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RESEARCH ARTICLE

A QUALITATIVE STUDY OF HOME MANAGEMENT PRACTICES FOR MINOR DISORDERS OF PREGNANCY AMONG ANTENATAL MOTHERS IN CENTRAL INDIA

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ABSTRACT

Background: Minor disorders of pregnancy are common and often managed at home using traditional and self-care practices, particularly in low-resource settings. Little is known about these practices among antenatal mothers in Central India. **Aim:** To explore the home management practices, decision-making processes, and sources of knowledge regarding minor disorders of pregnancy. **Methods:** A qualitative descriptive design was employed. Fifteen antenatal mothers attending the Obstetrics and Gynaecology OPD at AIIMS Raipur, India, were purposively sampled and participated in semi-structured in-depth interviews from July to August 2025. Data were analysed thematically using Delve software and the constant comparative method until saturation was reached. **Results:** Five major themes emerged: (1) Physical discomforts (gastrointestinal, musculoskeletal, neurological, urinary, and others); (2) Home remedies (food-based, topical/massage, lifestyle adjustments); (3) Decision-making in seeking care (preference for home remedies first, clear thresholds for medical help); (4) Sources of knowledge (predominantly family elders, supplemented by internet and occasional doctor validation); and (5) Cultural beliefs, cravings, and avoidance practices. Remedies such as ginger, salt–sugar solution, oil massage, and pillow support were widely used and perceived as culturally safe and effective. **Conclusion:** Antenatal mothers in Central India rely heavily on inexpensive, family-transmitted, culturally rooted remedies before seeking formal care. Healthcare providers should routinely inquire about these practices to provide respectful, evidence-informed guidance and strengthen maternal self-care education.

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INTRODUCTION

Pregnancy is accompanied by numerous physiological changes that frequently manifest as minor disorders such as nausea, vomiting, heartburn, constipation, backache, leg cramps, fatigue, and frequent urination. Although rarely life-threatening, these discomforts affect quality of life and are often managed at home, especially in settings where access to healthcare is limited or symptoms are considered "normal".[1,2] In India, many pregnant women view nausea, vomiting, and headache as inevitable and do not seek medical consultation unless symptoms become severe.[3] Home management relies heavily on remedies transmitted orally across generations, varying by region, caste, and socioeconomic status. While some practices (e.g., ginger for nausea) are supported by evidence, others lack scientific validation and carry potential risks if misused.[4] Nurses and midwives are ideally placed to provide anticipatory guidance, yet many lack detailed knowledge of local traditional practices.[5] Understanding these practices is essential for respectful maternity care, harm reduction, and strengthening self-care interventions recommended by the World Health Organization[6]. No qualitative studies have previously explored home management of minor disorders among antenatal mothers attending a tertiary centre in Chhattisgarh, Central India. This study aimed to fill that gap by exploring the lived experiences, practices, beliefs, and decision-making processes of antenatal mothers.

MATERIALS AND METHODS

Design: A qualitative descriptive design,[7] was used to provide a rich, straight description of participants' experiences.

Setting and Participants: The study was conducted in the Obstetrics and Gynaecology Outpatient Department of All India Institute of Medical Sciences (AIIMS), Raipur, Chhattisgarh, from 16 July to 23 August 2025. Purposive sampling was employed to achieve maximum variation in age, parity, education, and rural/urban residence.

Inclusion criteria: antenatal mothers (primi- or multigravida) who had experienced at least one minor disorder in the current pregnancy and were willing to participate.

Exclusion criteria: high-risk or complicated pregnancies, inability to communicate, or severe illness. Fifteen women were interviewed until data saturation occurred.

Ethical Considerations: Ethical approval was obtained from the AIIMS Raipur Institutional Ethics Committee (No. AIIMS/IEC/2025/74915). Written informed consent (including for audio recording) was obtained. Confidentiality and anonymity were strictly maintained; participants could withdraw at any time.

Data Collection: A semi-structured interview guide shown in Table:1 (16 main questions with probes) was developed from literature and expert consultation and pilot-tested. Interviews (20–40 minutes) were conducted in Hindi or English in a private room by the authors. Socio-demographic data were collected first, followed by the in-depth interview. All interviews were audio-recorded using mobile phone, transcribed verbatim within 48 hours, and translated into English and validated for its accuracy. Field notes supplemented recordings**.**

Data Analysis: Transcripts were imported into Delve qualitative software. Data analysis followed an integrated approach combining Colaizzi's (1978),[8] phenomenological framework with Braun and Clarke's (2006) thematic analysis,[9,10], incorporating the constant comparative method to ensure iterative refinement. The process began with Colaizzi's steps: (1) reading and re-reading transcripts to acquire a sense of the whole; (2) extracting significant statements relevant to the phenomenon; (3) formulating meanings from these statements; (4) organizing formulated meanings into clusters of themes; (5) developing an exhaustive description of the phenomenon; (6) reducing the description to a fundamental structure; and (7) validating findings through member checking. This was complemented by Braun and Clarke's phases: familiarization with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Initial open coding was followed by focused coding, category development, and theme refinement. A detailed codebook with definitions and exemplar quotations was maintained. Analytic memos and an audit trail enhanced transparency. Credibility was strengthened through member checking, triangulation of data sources, and peer debriefing with five qualitative and maternal-health experts.

RESULTS

The age of the participants ranged from 23 to 34 years. Educational status varied widely; while a few had completed only primary or secondary education, several had attained higher qualifications. All of the mothers belonged to the Hindu religion. The majority resided in urban areas (73.3%), whereas a smaller proportion (26.7%) were from rural settings. In terms of obstetric history, slightly more than half were multigravida mothers (53.3%). Occupation-wise, most respondents were housewives (80%). The gestational age of the participants ranged from 13 to 36 weeks, and the majority were in their third trimester. 5 themes and 18 sub-themes were developed during the thematic analysis. (Table 2)

Theme 1: Physical Discomforts During Pregnancy: Pregnant women across the interviews reported a wide range of physical discomforts. These were grouped into five sub-themes: *gastrointestinal problems, musculoskeletal discomforts, neurological symptoms, urinary issues, and other difficulties.* Each sub-theme captured the everyday bodily challenges women faced and the simple, mostly home-based strategies they used for relief.

Sub-theme 1.1: Gastrointestinal Problems: Nausea and vomiting were among the most commonly reported concerns, particularly during the early months of pregnancy. Several participants shared their reliance on home remedies. For example, one woman described, *"For vomiting I used ginger, chewed it in my mouth"* (R13). Another participant avoided certain food items, explaining that she *"stopped eating spicy food"* (R11). While some remedies such as ginger, lemon, or coconut water provided partial relief, others noted that their vomiting persisted despite efforts, requiring medical advice (R12).
Acidity and heartburn were also recurrent (R2, R7, R12, R14, R15). These were often managed by dietary modifications, such as avoiding oily and spicy foods or increasing fluid intake. Constipation emerged as another frequent gastrointestinal issue (R4, R7, R9, R13, R14, R15). Women typically relied on increasing their water consumption, drinking coconut water, eating curd, or taking small, frequent meals to reduce discomfort.

Sub-theme 1.2: Musculoskeletal Discomforts: Musculoskeletal discomforts were widely experienced, especially in the later months of pregnancy. Back pain was repeatedly reported (R5, R6, R9, R13, R14, R15). One participant noted, *"Now as time is progressing, I am getting back pain, leg pain, like I am not able to stand"* (R14). For leg cramps and pain (R3, R6, R9, R12, R15), women commonly used massage with mustard oil, often prepared with garlic for added relief. Swelling in the feet was also described by several women (R2, R4, R7, R13, R14, R15), for which remedies included warm water soaks with salt, massage, or resting indoors.

Sub-theme 1.3: Neurological Symptoms: Headaches (R5, R9, R12, R13, R15) and dizziness or weakness (R6, R7, R13, R14) were frequent. Headaches were generally managed with topical applications such as balm or cooling oils, as expressed by one woman, *"I apply balm, cold oil and take rest"* (R15). Weakness was often alleviated through rest or consumption of refreshing fluids such as coconut water, lemon water, or lassi (R11).

Sub-theme 1.4: Urinary Issues: Frequent urination was a near-universal experience across participants (R2, R4, R7, R13, R14, R15). Women generally accepted it as a natural outcome of pregnancy, though some tried modifying their practices, such as drinking water while sitting rather than standing (R12, R15).

Sub-theme 1.5: Other Difficulties: Additional physical discomforts included sleep disturbances (R9, R15), with participants reporting the need for frequent changes in sleeping position or the use of pillows for support. One woman shared, *"I put a pillow behind my waist, under my legs and behind my waist"* (R15). Another less common issue was genital itching and discomfort (R15), which was managed through local cleansing practices such as adding antiseptics to warm water.

The accounts illustrate that physical discomforts during pregnancy are varied and often interrelated. Women rely predominantly on home remedies such as dietary changes, fluid intake, massage, and rest to manage these discomforts. In many cases, these remedies provided sufficient relief, but participants also recognized the need to consult doctors if symptoms persisted or worsened.

Theme 2: Home Remedies for Minor Ailments: Pregnant women in the study described using a range of simple, culturally grounded home remedies to address minor ailments. These remedies were largely food-based, topical or massage-related, and lifestyle adjustments. They reflect women's reliance on traditional practices, often guided by family members, to manage discomforts without immediately resorting to biomedical treatment.

Sub-theme 2.1: Food-based Remedies: Food played a central role in self-care during pregnancy. Participants frequently described using ginger to manage vomiting. One woman explained, *"For vomiting I used ginger, chewed it in my mouth"* (R13). Others also reported that ginger relieved nausea and morning sickness (R1, R6). Another widely practiced remedy was the salt-sugar solution, consumed for both vomiting and dizziness. A participant shared, *"When vomiting or dizziness came, I drank water with salt and sugar"* (R13).

This was echoed by R6 and R14, who considered it a quick, affordable, and effective method. Food cravings were commonly acknowledged and managed through accessible foods such as curd, pickles, and spicy or sour items (R3, R6, R13, R14). For some, these foods also acted as comfort measures that alleviated nausea. Lemon water was also cited as a regular remedy for gastrointestinal discomforts. One participant noted, *"I used to drink lemon water by adding salt, sugar, lemon"* (R15), highlighting its multipurpose use for both gas and constipation.

Table 1. Semi-structured interview guide

Introduction by interviewer

"Thank you for agreeing to participate in this interview. The purpose of this interview is to understand how you manage minor health issues during pregnancy at home. Your responses will help us understand common practices and provide better support for expectant mothers."

Consent is taken

"Before we start, do you consent to participating in this interview? You can choose not to answer any question, and you can stop the interview at any time."

Interview Questions

- Is this your first pregnancy? If not, how many pregnancies have you had before?
- How far along are you in your pregnancy?
- Can you describe any common discomforts or minor health issues you have experienced during your pregnancy so far?
- Which of these issues have been the most troublesome for you? Why?
- For the discomforts you've experienced, how have you managed them at home?
- Prompt: Do you use any home remedies, medications, rest, or lifestyle changes?
- What kind of advice or guidance did you receive from healthcare professionals (doctors, midwives, nurses) about managing minor health issues at home?
- Have you used any over-the-counter medications or herbal remedies to manage these symptoms? If so, what kinds?
- How do you decide when to try home remedies versus when to seek medical help?
- Where do you usually get information on how to manage minor pregnancy disorders?
- How confident do you feel in the advice or information you receive from these sources?
- Have you ever consulted a healthcare provider specifically about a minor disorder? What was that experience like?
- Do you think managing minor pregnancy disorders at home is effective for you? Why or why not?
- What factors influence your decision to manage minor pregnancy disorders at home instead of seeking professional help?
- What challenges or concerns do you face when managing symptoms at home?
- What additional support or information would be helpful to you when managing minor health issues during pregnancy?
- If there was one thing you could change about the information or resources available to pregnant women regarding home management practices, what would it be?

Closing

"Thank you for sharing your experiences with me. Is there anything else you would like to add about how you manage minor disorders during pregnancy?" "Would you be willing to participate in a follow-up interview if needed? Thank you again for your time and insights!"

Table 2. Thematic Analysis

Sl.No	Theme	Sub-themes	Codes
1	Physical Discomforts During Pregnancy	• Gastrointestinal Problems	Vomiting/nausea
			Acidity/heartburn
			Constipation
		• Musculoskeletal Discomforts	Back pain
			Leg cramps/pain
			Swelling in feet
		• Neurological Symptoms	Headache
			Dizziness/weakness
		• Urinary Issues	Frequent urination
		• Other	Sleep disturbance
			Itching/discomfort in genital area
2	Home Remedies for Minor Ailments	• Food-based Remedies	Ginger for vomiting
			Salt-sugar solution for dizziness/vomiting
			Curd, pickle, sour/spicy foods for cravings
			Lemon water for gas/constipation
		• Topical & Massage Remedies	Oil massage (mustard oil, coconut oil, cold oil) for leg/back pain
			Balm/cold oil for headache
			Hot water/Dettol bath for itching
		• Lifestyle Adjustments	Pillow support for sleep and back pain
			Avoiding spicy/oily foods
			Rest and hydration
3	Decision-Making in Seeking Care	• Preference for Home Remedies First	Try home methods before consulting doctor
		• Threshold for Medical Consultation	Seek doctor if condition worsens or persists
		• Perceived Effectiveness	Most remedies considered helpful, some ineffective
4	Sources of Knowledge on Remedies	• Family Transmission	Advice from mother, mother-in-law, grandmother
		• Traditional Practices	Cultural/household remedies (ginger, pickle, oil massage, hot water with salt)
		• Media & Internet	Google/YouTube for information
		• Doctor's Guidance	Occasional doctor reinforcement of remedies
5	Cultural Beliefs, Cravings & Practices	• Food Cravings	Sour foods (pickles, mango)
			Spicy foods
			Sweets
		• Avoidance Behaviors	Not eating spicy food for acidity
			Avoiding cold exposure for swelling
		• Beliefs about Remedies	Belief in oil massage, pillow use, resting as culturally validated practices
			Some remedies passed down but not always effective

Table 3 32. Item COREQ (Consolidated Criteria for Reporting Qualitative Research) Checklist

Sl.No.	COREQ item	Details of the study
Domain 1: Research team and reflexivity		
1	Interviewer/facilitator	All interviews were conducted by the authors except Hitesh Choudhary
2	Credentials	Joyce Joseph, MSc Nursing, Lecturer, AIIMS Raipur.
3	Occupation	Full-time nursing faculty member at AIIMS Raipur, and 4th year students.
4	Gender	Females
5	Experience and training	Corresponding Author has 13 years of clinical experience in nursing after PG, and 5 years of experience in qualitative research; trained in in-depth interviewing and thematic analysis.
6	Relationship with participants	No prior relationship existed. Participants were informed that the interviewer was a nursing faculty member along with students conducting research; rapport was established during consent and socio-demographic data collection.
7	Participant knowledge of the interviewer	Participants were informed of the researcher's profession, purpose of the study (to understand home management of minor disorders), and that she was a nursing lecturer, and that the study was part of institutional research.
8	Interviewer characteristics	The interviewers used open-ended questions, avoided leading prompts, and maintained a non-judgmental stance toward traditional practices.
Domain 2: Study design		
9	Methodological orientation	Qualitative descriptive design with integrated Colaizzi's phenomenological method and Braun & Clarke's thematic analysis.
10	Sampling method	Purposive sampling with maximum variation (age, parity, education, rural/urban residence).
11	Method of approach	Face-to-face recruitment in the Obstetrics OPD waiting area after routine antenatal visit.
12	Sample size	15 antenatal mothers
13	Non-participation	No refusals recorded; all approached women agreed to participate.
14	Setting of data collection	Private counselling room within the Obstetrics & Gynaecology OPD, AIIMS Raipur (quiet, no non-participants present).
15	Presence of non-participants	No non-participants were present during interviews.
16	Description of sample	Age 23–34 years; 53.3% multigravida; 73.3% urban; 80% housewives; gestational age 13–36 weeks
17	Interview guide	16 main questions with probes; pilot-tested; guide reproduced in full in Table 1 of the manuscript.
18	Repeat interviews	No repeat interviews were conducted.
19	Audio/visual recording	All interviews audio-recorded with written consent in mobile phone.
20	Field notes	Field notes were taken during and immediately after each interview.
21	Duration	Interviews lasted 20–40 minutes.
22	Data saturation	Saturation discussed and achieved after 15 interviews (no new themes emerged).
23	Transcripts returned	Transcript summaries (not full transcripts) were shared with 5 participants for member checking; minor clarifications incorporated.
Domain 3: Analysis and findings		
24	Number of data coders	Primary coding by the corresponding author; 20% of transcripts independently coded by a second qualitative researcher (Dr. Hitesh Choudhary) for consistency.
25	Description of coding tree	Codebook with definitions and exemplar quotations was maintained.
26	Derivation of themes	Themes derived inductively using Colaizzi's 7 steps integrated with Braun & Clarke's 6 phases and constant comparative method.
27	Software	Delve qualitative analysis software.
28	Participant checking	Member checking performed with 5 participants; feedback incorporated.
29	Quotations presented	Participant quotations presented with identifiers (R1–R15) to illustrate each sub-theme.
30	Data and findings consistent	Clear consistency between data presented and findings; exemplar quotes support every sub-theme.
31	Clarity of major themes	Five major themes and 18 sub-themes clearly described with headings and narrative.
32	Clarity of minor themes	Minor variations (e.g., ineffective remedies) explicitly discussed within themes.

Sub-theme 2.2: Topical and Massage Remedies: Massage and topical applications were deeply embedded in the women's coping practices. Oil massage was one of the most frequently mentioned remedies, typically with mustard oil, coconut oil, or cold oils. It was used for both leg pain and back pain, and sometimes for swelling. For example, one woman explained, *"For swelling in the feet, I dipped the feet in hot water with salt, and massaged at home"* (R13). Such remedies provided both physical relief and emotional reassurance. Balm and cooling oils were used for headaches, applied to the forehead or scalp (R5, R12, R13, R15). Meanwhile, hot water or antiseptic baths (using Dettol or salt) were reported for itching and genital discomfort, particularly in the later stages of pregnancy (R15).

Sub-theme 2.3: Lifestyle Adjustments: Alongside food and massage remedies, women also described making lifestyle adjustments to cope with pregnancy-related discomforts. For instance, several participants emphasized the importance of pillow support during sleep, particularly to relieve back pain. As one participant shared, *"I sleep with the support of a pillow"* (R14). Avoidance strategies were also common, with many deliberately avoiding spicy or oily foods to reduce acidity and gastric discomfort (R7, R14). In addition, rest and hydration were frequently cited as self-care measures (R6, R7, R14, R15). These included resting during episodes of weakness or dizziness and drinking more water or coconut water to stay refreshed. The findings show that home remedies for minor ailments during pregnancy are varied and rooted in everyday practices. Women rely on food-based strategies (ginger, salt-sugar solution, lemon water), topical and massage remedies (oil massage, balm, antiseptic baths), and lifestyle adjustments (pillow support, dietary avoidance, rest, hydration). These practices highlight the importance of cultural knowledge and family influence in guiding pregnant women's health management.

Theme 3: Decision-Making in Seeking Care: Pregnant women in the study expressed a patterned approach to managing health concerns, beginning with home-based remedies and moving toward medical consultation only when symptoms worsened or persisted.

This illustrates a tiered decision-making process rooted in cultural traditions, accessibility, and perceptions of remedy effectiveness.

Sub-theme 3.1: Preference for Home Remedies First: Across multiple interviews, women emphasized that home remedies were always the first line of response to minor ailments. Guidance from mothers, mothers-in-law, and elder women in the family played a major role in shaping this preference. As one participant explained, *"In that, I do whatever is told at home. If it doesn't work, then I meet the doctor"* (R14). This sentiment was echoed by several others (R4, R7, R12, R13, R15), showing that trust in traditional practices outweighed immediate recourse to formal healthcare.

Sub-theme 3.2: Threshold for Medical Consultation: Despite reliance on traditional methods, participants described clear thresholds for when medical consultation became necessary. These thresholds were usually defined by worsening, persistence, or severity of symptoms. As one woman shared, *"If the problem gets worse, I go to the doctor"* (R13). Similarly, women emphasized that while minor discomforts such as nausea, acidity, or body aches could be managed at home, more serious or prolonged problems demanded professional attention (R6, R14, R15). This reflects a pragmatic balance between cultural reliance on self-care and recognition of the importance of medical expertise when complications arise.

Sub-theme 3.3: Perceived Effectiveness: Another layer in women's decision-making was their evaluation of the effectiveness of remedies. Most participants reported satisfaction with traditional methods, noting relief from symptoms such as vomiting, constipation, or swelling. However, a few acknowledged that remedies did not always work. For example, one participant explained, *"By the way, pain is a big problem. Sometimes cold oil does not work, so for headache one has to take a pill"* (R15). Others similarly reflected that while home remedies were useful, they were not foolproof (R12, R14). This evaluation of effectiveness directly influenced whether women escalated care from home-based methods to medical consultation.
The findings highlight that pregnant women's decision-making around care was shaped by a three-tiered process: beginning with home remedies as the primary strategy, establishing thresholds for medical consultation based on symptom persistence or severity, and critically evaluating the effectiveness of remedies in guiding further action. This pattern underscores the dynamic interplay between cultural traditions, experiential knowledge, and formal healthcare utilization.

Theme 4: Sources of Knowledge on Remedies: The study revealed that women's knowledge of managing minor ailments during pregnancy was shaped by a blend of traditional family wisdom, cultural practices, modern media, and occasional medical guidance. This interplay of sources reflects the coexistence of generational knowledge with contemporary influences in shaping maternal health practices.

Sub-theme 4.1: Family Transmission: For most participants, the primary source of knowledge came from mothers, mothers-in-law, and grandmothers. These women acted as custodians of generational wisdom, passing on practical remedies that had been relied upon for decades. As one participant noted, *"There is a grandmother at home, mummy, these people give it, mother-in-law"* (R14). Similar sentiments were reported by others (R1, R6, R12, R13, R15), showing that family advice was both trusted and deeply embedded in daily practices.

Sub-theme 4.2: Traditional Practices: Closely tied to family advice were cultural and household practices. Women described the use of ginger for vomiting, pickles for cravings, oil massage for body pain, and soaking feet in hot water with salt for swelling. These remedies were perceived as time-tested solutions, practiced across generations and seen as integral to the experience of pregnancy.

Sub-theme 4.3: Media and Internet: A growing influence was the use of digital media, particularly Google and YouTube, for seeking additional remedies. Younger antenatal mothers reported searching online to verify or supplement family advice. For instance, one woman shared, *"I used to do a little Google search and my mother and mother-in-law tell me"* (R13). Another reflected, *"Now my mother also tells me, and just like YouTube is also there these days, so I can watch it"* (R15). This highlights the integration of modern information sources with traditional channels.

Sub-theme 4.4: Doctor's Guidance: While family and media dominated, participants acknowledged occasional reinforcement from doctors regarding certain practices. Doctors' advice was sometimes used to validate or supplement home remedies, particularly regarding diet, rest, or safe symptom management (R13, R15). However, this influence was secondary compared to family and cultural traditions. The findings illustrate that antenatal mothers draw upon multiple layers of knowledge in managing minor pregnancy disorders. Family elders provide the foundation through oral transmission of remedies, cultural practices reinforce these traditions, modern media introduces additional options, and doctors offer limited but valued reinforcement. Together, these sources shape a hybrid knowledge system that guides decision-making during pregnancy.

Theme 5: Cultural Beliefs, Cravings & Practices: Pregnancy experiences were strongly influenced by cultural beliefs, traditional practices, and food-related cravings. These beliefs and practices shaped daily decisions about diet, remedies, and self-care, and were often reinforced by family members and community norms.

Sub-theme 5.1: Food Cravings: Participants described a range of pregnancy-related cravings, particularly for sour, spicy, and sweet foods. Sour foods such as pickles and mango were frequently mentioned, with one mother sharing, *"Home remedies include mango pickle, curd, etc."* (R13). Spicy foods were also craved, as one participant explained, *"I feel like eating spicy food... sometimes you ate some spicy mixture at home"* (R14). In contrast, some mothers expressed a preference for sweets, with one stating, *"I am normal, I don't feel like eating much, I eat sweets. I feel like eating sweets"* (R15). These cravings were seen as part of the normal pregnancy experience, though sometimes they conflicted with health-related advice.

Sub-theme 5.2: Avoidance Behaviors: Alongside cravings, women practiced avoidance behaviors rooted in both personal experience and cultural advice. For example, some participants consciously avoided spicy foods to reduce acidity (R14). Others avoided cold exposure, believing it could worsen swelling or body pain (R14). These avoidance patterns illustrate how women negotiated between cravings and perceived risks during pregnancy.

Sub-theme 5.3: Beliefs about Remedies: The study also revealed strong cultural validation of certain remedies. Practices such as oil massage, using pillows for back support, and resting were not only home-based interventions but also culturally endorsed methods passed down through generations. However, participants also acknowledged that while many remedies were traditional, they were not always effective in alleviating discomforts. As one participant explained, some remedies like balm or oil provided only partial relief, necessitating the use of medication (R14, R15). This theme highlights the role of cultural beliefs and practices in shaping pregnancy experiences. Food cravings and avoidance behaviors reflect a balance between desire and perceived health risks, while traditional remedies such as oil massage and rest are deeply embedded in cultural identity. Although widely practiced, women also recognized that not all remedies were effective, showing a pragmatic approach to blending tradition with modern solutions.

Rigour: To ensure the trustworthiness of the findings, this study adhered to Lincoln and Guba's (1985) criteria for qualitative research,[11]: credibility, transferability, dependability, and confirmability. Credibility was enhanced through prolonged engagement with participants during interviews, member checking (where summaries of transcripts were shared with five participants for

validation and feedback, leading to minor clarifications), triangulation of data sources (integrating interview transcripts, field notes, and socio-demographic data), and peer debriefing with five experts in qualitative methods and maternal health who reviewed coding and themes at multiple stages. Transferability was supported by providing thick descriptions of participant experiences, contexts, and quotations, as well as purposive sampling to capture diverse perspectives across age, parity, education, and residence. Dependability was maintained via a comprehensive audit trail documenting all methodological decisions, code-recode consistency checks (where 20% of transcripts were recoded after a two-week interval, achieving 95% agreement), and the use of Delve software for systematic data management. Confirmability was promoted through a reflexivity journal kept by the researcher to bracket personal biases (as a maternal health lecturer), bracketing during analysis to minimize preconceptions, and external review by two independent auditors who examined raw data, codes, and themes for neutrality. Additionally, the study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist,[12] to ensure comprehensive reporting, including details on researcher credentials, participant relationships, and theoretical frameworks (Table:3). These measures collectively mitigated biases, enhanced transparency, and strengthened the overall rigour of the qualitative inquiry.

DISCUSSION

This study confirms that minor disorders are almost universal in pregnancy and significantly affect daily life, consistent with previous studies. [13, 14, 15,16.] The reliance on family-transmitted, culturally embedded remedies mirrors findings from South India,[17,18] and Uttar Pradesh,[19] highlighting a pan-Indian pattern among lower- and middle-income families. Ginger for nausea, oil massage for musculoskeletal pain, and salt–sugar solutions align with both traditional Ayurvedic principles and contemporary evidence.[20] However, some practices (e.g., excessive pickle consumption) may exacerbate heartburn, illustrating the need for gentle, evidence-informed counselling rather than outright dismissal of traditional practices. The tiered decision-making process observed; home remedy first, doctor later; reflects pragmatic resource use and high trust in familial knowledge, but also risks delayed care if women misjudge severity. Healthcare providers rarely initiated discussions about home practices, representing a missed opportunity for partnership and safety counselling**.** The increasing use of internet sources among younger mothers signals an evolving landscape where traditional and digital knowledge intersect, consistent with global trends.[21]

Implications for Practice

- Routine antenatal visits should include open questions about home remedies and cultural practices.
- Culturally congruent educational materials (posters, short videos) incorporating safe traditional remedies could be developed.
- Training modules for nurses and ASHAs should cover common regional remedies and red-flag symptoms.

Strengths and Limitations

The study achieved rich data and saturation with rigorous qualitative methodology at a tertiary centre. Limitations include restriction to one urban tertiary hospital (may not fully represent rural practices) and possible social desirability bias, although private interviewing and rapport-building minimized this.

CONCLUSION

Antenatal mothers in Central India actively manage minor pregnancy disorders using inexpensive, family-taught, culturally validated remedies before seeking formal care. Healthcare professionals must proactively explore these practices to provide respectful, safe, and effective guidance that bridges traditional wisdom and evidence-based care.

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