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HEALTH BEHAVIOUR OF PREGNANT WOMEN TOWARDS THE PREGNANCY SCHOOL IN THE GREATER ACCRA REGIONAL HOSPITAL.

BY

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DECLARATION

DECLARATION

I, Sarah Christodia Egyir declare that this thesis is the results of my work conducted under the supervision of Dr Mary Ani-Amponsah and Madam Ernestina Asiedua for the Award of Master of Philosophy Degree in Nursing at the School of Nursing and Midwifery of the University of Ghana, Legon. All of the resources assessed as literature have all been duly referenced.

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DEDICATION

This thesis is dedicated to my husband, Mr. James Nkansah for his love and support during this academic journey. I also dedicate this study to my children (Maame Somuah, Nana Ama Fosua and Ohemaa) and my parents (Mr. Egyir and Madam Comfort Ayeh) for their unflinching love, encouragement and prayers.

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I give God all the Glory

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LIST OF ABBREVIATIONS

ANC-	Antenatal Care
CEC-	Childbirth Education Classes
FANC-	Focused Antenatal Care
FMH -	Free Maternal Healthcare
GAR-	Greater Accra Region
GARH-	Greater Accra Regional Hospital
GMHS -	Ghana Maternal Health Survey
IFA-	Iron and Folic Acid
IMPAC -	Integrated Management of Pregnancy and Childbirth
LMIC-	Low- and Middle-Income Countries
MDG-	Millennium Development Goal
MMR-	Maternal Mortality Ratio
NHIS –	National Health Insurance Scheme
SDG-	Sustainable Development Goal
UNICEF -	United Nations International Children's Emergency Fund
USA –	United States of America
WHO-	World Health Organization

ABSTRACT

Antenatal care is viewed as an important point of contact between health workers and women and an opportunity for provision of health education including how to detect pregnancy complications and development of a birth plan to ensure safe delivery at a health facility. Quality antenatal care and education given to pregnant women during antenatal visits could be used as one of the measures to curb maternal mortality since these somewhat preventable maternal deaths have hugely been attributed to the lack of quality contacts between the pregnant women and the professional caregiver. Owing to the fact that little has been done over the years on the health behaviour of pregnant women towards the pregnancy school, the study therefore explored the health behaviour of pregnant women towards the pregnancy school in the Greater Accra Regional Hospital using the theory of Information Motivation-Behavioural-Skill model to guide the research. A qualitative explorative approach was employed. Data were collected from Greater Accra Regional hospital using a purposive sampling method. Fourteen (14) participants who consisted of three (3) pregnant and eleven (11) postpartum women who consented to participate in the study were interviewed face to face using a semi structured interview guide which lasted for 30-45minutes. Data were analysed thematically. Four (4) main themes and eighteen (18) subthemes were formulated from the constructs of the IMB model and the objectives of the study. The results of the study emphasized that, the participants found the information given at the classes to be very useful and had concerns with the time frame of the classes. The findings suggest that although the pregnancy school is a good initiative all stakeholders should support in order to improve it. Future research should focus on the information needs of the husbands and partners attending pregnancy schools.

Keywords – Pregnancy school, antenatal care, pregnant woman.

CHAPTER ONE

INTRODUCTION

This chapter centres on the background of the study, problem statement, study objectives and significance of the study. It also includes definition of terms, abbreviation organization of the study.

1.1 Background of the Study

The season of pregnancy and childbirth ought to be a time of great delight for families. But be it as it may, pregnancy and labour have become a source of disdain and anxiety for many families in poorer countries as a result of poor pregnancy outcomes. WHO (2016), explains antenatal care as the care given to pregnant women and adolescent girls by competent health care professionals in order to guarantee the greatest possible health for both the mother and the baby throughout pregnancy. The WHO envisions that every pregnant woman and her child receives high-quality care during pregnancy, labour and the postnatal period (WHO, 2016). Whereas the ANC scenario in advanced regions remain impressive as highlighted by a study by Rui et al. (2015) which put forth prenatal care as being among the most frequently used health care services in the United States. More than 18 million prenatal visits occurred in the United States. Same cannot be said about the rather bleak outlook when considering third world and poor developing regions despite the relentless effort by international organizations with regards to pregnant women attendance to ANC.

Globally, 86% of pregnant women access antenatal care with skilled health personnel at least once, only two in three (65%) receive at least four antenatal visits. In a similar vein, a 2019 report by UNICEF revealed that in sub-Saharan Africa and South

Asia, where the incidence rate of maternal mortality is high, women received fewer antenatal visits 52% - 46% respectively.

Furthermore, there are significant differences in access to four or more ANC visits between rural and urban locations, with a gap of more than 20% in south Asia and Sub-Saharan Africa (UNICEF, 2019). According to the findings of a study conducted in India utilizing data from the National Family Health Survey (NFHS) on women of reproductive age (15–49 years), roughly 33% of pregnant women did not receive ANC during their pregnancy. Comparably, a study conducted by Muleya et al. (2017) in southern Zambia found that increased maternal fatalities due to pregnancy problems might be avoided with high-quality prenatal care.

This is further buttressed in a cohort study carried out in Ethiopia, which reported that having four or more Antenatal Care (ANC) visits was significantly associated with 81.2%, 61.3%, 52.4% and 46.5% reduction in postpartum haemorrhage, early neonatal death, preterm labour and low-birth weight, respectively (Hafitu et al., 2018). ANC is one of the three most essential care given to women during pregnancy (WHO, 2016) and a key indicator of the Sustainable Development Goal (SDG) 3 target 3.1 – which is aimed at reducing the global maternal mortality ratio to less than 70 per 100,000 live births. The maternal mortality ratio (MMR) for Ghana is 310 deaths per 100,000 live births (GMHS, 2017). With a ratio of 319 in 2015, Ghana's target to achieve Millennium Development Goal (MDG) 4 and 5 was unattainable. With the foregoing as a guide, quality antenatal care could be used as one of the measures to curb maternal mortality.

Nevertheless, most of the causes of maternal mortality are preventable. Antenatal education has the overall aim of providing expecting parents with strategies for dealing with pregnancy, childbirth and parenthood (Ahlden et al., 2012). The ANC has four basic

components which includes: identification of risk, prevention and management of pregnancy - related or concurrent diseases; and health education and health promotion. To this end, more specific aims include influencing health behaviour, increasing confidence in women's ability to give birth, informing about pain relief, and promoting breastfeeding. In this respect, antenatal care provides an important opportunity to prevent and manage concurrent diseases through integrated service delivery (IMPAC, 2016). The care given antenatally has been proven as intervention that saves the lives of pregnant women when accessed adequately (Miltenburg et al., 2015).

Health promotion (including birth planning for a facility-based delivery), screening and diagnosis, and disease prevention appropriate to gestational age, health status, and geographic context are among the services performed at the ANC (De Masie et al., 2017). One of the foundations of antenatal care is antenatal education, which strives to improve the health of mothers, newborns, and their families. Women and their families are better prepared for pregnancy, childbirth, and parenthood after receiving health information through antenatal education programs (Taiwo et al., 2013).

Pregnancy and its care; labour, delivery, and postpartum care of the mother and baby; role of women during the perinatal period; and psychosocial aspects of pregnancy are among the main areas of interest for women worldwide (Malata et al., 2011). Antenatal care is also seen as a crucial point of interaction between health workers and women, as well as an opportunity for health education – such as how to recognize pregnancy issues – and the development of a birth plan to ensure delivery at a health facility. Pregnant women's health and the health of their unborn children benefit greatly from health education provided to them and their families. There is a significant impact on both the pregnant lady and her partner's decision-making around the pregnancy. Counselling and health education had the lowest marks in the childbirth

satisfaction survey, according to a study conducted by Duysburgh et al. (2014) in selected health centres in the Northern Region of Ghana. Only 72% of Ghanaian women of reproductive age delivered at a health facility, according to Dankwah et al. (2019), while women who were not informed about pregnancy problems were more likely to deliver outside of a health facility. The implication is that pregnant women who do not receive adequate health education are more likely to be affected by indirect causes of maternal mortality, even though ANC coverage has increased (Boah et al., 2018). Dankwah et al. (2019) also found in their study that knowledge about pregnancy complications was linked to health facility delivery and hence the need to give increased attention to health education about potential delivery associated complications as part.

During pregnancy, social support is critical for both the pregnant mother and her unborn child's health. That being said, only a small percentage of them would suffer from post-partum depression, a condition that can be disastrous for families (Morikawa et al., 2015). Expectant mothers not only undergo physiologic and hormonal changes throughout pregnancy, but they are also mentally encircled by the fear of being unable to cope with the approaching new circumstances. As a result, individuals are in desperate need of social assistance in order to overcome their fears (Maharlouei et al., 2015). In the health sector, prenatal education is known by a variety of names with the geographical location being a key determinant; such as expectant parent classes, antenatal parenthood education, antenatal education, childbirth classes, and antenatal classes (Barimani et al., 2018). Nevertheless, the phrase ‘pregnancy school’ is used in this study since it is a well-known concept in Ghana.

The pregnancy school or classes, which began in 2009, is aimed at providing high-quality education to pregnant women and their families, as well as equip them with the necessary information and skills to make timely pregnancy decisions that

promote the health of the mother and unborn child, and thus contribute to the achievement of SDG 3 target 3.1. It must however be emphasized that, the pregnancy school is not a replacement of the regular ANC but similar to the group antenatal care which serves to promote links between all aspects of Clinical Care and Public Health to provide a holistic care to pregnant women, their partners and babies (Vanotoo, 2016).

The pregnancy school also helps to build a friendly and casual collaboration between health providers and pregnant women, as well as their spouses and families, which is sometimes lacking in our hectic antenatal clinic days. One of the goals of the pregnancy school is to encourage male involvement in the care of the women, as well as to educate them on pregnancy and its related conditions, birth preparedness and complication readiness, as well as support for the woman, the baby, family planning, and their fears (Vanotoo, 2016).

However, since the introduction of the pregnancy school or classes few studies in Ghana have been conducted on the impact of the pregnancy school on the health lifestyle and decisions, information needs and importance of social support of pregnant women who participate in the pregnancy school with or without their partners. It is against this background that this study will use the theory of Information Motivation Behavioural Skills model developed by Fisher and Fisher (1992, 2000), Fisher and Fisher (1993, 1999) to guide the research in examining the health behaviour of pregnant women towards the pregnancy school in the Greater Accra Region.

1.2 Problem Statement

Maternal death and morbidity influence not only the woman's immediate family, but also the community and society as a whole. The Sustainable Development Goal (SDG) of reducing maternal mortality remains a top objective (WHO, 2016). Despite the fact that

many interventions and policies have been implemented in Ghana to combat this threat, such as Free Maternal Healthcare (FMH), the National Health Insurance Scheme (NHIS), Focus Antenatal Care (FANC) Addo and Gudu (2017) and the pregnancy school, MMR continues to fall short of the Sustainable Development Goal (SDG) 3 target 3.1 of reducing maternal mortality to less than 70 per 100,000 live births (GMHS, 2017). Regardless, of the education given to pregnant women at the ANC, research shows that most pregnant women struggle to operationalize and interpret the information they receive (Jody et al., 2014), implying that health education does not convert into acceptable health behaviours. If pregnant women are unable to comprehend the information provided by health care providers, they may be unable to fully utilize the health system's benefits.

Based on clinical evidence, few studies in Ghana, Eghan (2016) have focused on the content of pregnancy schools. However, the majority of people in Ghana have become more informed about health issues. Most pregnant women and their partners get information from a variety of sources, including friends, family, magazines, and social media, which are frequently inaccurate and sometimes misleading. Furthermore, the importance of social support, particularly that of the pregnant woman's partner, plays a major role in the organization of the pregnancy school. Nonetheless, few studies have been conducted on whether the expectant father's information needs are met during the pregnancy school.

Few studies Greenaway et al. (2012) conducted in Ghana have assessed the causes of maternal mortality in relation to maternal literacy and most studies that examine a pregnant woman's knowledge of health topics use one-dimensional measure, in the event that she has heard of a specific illness rather than focusing on their overall understanding of the topic. While being aware of illnesses is important, it is unlikely to have the same

impact on women's health behaviour as having a broad understanding and knowledge of a number of health topics.

Furthermore, more questions are left unanswered concerning the quality of antenatal education given by health professionals. However, owing to the launch of the pregnancy school in 2009 and review of associated relevant literature shows limited published work have been done on the health behaviour of pregnant women who attend the pregnancy school in Ghana especially in the Greater Accra Region. To that effect, this work seeks to fill in the gap by finding out how pregnant women who attend the pregnancy school are able to practically use the information received through health education given at the school using the Information- Motivation- Behavioural skills module as a guide.

1.3 Purpose of the Study

To explore the health behaviour of pregnant women towards the pregnancy school in the Greater Accra Metropolis.

1.4 Objectives

The Objectives of the study were developed based on the constructs of the study.

The objectives were to:

1. Assess the information given to pregnant women at the pregnancy school in the Greater Accra Metropolis.
2. Identify the elements that motivate pregnant women towards the pregnancy school in the Greater Accra Metropolis.
3. Describe the skills acquired by the pregnant women at the pregnancy school in the Greater Accra Regional Hospital.
4. Examine the outcomes of the education on the health of the pregnant women who attend the pregnancy school in the Greater Accra Regional Hospital.

1.5 Research Questions

The study addresses the following questions;

1. What information is given to the pregnant women at the pregnancy school?
2. What are the elements that motivates pregnant women towards the pregnancy school?
3. What are the skills acquired during the pregnancy school?
4. What are the outcomes of the health education on pregnant women who attend the pregnancy school?

1.6 Significance of the study

The findings are expected to raise awareness about the purpose of pregnancy school which focuses on preparing the pregnant woman physically and psychologically for pregnancy, labour and the post-partum period. Also, the information given at the school will equip the woman and her family with the relevant health knowledge during pregnancy in order to increase the self-confidence. Again, it will enlighten the society on the importance of antenatal care services as well as seeking for professional care, early identification of danger signs, birth preparedness and complication readiness, importance of exclusive breastfeeding, essence of spacing children by using family planning method and how to care for the newborn. This will further help the woman, family and society at large to adhere to the instructions given during the pregnancy school and help to reduce the rate of maternal mortality which is the main aim of the pregnancy school organized for the pregnant woman and her family.

This study will help assess the quality of the pregnancy school by examining the impact of pregnancy school on the health behaviour of the pregnant women towards the pregnancy school. Additionally, this study will help identify the importance of social support for pregnant women who attend the pregnancy school especially the support of

the husband since they are the decision makers and also improve on the relationship between the midwife and the clients. Also, the findings of study will help identify the gaps in the organization of the pregnancy school and improve on it since the wellbeing of the pregnant woman is very crucial because it affects the health of the unborn child as well. Lastly, the findings of the study will offer directions for further studies in this area.

1.7 Definition of terms

Midwife- midwife is a person who has completed a midwifery education programme that is recognised in the country where it is located and is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the necessary qualifications to be registered and/or legally licenced to practise midwifery (ICM, 2017).

Pregnancy school- Organization of classes for pregnant women and their partners on a special day aside the normal antenatal clinic day.

1.8 Organization of the Study

The study was grouped into six chapters. The first chapter being the introduction of the background information, the problem statement, purpose of the study, objectives of the study both main and specific objectives and research questions, the significance of the study, definition of terms and the organization of the study.

The second chapter, involved justification of selection of the model, the explanation of the model and the review of literature using the constructs of the model. The third chapter also dealt with the method that used for the study which includes the research design, the research setting, the target population, inclusion and exclusion criteria, the sample size and the technique used for the sampling, tool used for the data collection, the procedure for the data collection, how the data was analysed and managed,

rigor and ethical considerations. The findings of the study were presented in the chapter four and the chapter five discussed the findings. Lastly, in chapter six the following were presented; the summary of the study, implication of the study, implication for nursing and midwifery practice and research, recommendation and conclusion.

CHAPTER TWO

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

This chapter begins with a description of the research model that will guide this study and review of related empirical literature on the health behaviour of pregnant women at pregnancy school.

2.1 Justification for the selected theoretical framework

In the search for models that would better describe what the research seeks to find out, two models on behaviour were reviewed, namely; the Health Belief Model and the Theory of Planned Behaviour. The health belief model was developed by social psychologists Hochbaun (1958) and Rosenstock (1966) was one of the models to be reviewed. It is used to predict health behaviours thus to understand the failure of people to adopt disease prevention strategies or screening tests for the early detection of diseases. The HBM proposes that a person's belief in a personally threatening illness or disease, along with a person's belief in the effectiveness of the recommended health practise or action, will predict their chance of engaging in or completing the behaviour or action. This model was not used because the beliefs about health conditions was not the focus of this study.

The second model reviewed was the Theory of Planned Behaviour (TPB) which was proposed by Ajzen (1985). TPB grew out of Theory of Reasoned Action, which was first proposed by Fishbein and Ajzen (1980). In order to explain all actions over which people have the ability to exert self-control, the theory has to explain how people acquire that ability. The most important component of this paradigm is behavioural intent. Behavioural intentions are influenced by one's attitude toward the likelihood that a particular behaviour would result in the expected outcome, as well as one's subjective evaluation of the risks and advantages of that event. This model was not suitable for the study because constructs of the model do not answer the research questions. The

information-motivation-behavioural skills model (IMB) was found to be useful for this study because its constructs suites the purpose of the study. The IMB model will also determine the direction and methodology for the research study.

The construct and relationship of the IMB model (Figure 2.1).

FISHER/FISHER/HARMAN

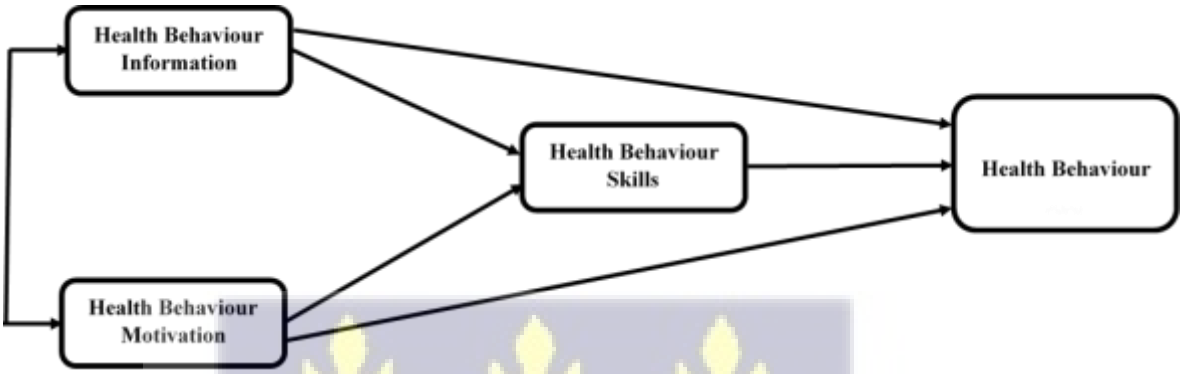

Figure 2. 1: The Information-Motivation-Behavioural Skills Model of health behaviour.
Source: Fisher and Fisher (1992). Changing AIDS risk behaviour

2.2 The Information-Motivation-Behavioural Skills Model

The Information-motivation-behavioural skills model identifies psychological factors that influence the performance of behaviours that have the potential to harm or benefit one's health (Fisher & Fisher, 1992, 2000; Fisher & Fisher, 1993, 1999). It was originally developed to provide an account of the psychological determinants of HIV risk and preventive behaviour. There are four main constructs of the model namely: the health-related Information, motivation, skills and health behaviour (Fisher & Fisher, 1992, 2000; Fisher & Fisher, 1993, 1999).

The IMB model asserts that health-related information, motivation and behavioural skills are important factors of health behaviour performance. Individuals will be more likely to undertake and continue health-promoting behaviours and experience

better health outcomes if they are well-informed, motivated to act, and have the necessary behavioural skills for effective action (Fisher & Fisher, 1992, 2000; Fisher & Fisher, 1993, 1999).

Health Behaviour-Information - According to the IMB model a major factor of health performance is information that is directly related to the performance of health behaviours and that can be easily implemented by an individual in his or her social ecology (Fisher & Fisher, 1992, 2000; Fisher & Fisher, 1993, 1999). In this study, the health behaviour information assessed the knowledge gained and the usefulness of the education.

Health Behaviour-Motivation - The IMB model specifies that motivation is an additional determining factor of health-related behaviour performance, and it can influence whether even well-informed people are willing to engage in health-promoting behaviours. According to the model, personal and social motivations are both major elements in health-related behaviour performance (Fisher & Fisher, 1992, 2000; Fisher & Fisher, 1993, 1999). In relation to this work, the health behaviour motivation of the pregnant woman attending the pregnancy school will be ascertained by examining the motivating factors that contributed to the attendance of the pregnancy school. Thus, whether the commitment towards the pregnancy school was because of social support the participants had and also what influenced participants attitude to participate in the pregnancy school.

Health Behaviour-Skills - The ability of well-informed and well-motivated persons to effectively implement health promotion behaviours is also determined by their behavioural skills for performing health promotion actions. The behaviour skills component of the IMB model emphasizes on an individual's objective abilities and sense

of self-efficacy (Rye, 1990, 1998) when doing a specific health-related behaviour. According to the IMB model, health information and motivation influence health behaviour mainly through health behavioural skills. In general, the impacts of health promotion information and motivation are predominantly observed in terms of the application of health-promoting behavioural skill. This is applied to the initiation and maintenance of health-promoting behaviour (Fisher & Fisher, 1992, 2000; Fisher & Fisher, 1993, 1999). The behavioural skills for the pregnancy school will be to describe the skills acquired through the education received in caring for the baby and whether participants were equipped with knowledge that informed their decision making concerning the pregnancy.

Health Behaviour - When complex or innovative behavioural skills are not required to perform the health behaviour in question, health promotion information and motivation may have direct effects on health behaviour performance (Fisher & Fisher, 1992, 2000; Fisher & Fisher, 1993, 1999). For example, acquiring information or knowledge gained at the pregnancy school can have direct impact on a person's health behaviour likewise the motivation. Also, a pregnant woman's attitude towards the pregnancy school as well as social support gained can affect the health behaviour. In addition, IMB model assumes that health promotion information and motivation as potentially separate constructs. In the sense that well-informed people are not always motivated to engage in health-promoting behaviours, and highly motivated people are not always well-informed about health-promoting practices (Fisher & Fisher, 1992, 2000; Fisher et al., 1994). In the area of the pregnancy school, the health behaviour of the pregnant women will be determined by assessing their adherence to health education given at pregnancy school and the impact on their pregnancy decision and health.

2.3 Literature review

The literature was reviewed using the constructs of the model used and the objectives of the study. The data bases consulted to perform the literature review were, Medline, Wiley Online Library, PubMed, CINAHL, Science Direct, JSTOR and Google Scholar, Articles were included from WHO (World Health Organization). The keywords used in the search for literature were, 'group antenatal care', 'childbirth classes', 'motivating factors for attending ANC', 'barriers in seeking antenatal care', 'benefits of antenatal education', and 'pregnant women behaviour towards antenatal education'.

2.4 The Health Behaviour-Information of Pregnant Women

Fisher et al. (1992) stated that information that is directly relevant to the performance of health behaviour and that can be easily enacted by an individual in his or her social ecology is a critical determinant of health performance. The information received by the pregnant woman through pregnancy health education which is used to improve maternal and newborn survival and positive pregnancy results is absolutely critical. Information received by pregnant women through pregnancy schools impacts greatly their choices concerning the pregnancy, labour and puerperium. It also enables women to control their health on the basis of the knowledge with which they have been equipped through education.

2.4.1 Knowledge of the pregnancy school

According to Taiwo et al. (2013), antenatal education which aims to improve the health of mothers, babies and family, is one of the pillars of pre-natal care. Women and their families are prepared for pregnancy, childbirth and parenthood through health information obtained from antenatal education sessions. On that premise, a study in Northern Iran on pain and anxiety interventions has shown that increased knowledge and skills during pregnancy prepare pregnant women for labour and lead to health promotion. The study

further asserted that during pregnancy and labour, prenatal education and psychological support are extremely beneficial to pregnant women. The recommendation that all pregnant women be educated **(**Firouzbakht et al., 2015). Reiterating further, Widarsson et al. (2012) acknowledges that pregnancy is associated with both physical and psychological changes. Hence, women and their families have to bear and are in better position to go through when they are equipped with adequate knowledge on pregnancy and its related issues.

Furthermore, on preparing for childbirth, Ricchi et al. (2020) findings revealed that the goal of child education classes is to increase knowledge on pregnancies, labour, delivery, parenthood, care of new-borns and effective pain and fear management techniques. A contrary opinion however, on antennal education for childbirth conducted by Cutajar et al. (2020), discovered that misinformation about contractions and the stages and phases of labour did occur during antenatal education. This in turn underscores the importance of strict adherence to purposeful antenatal education. On the issue of stress and other labour induced complications Hollander et al. (2017), were of the view that several factors that influence the occurrence of post-traumatic stress disorder in women after childbirth. Lack of communication and information throughout the prenatal period were among these causes. Women said that if their caregivers had communicated, clarified, or listened more, their painful birth experience could have been averted. Moreover, the findings revealed that the trauma was caused by interactions rather than interventions. As a result, childbirth educators play critical role in educating women and their support people with objective information and skills to help them navigate the birth process.

A comprehensive mental health education that seeks to include the inputs of husbands are seen as beneficial to the pregnant woman. This affirmed in a study by Wei et al. (2015), husbands' exposure to maternal health education and maternal health

knowledge were the most important predictors of their involvement in maternal care. In contrast to earlier studies, husbands' lack of awareness about maternal health prevented positive participation and interest in maternal issues (Kaye et al., 2014; Ampt et al., 2015).

2.4.2 Experiences with the pregnancy classes

According to Mateji et al. (2014), it is critical to understand a patient's experience with health care in order to receive accurate information on the quality of care and to identify problematic areas that could be improved. Also, patient satisfaction reflects the patient's perceptions of several areas of health treatment, such as technical, interpersonal, and organizational components. In order to improve the quality and efficiency of health care during pregnancy, the World Health Organization (WHO) recommends monitoring and evaluating maternal satisfaction with public health care services.

Kamil Dhahi et al. (2015) found that one of the common features of healthcare services is assessing patients' satisfaction. The lack of a tour of the maternity ward was linked to the lowest level of happiness in their study. Also, anxiety and depression in three groups of primiparous pregnant women not attending, irregularly attending, and regularly attending childbirth preparation programs. Hassanzadeh et al. (2021) notes that women's satisfaction with childbirth classes is just as crucial as their knowledge. It further remarked that women regard childbirth preparation classes as a constructive procedure for preparing them for childbirth. Again, women who attend on a regular basis report that childbirth preparation classes lessen their worry about labour. The participants in the Vamos et al. (2019) study evaluated the information relevance based on their participants' personal circumstances, values and views, and gestational age. The findings revealed that it was beneficial to have information arranged in meaningful pieces, such as gestational age and/or trimester, to reduce worry. The vast nature of information was frequently overwhelming and contributed to stress.

Additionally, the results of a study involving 132 primiparous women in Turkey showed that women who attended childbirth preparation classes had a greater level of knowledge, responded better to their labour pains, and started nursing earlier (Pinar et al., 2018). Another study found that 96.3 percent of women who took childbirth lessons expressed satisfaction with their sessions and found them to be extremely beneficial. These women were most pleased with the facilitator's performance, the utility of relaxation techniques, breathing techniques, and the overall effect of the lessons (Ricchi et al., 2019). Given that one of the predictors of stressful birth is fear and anxiety, taking birthing courses on a routine basis might help women have a better labour experience (Ghanbari-Homayi et al., 2019). According to Meedya et al. (2020), delivering technology-based education has been increasingly popular in the previous decade and may be regarded an alternative to face-to-face education during the COVID 19 pandemic.

However, many Iranian women who utilize public health care lack access to a mobile phone or high-speed internet, making education more difficult for those who need it the most. On the other hand, research published by Brixval et al. (2015) concluded that there is insufficient data to determine if prenatal education in small groups is helpful in terms of obstetric and psychosocial outcomes. They advocated for well-conducted, low-bias randomized controlled trials. These studies did not come to the conclusion that childbirth education is worthless. The topics covered, the objectives, the overall number of hours, the amount of time spent on each topic, and other aspects of the classes were all inconsistent. It was impossible to come to any meaningful conclusions. The substance of lessons varied based on the demographics of the students, the sponsors' aims and objectives, and the instructors' points of view (Simkin, 2017).

2.4.3 Usefulness

The mother's physical and emotional readiness for childbirth is aided by childbirth preparation education. Childbirth education programs help mothers overcome their concerns by improving their understanding about pregnancy, childbirth, and the postpartum period (Afshar et al., 2017; Pinar et al., 2018;). This gives them confidence in their capacity to bear labour pain. Stressing further, ample evidence has also indicated that attending childbirth classes lowers anxiety before delivery and promotes appropriate pain responses. A study on a psycho-education intervention by midwives in reducing childbirth fear in pregnant women found that training women can increase their confidence in their ability to cope with childbirth and labour pain (Toohill et al., 2015). The study further reiterated that this helps to reduce medical interventions during childbirth, medical costs, and improve maternal health.

Pregnant women frequently attend prenatal education classes to learn about different birthing options, pain management techniques, baby care, postnatal care, breastfeeding, and parenting (Stoll et al., 2012). Marufa et al. (2019) also noted that peer-to-peer information sharing is a significant finding of their research. First-time mothers benefited from hearing from experienced mothers who shared their experiences and learnt about typical discomforts and difficulties. The study also found that knowledge obtained through group prenatal care helped pregnant women become more aware of their own health and empowered to make healthcare decisions. Hence, influencing their family members who might otherwise discourage them from attending check-ups. According to Vilda et al. (2019), medical professionals offering basic information to women from lower socioeconomic backgrounds, will reduce misunderstanding between doctors and patients.

A study by Duncan et al. (2017) and Pinar et al. (2018) findings indicated that improving pregnant women's knowledge about labour, delivery, and pain-coping methods

can improve their self-efficacy in tolerating labour pain. Hassanzadeh et al. (2020) went on to say that improving women's understanding through prenatal education can help them prepare for childbirth. Furthermore, it will enhance their health, and that a lack of information and fear of the unknown during pregnancy and labour causes mothers to be frightened and nervous. After the adjustments for spouse's education, income, occupation, spouse's occupation, spouse's support, and marital satisfaction, the results revealed that the mean scores of childbirth fears, anxiety, and depression were significantly lower in the regularly attending group than in the non-attending group. Pinar et al. (2018) said that mother anxiety, sadness, and dread are linked to issues including preterm birth and low birth weight. Furthermore, babies delivered to mothers who are afraid and nervous are more likely to have weakened immune systems (Kiruthiga et al., 2017). Each childbirth educator went over the three stages of labour and contractions in great detail. As evidenced by the number of information statements, stage one attracted the most attention. Because early labour, established labour, water breaking, and contractions were all mentioned in the first stage. Each educator included definitions for early and established labour, as well as information aimed at teaching women and their partners how to recognise the stages and stay at home until labour is established. The findings of Cutajar et al. (2020) and Ferguson et al. (2012) concluded that antenatal education had a favourable effect in reducing false labour admissions.

However, according to Lincetto et al. (2012), antenatal care allows women and their families to obtain relevant information, such as information on healthy pregnancy, safe delivery, newborn care, postnatal healing. In addition, initiation of early breastfeeding, as well as making decisions about future pregnancies and improving pregnancy outcomes.

2.4.4 Views on number of appointments

Relating to views on the number of appointments, there was general lack of broad-reaching rules or criteria for arranging classes in the literature, the number, manner, and substance of sessions frequently differ (Ricchi et al., 2020). Marufa et al. (2019) used a mixed method approach to conduct qualitative study on group prenatal care experiences among pregnant women in a Bangladeshi community. According to the findings, the service provider generally only has a limited amount of time with each patient. The participants further added that, the providers are only able to answer a few of the patient's concerns or offer just the most basic facts during consultation. In contrast, however, Dinç et al. (2015) found that inadequacies such as too much information given in a short time, educational content tailored to the preferences of trainers rather than the needs of women. Furthermore, insufficient time to discuss transferred information, and non-practical reinforcement of relevant theoretical information may lead to antenatal education failing. Their findings also highlight the disparities in the goals, substance, and duration of prenatal education programs, indicating that current norms and guidelines are insufficient. Furthermore, research from low- and middle-income countries found a negative relationship between satisfaction with services and the length of time women spent at the health facility prior to delivering (Bitew et al., 2015; Srivastava et al., 2015).

2.5 Health Behaviour-Motivation

Health behaviour motivation construct focuses on motivational factors which is a person's personal attitude towards performance of health promotion behaviours. The social support for enactment of health promotion behaviours are all critical influences on performance of health-related behaviour. The purpose of the pregnant school is to help the pregnant woman to develop an attitude of making timely and good decision concerning the pregnancy. The pregnant women are not to be coerced to attend the pregnancy school but

rather helped to make an informed decision based on the pep talk given at the antenatal clinic to participate in the pregnancy school.

Personal motivation- This is a concept under the motivation constructs in the IMB model which focuses on intrinsic factors (of the pregnant women) that informs their attitude towards attendance of the pregnancy school. Considering the findings from Rasouli et al. (2016) it was noted that the childbirth preparation classes approach emphasizes on assisting a client in making their own decision to change. This beneficial rather than the client being forced by outside sources with attempts to convince or compel them to change. In motivational interviewing approaches, the findings revealed that the study participants had a key impact in establishing the desire to prepare for delivery by increasing the participants' intrinsic motivation. Exercises in decisional balancing helped women consider the benefits and drawbacks of preparing or not preparing for delivery. This exercise aided their progress in the direction of good development. When women chose to modify their behaviour, the counsellor assisted them in making plans to attend childbirth preparation classes and encouraging them to attend.

2.5.1 Social support received

Another integral concept under the motivation construct in the IMB model is social motivation which focuses on the variables that impact a pregnant woman's decision to attend pregnancy school. This type of assistance might come from the husband, partner, family, and friends. Social deprivation and social isolation negatively affect maternal health, which can lead to an increase in maternal death Upadhyay et al. (2014). Also, social marginalization and isolation have a negative impact on maternal health, which can contribute to an increase in maternal mortality (Morgan et al., 2014).

Regarding the role men play in reproductive and sexual health WHO (2014), it was noted that a steady increase has been recognized and seen as an important step in meeting men's needs, supporting women's health, and improving family health. Given men's role in decision-making, the importance of involving them in reproductive health programs has gained recognition since the mid-1990s. Furthermore, men's participation in reproductive and sexual health has increasingly been recognized as an important step in meeting men's needs, supporting women's health, and improving family health. Both women and their husbands impacted the decision to use ANC and delivery care although husbands were more influential, especially in teenagers and young adults (Esena et al., 2015). Besides the foregoing, the mother-in-law may have a role in influencing the choice to seek maternal health care (Some et al., 2013). Community-based research in Mali discovered that the traditional belief by mother-in-law in home delivery impacted the delivery location (White et al., 2013). This might be because the study was done in an urban environment, whereas the other three studies were conducted in rural regions where traditional culture still exists and gives the mother-in-law more control over household and health choices (Thapa et al., 2013; White et al., 2013).

In Nepal, research on the influence of spouses' participation in prenatal health education programs on maternal health knowledge found that women educated with their husbands had nearly double the knowledge level of women educated alone (Mullany et al., 2009). Fathers who received breast-feeding education and counselling had higher levels of breast-feeding knowledge, more positive attitudes toward early initiation of breast-feeding. Also, the fathers had a higher likelihood of actively supporting exclusive breast-feeding during the antenatal and postpartum periods than fathers who did not, according to a study in rural Vietnam (Bach et al., 2017). Furthermore, a study carried out by August et al. (2016) found that the intervention was associated with increased male

involvement in maternal care (from 39 % at baseline to 81% postintervention). In this study carried out in Tanzania, where health workers visited families at least four times during a woman's pregnancy and delivered home-based life-saving skills training to those women, their husbands, and other family members. During pregnancy, delivery, and the postpartum period, both men and women showed higher levels of understanding of at least three signals of risk.

Similarly, in a community participatory action program in Mozambique, Audet et al. (2016) deployed community health workers to involve males in prenatal care services and improve HIV testing and treatment uptake among the participants. The staff created a male-friendly clinical setting and offered couples therapy sessions. Male companionship during initial prenatal care (from 5% to 34%) and any antenatal care appointment (from 10% to 37%) increased after the intervention. This is also the case as did HIV testing among pregnant women (from 81 percent to 92 percent) and male partner HIV testing during antenatal care appointments (from 9 percent to 34 percent). In addition, accompanying a partner to prenatal care sessions was linked to a considerably higher likelihood of giving birth in a health facility (odds ratio, 19.4). According to a study done by Chikalipo et al. (2018), both men and women prefer to talk about the care of pregnant women. This is most likely because men and women were aware that care had an impact on pregnancy outcomes, necessitating the need for greater knowledge among couples to assist one another.

2.5.2 Motivation to partake

Concerning the issue of motivation to partake in the pregnancy school, it was revealed by Yargawa et al. (2015) that women who had support from their spouses and other social relatives were more likely to utilize ANC. This emphasizes the necessity of engaging married men in initiatives aimed at increasing ANC use, as male engagement has been

shown to enhance maternal health. However, one of the researches included in this analysis revealed that women who are currently single had a higher likelihood of hiring experienced ANC attendants. (Tarekegn et al., 2014.) One explanation is because unmarried women have sole decision-making authority, allowing them to seek and utilize ANC. Tierney et al. (2015) and Nicoloro-Santa et al. (2018) found that health care providers were the most desired source of information because they were perceived to be credible and reliable, which is consistent with previous research identifying them as the most influential sources for women's decision-making during pregnancy.

2.5.3 Impact of education on social support received

On the issue of the impact of education on social support received, a study undertaken by Serhatliolu et al. (2018) found that women who engaged in prenatal education with their husbands got emotional support from them during the labour process. According to the data, encouraging women and their spouses to attend childbirth education classes (CEC) is critical. Furthermore, training and counselling will help women develop their problem-solving abilities, expand their knowledge, stimulate active decision-making, raise their sense of control, and boost their self-confidence. Furthermore, regardless of who provided the continuous care, Hodnett et al. (2012) discovered that women who got continuous labour assistance were more likely to give birth spontaneously. The same were less likely to need pain medicines, were more likely to be satisfied. Moreover, when discussing support of partners in labour, positive suggestions were the primary language technique used by all three educators. The positive suggestions include 'they need to bring that confidence', that can-do attitude and dads and support partners were the oxytocin warriors, and were seen as keepers of the birth space (Cutajar et al., 2020). The inclusion of positive suggestion is important as parents will form their expectations based on how

antenatal information is communicated, which may be a key determinant of their subsequent experience (Hollander et al., 2017; Sercekus et al., 2016).

According to Leap et al. (2016) in their guide for supporting women and labour for birth mentioned that merely having someone in the room, or being there, was enough to shorten the labour. Touching on the same subject matter Hollander et al. (2017) and Sercekus et al. (2016) also made a very critical observation that positive advice should be included since parents' expectations. To that effect, this will be formed based on how prenatal information is presented, which might be a significant predictor of their later experience women who had previously given birth showed more confidence in giving birth again. Avery et al. (2019) also mentioned that spending time preparing for the delivery through talks with support people, completing a refresher class, or reading material. The findings of the study reveal that, several factors influenced women's sentiments of trust in physiologic labour and birth. Although many women went into pregnancy thinking their bodies were capable of giving birth, a range of perceived supports helped them acquire an inherent feeling that they could accomplish it and that their bodies were designed to give birth naturally.

2.5.4 Quality contact: Client-Midwife

Dwelling on the quality of contact between the midwife and her client, Dagmawit et al. (2020), in their acknowledgment of the fact emphasized that the majority of their respondents (87.8%) said that care providers were courteous. Clients who were regarded by health-care personnel were also strongly related with satisfaction, according to the researchers. During the birth, the midwife plays an important role in offering support and encouragement to the lady, as well as developing her confidence in her abilities to execute her new position as mother (Ricchi et al., 2020). In a like manner, midwives and nurses play a critical role in educating pregnant women and their families about childbirth

options and assisting them in making informed decisions. Women expect antenatal and postnatal care advice as well as delivery preparation training from a nurse or midwife (Laila et al., 2020). Similarly, Gao et al. (2019) found that attending birthing courses was linked to a better interaction with medical personnel and higher breastfeeding success.

Contrasting interpersonal relationship with the availability of infrastructure, Mueller et al. (2020) found that interpersonal interactions with nurse-midwives and personal privacy have strong associations with childbirth satisfaction. This is also true with the positive impact of being able to interact with nurse-midwives and having privacy during the hospital stay outweighing the negative impact of not having proper infrastructure. This conclusion is consistent with earlier research, which has found that the procedures surrounding labour have a greater impact on birth satisfaction than material components of care (Ferrer et al., 2016; Srivastava et al., 2015). To this end the WHO acknowledges that appropriate utilization of effective clinical and non-clinical treatments, enhanced health infrastructure, and optimal skills and attitudes of health workers (Tunçalp et al., 2015).

Further stressing the point, Avery et al. (2019) noted that women's connections with their maternity care providers, such as doctors, midwives, and other clinic personnel, were crucial in helping women feel prepared for labour and delivery. Notwithstanding the study further revealed that women valued the opportunity to ask questions, learn about pregnancy and what to anticipate during labour and delivery, get parenting and postpartum information, and discuss birth choices. The findings discovered that it was helpful, comforting, and unhurried midwifery care were especially noted, and that women occasionally described a physician or midwife with whom they did not have a strong bond. Women's confidence in labour and birth was boosted by maternity care provider interactions in which they got information, were given alternatives for care, and were

involved in care decisions and labour and birth plans. Underscoring further, the critically relevant relationship between the expectant woman and the midwife, Nicoloro – Santa et al. (2018) in their research came up that participant provided concrete instances of how they used material that they had obtained and assessed. Participants reported how this knowledge influenced their patient-provider communication experiences by affecting the creation of questions they would subsequently ask their health care providers.

Furthermore, prior study has indicated that women who prepare questions for their meetings are more likely to begin patient-initiated dialogues, resulting in patients revealing more information with their health care providers. Furthermore, Børøsund et al. (2014) discovered through their study that their participants felt more confident in their communication with health care professionals. And to that effect increases patients' overall satisfaction with the quality of their health care and their mental and physical health. Attitudinal change is another invaluable construct that the health behaviour motivation assesses. The overall effect of education on the paramount on a number of factors pertaining to how pregnant women make lifestyle changes after they receive the education. Adding to this, Christenson et al. (2018); Connor et al. (2018) stressed that pregnancy is a period when many women are motivated to make health-related changes. This quest may lead to the exposition to extra health information and services, such as information provided by prenatal health care professionals and information found on the internet.

This is further seen in the study according to Vamos et al. (2019), which emphasized that health care practitioners who have been educated in patient-centred counselling and cultural competency may treat patients with respect and respond to their needs and concerns. Participants in this study also discussed how such knowledge influenced their health-related decisions, such as nutrition and newborn care.

Furthermore, this knowledge provided as crucial anticipatory advice, preparing women for future pregnancies, births, and infant-rearing experiences.

2.6 Health Behaviour-Skills

The next construct of the IMB model to examine is the health behaviour skills which asserts that, behavioural skills for performance of health promotion actions are an additional critical determinant of whether well-informed and well-motivated individuals will be capable of effectively enacting health promotion behaviours.

2.6.1 New skill acquired

The acquisition of new skills and how they are put to good use by pregnant women is an integral component of the health behaviour skills. Skills learned through childbirth education have the potential to impact positively on the overall wellbeing of the expectant mother. According to Nazik (2017) stretching and posture correction exercises, relaxation methods, massages, and breathing techniques are among the skills taught to women. Adding to this, a similar childbirth education class have been on offer to women in Turkey, Australia (Levett et al., 2019) and in Italy (Ricchi et al., 2020). To reduce neonatal morbidity and death, mothers must be educated on proper newborn care practises. Parents' newborn care practises are key factors of neonatal death (Amolo et al., 2017).

2.6.2 Identification of danger signs

Further, the skills also looked to create awareness of danger signs during pregnancy. This is seen in a study carried out by Hibstu et al. (2017) which asserted that participants' awareness of obstetric danger signals was tested by asking them to name the danger signs that can occur during pregnancy, birth, and post-partum. Then, if a woman mentioned at least three significant risk signals for each of the three phases, she was considered informed. Women with at least an elementary education were more likely than those

without any formal education to be aware of obstetric danger signs. This discovery is in line with prior research conducted in Ethiopia's Tsegedie District, Tigray Region (Haliu et al., 2014). Previous research in Tanzania and Ethiopia likewise found a low prevalence of knowledge of danger signs (Maseresha et al., 2016; Urassa et al., 2012). Because difficulties can emerge at any time throughout pregnancy, every woman should be aware of the danger signs. Vaginal bleeding, severe headaches, visual issues, high temperature, swollen hands/face, and decreased foetal activity are all warning symptoms (Kearns et al., 2014).

Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) Tanzania remarked that, taking the proper steps to seek medical help means receiving prompt and adequate care, which lowers maternal mortality and morbidity. When women visit an ANC clinic, they should receive health education on pregnancy, including outcomes, danger signs throughout pregnancy, nutrition, and family planning, and other services (MoH, 2015). Vaginal bleeding was the most frequently stated danger sign of pregnancy (81.2%), maybe because it is the most obvious indicator compared to other signs like decreased foetal movement (Mwilike et al., 2018). Women, their partners, and the community as a whole need to be informed on obstetric danger signs so that they can seek timely care from qualified experts. One of the reasons women fail to recognize and seek appropriate emergency care is a lack of understanding of the significance of symptoms of obstetric complications. As a result, assessing women's awareness of obstetric danger signs and associated factors helps them learn more (Dessu et al., 2018).

2.6.3 Decision making process

Birth preparedness and complication readiness is a commonly utilized technique in low-resource nations to encourage the timely utilization of competent maternal and neonatal

care, particularly during childbirth. Certain important aspects related to child preparedness are regarded as cornerstones of birth preparedness and compilation readiness. These include raising awareness of danger signs; improving problem recognition and reducing delay in seeking care; choosing a birth location and provider in advance; knowing the location of the nearest skilled provider. Obtaining basic safe birth supplies and identifying someone to accompany them to the facility are also relevant (JHPIEGO, 2014).

The research further stressed that women in their research who were engaged in group care reported much greater rates of discussing where to deliver with the midwife, planning emergency transportation in the event of a difficulty, and saving money for their birth. For certain features, the husband's engagement in birth preparation was noticeably low. For example, spouses were found to be less involved in organizing transportation to the birth location (52.1%), obtaining a safe delivery kit (21.1%), and arranging for a possible blood donor (21.1%). Husbands frequently assume that health centres will supply all essential delivery supplies. As a result, low birth-preparedness for particular traits may be a result. Birth preparation kits have been shown to be an effective method for reducing maternal mortality in obstetric crises. Noting further however, the study pointed out that in Myanmar spouses are unfamiliar with the features of birth readiness, and awareness should be promoted not only for women but also for their partners. This might be related to the fact that in some regions of Africa, males do not help their pregnant wife since they are perceived as weak if they do (Kaso et al., 2014).

According to the study undertaken by Munguiko et al. (2019), it was revealed that pregnant woman who drew and discussed her birth plan with her spouse was nearly 2.0 times more likely to prepare for childbirth than a woman who did not engage her spouse. This is likely due to the fact that the practice enlists the male spouse's participation and

motivates him to assist his female companion. Furthermore, because it is a cultural practice in most African communities that a man is the family's chief executive and, as a result, he controls the family's income and expenditure. Involving him therefore in child birth planning brings on board the money that is desperately needed to procure all elements of BP. The study further went on to say that pregnant women who were led by their spouses during prenatal appointments were 1.7 times more likely than those who were not escorted to prepare for childbirth. This might be because men who participate in prenatal care are more likely to be educated about birth preparation, which increases the probability that men will assist their women in doing so. Our research also found that respondents who received health education on birth preparedness at an ANC visit were 1.9 times more likely than those who did not to prepare for skilful birth. This is because health education improves a woman's awareness of the importance of preparing for childbirth before the due date (Hiluf et al., 2008).

Moreover, because it is impossible to anticipate which pregnant women may have life-threatening obstetric difficulties, one of the most significant interventions in safe parenting has been to encourage all pregnant women to plan to seek expert delivery services as soon as feasible (Mukhopadhyay et al., 2013). Pregnant mothers who received prenatal training had a lower risk of caesarean birth, according to many studies (Cantone et al., 2018). Anxiety experienced at delivery was decreased (Miquelutti et al., 2013), childbirth-related self-efficacy rose, and fear of delivery reduced (Hong et al., 2020) mothers were more active during childbirth, and epidural anaesthesia was used less frequently. Childbirth education classes assist in making decisions regarding labour and delivery, pain management, and breastfeeding and parenting (Simpson et al., 2010; Stoll et al., 2012). Childbirth education programs also teach women how to recognize unforeseen problems that might lead to maternal death, such as gestational hypertension,

postpartum haemorrhage, and infection (Firouzbakht et al., 2013; Malata et al., 2007; Pinar et al., 2018;).

However surprisingly, Afshar et al. (2018) notes that having a birth plan, on the other hand, was not linked to an increased risk of chorioamnionitis, perineal lacerations, or postpartum haemorrhage, all of which may be considered obstetrical interventions. According to section 1.9 of the WHO (2006), healthcare professionals must include information about labour symptoms, danger indications throughout pregnancy, and emergency transport for newborn babies with problems during ANC. It also urges pregnant women to create a birth and emergency preparation plan. Similarly, this was also noted by Lori et al. (2017) in their research study which sought to explain that pregnant women are aware of danger indications in pregnancy and have established a birth and emergency preparation plan, among the process and outcome indicators for these criteria. On a similar premise, Haftom et al. (2015) observed that, including risk indicators in birth preparedness and complication readiness plans during couple prenatal education is important. This, it notes is likely to enhance male partners' engagement in satisfying the expectations of BP/CR. In like manner, a similar study by Chikalipo et al. (2018) highlighted that majority of participants they interviewed during their survey indicated birth preparations and complication readiness plan (BP/CR). This however, concentrated on goods to acquire in preparation for childbirth as a preferred topic, with a minority recommending the addition of danger signs throughout pregnancy.

2.6.4 Benefits of skills gained

Having gained the requisite skillset as a result of the prenatal education, an evaluation of the impact such skills bring to bear of the expected mother may be evident in the overall wellbeing of the mother and the baby. Numerous studies have shown that women who attend childbirth education classes are better able to manage anxiety during labour and

delivery. A study by Herberlein et al. (2016) showed the beneficial effects and thus revealed that moms who attended the GANC in the postpartum period were capable and prepared to handle their own transition to parenthood.

Similarly, Berge et al. (2019) found that participants in Minnesota felt they received a lot of knowledge, which prompted them to attempt new health behaviours, and they also suggested that group prenatal care be continued and expanded to additional clinics. It is also refreshing to note that according to Lori et al. (2017) a cohort study on improving health literacy through group antenatal care, there was a significant difference between women enrolled in group antenatal care versus individual antenatal care. This highlighted the differences in terms of preventing problems before delivery, understanding when to seek care, birth preparedness and complication readiness, and intent to use a modern method of family planning. GANC participants increased their health literacy by demonstrating a better knowledge of how to operationalize health education messaging.

An empirical research work carried out by Pinar et al. (2018) showed that women who took childbirth preparation classes were better able to adjust to labour discomfort, used less labour medications, and had fewer instrumental births. Furthermore, those engaged in the group ANC style of care were able to report substantially more favourable breastfeeding habits than women receiving individual care. Only 23.5 percent of mothers engaged in personalized care said they discussed infant issues with the midwife during ANC visits. However, the majority of maternal and newborn fatalities occur within the first month of life, with half of all maternal deaths occurring within the first 24 hours and 66% occurring within the first week this is according to a study undertaken by (Lawn et al., 2014).

Recognising the benefits gained from the prenatal education Rai et al. (2012) revealed that prenatal check-ups enable for the early detection and treatment of problems as well as the education of the expectant woman on how to manage her current pregnancy and the health benefits of spacing pregnancies apart. Difficulties that are addressed at the first indication of a problem can improve outcomes for expecting moms, therefore it is critical for a pregnant woman to be informed enough to seek medical attention for any potential complications. Also, guidance that not only focuses on providing information, but also on preparing women and their partners for delivery, including strengthening women's confidence in their capacity to labour and give birth was issued (National Health and Medical Research Council, 2018).

Additionally, women's birth experiences, according to Savage (2001), involve the transmission of wisdom from one who knows to others who need to know. This was demonstrated in the group when one of the women was expecting her third child. The woman offered her birth stories, which were integrated into the birthing educator's curriculum. The woman's experience about a posterior delivery in particular enriched and contextualized the educator's knowledge on prenatal posture for the class (Cutajar et al., 2020). Moreover, according to Kay et al. (2017), when women hear good birth experiences, they learn about the strength and power of delivering and may feel more confident in their physiological ability to give birth. Women who hear bad birth stories, on the other hand, may connect delivery with pain, danger, and dread. In addition, evidence suggests that knowing about delivery lessens fear, boosts confidence, and improves the desire for vaginal birth (Hassanzadeh et al., 2019).

According to a research analysis conducted by the University of Canberra's Faculty of Health, Disciplines of Nursing and Midwifery, prenatal education throughout pregnancy decreases anxiety during labour and delivery and improves partner engagement

(Ferguson et al., 2013). A prenatal course given by the British National Health Service led to significant reductions in stress, anxiety, and depression symptoms among pregnant women and their partner (Warriner et al., 2018). Prenatal education appears to decrease anxiety of labour and post-traumatic stress disorder symptoms after delivery (Isbir et al., 2016). On the contrary, it is well understood that the advantages of prenatal education are difficult to assess in a systematic way, and that more study is needed to establish the true impacts and agree on valid efficacy measures. Data collecting standards, various techniques and types of classes, and the influence of what happens during labour and delivery all appear to be contributing factors (Ricchi et al., 2020). Nonetheless, numerous studies such as the ones carried out by Hatamleh et al. (2019) and Makvandi et al. (2018) agree that women who attend classes have a lower risk of caesarean section. Moreover, they are less likely to request epidural analgesia and use alternative pain relief techniques, are more likely to be present at the hospital in active labour, breastfeed exclusively and for longer, and have a lower risk of postpartum emotional distress.

2.7 Health Behaviour

The information-motivation-skill on the health behaviour outcome is important in explaining the relevance of the information and skills the pregnant received at the pregnancy school as well motivating factors that contributed to the attendance of the pregnancy school.

2.7.1 Outcome of health behaviour

A study conducted by Lavett (2015) to evaluate the effectiveness of a complementary therapies antenatal education package provides evidence that antenatal education using complementary therapies CM techniques. This includes acupressure; yoga; massage; visualisation/relaxation; breathing techniques; continuous partner support; as well as education about normal birth physiology. To add to these, standard antenatal care is an

effective and viable method of managing pain during labour, increasing personal control for women, enabling partners and midwives to provide appropriate support. These thereby reduces some medical interventions and increases the normal birth rate. According to Zere et al. (2012), women who attend four or more ANC visits are more likely to deliver with the help of a professional. On the one hand, frequent ANC attendance reduces maternal mortality by assisting in the early detection of obstetric problems, and on the other hand, it influences women's decision to seek expert delivery support.

Moreover, information that allows mothers to grow and retain their well-being during pregnancy, as well as not only the dissemination of key information for promoting the health of mothers, but also the areas where the given information will be put into practise. They further said that the mother's cognitive abilities, which will allow her to gather information and utilise it to positively influence her life, are also important (O'Neill et al., 2014). Some antenatal education programmes, in addition to covering physiological changes during pregnancy, also cover emotional changes, but this is said to be less prevalent (Godin et al., 2015; Sercekus & Mete 2010). However, including information on emotional or psychological wellbeing following the delivery of the baby appeared to be more common (Brixval et al., 2016; Duncan & Bardacke 2010; Koushede et al., 2017; Svensson et al., 2009; Visger et al., 2009; Walker & Worrell 2008).

2.7.2 Expectation

Indeed, seeking to improve also leads to various expectation. According to Jakubiec et al. (2014) primiparous women experience more stress as they adjust to their new position as a mother who cares for her child. These women are more likely to enrol in childbirth education programs. On the other hand, men and women had equal prenatal information requirements, according to our findings. However, both men and women in this research favoured aspects such as caring for a pregnant woman, giving birth, baby care, and family

planning. Male participants, on the other hand, were more interested in sex and men's responsibilities during the perinatal period, PMTCT, and family life than female participants, who were more interested in birth readiness (Chikalipo et al., 2018). Conversely, unlike previous research from western contexts, participants did not list emotional support for males as a favoured topic (Smyth et al., 2015).

Providing further insight, a couple of studies have divulged how pregnant women evaluate and utilize health information. Participants in this study were aware that information may be inaccurate or biased, and they stated that they confirmed the accuracy of information using various sources. Other research has confirmed the importance of women being aware of potential misinformation outside of the clinical setting. This further stress the need for health care providers to be prepared to counteract patients' false information, particularly in societies where the internet is becoming more prevalent (Bert et al., 2016; Leiferman et al., 2014). In Sweden, Ahlden et al. (2012) polled 1117 women and 1019 partners on their intentions to attend antenatal education programmes. More information on preparation for parenting and newborn care was reported by both women and their spouses than on preparing for the birth itself. Others suggest that women in antenatal education programmes want greater knowledge about newborn care, parenting support, and breastfeeding (Martinez & Delgado, 2013; Moniz et al., 2016).

2.7.3 Impression

On the issue of impression in an ever-evolving technological world, research has shown that communication that employs extra resources such as eHealth apps and patient-provider communication that integrates health literacy concepts can be beneficial. These enhance obtaining, understanding, using, and evaluating health information (Best et al., 2018; Wittink et al., 2018). Furthermore, participants also discussed what made health information during pregnancy simple or difficult to grasp, such as the use of common

language rather than medical jargon (Vamos et al., 2019). According to previous research, clear language and audio and visual aids make health information more understandable (Coley et al., 2018).

Woman-centred care in the prenatal context is especially essential, since it enables two-way communication between the health care practitioner and the woman, allowing women to express questions when they don't comprehend information (Ledford et al., 2016; Washington Cole et al., 2016). This study's findings emphasize the importance of health care professionals welcoming and not dismissing women's inquiries in order to improve communication and overall satisfaction with the visit. Smith (2015) express worry about antenatal classes being used to ensure that women were aware of, and hence compliant with, hospital policies and procedures. Furthermore, many claims that class content has always been based on what educators believe women need rather than what women want (Hanson et al., 2009; Svensson et al., 2007; Tighe, 2010).

2.7.4 Ways of improvement

In spite of the foregoing, it has been noted that dealing with isolated instances of inconvenience that occasionally characterizes the delivery of the childbirth education would improve confidence of women and increase participation. Highlighting some of the inconveniences, Metinoğlu et al. (2021) notes that inappropriate sounds, background noise, the temperature of the room, inappropriate lighting, and lack of respect for privacy contribute to disturbances in focus. For instance, women who took part in CEC were given knowledge and practices relating to visualization, breathing, and attention methods in this study. These strategies allow these women to tune out external distractions and concentrate only on their bodies and the delivery process. Women's capacity to reach this trance-like state is aided by factors such as prenatal education, a secure and secluded setting, and ongoing support.

Looking at ways to improve current research and standards, health care providers should consider the language they use while delivering care (Mobbs et al., 2018; WHO, 2019). In that same regard, Nolan (2009) recommends that an optimal group size of twelve to twenty adults will be suited for the greatest discussion and interaction within a group. The Department of Health in Australia highlighted small classes as a characteristic that parents like because they foster social networking and are less frightening than big groups, making it simpler for women and their partners/support people to ask question (MRC, 2018). Future research should consider how to effectively combine hybrid health promotion that employs both mobile applications to give rapid, on-demand health information and patient-centered education and counselling, based on the findings of this study. These initiatives may aid and verify the use of correct health information by pregnant women, resulting in more informed decision-making. Such hybrid interventions can offer women with patient-centered information in forms they prefer, while exploiting the on-demand benefit of mobile apps and utilizing health care providers' time effectively, as noted by Vamos et al. (2019).

Part of the educator's role should be to tell their students about evidence-based practices that aren't being followed, as well as to provide direction on how to successfully communicate and negotiate with their caregivers about their preferences (Simkin et al., 2016). Respectful adult dialogue can occasionally end in pleasure for both parties, even if it isn't always effective. Family life is another suggested topic to address during prenatal education, according to Axelsen et al. (2014). Despite the fact that marital conflict has been related to the perinatal phase (Polomeno et al., 2014), stressors include a lack of sexual relationships, unfamiliar baby care, and adapting to parenting. As a result, healthy family relationships are critical for male engagement in spheres labelled as feminine domains (Nyondo et al., 2014). It is also quite evident that geopolitical location of women

plays a vital role of their respective improvement desires. For instance, women in Sweden desired more knowledge on postpartum issues including breastfeeding issues, whilst males sought information on infant care skills, sexuality, and relationships (Anderson et al., 2017). Contrarily, women in Nigeria, on the other hand, wanted their husbands to learn about the impacts of pregnancy on women, how to care for a pregnant woman, how to be patient and understanding with their partner, and how to have sex during pregnancy (Adeniran et al., 2015).

Evidence also suggests that tailoring instructional content to the requirements of program participants can lead to the creation of suitable and culturally acceptable information (Axelsen et al., 2014). However, according to Opondo et al. (2016), it is not just the father's physical activities that are beneficial to the infant, but also the father's emotional condition. If male engagement is to improve, we believe that fathers' preparation for their responsibilities should go beyond knowledge and skills and focus on the emotional element. This might be accomplished by highlighting to couples the advantages of male engagement in prenatal education (Chikalipo et al., 2018). There are a range of delivery formats available, including one-on-one sessions, small group or large group classes, integrated prenatal care groups with formal education possibilities (antenatal groups), and even online programmes, in addition to a choice of providers. Multiple birth classes, 'young mum's classes,' classes for father's/partners, same-sex couple classes, and in some regions, sessions for grandparents are available Childbirth and Parenting Educators of Australia (CAPEA, 2017; NSW, 2016; RCN, 2017).

Relaxation, meditation, controlled breathing, and yoga were all incorporated in some antenatal education programmes. Complementary therapy such as acupressure, relaxation, breathing techniques, massage, and yoga have lately been studied. Participants in a randomised controlled experiment comparing a prenatal education programme that

included complementary therapies with a standard programme had considerably reduced rates of epidural usage and caesarean section in the integrated programme (Levett et al., 2016). There is still evidence that health professionals have power over the organisation, scheduling, and content of antenatal education programmes, and there has been a reluctance to alter in the past (Gilmer et al., 2016; Hanson et al., 2009; Svensson et al., 2007; Tighe 2010). When creating new antenatal education programmes, consider conducting a needs assessment in the community where the classes will be held to ensure that the program's content and structure meet the needs of prospective respondents (Queensland Health, 2018).

There continues to be evidence to suggest that health professionals maintain control over the structure, timing and content of antenatal education programs and in the past there has been a reluctance to change (Gilmer et al., 2016; Hanson et al. 2009; Svensson et al., 2007; Tighe, 2010). When developing new antenatal education programs, thought should be given to undertaking a needs-assessment in the community where the classes will be offered to ensure the content and the structure of the program fits the needs of potential attendees (Queensland Health, 2018). Because it is widely acknowledged that a size fits all approach to antenatal education does not work for women, evidence supports allowing flexibility in programme offerings (Entsieh & Hallstrom 2016; Gilmer et al., 2016; Svensson et al., 2008).

2.7.5 Issuing of leaflets

An important way of making sure that women and their partners keep up and sustain what they learn at the pregnancy school is the issuance of educational leaflets. Although hard material is becoming less fancied with increasing technology, studies have shown that quite a number of women prefer the issuing of hard copied leaflets. Coley et al. (2018) in

their study pointed out that previous studies indicate that health information is more easily understood through plain language, audio and visual aids.

For instance, according to the study conducted by Lumbiganon et al. (2011) it was discovered that there was a marginally significant increase in exclusive breastfeeding at six months in a group receiving a booklet plus video plus lactation consultation compared with the booklet plus video group. A breastfeeding booklet plus video plus lactation consultation was significantly better than no formal breastfeeding education for exclusive breastfeeding at three months.

2.7.6 Summary of literature review

This chapter centred on the IMB model along with important literature. The literature was reviewed from both qualitative and quantitative studies and reviews published from 2006-2020. In addition, grey literature such as national guidelines from different countries in Africa and the other parts of the world were included. The main findings of the literature review revealed that, little studies have been conducted on the pregnancy school in Ghana. Most of the studies conducted on the pregnancy classes/ childbirth classes used quantitative methods.

It was found that, the 'pregnancy school' is named 'the childbirth classes' in most of the advanced-income countries. The literature revealed that government hospitals that organise the classes in advanced countries sometimes offer a low-cost program whereas it is free in Ghana and other African countries. In relation to their knowledge of the pregnancy school, majority of these studies found that the pregnant women and the husbands had foreknowledge of what the pregnancy school is about. In addition, most of the studies revealed the usefulness of the information given at the pregnancy school. Some of the articles compared the group classes to the traditional individualised care.

Furthermore, most of the literature listed parenting and emotional support as preferred topics for husbands. Others also remarked the importance of husband support and the need to strengthen it. Finally, the majority of the pregnant women revealed the impact of the social support they received as well the skills acquired through the education at the pregnancy school.

CHAPTER THREE

METHODS

This chapter focuses on the methods that were employed in conducting the study. It covers the areas such as research design, research setting, research population, sample size and technique, data collection, tool used and the procedure, inclusion and exclusion criteria, In addition, data processing and analysis, ethical clearance and methodological rigor.

3.1 Research design

The explorative qualitative design was used for this study. Burns and Grove (2003) explains a qualitative approach as a systematic subjective approach used to describe and give meaning to life experiences and situations. Explorative research is conducted when a new area is being explored or little is known about an area of interest (Polit et al., 2009). It does not seek to provide definitive solutions to the research topics, but rather to investigate the subject in various depths. As a result, the focus is on new topics that have received little or no prior investigation (Brown, 2006).

The focus of this approach is to gain a holistic understanding of experiences from individual perspective rather than on numbers. The study design used since the researcher was interested in exploration of an in-depth information from the respondents on the health behaviour of respondents towards the pregnancy school. This study used an open-ended question to explore the views of pregnant women attending the pregnancy school in the Greater Accra Regional Hospital. Furthermore, through this study design, the researcher was able to interact with the respondents to gain an understanding and know the views of the pregnant women who attend the pregnancy school.

3.2 Research paradigm

A research paradigm is explained as a set of underlying assumptions and beliefs about how the world is viewed that acts as a framework for the researcher's conduct (Jonker & Pennink 2010). According to Honebein (1996), people form their own understanding and knowledge of the reality by experiencing things and reflecting on them.

Due to the qualitative nature of this research, the study adopted the constructivism paradigm in order to understand the phenomenon from multiple perspectives as it is socially constructed, subjective and it focuses on the details of the situation and the reality behind these details (Hennink et al., 2011).

3.3 Research setting

The setting of this research was at the Greater Accra Regional hospital, which is part of Greater Accra Region the capital of Ghana (Figure 3.1). The region has been divided into sixteen districts. These districts are: Accra Metropolitan Area (AMA), Tema Metropolitan Area, Ga East District, Ga West District, Ga South, Ga Central, Dangme West District, Dangme East District, Adenta Municipal, Ashiaman Municipal, La Deda Kotopon, La Nkwantanang, Kpone Katamanso, Ningo Prampram, Ada East and Ada West. The City of Accra is bounded to the North by Ga West Municipal, the West by Ga South Municipal, the South by the Gulf of Guinea, and the East by La Dadekotopon Municipal. It covers a total land area of 139.674 Km^2 according to the 2010 population and housing census (PHC) (GSS, 2013).

The Accra Metropolitan District is one of the 254 Metropolitan, Municipal and Districts in Ghana, and among the 26 such districts in the Greater Accra Region with a population of 1,665,086 as of 2010 (GSS,2010). The Accra Metropolitan district covers a total land area of 60 km^2 (23 sq. mi). It is bounded to the north by the Ayawaso West

Municipal district and Okaikoi North Municipal district, to the west by the Ablekuma West Municipal district and Ablekuma North Municipal district, and to the east by the Ayawaso East Municipal district and the La Dade Kotopon Municipal district. The Gulf of Guinea serves as the southern border (GSS, 2014). The district was established by the Local Government Act of 1993 (Act 462) and Legislative Instrument 1615 (GSS, 2014).

The Greater Accra Regional hospital formerly known as the Ridge Regional Hospital is located at North Ridge (along the castle road) in the Osu-Klottey Sub-Metro of the Accra Metropolitan Area in the Greater Accra Region (GAR) and it serves as a referral centre for major health institutions in the region and beyond. It occupies a total land area of about 15.65 acres. The Greater Accra Regional Hospital serves as the regional hospital for the whole of the Greater Accra Region, with an estimated population of over 4,671,363 (2015 projection based on 2010 census by the Ghana Statistical Service, GSS). The following suburbs are within the local catchment area: Ridge, Nima, Maamobi, Kanda, Accra New Town, Kotobabi, Osu, La, Adabraka, Achimota, Airport Residential Area and Central Accra. It is centrally located in Accra, the Greater Accra Regional hospital (GARH) started as a Hospital for the European expatriates around 1928. It became a District Hospital after Ghana's independence in 1957 and in 1997, it was renamed the Ridge Regional Hospital. It has since been renovated and transformed into a state-of-the-art 620-bed hospital with a complete complement of specialty services that represents Ghana's fast increasing capital city's current socioeconomic goals (Greater Accra Regional Hospital, n.d).

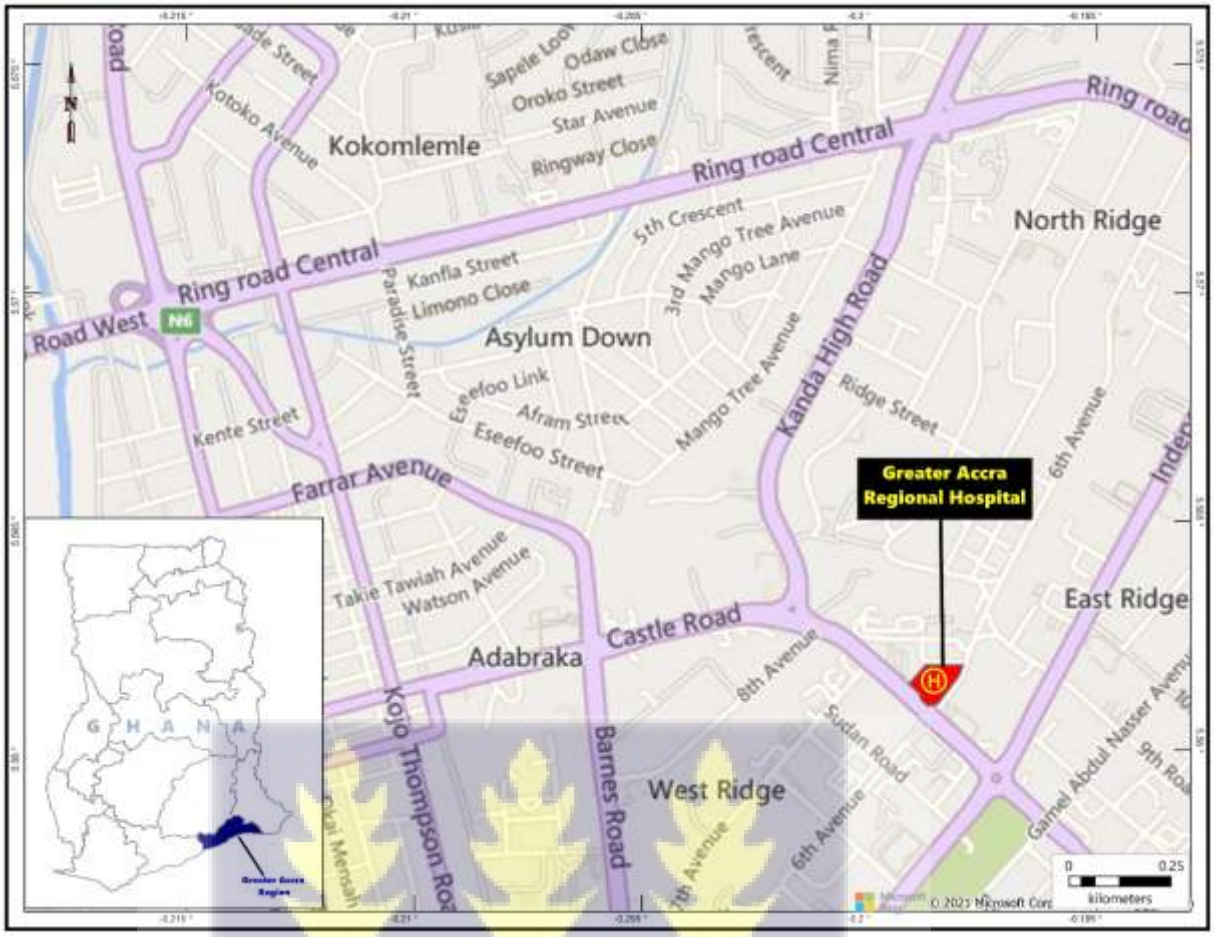

Figure 3.1: Location of Greater Accra Regional Hospital (research setting)

3.4 Target Population

Burns and Grove (2003) describes population as all of the elements in a study that meet the inclusion criteria. The target population for this study were pregnant and postpartum women who attended the pregnancy school at the Greater Accra Regional hospital.

3.5 Inclusion Criteria

Burns and Grove (2003) explained eligibility criteria as a list of characteristics that are required for the membership in the target population. The eligible women were pregnant and postpartum women who have participated in the pregnancy school at the Greater Accra Regional hospital.

3.6 Exclusion Criteria

The following are the exclusion criteria

(i) Pregnant women who have attended the pregnancy school before but are currently unwell.

(ii) Pregnant women who attended the pregnancy school at other health facilities.

3.7 Sample Size and Sample Technique

According to Polit et al. (2001) sample is explained as a proportion of a population. Purposive sampling technique was used for this study. Polit and Beck (2004) stated that purposive or judgmental sampling is based on the belief that researchers' knowledge about the population can be used to hand-pick sample members. The sample size of fourteen (14) was determined on the basis of data saturation due to the qualitative nature of the study. Sampling is continued until the point at which no new information is obtained and redundancy or data saturation is achieved (Polit & Beck 2004). The concept of data saturation, which is the point at which no new information or themes are observed in the data from the completion of additional interviews or cases is a useful one in terms of discussing sample size in qualitative research (Guest et al., 2006).

3.8 Data Collection Tool

Data were collected using a semi-structured interview (Appendix 3) guide with open ended questions and was based on the constructs of the conceptual framework and the research questions which were developed by the researcher. The interview guide consisted of two segments. The first segment consisted of the demographic data; the second was semi-structured questions which helped to assess the health behaviour information, what motivates pregnant women to attend the pregnancy school, skills acquired through the education and the impact of the health education on the health of the participant. The developed interview guide was pretested on two selected pregnant women who attend the

pregnancy school at the Ghana Atomic Energy Commission Hospital. The findings of the pretest were not included in the main study.

3.9 Procedure for Data Collection

An introductory letter (Appendix 2) was obtained from the School of Nursing and Midwifery, University of Ghana to the regional office of the Ghana Health service Ethical Review Committee for an approval (Appendix 1), subsequently permission was granted (GHS- ERC 029/01/21) to conduct the study. The letter was sent to the various administrators and Deputy Director of Nursing Services at the Greater Accra Regional hospital requesting permission to use pregnant and postpartum women as study participants taking into consideration the inclusion criteria. Participants were recruited from the antenatal and postnatal clinics. The purpose of the study as well as the expectations of the participants and researcher were documented and attached to the letter. When permission was granted, the purpose of the study was explained to participants. The participants obtained a consent form detailing the specifics of the research to request their permission and also indicate their desire to participate in the study. Interviews were done face to face and conducted in English language on a convenient day, time and comfortable location of the participants. Each interview session lasted thirty to forty-five minutes.

The participants were guaranteed their privacy and confidentiality as discussed in the ethical terms. The researcher ensured that the audio recorder functioned well and was fully charged for every interview session. The researcher established a rapport with the participants by discussing the topic to allay their anxiety. A semi-structured interview guide was used to perform the interview. Permission was asked from the participants to record interviews in order to ensure reliable data collection while maintaining their confidentiality. Furthermore, comments taken from the participants with their permission were added to the interviews reported. Additionally, participants were allowed to ask

questions before the interview started to address any concerns. The study used informative questions to help participants make a positive contribution to the discussion. The researcher avoided leading questions and allowed the participants to talk freely.

3.10 Data Management

The collected data were transcribed word for word. All recorded audios are secured electronically on a hard drive and also a copy has been retained and save as a backup, consent forms and field notes has been organized and stored appropriately. Only the researcher and her supervisors have access to the details and information provided by the participants. Clients' personal data was separated from the general data in order to ensure privacy. Each information was stored with the researcher under strict supervision and will only be provided should the need arise. Pseudonyms was used to represent participants in the study.

3.11 Data Analysis

Data were analysed using thematic analysis. Braun and Clarke (2006) explained and prescribed six steps involved as guidelines for conducting thematic analysis. Thematic analysis is the process of identifying patterns or themes within qualitative data. The steps involve the researcher familiarizing him/herself with the data, generating initial codes, searching for themes, defining and naming themes and producing a report. Thematic content analysis was used for this study in order to understand the experiences, views and opinions of the participants. The researcher familiarized herself with the data by repetitive listening and reading of the transcribed data collected from the participants to gain an understanding and made meaning out of the data. Codes were generated; themes were developed based on the constructs of the Information motivation-behavioural-skills model. Codes that do not seem to fit into the themes and subthemes were noted. A report

was written on the findings of the analysis supported with a verbatim quote of the participants.

3.12 Trustworthiness (Rigor)

In establishing trustworthiness, Lincoln and Guba created stringent criteria in qualitative research, known as credibility, dependability, confirmability and transferability.

Credibility- According to Polit and Beck (2004) credibility refers to the confidence in the truth of the data and interpretations of them. The researcher ensured that that the responses were transcribed verbatim. Member checking was done for clarification on ideas expressed by the participants, audios and transcribed data was made available to the supervisors for comments and correction. The tool was pretested among participants with similar characteristics who met the inclusion criteria.

Transferability- This looks at the degree in which findings can be transferred to other context where participants who did not take part in the study have similar characteristics. The researcher is to provide a thick description of the participants and the research process, to enable the reader to assess whether your findings are transferable to their setting (Korstjens et al., 2018). In this study, this was ensured by providing a detailed explanation of the research methods to enable other researchers to decide on its transferability.

Dependability- Polit and Beck (2004) state that the dependability of the data refers to the stability over time and conditions. Dependability involves participants' evaluation of the findings, interpretation and recommendations of the study such that all supported by the data as received from participants of the study (Lincoln & Guba,1985). For consistency to be ensured in this study, each process in the study was reported in

detail. The recordings, transcriptions, field notes, letter of consent, demographic questionnaires are preserved for future auditing and usage by external researchers.

Confirmability- Confirmability of findings means that the data accurately represent the information that the participants provided and the interpretations of those data are not invented by the inquirer (Polit & Beck, 2012). Confirmability deals strictly with the experiences of the participants only. The researcher ensured this by using open ended questions during the interview and also ensured that her beliefs and opinions were set aside and reported verbatim the information provided by the participants.

3.13 Ethical Considerations

The ethical principles that were followed in this study were: do no harm, seek consent, and protect participants' personal information (Collins et al., 2000). Participants rights and confidentiality were guaranteed. Participants were made to sign a voluntary consent form after providing them with an open information about the study. All participants signed the consent form. The participants were informed on their right to withdraw from the study. They were assured on anonymity and were reminded not to mention their names. The data collected is being handled alone by the researcher and only the supervisor will have access to the data. All audio recordings and transcribed data are saved electronically and secured with a code.

An ethical clearance and approval (GHS-ERC 029/01/21, Appendix 1) was obtained from the Ghana Health Service Ethical Committee Review Board, in the Greater Accra Region. An introductory letter seeking permission was taken from the School of Nursing and Midwifery to the authorities at the Greater Accra Regional hospital in the Greater Accra Metropolis.

CHAPTER FOUR

STUDY FINDINGS

In this chapter, the findings were developed using the constructs of Fisher and Fisher's information-motivation-behavioral skills model. The use of pseudonyms ensured participants anonymity.

4.1 Demographic Characteristics

The research participants were pregnant and postpartum women. The fourteen (14) women who took part in this study included three (3) pregnant women and eleven (11) postpartum women were interviewed. Their ages ranged between 22 to 37years. Thirteen (13) out of the participants were married with only one (1) being single. In terms of educational background, three (3) participants have master's degree, seven (7) have their first degree, three (3) senior secondary school certificate and one (1) has Junior high certificate. Eight (8) of the participants were multiparous women, four (4) of the participants were primiparous with two (2) being nulliparous women. Three (3) of the participants had suffered miscarriages. All fourteen (14) participants reside in Accra. The comprehensive overview of the participants has been provided in Table 4.1.

Table 4.1: Profile of Participants

Number	Pseudonym	Age (years)	Occupation	Marital Status	Educational Level	Gravida & Parity	Religion	Location
1	Thelma	34	Seamstress	Married	Tertiary	G4P2+2	Christian	Banana-Inn
2	Ama	34	Researcher	Married	Tertiary	G3P3	Christian	Dome
3	Adobea	32	Unemployed	Married	Tertiary	G3P3	Christian	Kwahsieman
4	Joan	24	Shop attendant	Single	SHS	G1P0	Christian	Kwabenya
5	Aisha	31	Trader	Married	SHS	G4P4	Muslim	Maamobi
6	Mercy	22	Secretary	Married	Tertiary	G2P2	Christian	Ablekuma
7	Tricia	27	Teacher	Married	SHS	G1P1	Christian	Labadi
8	Nakwor	31	Banker	Married	Tertiary	G3P2	Christian	West Legon
9	Esi Newman	33	Administrator	Married	Tertiary	G3P3	Christian	North Kaneshie
10	Olivia	32	Beautician	Married	JHS	G3P2	Christian	Agbogba
11	Mavis	30	Trader	Married	Tertiary	G3P2	Christian	Adenta
12	Akos	37	Relation Officer	Married	Tertiary	G1P0	Christian	Haatso
13	Abena	31	Accountant	Married	Tertiary	G1P1	Christian	Adenta
14	Sandra	30	Self Employed	Married	Tertiary	G4P3	Christian	Haatso

4.2 Organization of Themes

The thematic findings have been grouped into four main themes from the model guiding the study, with eighteen (18) subthemes emanating from the study. Table 4.2 presents the themes and their corresponding sub-themes.

Table 4.2: Organization of Themes and Sub-themes

Number	Theme	Sub-Theme
1.	**Health behaviour information**	i. Knowledge of the Pregnancy School
		ii. Experiences with the Classes
		iii. Usefulness of the information
		iv. Views on Number of Appointments
2.	**Health behaviour motivation**	i. Social support Received
		ii. Motivation to Partake
		iii. Quality Contact: Client-Midwife
		iv. Impact of Education on Social Support Received
		v. Attitudinal Change
3.	**Health behaviour skills**	i. New Skills Acquired
		ii. Identification of Danger Signs
		iii. Decision Making Process
		iv. Benefits of Skills Gained
4.	**Health behaviour**	i. Outcome of Health Education on Health
		ii. Expectation
		iii. Impression About the School
		iv. Ways of Improvement
		v. Issuing of Leaflets

4.2.1 Health Behaviour Information

The education given to pregnant women are very vital during pregnancy. Pregnancy without complication and a healthy baby are mostly dependent on the antenatal education the pregnant women receive. It is therefore very important for pregnant women to gain

adequate knowledge on pregnancy and its related issues. All participants had information about the pregnancy school. It was discovered that participants had knowledge of the pregnancy school, shared their experiences, the usefulness of the information and their views on the number of appointments.

4.2.1.1 Knowledge of the Pregnancy School

Understanding the purpose of the pregnancy school can help the pregnant woman and her family to learn more about pregnancy. Most of the pregnant women were aware of the pregnancy school. They had different meanings and description about the pregnancy school. The pregnancy school according to the majority is a place where health professionals educate pregnant women on what to do and what not to do.

> *I would say pregnancy school is a place of study for pregnant women for them to know about themselves, what they are supposed to and not supposed to do or things they would do to ensure that they have a healthy life throughout, during and after their pregnancy… (**Mercy, 22 YEARS, G2P2)***

> *The pregnancy school I know is a… is a school for pregnant women, which we are taught how to manage pregnancy. The dos and the don'ts what we're supposed to know in pregnancy… **(Abena, 31 YEARS, G1P1)***

> *It is a school that helps pregnant women to keep their health and the baby's health well. It helps us to know where we stand in the child's life and how to protect the child's against so many diseases. Also talks about things to do and things not to do during pregnancy… **(Joan, 24 YEARS, G1PO)***

Some were also of the view that it is a place where pregnant women are educated on the need for exercising and good nutrition.

> *I think it's a school they organized for all the pregnant women. To educate us on let's say the food we should eat. Water and sometimes even the drinks that we take, especially like those carbonated drinks me, for instance, I normally take these*

carbonate drinks, but when I started the pregnancy school, I found out that it's not good for me and the baby as well… ***(Mavis, 30YEARS, G3P2)***

*Is a school where they teach we the pregnant women on how to take care for the pregnancy when we are pregnant from the first day to the time that you will give birth, how to take care of the pregnancy, the food that you will eat, the exercise, what you have to do to take care of the pregnancy so that the pregnancy will not spoil or how you will manage to take care of the pregnancy so that the time that you are coming to give birth it will be easy for you, like you have to do some exercise, you have to do some exercise for the pregnancy and you have to rest. And sometimes too you must do some exercise, not only to rest but you must do exercise so that it will make the baby strong and healthy. So that when you are coming to give birth it will be easy for you, to give birth. That is what I know about the school… (**Olivia, 32 YEARS, G3P2)***

The above responses indicated that participants had knowledge of the pregnancy school, this being said, participants shared their experiences with the pregnancy school.

4.2.1.2 Experiences with the classes

A person's experience with an activity is important since it determines whether they will show up or have an interest in the program again, as well as whether they will put what they learn in to practice. The participants shared their experiences with the pregnancy classes as follows:

*I would say pregnancy school is the best, I have learnt a lot and I now l know a lot too and I'm a proud mother today because of the pregnancy school…. (**Mercy, 22 YEARS, G2P2)***

*Since it was my first time and I have not attended before. It opened my understanding of things I was supposed to know. For example, it's not good to bleed when you are pregnant. If you see anything of the sort you have to rush to the hospital and inform your midwife. It is through the pregnancy school that I got to know about it. And the importance of exercising too…. **(Adobea, 32 YEARS, G3P3)***

> *It is particularly good. It helps you know and understand various things. It is particularly important; therefore, you must keep doing the teachings….* ***(Aisha, 31 YEARS, G4P4)***

Some of the participants of the online pregnancy school also expressed their thoughts on how the classes could be structured.

> *So far it's been good, it's been good, it's been good … except that I felt eeerm, it should be more structured, it should be more structured like, eeerm, because we are at different stages of pregnancy and we have different backgrounds some people are experienced and others are first timers and even with the experienced people, day in day out knowledge comes in and therefore there should be, so those who are within trimester, those who are within second trimester this is what you need, in our books you see it there but I thought that , the school should be structured that it will group this people and then possibly pass them out. ….* ***(Akos, 37 YEARS, G1P0)***

> *So far, what I can say is that its good school Ridge hospital is a very good hospital. The Nurses and the midwives with my little experience or my little encounter I have had, I can say, they are very good. The midwives are very good. They have patience to take care of you. I don't really have any problem with them. They should have a fixed time for the lectures….* ***(Tricia, 27 YEARS, G1P1)***

Participants remarked that, the overall outlook of the classes was commendable however there were some concerns about the way the classes were structured together for women pregnant women of different classes. The following section presents the results of the usefulness of the information received.

4.2.1.3 Usefulness of the Information

A person who is well- informed on health-related problems has a better understanding of their health and is more likely to adopt a healthy lifestyle. Almost all the participants believed that the information was quite useful.

> *It has been useful a lot like sleeping under mosquito nets was something I never liked doing. But when I learnt that malaria and pregnancy are like friends, I started using mosquito net. It also helped me know about foods I must not eat for example fried meals, this junk foods and the rest, and then drinking of the berries, I didn't know about it and drinking it has really helped…* ***(Joan, 24 YEARS, G1P0)***

> *It has been useful to me because for pregnancy, each one has symptoms of whatever she goes through and through the platform I came to learn about a whole lot about the pregnancy and about other people's issues so if I am going through the same issue, I knew it's something normal or something I must immediately go to the hospital….* ***(Nakwor, 31 YEARS, G3P2)***

> *To me, it is very useful to me because am naive when it comes to pregnancy and its do's and don'ts so when I went there, they are always in touch with us which… they even created a platform, and the platform people bring their complaints, and the complaints were addressed. Even if you are ok you still read what is going on and your advice yourself…* ***(Abena, 31 YEARS, G1P1)***

Aside expressing their views on how useful the information was, participants expressed their views on the number of appointments.

4.2.1.4 Views on number of appointments

The routine and schedule of the pregnancy classes are divided into lessons. Information given at the pregnancy school is put into lessons depending on the facility. Regularization of the pregnancy school is very important in order not to overload them with too much information at a given session. Participants expressed their views on the number of appointments they have participated in and the contents of the lessons they have received as follows:

> *I think if other sections can be added I would be grateful because some of us we are not leaving with our mothers to be taught some of the nitty gritty about pregnancy, so we take this one as an opportunity to understand your system, how to take care of the home so that you don't feel depressed. I think pregnancy is a*

wonderful experience if you know what it's about. So, the schooling is a very good platform for some of us. We even wish other sections can be added. Myself I remember my first pregnancy, I attended almost five times. I kept on going, if I have any issue even if there's a particular section, I've already attended I want to go again so that my issues can be addressed before any antenatal day…. ***(Adobea, 32 YEARS, G3P3)***

It takes about an hour, but in parts. Sometimes three midwives come to teach on different topics, I wish for more. I like the fact that as I keep learning new things, I can get the chance to remember the old teachings that I may have forgotten…. ***(Joan, 24 YEARS, G1P0)***

We would like it if more of teachings were done. But if they arranged the teachings according to each month from the first to the ninth and if the pregnancy exercise routine and yoga were added to it, it would be beneficial because lots of pregnant women find it difficult to bend but the exercise could help in that regard…. ***(Aisha, 31 YEARS, G4P4)***

Some of the participants narrated that the pregnancy school conflicts with the antenatal appointments and the time frame.

I think it's okay because not only one person comes to lecture. Somebody can come in and say something and another person will also come and say something and then go. But then there was only one problem that we have that maybe when, the pregnancy school is going on, then you see some of the nurses, mentioning names for those that must go see the doctor. So, at times it's very disturbing…. ***(Tricia, 27 YEARS, G1P1)***

With the duration, I think like an hour will be okay but time frame, if we start too early, some people will not come and meet it, so am thinking you weigh through in-between from the crowd you see maybe from 7-9 you weigh the crowd and see if they are enough for you to educate and how to have more people to get knowledge about whatever you are teaching, I think it will be the best…. ***(Esi Newman, 33 YEARS, G3P3)***

> *I think is too early and maybe if you can organize once or twice in month and they should push the time to 11am and we will benefit from it due to the work we do….* ***(Nakwor, 31 YEARS, G3P2)***

> *I would say it is enough and not enough. And the reason why I'm saying this is that because we do come for the main thing being ante natal, and you don't have much time teach us because you would want to do things fast for other things to be continued. I don't think the time given is enough. And the starting time too it is always to early. I would have wished for more…* ***(Mercy, 22 YEARS, G2P2)***

A few of the participants expressed how satisfied they were with the number and duration of the appointment.

> *It is okay as well. They have other things and work to do, and we the pregnant women want to go home early and rest too….* ***(Adobea, 32 YEARS, G3P3)***

> *Being pregnant and sitting down is already exhausting so if it's too long it won't be easy for us to handle but it was not long nor short, it was okay whiles we were waiting for the nurses to start mentioning names and stuff. You come early; you wait that day they teach before they start the normal routine….* ***(Thelma, 34 YEARS, G4P2+2)***

A few of the participants expressed their satisfaction with the appointment with the majority complaining of the time frame. Nonetheless, participants narrated the motivating factors that influenced their participation in the pregnancy school.

4.2.2 Health Behaviour Motivation

When a person decides to make a health- related decision, personal and social motivation are very important. This section which is the second major theme has two main sub-themes from the health behaviour model which is personal and social motivation (social support received) to act. The two main sub-themes examined the motivating factors that influences the participation in the pregnancy school. Three additional sub-themes were identified based on the data gathered from participants namely, impact of the social

support received, quality of contact between midwife-client and attitudinal change experienced due to the information given at the classes. Most of the participants expressed how they were personally and socially motivated to attend the classes.

4.2.2.1 Social support received

Most of the participants stated that they received social support from their husbands and partners, family (specifically mothers and sisters), as well as friends.

> *Initially he was complaining about time, but I made him understand that it's for the betterment of the baby and for us. Per this understanding he went with me, seriously when he came back, he recommended the class….* ***(Ama, 34 YEARS, G4P2)***

> *Myself and my husband are both on the platform. He asks if He could also be put, and the midwife said they are even interested in partners who are willing to participate in some of this thing, so they agreed and they said they have even males there already….* ***(Akos, 37 YEARS, G1P0)***

> *Yes, I always come with my sister not my husband because he goes to work and stuff….* ***(Thelma, 34 YEARS, G4P2+2)***

> *Sure, sure, my husband sometimes goes with me. Most at times too my mom….* ***(Abena, 31 YEARS, G1P1)***

The results indicated that majority of the participants were either supported by their husbands or partners. The next session presents the findings of their personal motivation to partake in the classes.

4.2.2.2 Personal motivation to partake

In narrating their personal motivation to partake in the pregnancy school, some participants were of the view that they participated because they wanted to gain knowledge, receive reliable information about pregnancy and how to care for the baby. These were expressed in the narratives below;

I found the information quite useful which I know it will help me after birth, so I decided to stay and listen…. ***(Thelma, 34 YEARS, G4P2+2)***

I felt I needed information, I needed up to date information and also information from practitioners; also because I have never been pregnant before and I have never delivered before so I really want information from people that are attending to me directly apart from that I also read from other places, other foreign materials but I really wanted to know how I am doing and then how my baby is doing whether we are fine or not and that I should get somebody who is ready to respond to my issues and my concerns for me. That is how come I was interested… ***(Akos, 37 YEARS, G1P0)***

To learn more because you know but you don't know all, and you might also not know the next step that you have to take in each decision you take during your pregnancy…. ***(Esi Newman, 33 YEARS, G3P3)***

It is there to help and educate us with knowledge about the pregnancy situation that we are in, so that in case anything happens to us, and the midwife is not there, you will know what you do in that instance, it will serve as a first aid for you before you rush to a hospital. I attended because of these things, to know about what is going on with my pregnancies before you rush to the hospital. It saves you too and the baby. So, it's very important…. ***(Adobea, 32 YEARS, G3P3)***

In addition, a few participated because it was their first-time hearing about it and wanted to know more.

Okay. For me this is my first pregnancy. So, I really want to know more. So that's what influenced me to attend…. ***(Tricia, 27 YEARS, G1P1)***

The main reason why I participated is that I haven't heard about it before so the first day they came there and try to talk and teach us, I say eeeeh then this thing is good then I have to be coming to listen because it will help me a lot because I haven't heard about it I heard about pregnancy school but I haven't seen the midwife talking about this holding some toy babies showing us how we will do it and bringing the child for us to see it, how the place will open, so it helped me a lot… ***(Olivia, 32 YEARS, G3P2)***

In narrating their personal motivation, the results indicated that the majority of the participants participated in the classes in order to acquire new knowledge as well as reliable information. Subsequently, participants shared their views of the relationship they had with their midwives.

4.2.2.3 Quality Contact: client - midwife

Midwife-client relationship plays an important role for client to decide on attending the pregnancy school. Some of the participants were of the view that the attitude of their attending midwives and the relationship that existed between them had an influence on their decision to partake in the pregnancy school.

> *I'll always talk about my midwife because as I said, she motivated me on this. Okay. Eh, pregnancy school, because left with me alone, I don't think. I'll really show interest for that. Yeah. Let me not lie to you. I think she was really, really, more than helpful. Okay. As I said earlier, she's very kind. And even if you have a question, like she's never tired, she's never, she never tired. She's always open, ready to, you know, it ready to help. Ready to answer a question….* ***(Sandra, 30 YEARS, G4P3)***
>
> *Oh yes, I have been the one who has not been too forth, okay I am the type that don't talk but when I begin to talk, I talk, I don't initiate conversation so much, but my midwife is very good, I just chatted with her this morning, so we are almost always in touch she wants to know what is happening and she is ready to offer support anytime. And apart from those other midwives on the platform because of the school we have access to all the midwives. It's a very good relationship….* ***(Akos, 37YEARS, G1P0)***

Some also reported that they had very good relationship with their midwives and that their midwife was always ready to answer all their questions.

> *Well, to me I may say the midwives are very good because per where I was before coming nobody have enough time for you, they don't have time and we are workers, so you only pass by the doctor; they check you they use the … what and what to check to measure your stomach. Quick, quick, quick then you go because you are*

working there. But over there at Ridge because you go there purposely for one thing, they have enough time for you. And I don't know maybe my team have been meeting there they are correct. My midwife had time to answer all my questions, even when I got in to labour, I called her and she was coaching me on phone…. ***(Abena, 31YEARS, G1P1)***

It was more interactive and then yeah. Initially, numbers weren't written in the ANC book, so IT is either you ask for it or the midwife herself will give it to you. Myself I'm very curious and I ask a lot of questions and at the pregnancy school I realized I even have the privilege, she gave me her number and the relationship were great, I could call her and share anything that was bothering me. She was always available to address it…. ***(Ama, 34 YEARS, G3P3)***

The following session addresses the impact of the social support gained during pregnancy classes.

4.2.2.4 Impact of education on social support received.

Pregnant women who received social support from their husbands, partners, mothers and sisters narrated the impact of the social support they received. Those whose husbands participated in the classes added that it was highly beneficial and formed a bond between them.

He has always been supportive. With my first pregnancy a couple of times and even this one he was with me. Seriously, especially our first pregnancy, we didn't know much about pregnancy and what is happening, and being a man, he also expressed his own fears in terms of sexual intercourse, even if I'm showing signs of pregnancy, he doesn't really understand, at times he will get depressed, offended, he will get irritated but after we attended the school he fit in so well. He understood me, he knew what each sign means, he understood what everything. It was super, now when he goes to the office, he calls to check on me and throughout my ANC visit he was there with me. He was in the delivery room with me, and I appreciate that even when after delivery, at times he will just ask me to express the breastmilk and whiles I'm deeply asleep he will pick the baby and give him the breastmilk. And it was so beautiful. People didn't even know what was working

*for us, we were young couples leaving together with no house help, but we were managing it and people were surprised…. **(Ama, 34YEARS, G3P3)***

*It is a great bond. I think it has really helped the growth in our love as we expect the baby. It has made me less stressed up with the timekeeping and the dates. Sometimes I will be sleeping but he will remind me by waking up to remind me that I have an appointment, sometimes I feel lazy in going but he will give me pressure to go…. **(Joan, 24 YEARS, G1P0)***

*Sometimes men don't involve themselves on things about women but he being a man involving himself in that school, he cares a lot, especially at home, helping me in domestic chores, it was helping. It was very helpful so that I will not stress myself so that I'll get enough time to rest the body so that the baby and the mother will also be safe when the time is due for us to deliver. It was impactful. It had a great impact on our relationship…. **(Adobea, 32 YEARS, G3P3)***

Some participants also mentioned that their husbands became more supportive, which offered them peace of mind.

*He was very supportive. So, at times when I'm coming for antenatal, he decides to come with me to come and listen to the lecture. Because he knows that when I go alone and I go to the consulting room, I won't be there to listen to what they are saying. So, I think in way that's really helped me…. **(Tricia, 27 YEARS, G1P1)***

*There were certain things, if you ask him to do, he wouldn't do it. In my last trimester, even within the ninth month I used to wash and do chores. If I refuse to do it and complain it will be seen as you are being lazy but after confirming some of the things said at the pregnancy school, he came in and helped me do some after I told him that I need some more rest. He gave me my freedom and he started doing the chores. I would say it has given me the comfort of mind. I have been able to have enough time for myself, that is, preparing the mind towards delivery., my man, he used to shout on me. when I say something, He wouldn't even listen to me but with this education, he got to realize that He was hurting me, which was also affecting the child so since then, he stopped…. **(Mercy, 22 YEARS, G2P2)***

In fact, it's good because they are the people around you so involving your husband especially if he is around, is the best because they are the people around

> *you, you wake up every day you see them. Of course, it helped them to treat me like a pregnant woman. Yes, and even my husband even reminds me sometimes about the drug am supposed to take. Have you taken your drugs and stuffs which is good he knows that when you are pregnant you are supposed not do this, not to do that? It really helps, it really helps, it really helps when he followed you and then he also listens to some for instance; like the resting am talking of, reminding you have you taken your drugs….* ***(Abena, 31 YEARS, G1P1)***

A few of the participants also mentioned that they shared the information given at the pregnancy school with their mothers and friends and it was helpful.

> *I have one tenant. Recently she also took a seed, I've been advising her just to come to read and anytime I read something on the platform I share it with her….* ***(Thelma, 34 YEARS, G4P2+2)***

> *Normally when I go home, especially I go to the market, so sometimes I ask my mom. Maybe when we went there this and this was what they taught us, what is her opinion, and then she told me her opinion. Both of us learnt a lot….* ***(Mavis, 30 YEARS, G3P2)***

Consequently, it was established in the preceding results that most of the participants modified their eating habits, became less temperamental and reduced their stress levels.

4.2.2.5 Attitudinal change

It was established from the study that, knowledge gained by most of the participants modified their eating habits and sleeping posture. Some of the participant admitted to not eating properly hitherto.

> *And that was what I did at first. I used to take these carbonated drinks a lot. But I think one day I was taking it the morning when the midwife. Saw me, even in the school, when we have having a class and she told me, no, it's not good for you. When you take the carbonated drink, it's not good for you and the baby. At least if you feel like taking any drink just take let's say Malt and even, they taught us that this fruit juice. There's the one that they HAVE preserved, and it is not healthy for us, so we should take fruit. So, from that time, I thought that at least once a*

day, I'll take fruits, like watermelon and those things. So, I changed it and, then I think I loved eating Oily foods too as well. Yes. So, I stopped eating it and I started like eating soups and all those things…. ***(Mavis, 30 YEARS, G3P2)***

My eating habits. I was eating a lot of junk meal like fried rice and chicken and the rest. But they have been advising us to eat more green foods like the vegetables and more fruits. They advised to reduce carbohydrates in-take and drink lots of water. I think I have improved my eating habits too. Another attitude change is how is sleep too. I have changed to sleeping on the sides and our left side as we have been advised. I used to sleep on my back and front…. ***(Joan, 24 YEARS, G1P0)***

A few women also claimed that they were temperamental and used to argue with their husbands, but they have grown more tolerant as a result of the education they received on the effect of these lifestyle on their health and that of their babies.

Yeah, the time I wasn't pregnant sometimes me and my husband we use to get some arguments which will lead to some things but the time I listened to the education at pregnancy school, I realized that the time I was pregnant I stopped it, I stopped it because if I continue it will not help me, it will not help me at all, I have to stop it, I stopped it, and up to now I have stopped…. ***(Olivia, 32 YEARS, G3P2)***

Yes. I used to be very temperamental. Something small and I might become angry, but pregnancy school made me understand that anger should be the last thing pregnant women should exercise. Not because of yourself, but the child and sometimes too the eating habits, you don't eat anything, and you don't eat outside home too…. ***(Mercy, 22 YEARS, G2P2)***

Additionally, some admitted that they used not to rest but with the support they received from their families and husbands by attending the pregnancy school helped them to appreciate the importance of rest. They received support from their partners going about house chores thereby allowing them to release a lot of stress and at the same time having rest periods.

> *Most of the information we received there will help you and since your people who you introduced to the school; like my husband and then my mom sometimes they will advise you to, oh don't do this, go and sleep or go and rest small and we will do it. It really helps me by then, maybe allowing me to have enough rest. I used not to rest. They were helping me to do most of the house chores and I was resting more because of the education they also had….* ***(Abena, 31 YEARS, G1P1)***

> *I read a lot, even so before I got pregnant, I was reading things about it. How to carry yourself as a pregnant woman. Adding the school to it gave me more knowledge as well. But err mm…. I am somebody who finds it very difficult to sleep but through the education I realized that rest is good for pregnant women for the benefit of the baby as well, therefore I tried my best not to stay awake for a long time….* ***(Adobea, 32 YEARS, G3P3)***

Besides the attitudinal change experienced, the results also indicated that participants acquired new skills through the education.

4.2.3 Health Behavioural Skills

A person's output reflects the knowledge gained through the education. Most of the education given at the pregnancy school is aimed towards equipping the pregnant women, their husbands and their families with knowledge to assist them take control of their health and make informed decisions about pregnancy, labour and postpartum care. The data gathered on behavioural skills revealed four subthemes; new skills acquired, decision-making process, identification of danger signs and benefits gained from the information provided.

4.2.3.1 New skills acquired

The information given at the pregnancy school is not just verbal but also includes demonstrations. Clients are occasionally picked to do a return demonstration so that the programme organizers can ensure that they understand everything. In response to the question of whether they developed new skills as a result of the education received, most

of the participants stated that they developed appropriate breastfeeding skills and how to handle the baby properly.

> *I didn't know how to breast feed the baby that much. I didn't know how to do it, but with the school they taught me how to breastfeed, like putting my four hands down and one on top to breastfeed the baby. And how to even handle the baby when I'm breastfeeding…* ***(Mavis, 30YEARS, G3P2)***

> *Position of baby in breastfeeding that's what I learnt in the education because I didn't position my baby well during breastfeeding but through the education I went through, I was able to gain knowledge on how to breastfeed well….* ***(Esi Newman, 33YEARS, G3P3)***

> *Yes, I did, I did especially of breastfeeding, I didn't know how to hold the baby to breastfeed, but the school taught me how to hold the baby when breastfeeding, then how to maintain the expressed breastmilk, how to refrigerate it so that it doesn't get contaminated, how to care for my episiotomy wound and keeping it clean, this is just among the few of them….* ***(Adobea, 32 YEARS, G3P3)***

Some also mentioned how it helped them in deciding on doing exclusive breastfeeding and the kinds of foods to feed the child with when they start to wean them.

> *Like the food you must give to the child even after exclusive breast feeding, they informed me about that, the kind of food you are supposed to give and how to prepare it's not to put too much pepper and salt. Like you as an adult your food is different, they cannot take the hard food you have been taking. Their own needs to be soft and very rich in all the nutrients so that they will grow well….* ***(Adobea, 32 YEARS, G3P3)***

> *I planned not to do exclusive breastfeeding but because of the pregnancy school I learnt the benefits of exclusive breastfeeding and I have benefited from it. I could see my baby is very strong and hasn't fallen sick….* ***(Nakwor, 31 YEARS, G3P2)***

A few also mentioned that the education has equipped them with skills that enabled them to recognise when their baby was unwell and the need for exercise

For me what I gained was the how to or detect if a baby is sick because some babies will be crying, and you won't know what is wrong with them so how to make them not to cry. I have been able to know that how to put the baby to sleep, how to comfort the baby …. ***(Abena, 31YEARS, G1P1)***

Exercise. I used to be someone who doesn't like walking, but pregnancy school made me understand that exercise is good not only for the pregnancy but the system as well exercise for the system…. ***(Mercy, 22 YEARS, G2P2)***

Consequently, participants knowledge on danger signs were assessed. The commonest mentioned danger sign was bleeding and reduced foetal movement.

4.2.3.2 Identification of danger signs

The participants' knowledge on danger signs in pregnancy was examined by asking them what they knew about the danger signs in pregnancy and whether they had experienced or could recognise any of them. Most of the participants could name at least two of the eleven danger signs in pregnancy.

Not hearing the heartbeat and that one is different from the one they check when we go for ANC, sometimes you know the kicking so when you don't hear it for a couple of times, in a day or so during some weeks of the pregnancy it's not a good sign you can go…. ***(Thelma, 34YEARS, G4P2+2)***

Yes, bleeding and having swollen foot and diarrhoea and when you do not feel the movement of the baby…. ***(Adobea, 32 YEARS, G3P3)***

I didn't experience any of them. But some are when you see blood, you should report to your midwife and when it's not time for you to deliver, when your time is not up and you see that blood, you must immediately come. Don't wait. To say that. Maybe it's not my turn to come to Ante natal. Maybe I'll come on next week. So, you stay in the house, it is dangerous. Yes. And they said, if you don't feel the baby too, you must come as early as possible…. ***(Mavis, 30YEARS, G3P2)***

When asked if they had recognized any of them, they described their experience and how the education had helped them recognize that it was a danger sign, necessitating a rush or come to the hospital.

> *In my pregnancy I get hypertension in my latter part thus my last trimester which I know is also a danger sign because If your B/P keeps going up it's not the best for you the mother and the baby as well. I was told you can get headache, when you check you know the B/P is going up. Swollen face and feet as well….* ***(Esi Newman, 33YEARS, G3P3)***

> *Yeah, it got to a point in time, my feet and my hands, my face got swollen. It was discussed that it is part of the danger signs So what I realized that then my husband, told me to go and see the midwife, so that was last week. I went to tell her, and then they gave me some labs to do….* ***(Tricia, 27YEARS, G1P1)***

> *Yes, it did, it did. once I think my lab results came and I realized that there was protein in my urine and I was taught at the pregnancy school what causes that, so quickly I revised my notes from the pregnancy school and started doing what he was taught to prevent that. In my next visit that thing was corrected…* ***(Adobea, 32YEARS, G3P3)***

Although the results revealed inadequate knowledge on danger signs, the findings revealed majority of the participants were able to make sound decisions concerning their health.

4.2.3.3 Decision making process

The ability to make sound decisions about a health-related issue is mostly determined by one's understanding of the issue and the ability to put that knowledge in to practice. The participants were asked how the information received and the knowledge gained influenced or contributed to their decisions about pregnancy, labour, postpartum and family planning. Participants in this study revealed how the education they received helped them to plan for the delivery, complication readiness and even consent to have a caesarean section.

My baby was four kilos, when I went for the last scan. And she was like, because I read like, oh, if your babies over a 3.5. Yeah. More than, no more than four, you may go through um, how do we call it? Caesarean section, and yeah, I didn't want that.my midwife encouraged me to do it. You need to know that C/S too is part of, you know, it's part of what we are teaching you guys. And she knows what she herself went through. She said, oh, she delivered through CS. This is what, so is something that I shouldn't be alarmed. I shouldn't listen to what people are saying out there. It really helped me to decide to do the c/s…. ***(Sandra, 30 YEARS, G4P3)***

Before you get into labour, you should take the decision of whoever you want to be in the hospital with and then maybe for transportation, your medications and the items you may need for delivery, all these things should be put in place before you go into labour so that when you just get into labour, you just call the person you are in with then you move on to the next… ***(Esi Newman, 33YEARS, G3P3)***

Yes, we were told that we need to even prepare some money, we need to even get transport, we need to get emergency person's contact down so that when anything happens and even for the labour so that when, the time you have rushed there you might not be conscious and therefore your things would have to arrange so that the person helping you can easily. I also learned how to even go to the labour process because I was telling my midwife that I am a bit anxious about the labour because I have never delivered so am a bit anxious, you hear a lot of stories, so they told us that there are breathing techniques, there are things you have to do so, so that it would help you yourself, you listen to the midwife when she says do this at this time push you push, you breathe through your mouth…. ***(Akos, 37 YEARS, G1P0)***

Some participants also talked about how they maintained COVID 19 protocols due to education they received.

We were also educated on caring for ourselves and the baby because of this pandemic. Sanitizing, washing our hands frequently. You can even decide not to show the baby to people for your own good, people washing their hands before they enter your house, so for me, I have a veronica bucket where I make people wash their hands before coming inside…. ***(Thelma, 34YEARS, G4P2+2)***

> *Taking care of the baby and washing our hands and in this covid era they have taught us that if someone gets offended that I won't wash or sanitize my hands just keep the baby in your room or breastfeed the baby, the person can't come and take the baby away from you, it has really made me learn that if you don't sanitize or wash your hands, I'll just put my baby to breast….* ***(Joan, 24 YEARS, G1P0)***

A few also mentioned how the information helped them to make informed decision about spacing of their children and adherence to all prescribed medications.

> *One thing that you learnt that after delivery you should space your children…Olivia*

> *Those days, I thought if you get pregnant you don't need to eat plenty, because the baby will grow big and cannot give birth normally. So sometimes, because of that I don't eat, because of that perception I was not eating, but through the pregnancy school I got to know that is not what it means. Through the pregnancy school I realized it was false and I need to eat balanced diet for the baby to be healthy. And, to donate blood and keep some money for hospital bills and taking your medications being prescribed for you….* ***(Nakwor, 31YEARS, G3P3)***

> *The food you are supposed to eat and then the medication you are supposed to take for you and the baby to be strong are also taught at the classes. ….* ***(Abena, 31YEARS, G1P1)***

The following section centres on the benefits of the skills gained through the education given at the pregnancy school.

4.2.3.4 Benefits of skills gained

Every pregnant woman and her family should be given an education on pregnancy. The life of a pregnant woman and her unborn child is very important not only to their immediate families, but also to society and country at large. Therefore, the content of the lessons given to them and their partners and other supporting family and friends must not be overlooked. The majority of the pregnant women who participated in the study stated some of the benefits of the skills they have learned from the pregnancy school. They

narrated that they received reliable information from professional, the required nutrition for a pregnant woman and how their haemoglobin levels got improved.

> *I have learnt… I have learnt a lot of things, apart from the general education they give us at the class, antenatal class, the information, because of this I also got to know that there are some foods that do not go well with… okay I started with… errrm my HB was below the average or the minimum so I was always being referred to the nutritionist so they always talk about foods that hinders the absorption of the iron so that one is there….* ***(Akos, 37 YEARS, G1P0)***

> *I did not have any complications with my regulating my blood. There was a case where I had low blood count but nothing serious happened due to the how I slowly followed the teachings. I would say that after birth as I did not have to receive any blood transfusions….* ***(Aisha, 31 YEARS, G4P4)***

> *The education I received helped me, it helps me during my pregnancy. For instance; after my thirty-eight (38) weeks I thought I was feeling some abdominal pain I thought I will just pack my things and go and deliver, but it did not happen that way. In fact, I called my midwife and she gave me some she was, she asked me I told her I was getting contractions but she gave me time and certain things to listen to and gave her feedback so because of the school and the platform they created some of the things she will ask you to do if you pay attention to them, it will help you. It helps me by not going to sleep at the hospital thinking that am given birth at that time. So, the school help me to know that I have to wait till so and so happen before I pack my things to go because am the type who don't want to go and sleep there. Because of the school and what, so my own too plus my midwife helped me a lot to keep calm and stay at home until I see so and so before I come….* ***(Abena, 31YEARS, G1P1)***

Some also remarked how being mixed among their peers, both online and in person interaction helped them to learn from each other and also educated their friends at home.

> *A lot, I met a lot of people and heard their stories and I have used their stores to advise myself not to do this or that, not to get worried because it rises your hypertension and hypertension in pregnancy is not a good thing and diabetes in pregnancy too is not something pregnancy can accommodate, I have also*

benefited because they talked about that and God being so good it has really benefited me and I also shared mine too with them…. ***(Joan, 24YEARS, G1P0)***

I have gained a lot. good communication between my partner and also a boost of social confidence and self-confidence. I used to be the shy type and not know how to relate to people in public but pregnancy school has made me become a social partaker and good communicator and also very confident. Anytime you ask question, new things come up, it gave us the chance to ask questions to know more and getting to more know more has made me confident to talk too…. ***(Mercy, 22YEARS, G2P2)***

I also use the knowledge to educate other women and first-time mothers like my neighbour. They ask questions Auntie Ama this and that but because I have the fore knowledge, I encourage them to do the right things and contact the midwives in any situation. I benefited from it too because I'm also a midwife at home…. ***(Adobea, 32YEARS, G3P3)***

A few of the participants also mentioned how the education helped them to dress well.

It helps me on how to dress, before I use to wear tight clothing but I was made to understand that at my state it good to wear loose so it can accommodate the pregnancy. So, it changed my wardrobe and mode of dressing, because I carried a very high and big pregnancy, I easily get irritated at people's comment, so after the school I realized that it was just for a short period. So, I started ignoring when people were talking about my big tummy. It made me love myself the more…. ***(Ama, 34YEARS, G3P3)***

Going to the pregnancy school. It's made me learn so many things like in terms of pregnancy and even how to dress, at first my dressing was somehow. Like some of the pregnant women you know how to dress, but sometimes we put on this pair of jeans to tight the baby and those things so me, going to that school, I was taught how to dress…. ***(Mavis, 30YEARS, G3P2)***

The concluding theme examines the outcome of the education on the health of the pregnant woman.

4.2.4 Health Behaviour

The knowledge offered to the pregnant woman is frequently expected to be reflected in the way she and her family deal with pregnancy-related issues. Personal motivation to stay healthy, as well as social support from family and friends plays an important role in the life of the pregnant woman. This theme examines how a well-informed individual is more likely to engage in health-promoting behaviour as well as how physical and social motivation affects the health behaviour. Five major sub-themes emerged from the data gathered namely: Impact of health education on health, expectation, impression about the school, ways of Improvement and their views on issuing out leaflets.

4.2.4.1 Outcome of health education on health

Health education broadens one's understanding on health-related issues and increases one's ability to deal with the issue. The majority of the participants reported on how the information given at the pregnancy school and the motivation they received had an impact on their health. They mentioned that there was an improvement in their health and eating habits.

> *I have been able to control my sugar levels due to the education. My sugar has been well controlled, my sugar was high I did not know it was not good for the baby but now it has been well controlled because they taught us that if the sugar is not well controlled you can get obese baby or a still birth baby so due to the education I have really controlled how to eat, time to time eating, healthy meals and the rest….* ***(Joan, 24YEARS, G1P0)***

> *I have had good improvements in my health. I can say I am in good health. I used to eat food without meat and finish because I did not like them. But I began taking meat and fish to improve my health and then also I did not take in many fruits during pregnancies, but I began taking in more fruits after the education and it helped me well….* ***(Aisha, 31 YEARS, G4P4)***

During my pregnancy, I became anaemic but then through pregnancy school, they told us some food to eat like the turkey berries. We should eat the greens and the fruits and the vegetables. I started practicing it. And then I realized that. My HB was shooting up…. ***(Tricia, 27 YEARS, G1P1)***

I think I feel better than how I used to be first, even when I was pregnant, when I was up at nights, I eat anything that I see, but even after the first pregnancy though I didn't go for the pregnancy school. But for this one, I check everything, every food that I eat to make sure that maybe there's a little meat, protein, vegetables, cereals, and those things, and even in the morning, I have to eat this food in the afternoon, one in the evening, but first, I don't check it… ***(Mavis, 30YEARS, G3P2)***

Some of the participants also reported that, as a result of the education, they are now more health conscious and have a sound mind and sense of security.

I think it has helped me in a way to be able to check up on my health especially when am pregnant so I don't go off track since I know my blood pressure has been going up, with the education on my part I monitor so when it's going up, I alert or when I start feeling the symptoms of high blood pressure, I inform my midwife about it…. ***(Esi Newman, 33YEARS, G3P3)***

Yes, before I used to be very temperamental and because of that my BP goes high but when I attended the pregnancy school and I got to learn these things I realized that I was only hurting myself, I needed my body and mind to relax. And aside that too. my eating habits have improved. And I use not to drink much water then, but I heard that when we drink lots of water it helps to boost your immune system…. ***(Mercy, 22YEARS, G2P2)***

With the Bp, I was told it's better to get Bp monitor in your house yourself and keep checking and recording it yourself. In case you check and it's consecutively high you can come to the Antenatal and report to your midwife. So, I got the machine was also educated on the normal value. So, I currently have one I've been using to check at home…. ***(Thelma, 34YEARS, G4P2+2)***

A few others also revealed that the education they received helped them to adhere to the medications that was prescribed for them.

Yes, it did, myself I am not too uncomfortable taking multivitamin because it will make you put on weight, myself I'm a bit heavy and endowed so I didn't want to take any multivitamin, but I was made to understand that it will keep my HB high and then it's also good for myself and the baby. That made me take it, honestly speaking I wasn't taking it as expected but I made sure I finish all the containers… ***(Ama, 34YEARS, G3P3)***

The thing I have learnt from the education is that whenever you give birth the drugs that the doctor will write for you, you have to take that medication. When you take the medication, it helps you the mother and also helps the baby…. ***(Olivia, 32YEARS, G3P2)***

And then when it comes to taking medicine you have to be serious because it's going to help yourself not them, me I don't like taking my medicines. It helped me to take my medicine and put my body in shape…. ***(Ama, 34YEARS, G3P3)***

The findings revealed how majority of the participants became health conscious due to the information they received the pregnancy school. However, they shared their views on their expectations when they were informed about the pregnancy school.

4.2.4.2 Expectations

The participants were asked whether they had any expectations and if those expectations were met. Most of the participants shared their views on their expectations when they were informed about the pregnancy school. Some stated that they needed a reliable information from experts which will help them gain knowledge about pregnancy and also having a safe delivery.

At least I should be able to know about my condition with this, I should do. Things I should do and things I shouldn't do. Again, I should have benefits, at least at the end of everything I should achieve something good…. ***(Mercy, 22YEARS, G2P2)***

I was expecting that all the questions I have in mind would be answered and truly it was, answered. Because sometimes they treat, some topics and I'm like wow. Is

that the case? I didn't even know. So, when they treat the topic, I have to go online and do some research too. So, I think it's good…. ***(Tricia, 27YEARS, G1P1)***

Well, my main aim for attending the school wasn't just to go and waste my time but to learn what I'm going through, to learn the physical and the emotional processes I was going through, seriously I attended the school to have an in-depth knowledge of pregnancy, the dos and don'ts, and then anything, all the information about pregnancy, all the nitty gritty…. ***(Ama, 34YEARS, G3P3)***

So, me what I was expecting is I should get answer to my questions my petty, petty question like I said I have never given birth before so I don't know much about it but the basic things I was expecting. My questions should be answered which the few gave me that…. ***(Abena, 31YEARS, G1P1)***

Another participant also mentioned that they expected refreshments and a comfortable environment.

For that, I expected some refreshment at least in some afternoons. I would have preferred sobolo, or asana with nice pastries. I expected some improvements in the seating too but the time you get home your legs will be swollen. You can with a flat leg but by the time you get home your feet will be swollen. And the people are plenty and the up and down in this situation it should reduce, it would be good for more doctors and nurses to be around for faster consultations and attending to us…. ***(Joan, 24 YEARS, GIP0)***

Despite the fact that all their expectations were not met, they had a positive impression of the pregnancy school. The findings revealed that the pregnancy school is a good initiative and it is commendable,

4.2.4.3 Impression about the school

From the interview responses, majority of the participants showed impressed about the pregnancy school. They stated that the pregnancy school is a very good initiative, it is the best place to educate pregnant women and their husbands, partners and family and that they were satisfied with the information given.

It is good, and you must continue. Yes, I believe so, with regards to my blood regulations I think I got what I wanted and more benefits too…. ***(Aisha, 31YEARS, G4P4)***

What I can say is that the pregnancy school is very, very educative. I have learned a lot being my first pregnancy. I really, really, learnt a lot. My husband and I know too many things now. So, in general, I say that it's good. The midwives, they have the patience to answer any questions that you asked them. I think that they also did very well…. ***(Tricia, 27YEARS, G1P1)***

Okay so one thing about the pregnancy school that I forget to mention is that during the pregnancy school they organize labour tour for us to go and know how the processes through labour when you go in, where you should to and the process all the processes what you need to do so and pregnancy school organized that for us. So that is one of the pluses and they do it quite often. Yes, am satisfied, not fully satisfied but I am satisfied. I think they are doing a good job, just that we can always improve upon it…. ***(Akos, 37YEARS, G1P0)***

It's really helping. it really helping. Sometimes we have some questions, some symptoms and some perceptions but after participating in the school you will be clear, everything will be clear and understand whatever is about pregnancy, what you are going through in pregnancy, so that you understand pregnancy. It's really helping…. ***(Nakwor, 31 YEARS, G3P2)***

A few others also stated that it is recommendable and should be available to all pregnant women whether physical or online sessions.

The pregnancy school, I think it's helpful. And I'll recommend it to anybody pregnant women, and even those that are not pregnant. Yes. Because. It has a great impact on us and it will help us, even after birth…. ***(Mavis, 30YEARS, G3P2)***

I think it's a good initiative and it should be made available to all pregnant women, whether online or physical. It an undeniable fact that the physical tuition is better, but there should be an alternative if the person is not available for a particular tuition…. ***(Ama, 34YEARS, G3P3)***

It's a very good thing. I can recommend it. And as I said, they need to just check their time. out. Even if it's from 7am to 12noon as I said earlier…. ***(Sandra, 30 YEARS, G4P3)***

Subsequently, views on ways to improve on the pregnancy school was explored. The results indicated the need to motivate midwives and strengthen husband support.

4.2.4.4 Ways of improvement

Evaluating the pregnancy school from the perspective of the pregnant women is very important since they are the main recipients of the programme. The majority of the participants talked about the time frame for the programme and the content of the curriculum with more demonstrations being preferred.

Well, I think the syllabus or curriculum should be revised. It should be more practical. With the breastfeeding aspect a couple of us were made to sit and hold the baby in a comfortable position where we can breastfeed the baby. And it helped us and also, I think it should be more frequent…. ***(Ama, 34YEARS, G3P3)***

I think they should inform everybody that maybe there is a pregnancy school and it is compulsory for all pregnant women and they should set a time. What I noticed here is 6:00am – 7:00am the people that attended pregnancy school are not that much, but after seven, some people know that the midwife, we start at 7:30am So from that time, a lot of people come around that time they have already ended the class…. ***(Mavis, 30YEARS, G3P2)***

I think it's okay but the time and duration because it is held early in the morning and not all of us are in, so at least maybe in the mid of the day they can when they have enough people around, they can chip in 30minutes to educate us so that everyone can benefit too. So that if early in the morning people are not in just a few people will benefit and so will come late but you know you have given the education and somebody will come late and be like they don't teach anything meanwhile you are coming late and the education has been given but if the number

us huge and you give the education around 11:30am- 12 by then you have enough people around so that they can also benefit…. ***(Adobea, 32YEARS, G3P3)***

A few of the participants also touched on motivating the midwives and strengthening of husband support.

I also think midwives should be motivated. They should be motivated monitory, they should be given logistics, so that they can continue and do it well. I don't think initially it was part of the midwifery system, I think it has come to stay so I believe we should make it better, so that they can do it well, they should be given flexible working hours and allow to upgrade themselves by going to school and learn more because a lot of children lives depend on them. Whether you have a healthy delivery or not it depends on the midwife…. ***(Ama, 34YEARS, G3P3)***

It is not only the pregnant woman that should be educated on this but at least, their partners too should have days to be taught. For some men when you ask them to come with your wife. Some of them will not come. A notice should be given that every husband is supposed to come to the hospital on this date, whereby you educate them, then they sit there to hear things for themselves…. ***(Mercy, 22YEARS, G2P2)***

The pregnancy school can be improved there and then in the home when you are pregnant is you that go through a lot but the people around you also matter so when they know the situation you are inside so for me, I think that the people around you should sometimes at least follow you there so that they also get the education some. In order for them to help you to come out successfully it's not only about you. When you get it and the people around you don't get it you come home and everything is mixed up for you. Or if maybe for instance like the platform which maybe the midwives can talk more to our husbands for them to avail themselves so that it won't be like only you know it but the people around don't know…. ***(Abena, 31YEARS, GIPI)***

Some of the participants also mentioned that the education should be structured by trimesters so that pregnant women can be assigned to different classes and that the Government must ensure it is done in every hospital.

> *One thing I would also propose is to form a WhatsApp group for the trimesters for not more than twenty so that we share our experience. You know we are all pregnant women and what you might be going through might be the same thing, so if the person shares the experience, it will equip you on how to manage yourself until your next ANC. This will help reduce the too much burden on the midwife, it will also help to equip us and make their work easy for them….* ***(Ama, 34YEARS, G3P3)***

> *And then also like I mentioned, the school should be structured and possibly pass people out. Yes, so you group them, so first trimester group. Education tailored towards second trimester and third trimester and then we know we are finish with you….* ***(Akos, 37 YEARS, GIP0)***

Some of the participants remarked that they should go over the previous lessons and also add creational activities to the classes

> *I think more teachings can be added to make it more interesting. Yoga can be a good addition as well with more playful and funny activities, that can attract people. Give-away and few events like the drink the nutritionist came to share, and the party they did for the kids can also be a good addition….* ***(Aisha, 31YEARS, G4P4)***

> *So far so good because we do it in the local dialect which I think it's the best we can add leaflet to it. And then maybe when we come the following week let's say Friday clinic, whatever was thought on this Friday, when we come the following Friday, an overview and ask questions so that you know the information has gone done well with the client….* ***(Esi Newman, 33YEARS, G3P3)***

On the issue of giving out leaflets for further reading, majority of the participants preferred audio visuals to the leaflets although they think it is a great initiative.

4.2.4.5 Issuing of leaflets

Issuing of leaflets containing information on pregnancy, postpartum care and family planning is seen as another way of assisting the pregnant woman, husband, partner and family in gaining more knowledge about pregnancy and help make informed decisions

that can benefit the pregnant woman and her baby's overall health. Participants were asked their views on issuing out leaflets. Some stated it would be useful for further reading as well as refreshing their memories.

> *Some of us might forget what we learnt that day but if you are having the leaflets, just seeing it and reading it will remind you of something you have learnt….* ***(Thelma, 34YEARS, G4P2+2)***

> *I think it's good to give out leaflet because maybe you are giving the talk or educating at that moment it's not everybody's mind that is there with you to listen and having everything you are teaching. But when you give out the leaflet though it's not everyone who can read and write, but some of the sketches or drawings can also give out information to the person. So, when they go home, they can be looking throughout it every now and then so that they if I get to this stage, I will do this and that….* ***(Esi Newman, 33 YEARS, G3P3)***

> *Oh, if leaflets could be issued to us for us to do further reading is ok. So far as you are reading and you also know is ok….* ***(Abena, 31 YEARS, G1P1)***

> *Yes, it would be very useful, it would be very useful. And I, I …, whiles I was searching for information Ghana Health Service had information, their website contains information about this or even the clinic, the hospital I attend too has information about some those things but you realize that not on this issue. Pregnancy and other health related information but I had to rely on foreign articles. Yes, media and hospitals and their website and information. Coupled with the already, education that we are having, I think it would be fine. Coupled with the already, education that we are having, I think it would be fine….* ***(Akos, 37YEARS, G1P0)***

The majority stated that it if the person is an illiterate, it will be very difficult. They suggested that audio recordings be made available, as well as include pictures in the leaflet and face-face presentations.

> *Not all of us know how to read, some of them maybe you have to do some video, audio for them to listen….* ***(Olivia, 32YEARS, G3P2)***

Not all pregnant women can read. So sometimes even the face-to-face school we sometimes help those who cannot read because they do ask questions and so most of them cannot be on the platforms. So, giving them the leaflet that means you have to factor in those who cannot read and have to be sure with those who can read in other for you to give them the leaflets…. ***(Nakwor, 31 YEARS, G3P2)***

Yes, it would be okay. But I do not think everyone can read and write but I think those that cannot read can give it out to their spouse or someone else to read to them. I believe the leaflets will be good compared to taking notes ourselves. And pictures should be on it, at least if you cannot the pictures will show you how to sit down all that…. ***(Joan, 24 YEARS, G1P0)***

It's very, very important. At least if the person cannot read by herself, at least she can give it to her husband or a relative who can read and understand to help her, so it's very important…. ***(Ama, 34 YEARS, G3P3)***

The information given to pregnant women antenatally helps the pregnant women their husbands, partners and family to make good decisions concerning pregnancy and delivery.

4.3 Summary of Findings

In summary, the chapter represents the findings of the study which was based on themes from the theoretical framework and sub-themes which emerged from the data gathered. Fourteen (14) participants were used for the study with their ages ranging between 22 to 37 years. In order to help reduce the maternal mortality and create awareness about pregnancy, the information or education given to the pregnant woman, her husband, partner and the family is very important. The findings indicated that all the participants who attended the pregnancy school have had foreknowledge about the school. Participants shared their experiences about the pregnancy school, saying that they gained good understanding on pregnancy and its challenges. Some of the participants also shared their thoughts on how well their midwives handled them. The usefulness of the information was also touched on. A few also stated that it helped them to learn from their colleagues. They also expressed their views on the number of appointments they received. Some

wished for more while's others were satisfied with number of times the classes were held. Majority of participants talked about the time frame; desiring something could be done concerning the starting time. Stating that whiles one is listening to the talk could be called to see the doctor, they wished this conflicting time would be addressed.

The second theme focused on the influence of personal and social motivation on participants willingness to attend the classes. Participants were asked what motivated them to attend the classes. Some stated that being treated well by their midwives motivated them to participate and the majority were of the opinion of needing reliable information regarding pregnancy from experts. The majority of the women had support from their husbands, however a few also received support of their partners, mothers and friends. When asked about the impact of education on social support they received, the majority stated that their husbands became more affectionate, and helpful as a result of learning about the changes they might experience as well as emergency planning and birth preparedness. Most of the participants were satisfied with the information but some recommended that the content of the lessons should be reviewed. Strengthening of husband support was one major point that was mentioned by the majority of the participants. On the whole, it was overwhelmingly evident from participants responses that the pregnancy school is a good initiative that all stakeholders should support in order to improve it.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter focuses on the discussion of the study findings. The participants' demographic characteristics are discussed, as well as the model's theme, which include health behavioural-information, health behavioural-motivation, health behavioural-skills, and health behaviour. The major subthemes that emerged from the study are discussed.

5.1 Demographic Characteristics

There was a total of fourteen participants, out of whom nine were multiparous, three were primiparous, with two being nulliparous; with ages ranging from 22 to 37. Pell et al. (2013) studies disclosed that as a predisposing factor, the role of high parity in reducing the odds of ANC attendance and initiation could have been because women who have had previous pregnancies may consider themselves experienced. To this end, they may be used to the routine care offered during ANC and so delay ANC initiation and number of ANC contacts made. Contrarily, in this study majority of the participants who adhered to the ANC classes were multigravida or had a high parity.

A few studies however have found that younger women attended ANC clinics more than older ones. Confounding effect by parity on age may also have affected the relationship between age and ANC use as low parity was associated with early ANC booking and increased number of ANC contacts in the studies reviewed (Akowuah et al., 2018; Dahiru et al., 2015; Ononokpono et al., 2014). In contrast, Tekelab et al. (2019) mentioned that age was not significantly associated with the utilisation of ANC in a review of factors affecting ANC in Ethiopia. Because the majority of the participants were multiparous women and adults, this implies that a woman's participation in pregnancy education is unaffected by her gravida or parity status or age.

Concerning educational background and occupation, three participants (3) have master's degree, seven (7) have their first degree, three (3) senior secondary school certificate and with only one (1) having a Junior high certificate. Thirteen out of the fourteen participants (14) were employed, with the exception of one (1) participant being unemployed. This demonstrates that a woman's educational and employment status can have a positive impact on her decision to seek health care. This is backed by Okedo et al. (2019), who found in their studies that women with a working status (employed) were found to be more likely to attend at least one and at least four ANC visits than the unemployed. Being employed also increased the odds of early initiation of ANC. Employment status is closely related to income and educational status as educated women tend to be employed and consequently earn more income. Beyond being a source of funds for sponsoring ANC use, employment can also increase women's exposure and access to information on ANC, thus further promoting utilisation. Furthermore, Verney et al. (2018) mentioned that, a woman's degree of schooling showed a significant positive relationship with nearly every outcome variable in ANC uptake. Studies analysing DHS data in Ethiopia found that maternal education was more strongly associated with the early initiation of ANC than with the number of visits (Tsegay et al., 2013), whereas our findings showed positive associations with all ANC outcomes. This perhaps is because more educated women are much aware of the benefits that will be accrued by ANC visits or because a more educated women feels greater empowerment to overcome barriers that inhibit access to ANC services.

Additionally, three studies documented the impact of occupation / employment status on uptake of ANC. In six of the studies, women who were employed and those who had a working status were found to be more likely to use ANC than the unemployed/not working (Assefa et al., 2017; Akinyemi et al., 2016; Verney et al., 2018). However,

Rasouli et al. (2017) stated, the fact that the level of education is high does not always mean that the level of literacy is also high. The pregnancy period should be seen as an important opportunity to improve the health literacy of women, especially those who are socioeconomically disadvantaged.

5.2 Health Behaviour-Information

Health behaviour information is essentially the information the pregnant woman receives through health education given during pregnancy that contributes to maternal and newborn survival and positive pregnancy outcome. This section discusses the participants knowledge of the pregnancy school, their experiences with the classes, their views on the number of appointment and the usefulness of the information.

Concerning the knowledge of the pregnancy school, the description of the school was used to assess the participants' knowledge about it. The current study revealed that most of the participants had knowledge of the pregnancy school which is one of the pillars of prenatal care and women and their families are prepared for pregnancy, childbirth and parenthood through the health information obtained from the antenatal education. This is in line with the findings (Ricchi et al., 2020; Taiwo et al., 2013; Widarsson et al., 2012). This point towards the fact that the content of the information given to the pregnant woman and her family is very critical since Ghana is aiming to achieve the SDG Goal 3 Target 3.1 by reducing maternal mortality ratio to less than 70 per 100,000 live births by 2030. A contrary opinion however, on antennal education for childbirth conducted by Cutajar et al. (2020), discovered that misinformation about contractions and the stages and phases of labour did occur during antenatal education. This in turn underscores the importance of strict adherence to purposeful antenatal education. The discrepancy between the current study's findings and previous findings of misinformation could be due to misinterpretation caused by a lack of expertise in that area among birthing educators.

Moving on to the experiences with the classes, participants discussed their experiences at the Greater Accra Regional Hospital's antenatal school. Despite the fact that the majority of them had a favourable experience with the school and spoke highly of how educative the programme has been. However, some were of the opinion that it would be more beneficial if the school and its educative delivery were more structured, a situation similarly reported in previous studies (Brixval et al., 2015). That study indicated that insufficient data to determine if prenatal education in small groups is helpful in terms of obstetric and psychosocial outcomes. The topics covered, the objectives, the overall number of hours, the amount of time spent on each topic, and other aspects of the classes were all inconsistent. This was also supported by Simkin (2017) who added that the content of lessons varied based on the demographics of the students, the sponsors' aims and objectives, and the instructors' points of view. The similarities between the current and previous studies indicate insufficient classes hours as the pregnancy school and antenatal clinic are concurrently held on the same day. As clients and their support persons receive too much information within short space of time leading to possible mental fatigue especially for those unable to read and write.

Despite this, some of the participants also recommended the performance of the facilitators of the pregnancy school. The findings indicated that participants had better understanding of the information, prompt responses from the facilitators and also learned from their colleagues. Correspondingly, Ricchi et al. (2019), found out that 96.3% of women who took childbirth lessons expressed satisfaction with their sessions and found them to be extremely beneficial. These women were most pleased with the facilitator's performance, the utility of relaxation techniques, breathing techniques, and the overall effect of the lessons. Similarly, Matejić et al. (2014) also revealed it is critical to

understand a patient's experience with health care in order to receive accurate information on the quality of care and to identify problematic areas that could be improved.

A few of the online pregnancy school participants also remarked that it was a great experience to read and receive reliable information from professionals. This outcome corresponds to findings of Meedya et al.(2020), who posited that delivering technology-based education has been increasingly popular in the previous decade and may be regarded an alternative to face-to-face education during the COVID 19 pandemic. The classes being held online brings about technological innovation in the organization of the pregnancy school and should be well encouraged in health facilities with wherewithal to smoothly implement such innovations. This to a large extent will enable clients who for some reasons are not able to partake in the face-to-face discussion. Furthermore, majority of participants recommended that online classes be grouped into their respective trimesters as this will facilitate smooth delivery and absorption on information.

Regarding the participants view on the number of appointments, the majority of facilities in the Accra Metropolis hold their pregnancy school on days other than antenatal clinic days. The antenatal clinic day and the pregnancy school are combined at the Greater Accra Regional Hospital. It is done first thing in the morning, while the antenatal clinic is ongoing. Further, the majority of the participants stated that they occasionally miss parts of the lessons as a result of this. Participants however reiterated that the number of appointments they received was satisfactory because they attended the antenatal clinic on a regular basis. Moreover, the majority of the participants reported that although there was limited time to ask questions, all pregnancy and delivery misconceptions and rumours were dispelled. Similarly, Marufa et al. (2019) indicated that the respondents, in

conventional individualized care, the service provider generally only has a limited amount of time with each patient, and they are only able to answer a few of the patient's concerns or offer just the most basic facts during consultation. Again, Dinç et al. (2015) who worked on pregnancy education found inadequacies that lead to the failings in antenatal education. Such inadequacies include too much information given in a short time, educational content tailored to the preferences of trainers rather than the needs of women, insufficient time to discuss transferred information, and non-practical reinforcement of relevant theoretical information. The findings also highlight the disparities in the goals, substance, and duration of prenatal education programs, indicating that current norms and guidelines are insufficient. This similarities between the current and previous findings reveals that educational material as well as the organization of the classes must be looked at in terms of how it is structured.

The usefulness of the information is intrinsic to how beneficial it would be to those that put that information to use. Because we are mainly formed up by what we hear and know, the knowledge provided by specialists to pregnant women and their families during pregnancy is critical. This improves good conscious health behaviours in mothers and enlightens the support individuals who accompany them to the antenatal clinic. This enables individuals to make more informed decisions during their pregnancies. In view of this, the majority of multiparous women admitted that, despite being multiparous, there are still a lot to learn. The participants find the information to be quite useful, and they learn new things in the classes. This view affirms the study by Stoll et al. (2012) that Pregnant women frequently attend prenatal education classes to learn about different birthing options, pain management techniques, baby care, postnatal care, breastfeeding, and parenting. Similarly, Hassanzadeh et al. (2020) also found out that improving women's understanding through prenatal education can help them prepare for childbirth

and enhance their health, and that a lack of information and fear of the unknown during pregnancy and labour causes mothers to be frightened and nervous. This further impresses on the point that despite the gravidity of client, there is that need to provide them with information on pregnancy, labour and delivery as this will help them to be up to date with new trends in coping as pregnant women in preparing for safe delivery.

Some of the participants reported that they learnt not only from the experts, but also from their peers and went on to say that the information had made them more conscious of what they must eat as pregnant women. This is in accordance with the findings of Marufa et al. (2019) who stated that that peer-to-peer information sharing is a significant finding of their research. First-time mothers benefited from hearing from experienced mothers who shared their experiences and learnt about typical discomforts and difficulties. The study also found that knowledge obtained through group prenatal care helped pregnant women become more aware of their own health and empowered to make healthcare decisions, influencing their family members who might otherwise discourage them from attending check-ups. Few of the participants did indicate however that they obtained reliable information from experts, and that the session was very interactive. This is in line with what Vilda et al. (2019) observed that doctors and medical professionals offering basic information to women, particularly women from lower socioeconomic backgrounds, will reduce misunderstanding between doctors and patients. Some of the participants said they received information on each stage of pregnancy, and few did add that they were very much conscious of when to go to the hospital when labour started because of the education received. Validating this assertion, Cutajar et al. (2020) disclosed that each childbirth educator went over the three stages of labour and contractions in great detail. As evidenced by the number of information statements, stage one attracted the most attention. Because early labour, established labour, water breaking,

and contractions were all mentioned in the first stage, this was the case. Each educator included definitions for early and established labour, as well as information aimed at teaching women and their partners how to recognise the stages and stay at home until labour is established. Additionally, this is consistent with the findings of Ferguson et al. (2012) who concluded that antenatal education had a favourable effect in reducing false labour admissions.

5.3 Health Behaviour-Motivation

This section discusses the personal and social motivation that influenced participants to partake in the classes, the impact of the social support they received, the relationship between the participants and their midwives and whether they experienced any attitudinal changes due to the education. People's willingness to put their knowledge to good use is largely determined by their own intrinsic factors, however family and friends can also influence them. The pregnant women are not to be forced to attend the lessons, therefore how they are treated at the antenatal clinic can influence them to participate.

With regards to motivating factors that influenced participation in the classes, some of the participants in this current study mentioned that they participated in the classes because it was their first-time hearing of the pregnancy school and they wanted to know what the pregnancy school is really about. Furthermore, the findings revealed that they participated in the classes in order to acquire new knowledge. This suggests that if the pregnancy school is interesting and the information is provided effectively, it might even be a source of encouragement for people to go without being forced. This is similar to the findings of Rasouli et al. (2016), it was noted that the childbirth preparation classes approach emphasizes on assisting a client in making their own decision to change, rather than the client being forced by outside sources with attempts to convince or compel them to change.

The findings of the study established that social support being it their husbands, partner, family and friends also had influence on deciding to partake in the classes. This finding concurs with that of Upadhyay et al. (2014) that maternal decisions are influenced by structural and social support. Most of the participants mentioned that they were accompanied by their husbands. One of the most important aims of the pregnancy school is to promote male involvement in the pregnancy school since they are mostly the decision makers when it comes to the Ghanaian context and parts of Africa. Similarly, Yargawa et al. (2015) emphasizes the necessity of engaging married men in initiatives aimed at increasing ANC use, as male engagement has been shown to enhance maternal health. Contrarily, a study by Sein et al. (2013) revealed that, husbands were less active during the postnatal period than they were during the prenatal and delivery periods. The use of PNC services in many developing nations, including Myanmar, is lower than at other periods. Also, men may assume that female family members should care for wives and children during the postnatal period rather than male family members (Kwambai et al., 2013). However, it was not determined whether their husbands accompanied them to the postnatal clinic in this study.

Moving on to their views on midwife's client relationship, most of the participants also believed that because they had been treated well by their attending midwives, it served as motivation to join the lessons when the midwives informed them of the opportunity. This finding corroborates with the findings of (Dagmawit et al., 2020; Mueller et al., 2020) who mentioned that clients who were regarded by health-care personnel were also strongly related with satisfaction, to the point that they felt comfortable discussing personal matters with them. Two of them indicated that they were having issues with their husbands and mothers-in-law, which was affecting their health, but that coming to the antenatal clinic to speak with their attending midwives was

reassuring. As a result, they were able to follow most of their midwife's instructions. This finding is in consonance with, Børøsund et al. (2014) who mentioned that their participants felt more confidence in their communication with health care professionals, which increases patients' overall satisfaction with the quality of their health care and their mental and physical health. It appears from anecdotal data that healthcare workers in urban areas of the majority of African nations behave very well towards their clients or patients. This may be because the majority of clients who visit urban health care facilities are well-informed and educated; they appear to be aware of their rights as outlined in the patient's charter; consequently, the healthcare professionals treat them with the respect they deserve because any minor disagreements will be reported in the media. Which will be detrimental to the facility and the participating healthcare professional.

On the issue of the impact of social support, the majority of the participants mentioned that their spouses became very supportive after they attended the classes since they gained a lot of knowledge about pregnancy and its issues. This study's findings are similar to those of a study in Mozambique by Audet et al. (2016). Furthermore, the findings of the study revealed that husbands' participation at the classes helped form a strong bond because they accompanied them from the antenatal period to the childbirth. This is in consonance with the findings of Serhatlioğlu et al. (2018) found that women who engaged in prenatal education with their husbands got emotional support from them during the labour process. A few of the participants added that, the knowledge their husbands acquired, helped both of them in making decisions about the pregnancy and delivery. Serhatlioğlu et al. (2018) further reiterated that, encouraging women and their spouses to attend childbirth education classes (CEC) is critical. Furthermore, training and counselling will help women develop their problem-solving abilities, expand their

knowledge, stimulate active decision-making, raise their sense of control, and boost their self-confidence.

Additionally, according to some of the participants, their deliveries went smoothly since their husbands accompanied them while they were in labour, giving them peace of mind. This finding is congruent with Leap and Hunter (2016) who indicated that merely having someone in the room, or being there, is enough to shorten the labour. With respect to the attitudinal change experienced due to the education received, most of the participants mentioned that they modified their eating and sleeping habits. This finding is in consonance with the findings of Vamos et al. (2019) who reported that participants in their study also discussed how such knowledge influenced their health-related decisions, such as nutrition and newborn care.

5.4 Health Behaviour-Skills

The information provided during the pregnancy school is not just verbal, but it also involves demonstrations. Clients are sometimes selected to do a return demonstration to ensure that they understand everything. New skills acquired, identification of danger signs, decision making process and benefits of skills gained at the pregnancy school will be discussed in this section.

Concerning skills acquired, the pregnancy classes were helpful in teaching the majority of the current study participants how to breastfeed. The findings of the study revealed that they learned how to position the baby to the breast and how to practice breastfeeding on demand without adding any supplementary feed. Hawkins et al. (2015) cited a study with comparable findings. On the contrary, Tarrant et al. (2014) previous findings revealed that many factors influence the decision to wean from breastfeeding altogether or to supplement with formula, mothers who stopped breastfeeding early have

reported insufficient antenatal preparation for their early breastfeeding experiences. This is incongruent to the current study findings, and this could be as a result of difference in the settings of the research.

Although many of the multiparous study participants were aware of cord care, the findings indicated that the demonstrations given by the midwives at the classes improved participants skills in caring for the cord. Similarly, Amolo et al. (2017) remarked that, parents' newborn practices are key factors of neonatal death. When it comes to the identification of danger signs, the study participants' ability to identify danger signs were assessed by requesting them to name obstetric danger signs. Despite the fact that the majority of the study participants were literate and mentioned that they were counselled on the pregnancy danger signs during classes, most of the participants could only name two of the eleven pregnancy danger signs. Previous research in Tanzania and Ethiopia likewise found a low prevalence of knowledge of danger signs (Maseresha et al.,2016; Urassa et al., 2012). In contrast to the current findings, Hailu et al. (2014) found that women with at least an elementary education were more likely than those without a formal education to be aware of pregnancy danger signs. This outcome is incongruent with the current study because the majority of the individuals had formal education but were unable to name more than two pregnancy danger signs. It's possible that this is due to the fact that the participant got counselling in large groups rather than smaller groups. The most common danger sign mentioned in this current study was vaginal bleeding and decreased foetal movement. This finding is similar to that of a study conducted in Tanzania (Mwilike et al., 2018).

The decision-making process assessed how the information provided at the pregnancy school helped current study participants in taking decisions concerning the pregnancy, delivery, postpartum care and family planning. Two nullipara study

participants indicated that they were afraid of labour and informed their midwives. The midwives therefore taught them of the pain management strategies used in labour and that as a result refuted most of the rumours they had heard. Similarly, Miquelutti et al. (2013) indicated that when expectant mothers received antenatal education, they experienced less anxiety during labour, had less fear of childbirth, and had more childbirth-related self-efficacy. The findings of the current study revealed how majority of the study participants prepared for delivery and complication readiness. This is in line with findings of (Firouzbakht et al., 2013; Stoll & Hall, 2012; Pinar et al., 2018). However, in contrast to the present study, Chikalipo et al. (2018) findings indicated that BP/CR focusing on items to purchase in preparation for childbirth were mentioned as a preferred topic with a few suggesting the inclusion of danger signs during pregnancy. The difference between the results of the current study and the previous study could be attributed to content of material for the education.

The findings further revealed that, some participants took all of their prescribed medication, and that all rumours about IFA were dispelled through the education. In addition, few spoke about spacing of their children after delivery. This finding agrees with the previous findings of (Lori et al., 2017). Finally, study participant mentioned the benefits they gained at the pregnancy school. According to the findings, they obtained reliable information from experts, which helped them in establishing good eating habits that improved their haemoglobin levels. The results of the current findings are in concordance with the findings of Berge et al. (2019) who revealed that participants felt they gained a lot of knowledge that led them to try new health behaviours and also recommended that group prenatal care was an intervention worth continuing and spreading to other clinics.

In addition, the findings of this current study remarked how being mixed among their peers, both online and in person interaction helped them to learn from each other. Similarly, Kay et al. (2017) identified that when telling positive birth stories women hear of the strength and power in birthing and may be assured of their capacity to birth physiologically. Conversely, women that encounter negative birth stories may associate birth with suffering, risk, and fear. A couple of the participants remarked that because of the knowledge they had gained, they knew when to go to the hospital when they went into labour. This corroborates with the findings (Hatamleh et al., 2019; Makvandi et al., 2018). On the contrary, Ricchi et al. (2020) mentioned that the benefits of antenatal education are difficult to systematically evaluate and that further research is required to determine the real effects and agree upon reliable indicators of effectiveness. These difficulties seem to be attributable to data collection standards, different methodologies and types of classes, and the impact of what happens during labour and delivery.

5.5 Health Behaviour

The fourth theme touched on the health behaviour outcome of the study participant. It discusses the outcome of the health information, motivation and the skills acquired on their health behaviour.

With regards to the impact of health education on health, O'Neill et al. (2014) remarked that information that allows mothers to grow and retain their well-being during pregnancy, as well as not only the dissemination of key information for promoting the health of mothers, but also the areas where the given information will be put into practise. They further said that the mother's cognitive abilities, which will allow her to gather information and utilise it to positively influence her life, are also important. The findings of the previous study concur with the current study findings where majority of the participant mentioned that putting into use the education given at the classes improved

their health and eating habits. Additionally, the findings revealed that some of the study participant became health conscious and gained a sound mind.

With regards to their expectation, the findings revealed that majority of the participants trusted to gain knowledge about pregnancy, labour and safe delivery from the expertise. Contrary to a study by Ahlden et al. (2012) most of their study participants preferred more information on preparation for parenting and newborn care was reported by both women and their spouses than on preparing for the birth itself. A similar finding was reported by (Martinez & Delgado, 2013; Moniz et al., 2016). The results of the previous study could be influenced by the fact that their participants were better knowledgeable about pregnancy and labour, which is why they preferred parenting topics. A few of the participants added that they expected to be served with some snacks and juices. Also, the findings revealed that, most of the participants trusted the information given by the midwives and this is inconsistent with the findings of (Bertet al., 2016; Leiferman et al., 2014). Their findings indicate how pregnant women evaluate and utilize health information. Participants in their study were aware that information may be inaccurate or biased, and they stated that they confirmed the accuracy of information using various sources. This discrepancy in results could be due to the study's environment and persons engaged in its organization.

Concerning participants impression about the school, majority remarked that the program is recommendable. Some added that it is the best place to educate pregnant women, husbands, partner and family. However, Smith (2015); Tighe (2010) express worry about antenatal classes being used to ensure that women were aware of, and hence compliant with, hospital policies and procedures. Furthermore, many claims that class content has always been based on what educators believe women need rather than what women want (Hanson et al.,2009; Svensson et al.,2007; Tighe 2010). In view of this

previous findings, pregnant women's perspectives should be considered when developing the materials for the classes.

Moving on to ways in which the classes can be improved, most of the study participants mentioned that the timing of the classes should be worked on. The findings also revealed that participants had issues with the environment in which the school is organized. With regards to the environment, a few mentioned the seats and some also complained about the washrooms. Similarly, Metinoğlu et al. (2021) notes that inappropriate sounds, background noise, the temperature of the room, inappropriate lighting, and lack of respect for privacy contribute to disturbances in focus. Additionally, some of the participants recommended that husband support should be strengthened with only a few stressing on educating their husbands on sex. Similarly, women in Nigeria, on the other hand, wanted their husbands to learn about the impacts of pregnancy on women, how to care for a pregnant woman, how to be patient and understanding with their partner, and how to have sex during pregnancy (Adeniran et al., 2015). Contrarily to both findings, Anderson et al. (2017) reported that women in Sweden desired more knowledge on postpartum issues including breastfeeding issues, whilst males sought information on infant care skills, sexuality, and relationships. In view of these discrepancies in the findings, Axelsen et al. (2014) remarked that evidence also suggests that tailoring instructional content to the requirements of program participants can lead to the creation of suitable and culturally acceptable information.

Furthermore, Chikalipo et al. (2018); Opondo et al. (2016) added that it is not just the father's physical activities that are beneficial to the infant, but also the father's emotional condition. If male engagement is to improve, we believe that fathers' preparation for their responsibilities should go beyond knowledge and skills and focus on the emotional element. This might be accomplished by highlighting to couples the

advantages of male engagement in prenatal education. Given that the pregnancy school is intended for both pregnant women and their husbands, partners, and families, their input should always be considered when deciding on the program structure and content to be taught in the classes.

Again, the findings disclosed that, a few of the study participants stressed on the need to motivate programme facilitators and emphasized the need for improved demonstration. Lastly, on the issuing of leaflets, majority of the study participants responded affirmatively to it. A few of the participants preferred more audio visuals with the reason that it would be a problem if the person cannot read. Similarly, the findings of Lumbiganon et al. (2011) revealed that there was a marginally significant increase in exclusive BF at six months in a group receiving a booklet plus video plus lactation consultation (LC) compared with the booklet plus video group. A breastfeeding booklet plus video plus lactation consultation was significantly better than no formal breastfeeding education for exclusive breastfeeding at three months.

5.6 Evaluation of Theoretical Framework

The Information-motivation-behavioural skills model of health behaviour developed by Fisher and Fisher (1992) was used as the theoretical framework to guide this work. The IMB model has four major constructs namely: the health Information, motivation, skills and health behaviour (Fisher & Fisher, 1992; 2000; Fisher & Fisher, 1993; 1999). The IMB model was useful for the research because its constructs suited the purpose of this research.

The health information construct states that information that is directly relevant to the performance of health behaviour and can easily be enacted by an individual is a critical determinant of health performance.

The research participants mentioned that they gained adequate knowledge and reliable information on pregnancy, labour and puerperium from experts and thus the information was very useful. These findings are consistent with the framework.

The second construct of the framework work tackles factors that motivates and influence people in making health related decisions. Two major sub-themes were mentioned under this construct which are personal and social motivation. On their decision to partake in the pregnancy classes according to the findings of the study, most of the pregnant women were either influenced by the attitudes of their attending midwives or the social support received from their relatives and partners. In narrating their personal motivation to participate in the classes, the findings indicated that participants wanted to gain more knowledge on pregnancy. Furtherance to this, because the pregnancy school is a new concept to many, they wanted to know what it was all about. This confirms the study outcomes consistency with the framework.

The third and fourth constructs of the framework discusses the skills acquired through the health education and the impact of the education on their health respectively. The education offered to the pregnant woman is expected to reflect in the way she and her family deal with pregnancy related issues.

As mentioned in the theoretical framework, most participants acquired skills through the health education, thereby impacting positively on their health and thus appraised the pregnancy school as a good initiative.

5.7 Summary of Discussion

In summary, the discussion was guided by the constructs of the IMB model as well as the subthemes that were formulated from the study namely: health behaviour-information, health behaviour-motivation; health behaviour-skills and the health behaviour-information-motivation-skills and the health behaviour. The study revealed that pregnant women who attend antenatal clinic at the Greater Accra Regional hospital had foreknowledge of the pregnancy school. The study found that, the classes were very useful. However, it was discovered that there were issues concerning the timing and the structure of the classes. It conflicts with the antenatal clinic which they find it to be disturbing.

In addition, it was established that participants mostly attended the classes because they wanted to gain knowledge about pregnancy, delivery and postpartum care. It also discovered that, the attitude of their attending midwives also influenced their decision to partake in the classes. Husband support was found to be another source of influence in the participation of the classes. It also discovered that husband support had a great impact on the participants who were accompanied by the husbands. It also established that majority of the participants gained skills that helped them to take good decision concerning their pregnancies, childbirth and postpartum care. The study disclosed that the overall impression about the pregnancy school is positive. It was brought up that the pregnancy school is highly recommendable, however there is room for improvement.

CHAPTER SIX

SUMMARY OF THE STUDY, IMPLICATION, LIMITATION, CONCLUSIONS AND RECOMMENDATIONS

This concluding chapter outlines the summary of the study, implication of the study, limitation, recommendation and conclusions.

6.1 Summary of the study

Antenatal care plays an important role to achieve a successful labour and delivery process. The labour and delivery process could be both stressful and joyous for most pregnant women. Many women and their spouses attend pregnancy classes to learn more about the process and reduce their anxiety. Antenatal care and education given to the pregnant women serves as one of the components being used to curb maternal mortality. In most households, the necessity of antenatal care is exaggerated, as the would-be mother is overwhelmed with suggestions on what is good and wrong for her. Several studies conducted in Ghana have assessed the causes of maternal mortality in relation to antenatal care services but few have examined the impact of education (pregnancy school) given to pregnant women and their partners antenatally. Furthermore, more questions are left unanswered concerning the quality of antenatal education given by health professionals. Using Fisher and Fisher's (1992) Information-motivation-behavioural Skills model as a guiding framework, this study explored the health behaviour of pregnant women towards the pregnancy school at the Greater Accra Regional Hospital in the Accra Metropolis.

The study objectives were set using the model's constructs. Explorative qualitative design with purposive sampling technique was employed for the study. Fourteen participants who met the inclusion criteria were used for the study. An introductory letter seeking permission for the study was taken from the school of Nursing and Midwifery to the Ghana Health Service Ethical Committee Board. The tool was piloted on two

participants with similar characteristics at the Ghana Atomic Energy Commission Hospital after procedure explained to them and they consented to it. Interviews were done face-to-face under strict adherence to all the protocols of COVID-19. Each interview was recorded and data was transcribed verbatim. Data was analysed using thematic analysis.

The health behaviour-information was assessed through the participants knowledge of the pregnancy school, their experiences with the classes, their views on the number of appointment and the usefulness of the information as received. The description and definition of the pregnancy school were used to assess the participants knowledge of the pregnancy school. The majority of the participants were knowledgeable of the pregnancy school's objective. The participants shared their thoughts on the classes. Although the participants found the lectures to be very useful, there were concerns with the time and organisation of the classes, according to the study findings. In both face-to-face and online classes, the majority stated that the classes should be grouped according to their trimester. The study discovered that the lessons conflict with antenatal days, with participants stating that you would be called to see the midwife or doctor while the programme is in session.

It was discovered that social support and the attitude of the attending midwives had a significant influence on participants decision to attend the lessons. Some of the participants said their attending midwives were so nice to them that they felt comfortable discussing personal matters with them. Most of the participants also stated that it was their first-time hearing about it and that they were curious as to what it was all about. The majority of the participants in the study experienced attitudinal changes as a result of the education received. The most common behavioural change the findings reported was in regard to their eating habits and medication adherence. Bleeding and decreased foetal movement were the two most commonly stated danger signs mentioned by the

participants. The participants added that the pregnancy school is a good initiative and it is recommendable.

6.2 Implication of the Study

The findings of the study have implication on midwifery practice, nursing and midwifery research, and implication for health policy.

6.3 Implication for Nursing and Midwifery Practice

Antenatal education provided to pregnant women in pregnancy classes aims to equip pregnant women and their families with the necessary information and skills to make informed pregnancy decisions and contribute to the achievement of SDG Goal 3. For this reason, it is imperative to factor in the needs of the pregnant women and their family. The findings of the study revealed that there are issues with the timing of the classes. The pregnant women stated that they either miss part of the lecture or miss the pregnancy classes entirely because they are held quite early in the morning. Also, the participants stated that it conflicts with the antenatal clinic days. The midwives in charge of the pregnancy school should gather feedback from the women during the sessions in order to determine the best time for the classes.

The findings indicated that, participants had issues with the structure of the pregnancy school and wished they were grouped according to their trimesters. In addition, grouping the women by trimester will encourage peer counselling and social networking. Most of the participants mentioned that husband support should be strengthened. Midwives can therefore collaborate with community health workers to help educate the community on the importance of husband support. Furthermore, the study discovered that most of the participants preferred more practical session(demonstration) and yoga

exercises. Pregnancy school should be offered in small groups to facilitate return demonstrations, and exercise venues should be considered outside of hospital premises.

6.4 Implications for Nursing and Midwifery Research.

The findings indicate that the majority of participants had difficulty with the class schedule, which affected their attendance. Additionally, the majority of participants requested that classes be structured by trimester. Therefore, midwives involved in the organisation of pregnancy schools can conduct research on the organisation of pregnancy schools both online and in person, due to scanty research on the pregnancy school in Ghana.

Again, the study indicated that, while the majority of participants were educated, they lacked information regarding danger signs in pregnancy. Additional research can be conducted to better identify specific antenatal practices that can assist women in increasing their awareness of danger signs throughout pregnancy. Finally, further research can be done on the information needs of husbands and partners attending pregnancy schools.

6.5 Implication for Health Policy

The Ministry of Health and Ghana Health Service should structure and strengthen pregnancy classes by regularising them and make them accessible in all health facilities, as well as increasing the number of staff who are certified to teach the pregnant women and their partners.

6.6 Limitations of the Study

The study's limitation is that husbands who attended pregnancy classes were not included in the study, therefore their experiences with the pregnancy school were not assessed. Additionally, it was difficult to explore other areas of the pregnancy school from the perspectives of the midwives. Furthermore, the study was limited to one facility (Greater

Accra Regional Hospital), therefore the health behaviour of pregnant women in other facilities could not be examined. Another study limitation was not assessing postpartum mother's perspectives on whether the information helped in the transition to parenthood. Future research should be conducted on midwives' perspectives of the pregnancy school.

6.7 Recommendations

The following recommendations have been made to the Ministry of health, Ghana Health Service and Greater Accra Regional Hospital.

6.7.1 The Ministry of Health

1. Introduce the pregnancy school in all health facilities in Ghana
2. Monitor the organization of the pregnancy schools in health facilities.
3. Allocate resources to Ghana Health Service to help in the organization of the pregnancy schools.
4. Ensure workshops and seminars are organized for all facilitators of the pregnancy school.
5. Provide funding for more research on the pregnancy schools.

6.7.2 Ghana Health Service

1. Equip pregnancy school facilities with needed logistics to facilitate practical sessions.
2. Implement policies that will help in the regularization of the classes and periodic review of the content of the materials being used for the education.
3. Organize periodic training of staffs involved in educating of the mothers.
4. Promote and strengthen online classes to solve issues concerning conflicting antenatal clinic days with the pregnancy school.

6.7.3 Greater Accra Regional Hospital

1. Organize periodic training of staff to update them on new trends in the organization of pregnancy school.
2. Evaluate the pregnancy classes regularly.
3. The classes should be grouped according to the trimester to promote peer interactions and discussions among pregnant women within their respective classes.
4. Upgrade wooden seats from benches to comfortable ones to make participation conducive.
5. The timing of the classes should be made flexible and could include online meting platforms such as zoom, google classroom.
6. Periodic needs assessment of the pregnant women and their support persons should be undertaken during antenatal clinic days.
7. There should be more practical sessions on handling and caring for the baby as well as encourage return demonstrations.
8. The midwives should be incentivised to serve as a means of motivation for their service and efforts.

6.8 Conclusion

The health behaviour of pregnant women who attend the pregnancy school was assessed using the information-motivation-behavioural skills model. The study findings revealed that the participants had knowledge of the pregnancy school and find the information provided very useful. Participants find the midwives' attitude to be very encouraging, which motivates them to participate in the pregnancy school. Support from husbands was found to have a positive impact on the participants. The information provided in the classes helped them in making well-informed decisions about pregnancy, delivery, and postpartum care. The timing of the classes was identified as a significant problem. When

delivering the education, participants suggested that they should be organized into trimester groups. Because there was a lack of awareness of pregnancy danger signs, more emphasis should be placed on providing information on these signs throughout the period of pregnancy and early reporting for the pregnancy school should be emphasized to promote healthy pregnancy outcomes.

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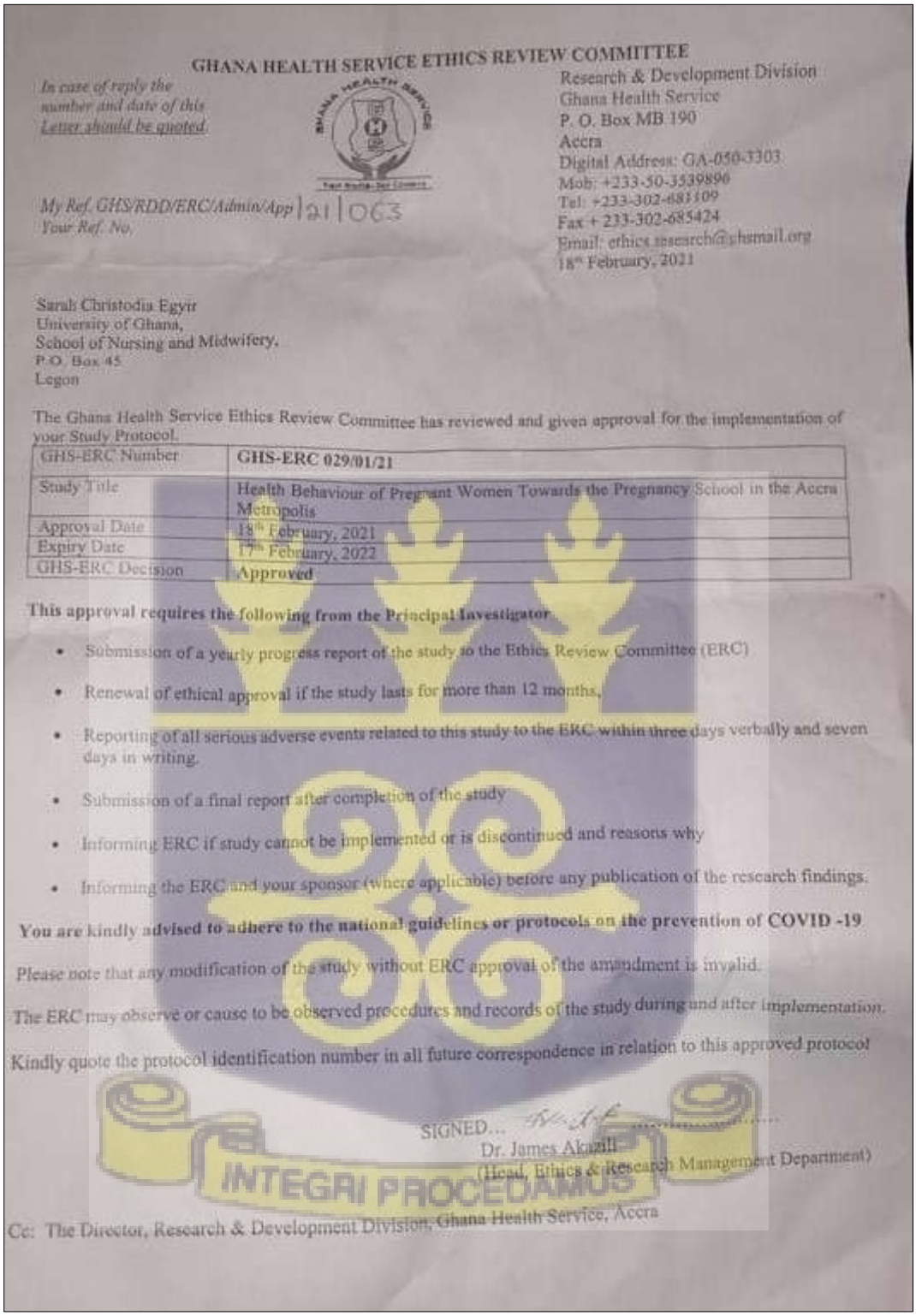
APPENDICES

Appendix 1: Ethical Clearance



GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

My Ref. GHS/RDD/ERC/Admin/App/21/063
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Digital Address: GA-050-3303
Mob: +233-50-3539896
Tel: +233-302-681109
Fax + 233-302-685424
Email: ethics.research@ghsmail.org
18th February, 2021

Sarah Christodia Egyir
University of Ghana,
School of Nursing and Midwifery,
P.O. Box 45
Legon

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 029/01/21**
Study Title	Health Behaviour of Pregnant Women Towards the Pregnancy School in the Accra Metropolis
Approval Date	18th February, 2021
Expiry Date	17th February, 2022
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of a yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months.
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

You are kindly advised to adhere to the national guidelines or protocols on the prevention of COVID -19

Please note that any modification of the study without ERC approval of the amendment is invalid.

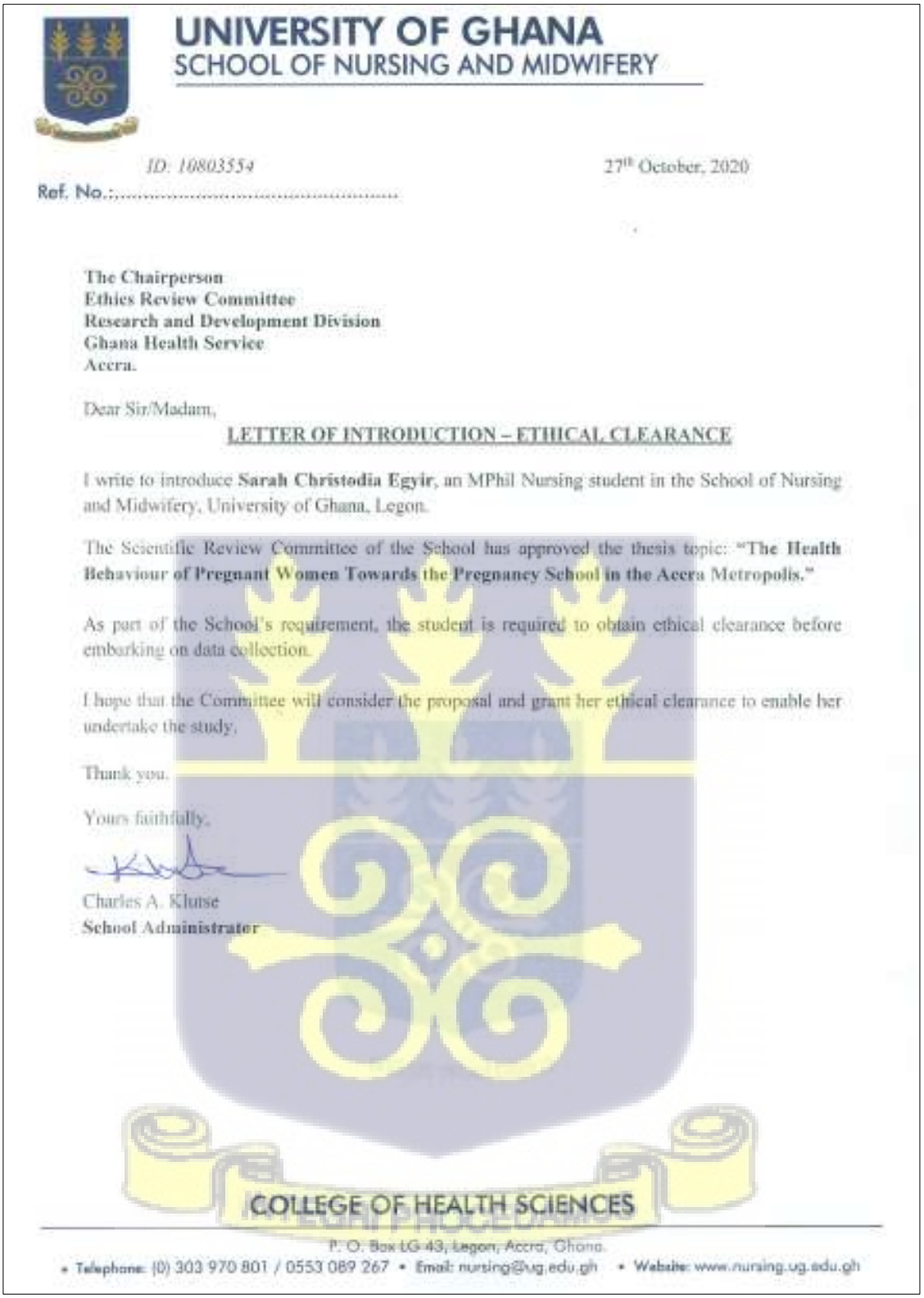
The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED...
Dr. James Akazili
(Head, Ethics & Research Management Department)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra

Appendix 2: Letter Of Introduction



UNIVERSITY OF GHANA
SCHOOL OF NURSING AND MIDWIFERY

ID: 10803554

27th October, 2020

Ref. No.:.....

The Chairperson
Ethics Review Committee
Research and Development Division
Ghana Health Service
Accra.

Dear Sir/Madam,

LETTER OF INTRODUCTION – ETHICAL CLEARANCE

I write to introduce **Sarah Christodia Egyir**, an MPhil Nursing student in the School of Nursing and Midwifery, University of Ghana, Legon.

The Scientific Review Committee of the School has approved the thesis topic: **"The Health Behaviour of Pregnant Women Towards the Pregnancy School in the Accra Metropolis."**

As part of the School's requirement, the student is required to obtain ethical clearance before embarking on data collection.

I hope that the Committee will consider the proposal and grant her ethical clearance to enable her undertake the study.

Thank you.

Yours faithfully,

Charles A. Kluise
School Administrator

COLLEGE OF HEALTH SCIENCES

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Appendix 3: Interview Guide

Study title: HEALTH BEHAVIOUR OF PREGNANT WOMEN TOWARDS THE PREGNANCY SCHOOL IN THE ACCRA METROPOLIS.

SECTION A

Pseudonym:

Date of interview:

Time of interview:

Duration of interview:

SECTION B

DEMOGRAPHICS

The demographic section is the database engine of the research. Demographics is the study of a set of population based on factors age, sex, marital status, race etc. Statistically, the demographic data will be analyzed to help bring underlying themes and trends within the data set.

1. Age
2. Marital status
3. How many times have you been pregnant including your current pregnancy and miscarriages?
4. How many children do you have?
5. What is your employment status?
6. Educational level
7. Nationality

SECTION C

This section takes into account the constructs of the model that will be used to guide the research work. The constructs are Health Behaviour Information, Health Behaviour Motivation, Health Behaviour Skills and Health Behaviour Information, Motivation and Skills on the health behaviour outcome. These are outlined as follows;

i. Health behaviour information

1. What do you know about the pregnancy school?
2. How did you get information about the pregnancy school?
3. How useful was the education received at the pregnancy classes?
4. Was the information tailored towards each trimester?
5. Tell me about your experience with the classes?
6. During your current pregnancy, how many times did you attend the pregnancy school?
7. Please what is your view about the number of appointments you received for the pregnancy school?
8. Tell me about what you think about the duration of the pregnancy classes/school.

ii. Health behaviour motivation.

1. What influenced your opinion to participate in the pregnancy school?
2. Tell me about the social support you received?
3. What was the outcome of social support you received?
4. Tell me about the attitudinal change experienced through the education?
5. Please what is the impact the information you and your partner received had on your relationship.

6. Can you tell me about your partner's reaction when he was told to participate in the pregnancy school?
7. Please can you tell me about your opinion on quality of contact between you and your midwife during the period of participating in the classes.

iii. Health behaviour skills

1. Can you talk about some of the benefits you have gained by attending the pregnancy school?
2. What influence did the information /education have on your decision-making process during pregnancy, delivery and postdelivery?
3. What are some of the danger signs you were able to recognize during pregnancy through the education received?
4. What were you expecting to achieve through the pregnancy school?
5. What new skills have you acquired through the pregnancy school.

iv. Health behaviour

1. Please can you tell me about the impact of the health education on your health?
2. What are some of the objectives you set prior to participation of the pregnancy school?
3. In what ways do you think the pregnancy school can be improved.
4. Give your general impression about the pregnancy school.
5. Tell me what your expectations were about the pregnancy classes.
6. How were you able to make your own antenatal notes during the classes?
7. Please can I know your opinion on receiving written information about pregnancy, labour and care of the baby to take home with you?

8. Please is there anything else you will like to share with me or any questions you will like to ask me?

Appendix 4: Consent Form

STUDY TITLE: HEALTH BEHAVIOUR OF PREGNANT WOMEN TOWARDS THE PREGNANCY SCHOOL IN THE ACCRA METROPOLIS.

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and all questions satisfactorily explained to me in a language I understand (English). I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name of Participant……...

Participants' Signature ……...OR

Thumb Print……

Appendix 5: Codes and Descriptions

THEME	SUB-THEME	CODE
Health behaviour information	Knowledge of the pregnancy school	• Awareness • Educative • Education on pregnancy and family planning
	Experiences with the classes	• Educative • Better understanding • Great • Good and understanding of pregnancy related issues • Good midwives • Regulate schedule • Prompt responses from health workers • Educated on signs of labour • It should be structured
	Usefulness of the information	• Acquired new knowledge • Useful • Good nutrition • Very educative • Social learning • Knowledge acquired on each stage of pregnancy • Reliable information • Expert advise • Interactive • Need for exercise • Helpful
	Views on number of appointments	• Satisfactory • wish for more • Add yoga exercises • Limited time • Time frame • Conflicts with antenatal appointments

THEME	SUB-THEME	CODE
Health behaviour motivation	Social support received	• Supported • Shared knowledge with partner
	Motivation To partake	• Useful • Wellness • Health conscious • For safety and protection • Awareness • To be informed • Reliable information • Expert advise • Lingering questions • Time frame • Attitude of attending midwife
	Quality contact: client-midwife	• Interactive • Welcoming • Good relationship • Gained confidence to ask questions • Peaceful • Nice person • Good • Very kind
	Impact of education on social support received	• Helpful • Affectionate • Great bonding • Supportive • Comfort of mind • Unaware • Empathetic • Educated • Birth preparedness • More concerned
	Attitudinal change	• Forgotten • Rest • Improved eating habit • Good sleeping posture • De-stress and cessation of douching • Calm • Discontinuation of strong detergents • Knowledge acquisition • Less temperamental

THEME	SUB-THEME	CODE
Health Behaviour Skills	New skills acquired	• Baby bathing • Right nutrition • Breastfeeding skills • Exercise • Sleeping posture • Handling of babies • Positioning of baby when breastfeeding • Cord care • Detection of a sick baby
	Identification of Danger signs	• Recognize • Awareness • Emergency plan • Maintenance of covid protocols • Breaking of water • Reduced foetal movement • Swollen feet, hands and vaginal discharge • Pain and bleeding • Awareness on Signs of high blood pressure
	Decision making process	• Helped to agree to scheduled caesarean section • Awareness • Emergency plan • Maintenance of covid protocols • Caring for baby • Correct breastfeeding practices • Good nutrition • Birth preparedness • Complication readiness • Adherence to taking of IFA • Emergency person and transportation • Spacing of children
	Benefits of skills gained	• Good nutrition • Knowledge • Educated by health professionals • Educated by peers • Boost in hemoglobin level • Effective communication with partner • Self confidence • Well oriented • Exercising • Positing during breastfeeding

THEME	SUB-THEME	CODE
		• Caring for the newborn • Importance of immunization • How to manage pregnancy • Preparation for delivery • Improved self-care
Health behaviour	Impact of health education on health	• Health Conscious • Safety • Improvement in health • Improved eating habits • Relaxing mind • Boost in hemoglobin level • Personal hygiene • Adherence to medication • Good nutrition • Adherence to prescribed medication
	Expectation	• Having a safe delivery • To gain insight • Refreshment • Improve environment • Reliable information • Pregnancy education • To acquire knowledge • Expert advise
	Impression about the school	• Good • Great • Best place of education • Educative • Helpful • Well oriented • Fully satisfied • Room for improvement • Enlightened on pregnancy issues • Recommendable
	Ways of Improvement	• Okay • Time Frame • Comfortable seats • More demonstrations • Exercises • Interesting activities • Strengthening of partner support • Addition of special days • overview of previous lesson

THEME	SUB-THEME	CODE
		• Grouping according to the trimester • More face-face interaction • Enforcement of husband support • Enforcement of pregnancy school in every health facility
	Issuing of leaflet	• Refresh memory • Beneficial • Satisfactory • Preferred verbal face-face method • Issued to only pregnant literates • Good idea • Very useful • very good for further reading • Content review • Prefers an audio recording
Questions to ask or anything to share		• Personal appointment • Entertaining • Online placement • Record keeping • Recreation activities • Television broadcast • Satisfied with information from expert • Structuring on online classes. • Encourage husband support • Pregnancy school should be a requirement • Sex education for their partners • Counselling sessions should be added.