

Based on table 2 of respondent characteristics, the distribution of educational data for pregnant women was obtained, namely high school as many as 24 respondents (24%), with undergraduate education as many as 59 respondents (59%), with postgraduate education as many as 17 respondents (17%).

Table 3. Frequency of Pregnant Woman's Work Activity

		Frequency	Percent%	Valid Percent%	Cumulative Percent%
Valid	IRT	45	45	45.0	45
	Private employees	17	17	17.0	62
	Civil servants	28	28	28.0	90
	Self-employed	5	5	5.0	95
	Lecturer	5	5	5.0	100
	Total	100	100	100.0	

According to the data presented in table 3 detailing respondent characteristics, an examination reveals the employment distribution among pregnant women. Domestic workers constituted the majority, comprising 45 respondents, accounting for 45% of the sample. Private employees represented 17% of the respondents, totaling 17 individuals. Civil servants comprised 28% of the sample, with 28 respondents falling into this category. Additionally, 5 respondents identified as self-employed workers, constituting 5% of the sample, while 5 respondents were identified as lecturers, also making up 5% of the overall distribution.

Table 4. Frequency of Pregnant Woman's Pregnancy Period

		Frequency	Percent%	Valid Percent%	Cumulative Percent%
Valid	Trimester I	20	20	20	20
	Trimester II	34	34	34	54
	Third trimester	46	46	46	100
	Total	100	100	100	

Derived from the data presented in Table 4 illustrating respondent characteristics, the distribution of pregnancy periods among the surveyed pregnant women was ascertained. Specifically, during Trimester I, 20 respondents were accounted for, constituting 20% of the total. Trimester II encompassed 34 respondents, making up 34% of the sample, while Trimester III comprised 46 respondents, representing 46% of the total population under consideration.

Table 5. Frequency of Pregnant Woman's Parity

		Frequency	Percent%	Valid Percent%	Cumulative Percent%
Valid	Nulliparous	30	30	30	30
	Primipara	30	30	30	60
	Multiparous	40	4	40	100
	Total	100	100	100	

Derived from the respondent characteristics presented in Table 5, an analysis of parity distribution among pregnant women revealed that there were 30 respondents (30%) classified as nullipara, an equal number of 30 respondents (30%) identified as primipara, and a group of 40 respondents (40%) falling into the multipara category.

Table 6. Frequency of Pregnant Woman's BMI

		Frequency	Percent%	Valid Percent%	Cumulative Percent%
Valid	Light Skinny	9	9	9	9
	Normal	36	36	36	45
	Light Fat	18	18	18	63
	Heavy Fat	37	37	37	100
	Total	100	100	100	

Derived from the data presented in Table 6 outlining respondent characteristics, the breakdown of Body Mass Index (BMI) among pregnant women reveals a varied distribution. Specifically, 9% of respondents fall into the category of mild thinness, 36% are classified as

having a normal BMI, 18% exhibit mild obesity, and a notable 37% are categorized as significantly obese.

Table 7. Frequency of Pregnant Woman's Husband Support

		Frequency	Percent%	Valid Percent%	Cumulative Percent%
Valid	Enough	30	30	30	30
	Good	70	70	70	100
	Total	100	100	100	

Derived from the demographic details presented in Table 7, the data distribution pertaining to the level of support from husbands for pregnant women reveals that 30% of respondents fall within the category of "adequate support," while the majority, constituting 70% of the respondents, falls into the "good support" category.

Table 8. Frequency of Pregnant Woman's Fear Levels

		Frequency	Percent%	Valid Percent%	Cumulative Percent%
Valid	Light	65	65	65	65
	Currently	12	12	12	77
	Heavy	23	23	23	100
	Total	100	100	100	

Extracting insights from Table 8, the distribution of Anxiety Levels among pregnant women is discerned. Specifically, 65% of respondents fall within the Mild Anxiety category, signifying a moderate level of anxiety. Another 12% are situated in the Medium Anxiety category, reflecting a relatively lower prevalence. Conversely, 23% of respondents find themselves in the Severe Anxiety category, indicating a notable proportion experiencing heightened levels of anxiety.

The relationship between the age of pregnant women and the level of fear

Understanding how age may influence the emotional well-being of expectant mothers is crucial for developing targeted interventions and support systems. Numerous studies have explored the intricate dynamics between maternal age and the various psychosocial factors associated with pregnancy. According to (Correa-De-Araujo & Yoon, 2021), the emotional experiences of pregnant women can vary based on age, with potential implications for maternal and fetal health outcomes. In this discussion, we delve into the existing literature to unravel the complexities of the relationship between maternal age and fear during pregnancy. Furthermore, to provide concrete insights, relevant data has been extracted and is presented in Table 9, offering a visual representation of the observed patterns. This discussion aims to contribute to the broader understanding of maternal well-being and inform healthcare practices for diverse age groups of pregnant women.

Table 9. Levels of Fear Based on Age of Pregnant Women

Age	Light		Currently		Heavy		Total		P-Value
	N	%	N	%	N	%	N	%	
< 25 years	10	10	0	0	4	4%	14	14	
25 - 30 years	27	27	8	8	12	12%	47	47	0.37
> 30 years	28	28	4	4	7	7%	39	39	
Total	65	65	12	12	23	23%	100	100	

Based on Table 9, which illustrates the correlation between the age of pregnant women and their level of fear, intriguing patterns emerge. The data reveals that pregnant women below the age of 25 predominantly experience a mild level of fear, accounting for 10% of the sample. Moving into the 25-30 age group, a noteworthy 27% of pregnant women exhibit a level of fear, predominantly mild in nature. Similarly, in the >30 age group, a majority of 28% also report a mild level of fear. However, a closer inspection of the statistical analysis, with a significance value of 0.367, indicates that there is no statistically significant relationship between the age of pregnant women and the level of fear. This finding prompts further exploration into the implications of age on pregnancy.

According to established medical knowledge, the safe reproductive age for pregnant women falls within the range of 20-35 years. Beyond this age bracket, both younger (<20 years) and older (>35 years) pregnant women face distinct risks during pregnancy and childbirth. (Malinga & Ann Ostler, 2022) states, that younger women may encounter challenges due to

incomplete physical and mental development, rendering them unprepared for motherhood. Conversely, older pregnant women (>35 years) confront a heightened risk of obstetric complications, stemming from increased health concerns (Correa-de-Araujo & Yoon, 2021); (Allotey et al., 2020). Therefore, while the fear levels may not vary significantly with age, the broader implications on maternal health underscore the importance of age-related considerations in reproductive health.

The relationship between pregnant women's education and level of fear

Numerous studies have explored the intricate interplay between a woman's educational background and the emotional aspect of pregnancy. Education is widely acknowledged as a key determinant of health-related knowledge and decision-making, and its impact on maternal well-being during pregnancy is an evolving area of research (Stollak et al., 2023). Understanding the nexus between education and fear during pregnancy is crucial for healthcare professionals, policymakers, and educators alike. This discussion aims to delve into existing literature, analyze pertinent data, and shed light on the intricacies of the relationship. Additionally, insights from Table 10 will be incorporated to enrich our comprehension of the dynamics between educational levels and the varying degrees of fear experienced by pregnant women.

Table 10. Level of Fear Based on Pregnant Mother's Education

Education	Light		Currently		Heavy		Total		P-Value
	N	%	N	%	N	%	N	%	
Senior high school	16	16	4	4	4	4	24	24	
S1	36	36	4	4	19	19	59	59	0.03
S2	13	13	4	4	0	0	17	17	
Total	65	65	12	12	23	23	100	100	

Based on Table 10, the investigation delves into the correlation between the education level of pregnant women and their fear levels, as illustrated in Table 10. The data showcases distinct patterns among different educational backgrounds. Notably, pregnant women with high school education predominantly exhibit a mild level of fear at 16%. Conversely, those with a bachelor's degree demonstrate the highest level of fear, with 36% experiencing a mild level. Similarly, postgraduate-educated pregnant women display a predominant mild fear level at 13%. The statistical analysis, with a significance value of 0.031 < 0.05, underscores a meaningful association between the education of pregnant women and their fear levels. This research suggests that higher education has a notable impact on a pregnant mother's fear levels, emphasizing a positive correlation. The findings emphasize the importance of educational attainment, indicating that pregnant women with a higher education background tend to experience a milder fear of childbirth. Conversely, pregnant women who are illiterate or unemployed are more prone to heightened levels of fear during the birthing process, as previously noted by (Eleke et al., 2020). This insight highlights the potential benefits of addressing educational disparities to alleviate maternal fears and enhance overall childbirth experiences.

The relationship between pregnant women's work and levels of fear

Understanding the intricate relationship between pregnant women's employment and the varying levels of fear they may experience is a crucial aspect of maternal health research. As societal norms continue to evolve, an increasing number of women choose to balance both work and pregnancy simultaneously (Padavic et al., 2020). This dual commitment raises pertinent questions about the potential impact of occupational responsibilities on maternal well-being, particularly in relation to anxiety and fear during pregnancy. To delve into this topic, it is essential to explore existing literature, considering studies that shed light on the psychological aspects of maternal experiences in the workplace.

Additionally, empirical evidence plays a vital role in substantiating these claims. Referencing Table 11, which presents relevant data, will enhance our understanding of the nuances surrounding the correlation between pregnant women's employment and their levels of fear. By examining this interplay, we can gain insights that contribute to the development of supportive policies and workplace environments conducive to the holistic well-being of pregnant women.

Table 11. Level of Fear Based on Pregnant Women's Occupation

Occupations	Light		Currently		Heavy		Total		P-Value
	N	%	N	%	N	%	N	%	
IRT	32	32	4	4	9	9	45	45	
Private employees	13	13	4	4	0	0	17	17	0.00
Civil servants	10	10	4	4	14	14	28	28	
Self-employed	5	5	0	0	0	0	5	5	
Lecturer	5	5	0	0	0	0	5	5	
Total	65	65	12	12	23	23	100	100	

Based on Table 11, which illustrates the fear levels among pregnant women based on their occupations, it is evident that domestic workers constitute the majority with a mild level of fear at 32%. Interestingly, private employees, although fewer in number, exhibit the highest fear levels, predominantly at a mild level (13%). Civil servants, on the other hand, display a moderate level of fear at 10%, while self-employed pregnant women show the highest fear level at 5%, primarily falling within the mild category. Surprisingly, a notable 5% of lecturers also experience a mild level of fear. The statistical analysis of the data reveals a significant relationship between the occupation of pregnant women and their anxiety levels, as evidenced by a significance value of 0.002, which is less than the standard threshold of 0.05. This implies that the nature of a pregnant woman's work is a contributing factor to the anxiety levels experienced.

Moving beyond the statistical findings, the research delves into the methods employed in addressing the anxiety levels among pregnant women. (O'Connor et al., 2019) states, that among the various approaches, emotional management emerges as the most frequently utilized method. Midwives play a crucial role in guiding pregnant women to manage their emotions effectively, preventing the emergence of negative thoughts that could adversely impact the well-being of the pregnant woman. Furthermore, the study introduces hypnobirthing training, particularly for pregnant women in their third trimester. This training focuses on breathing and movement pattern exercises, designed to alleviate physical tension and promote relaxation. The goal is to prevent the pregnant woman's body from becoming stiff due to limited movement during this critical stage of pregnancy.

The relationship between the period of pregnancy of pregnant women and the level of fear

The relationship between the duration of pregnancy in expectant women and the level of fear they experience is a complex yet crucial aspect of prenatal care. Research, as highlighted by (Vyawahare et al., 2023), underscores the significant impact of maternal anxiety on hormonal balance, fetal development, and birth outcomes. This study aims to delve into the nuanced factors contributing to fluctuating fear levels throughout gestation, considering cultural, social, and personal influences. The analysis, supported by data from Table 12, seeks to provide valuable insights that can guide healthcare professionals, policymakers, and support networks in tailoring interventions to alleviate maternal fears and enhance the overall prenatal experience.

Table 12. Levels of Fear Based on Pregnancy Period of Pregnant Women

Pregnancy Period	Light		Currently		Heavy		Total		P-Value
	N	%	N	%	N	%	N	%	
Trimester I	5	10	8	0	7	4	20	14	0.00
Trimester II	25	27	0	8	9	12	34	47	
Third trimester	35	28	4	4	7	7	46	39	
Total	65	65	12	12%	23	23	100	100	

Based on Table 12, which presents the fear levels categorized by the age of pregnant women, a clear pattern emerges. During the first trimester, a noteworthy 8% of pregnant women experience a moderate level of fear. Moving to the second trimester, the data reveals a significant shift, with 27% of women reporting the highest level of fear, albeit at a mild intensity. Surprisingly, as pregnancy progresses into the third trimester, the majority, encompassing 35%, still maintain a mild level of fear. The statistical analysis of the data further supports these observations, with a calculated significance value of 0.000, which is less than the conventional significance threshold of 0.05. This implies a statistically significant relationship between the pregnancy period and the anxiety levels of expectant mothers.

Such findings underscore the importance of recognizing and addressing the psychological aspects of pregnancy. (Brennan et al., 2019) states, in light of the identified patterns, it becomes imperative to adopt

proactive measures in assisting pregnant women, both pre- and post-natally, in managing their emotions. This becomes particularly crucial given the observed correlation between fear levels during pregnancy and postnatal anxieties. It is evident that anticipating and addressing these concerns during the pregnancy period is pivotal to mitigating postnatal fears. Consequently, choosing an effective strategy to aid mothers in overcoming these fears becomes a paramount consideration in the overall care and support provided.

Relationship between parity of pregnant women and level of fear

The relationship between the parity of pregnant women and the level of fear is a topic of significant interest and concern in maternal healthcare. Parity, referring to the number of times a woman has given birth, has been recognized as a potential factor influencing the psychological well-being of expectant mothers. This discussion aims to explore the nuanced dynamics between parity and fear during pregnancy, shedding light on how the experience of previous childbirths may impact the emotional state of women in subsequent pregnancies. Understanding this relationship is crucial for healthcare providers to tailor support and interventions effectively. As a point of reference, Table 13 provides a comprehensive overview of pertinent data, offering valuable insights into the correlation between parity and fear levels among pregnant women. The inclusion of such empirical evidence adds depth and credibility to our exploration, enhancing the foundation for informed discussions and evidence-based interventions.

Table 13. Level of Fear Based on Parity of Pregnant Women

Parity of Pregnant Women	Light		Currently		Heavy		Total		P-Value
	N	%	N	%	N	%	N	%	
	15	15	4	4	11	11	30	30	
Nulliparous	21	21	4	4	5	5	30	30	
Primipara	29	29	4	4	7	7	40	40	0.27
Multiparous	65	65	12	12	23	23	100	100	
Total	15	15	4	4	11	11	30	30	

Based on Table 13, which presents the fear levels among pregnant women categorized by their parity, it is evident that nulliparas predominantly exhibit a mild level of fear at 15%. Interestingly, some primiparous women display the highest fear level, yet it remains at the mild level, accounting for 21% of the cases. Similarly, multiparas, while having the highest fear level, also fall within the mild category, with a prevalence of 29%. Upon statistical analysis, the significance value derived from the data is 0.267, exceeding the conventional threshold of 0.05. This result indicates a lack of a significant relationship between the parity of pregnant women and anxiety levels. Further exploration through qualitative analysis reveals compelling insights. Women with no prior pregnancy experience tend to harbor greater fears regarding labor pain, express concerns about potential complications during childbirth, and exhibit apprehension towards the attitudes of medical staff. These findings align with the core dimensions of pregnancy-related anxiety, as identified in previous research by (Brunton et al., 2019); (Donnici et al., 2021) . In summary, while the fear levels vary among pregnant women based on parity, the statistical analysis suggests that this variance does not constitute a significant relationship. Sheds light on specific anxieties experienced by nulliparas, offering a comprehensive understanding of the intricate dynamics of fear in relation to pregnancy and childbirth.

Relationship between BMI of pregnant women and level of fear

Understanding the relationship between the Body Mass Index (BMI) of pregnant women and their levels of fear is a crucial aspect of maternal healthcare. Pregnancy introduces both physiological and psychological changes, and investigating how BMI may influence fear levels contributes to comprehensive care strategies. In this discussion, the focus will be on exploring this intricate connection, drawing insights from relevant scholarly references. Additionally, data presented in Table 14 will be analyzed to provide empirical support for the ongoing discourse on the interplay between BMI and fear during pregnancy. This exploration aims to enhance our understanding of maternal well-being, ultimately fostering improved healthcare practices for expectant mothers.

Table 14. Level of Fear Based on Pregnant Women's BMI

Pregnant Women's BMI	Light		Currently		Heavy		Total		P-Value
	N	%	N	%	N	%	N	%	
Light skinny	5	5	4	4	0	0	9	9	
Normal	25	25	0	0	11	11	36	36	
Lightly fat	14	14	4	4	0	0	18	18	0.00
Heavy fat	21	21	4	4	12	12	37	37	
Total	65	65	12	12	23	23	100	100	

Based on Table 14, which illustrates the fear levels correlated with the BMI of pregnant women, we observe distinct patterns. Among pregnant women classified as light skinny, a majority exhibit a light level of fear (5%). Surprisingly, normal-weight pregnant women show a contrasting trend, with most experiencing a heightened fear level, primarily at the mild level (25%). Similarly, those with mild obesity display a prevalent mild fear level (14%), while the most obese pregnant women also register a noteworthy proportion at the mild fear level (21%). The statistical analysis further strengthens these observations, as the significance value obtained is 0.001, which is less than the conventional threshold of 0.05. This statistical significance underscores a meaningful association between the BMI of pregnant women and their anxiety levels (refer to Table 14 for detailed information). The findings on (Slade et al., 2021) suggest that varying BMI categories may influence the anxiety levels experienced by pregnant women, providing valuable insights for healthcare professionals and researchers in understanding and addressing maternal well-being.

Relationship between husband's support for pregnant women and level of fear

In exploring the intricate dynamics of pregnancy, this study focuses on the critical relationship between a husband's support for pregnant women and the resulting impact on the women's fear levels. The significance of social support during pregnancy has been extensively studied, with documented positive effects on maternal mental health (Bedaso et al., 2021). However, the specific connection between husband's support and fear levels remains relatively unexplored. Utilizing data from a comprehensive survey, this research, as indicated in Table 15, aims to unravel this relationship. The findings are expected to contribute valuable insights, informing interventions that can enhance the support systems available to pregnant women and fostering healthier family dynamics.

Table 15. Level of Fear Based on Pregnant Women's Husband Support

Pregnant Women's Husband Support	Light		Currently		Heavy		Total		P-Value
	N	%	N	%	N	%	N	%	
Enough	15	15	8	8	7	7	30	30	
Good	50	50	12	12	23	23	70	70	0.01
Total	65	65	12	12	23	23	100	100	

Based on Table 15, the fear levels among pregnant women in the fair category vary, with the majority experiencing a mild level of fear (15%). Interestingly, pregnant women whose husbands fall into the good category exhibit the highest level of fear, predominantly at the mild level (50%). These findings suggest a nuanced relationship between husband support and fear levels during pregnancy. The statistical analysis further strengthens this observation, revealing a significance value of 0.001, which is less than the commonly accepted significance level of 0.05. This statistical significance underscores a substantial association between the level of support from pregnant women's husbands and the corresponding anxiety levels. The results of this study align with the growing body of literature emphasizing the crucial role of spousal support in influencing the emotional well-being of pregnant women (Eddy & Fife, 2021). The findings contribute valuable insights to the understanding of the intricate dynamics between husband support and maternal anxiety during pregnancy.

Conclusion

Based on the description of this research, the midwife's experience in treating pregnant women highlights effective approaches, including regular counseling to monitor both physical and psychological development. Training activities, such as emotional management, mindfulness, hypnobirthing, and Mindfulness Based Cognitive Therapy (MBCT), have been implemented to address fear in pregnant women. Analysis of medical records indicates that factors like education, work, pregnancy, BMI, and husband's support show a significant relationship (< 0.05) with fear-induced paralysis. However, age and parity demonstrate no significant relationship with this fear in pregnant women.

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Author Contributions

Conceptualization; methodology; validation; formal analysis.; investigation.; resources; .data curation: writing—original; draft preparation; writing—review and editing; Visualization: M. P.

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Conflicts of interest

The author declares that there is no conflict of interest in the research and publication of this research.

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