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Knowledge, attitudes, and practices regarding pregnancy-related health problems among pregnant women in Tiznit, Morocco: A cross-sectional study in public health facilities

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Original article

Abstract

Introduction: Pregnancy-related complications remain a major public health concern, particularly in low- and middle-income countries where maternal health literacy may be limited. Adequate knowledge, positive attitudes and appropriate practices (KAP) during pregnancy are essential to prevent avoidable maternal and neonatal complications. This study assessed KAP regarding pregnancy-related health problems among pregnant women in Tiznit, Morocco, and explored associated socio-demographic and obstetric factors.

Methods: A cross-sectional study was conducted from 27 April to 13 May 2025 among pregnant women attending antenatal consultations in public health facilities in Tiznit. Data were collected using a structured questionnaire assessing socio-demographic characteristics and KAP. Knowledge was scored from 0 to 10, with scores ≥5 classified as good knowledge. Attitudes and practices were considered positive/good when ≥50% of responses were favourable. Associations were analysed using χ^2 tests and multivariable logistic regression. Statistical significance was set at $p < 0.05$.

Results: Forty pregnant women participated. Most were aged 18–28 years (52.5%), lived in urban areas (80.0%), were housewives (92.5%) and had no formal education (42.5%). Good knowledge was observed in 25.0% of participants, whereas 75.0% demonstrated poor knowledge. In contrast, attitudes and practices were predominantly positive/ good

Keywords

- pregnancy
- maternal health
- knowledge
- attitudes
- practices
- antenatal care

Contribution

A – Preparation of the research project
B – Assembly of data
C – Conducting of statistical analysis
D – Interpretation of results
E – Manuscript preparation
F – Literature review
G – Revising the manuscript

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(92.5%). Secondary education was independently associated with higher odds of good knowledge (adjusted OR 6.72; 95% CI 1.02–44.38).

Conclusions: Poor maternal knowledge was common despite favourable attitudes and practices. Strengthening structured antenatal education, particularly for women with low educational attainment, is essential to improve maternal health literacy and prevent pregnancy-related complications.

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Introduction

Maternal health remains a key public health priority worldwide, with pregnancy representing a critical period in a woman's life that requires comprehensive medical, nutritional, and psychosocial support. Complications during pregnancy and childbirth account for significant morbidity and mortality, particularly in low- and middle-income countries, where access to healthcare and maternal health education may be limited.[1] The World Health Organization (WHO) emphasizes that improving maternal knowledge, promoting positive health attitudes, and encouraging appropriate health practices are essential to reducing preventable adverse pregnancy outcomes.[2]

The concept of Knowledge, Attitudes, and Practices (KAP) has been widely used in public health to assess how individuals understand health problems, perceive their importance, and translate such perceptions into preventive behaviours.[3] In the context of pregnancy, adequate knowledge about antenatal care, warning signs, nutrition, and risk factors can empower women to seek timely healthcare. Positive attitudes, such as valuing antenatal consultations, and safe practices, such as adhering to medical advice, are critical in ensuring healthy pregnancies and safe deliveries.[4] However, gaps in knowledge or harmful practices can lead to increased risks of complications such as anemia, hypertensive disorders, infections, and adverse neonatal outcomes.[5]

In Morocco, maternal health indicators have improved over recent decades, yet disparities persist between urban and rural areas, and between women of different socio-economic and educational backgrounds.[6] According to the Moroccan Ministry of Health, although antenatal care coverage is increasing, challenges remain in reaching vulnerable populations with adequate information and resources.[7] Tiznit, a city in the Souss-Massa region of southwestern Morocco, presents a unique setting to examine these issues due to its mixed urban and rural population and the central role of public health facilities in providing maternal care.

Several studies in other countries have shown that socio-demographic factors such as age, education, occupation, and parity are significantly associated with maternal health knowledge and behaviours.[8–10] However, limited research has been conducted in Morocco to specifically assess pregnant women's KAP regarding maternal health problems, particularly at the local level. Understanding the interplay between these factors in Tiznit could inform targeted health education strategies and improve maternal and neonatal outcomes. Recent evidence suggests that maternal health literacy and awareness of pregnancy danger signs are key determinants of timely care-seeking and prevention of maternal complications. Studies conducted in low- and middle-income contexts have shown that inadequate knowledge may persist even when antenatal attendance is relatively good, emphasizing the need for structured and culturally adapted education during antenatal care.[11,12]

This study aimed to describe the knowledge, attitudes, and practices of pregnant women regarding health problems during pregnancy in public health facilities in Tiznit, Morocco, and to identify the socio-demographic and obstetric factors associated with these domains. By identifying knowledge gaps and their predictors, this research may support the development of tailored interventions to enhance maternal health literacy and promote positive pregnancy outcomes.

Materials and methods

We conducted a descriptive, cross-sectional study from 27 April to 13 May 2025 in public health facilities in Tiznit province, Morocco. The study aimed to assess pregnant women's knowledge, attitudes, and practices (KAP) regarding maternal health problems.

Setting – Tiznit, located in the Souss-Massa region (population 205,182; area 8,700 km^2), has a mixed urban–rural population. Data collection took place in the maternity department of the Provincial Hospital Center (≈1,866 deliveries/year) and two primary health centers

(Elmers and Abdellah Chefchaouni), which provide antenatal care and follow-up services.

Population and sampling: The target population included all pregnant women residing in Tiznit province (N = 1,580). A convenience sampling strategy was used, enrolling those attending the selected facilities during the study period. Women who refused participation or were only passing through the city were excluded.

Data collection tool: A self-administered questionnaire, developed for this study, captured socio-demographic characteristics, knowledge about pregnancy-related health problems, attitudes toward antenatal care, and health practices (e.g., diet, hygiene, service use). For illiterate participants, questions were read aloud, and responses recorded by trained staff. Knowledge was assessed using 10 closed-ended questions. Each correct answer was assigned one point, while incorrect or "don't know" responses received zero points. The total knowledge score ranged from 0 to 10. A score of ≥5 was considered as good knowledge, while a score <5 was considered as poor knowledge.

Attitudes were assessed using dichotomous (yes/ no) items. Participants who achieved at least 50% positive responses were classified as having a positive attitude. Practices were evaluated in a similar manner. A score of ≥50% positive responses was considered indicative of good practices, whereas scores below this threshold were classified as poor practices. The internal consistency of the questionnaire was assessed using Cronbach's alpha coefficient. The overall reliability was high ($0.8 \leq \alpha < 0.9$), indicating good internal consistency of the instrument.

Sample size and analysis: Forty women participated. Data were analysed using Excel and JAMOVI. Frequencies and percentages were reported; Chi-square tests assessed associations between socio-demographic variables and KAP scores, with $p < 0.05$ indicating significance. A formal a priori sample size calculation (e.g., using G*Power) was not performed due to the exploratory nature of this study and logistical constraints within the study setting. The sample size therefore corresponded to the number of eligible pregnant women attending antenatal consultations in the selected public health facilities during the data collection period and who agreed to participate. This limitation is acknowledged and considered when interpreting the findings. Given the small sample size and the limited number of events (good knowledge cases), the number of variables included in the multivariable model was restricted to avoid model overfitting.

Ethics: The study was conducted in accordance with the Declaration of Helsinki. Administrative and ethical authorization was obtained from the competent local health authorities in Tiznit Province prior to data collection. All participants received clear information about the objectives of the study, and written informed consent was obtained before enrolment. Confidentiality and anonymity were guaranteed, and no identifying information was collected. The approval reference number was 57/2023.

Results

Socio-demographic characteristics

Most participants (n = 21, 52.5%) were between 18 and 28 years of age, followed by 28–38 years (n = 13, 32.5%) and 38–48 years (n = 6, 15.0%). The majority of respondents lived in urban areas (n = 32, 80.0%) and were housewives (n = 37, 92.5%). Regarding educational attainment, 42.5% (n = 17) were illiterate, 35.0% (n = 14) had completed primary education, and 22.5% (n = 9) had completed secondary education.

In terms of their husbands' occupation, 42.5% (n = 17) were employed full-time, 37.5% (n = 15) part-time, 7.5% (n = 3) were unemployed, and 12.5% (n = 5) were on sabbatical or medical leave. Most respondents lived in extended families (n = 28, 70.0%), followed by nuclear families (n = 11, 27.5%), with only one participant (2.5%) living in a blended family.

Chi-square tests revealed that only secondary education was significantly associated with a higher knowledge score ($p = 0.015$). No other socio-demographic variable was significantly associated with knowledge level (Table 1).

Table 1. Socio-demographic characteristics of the participants (n = 40)

Variable	Category	% (n)
Age	18–28	52.5 (21)
	28–38	32.5 (13)
	38–48	15.0 (6)
Residence	Urban	80.0 (32)
	Rural	20.0 (8)
Employment status	Housewife	92.5 (37)
	Private sector	5.0 (2)
	Public sector	2.5 (1)
Education level	Illiterate	42.5 (17)
	Primary	35.0 (14)

Variable	Category	% (n)
Education level	Secondary	22.5 (9)
Husband's occupation	Full-time	42.5 (17)
	Part-time	37.5 (15)
	Unemployed	7.5 (3)
	Sabbatical/ medical leave	12.5 (5)
Family type	Nuclear	27.5 (11)
	Extended	70.0 (28)
	Blended	2.5 (1)

Obstetric and pregnancy-related characteristics

Obstetric and pregnancy-related characteristics are shown in Table 2. Half of the participants (n = 20, 50.0%) reported that their husbands were present daily during pregnancy, while 35.0% (n = 14) reported presence several times per week, 12.5% (n = 5) once per week or less, and 2.5% (n = 1) reported absence throughout pregnancy.

The majority of pregnancies were desired (n = 24, 60.0%). Most participants had experienced two pregnancies (n = 14, 35.0%), followed by one pregnancy (n = 11, 27.5%) and four or more pregnancies (n = 10, 25.0%). Regarding parity, the most common number of children was one (n = 17, 42.5%), followed by no children (n = 10, 25.0%).

The most frequently reported experiences of previous pregnancy and delivery were "very positive" (n = 13, 32.5%) and "neutral" (n = 13, 32.5%). The majority had no history of pregnancy-related health problems (n = 29, 72.5%) and no difficulty in accessing healthcare during pregnancy (n = 28, 70.0%). No obstetric variable was significantly associated with knowledge level.

Table 2. Obstetric and pregnancy-related characteristics (n = 40)

Variable	Category	% (n)
Husband's presence	Daily	50.0 (20)
	Several times/ week	35.0 (14)
	Once/week or less	12.5 (5)
	Absent	2.5 (1)
Pregnancy desired	Yes	60.0 (24)
	No	40.0 (16)
Number of pregnancies	1	27.5 (11)
	2	35.0 (14)
	3	12.5 (5)
	4+	25.0 (10)
Number of children	0	25.0 (10)
	1	42.5 (17)
	2	17.5 (7)
	3	7.5 (3)
	4+	7.5 (3)
Experience of pregnancy/ childbirth	Very positive	32.5 (13)
	Rather positive	27.5 (11)
	Neutral	32.5 (13)
	Rather negative	5.0 (2)
	Very negative	2.5 (1)
History of pregnancy-related health problems	Yes	27.5 (11)
	No	72.5 (29)
Difficulty accessing healthcare	Yes	30.0 (12)
	No	70.0 (28)

Knowledge, attitudes, and practices

The distribution of knowledge, attitudes, and practices is presented in Table 3. Three-quarters of the participants (n = 30, 75.0%) demonstrated poor knowledge regarding maternal health problems, while only one quarter (n = 10, 25.0%) had good knowledge. In contrast, attitudes and practices were largely positive, with 92.5% (n = 37) classified as good, and only 7.5% (n = 3) as poor (Table 3).

Table 3. Knowledge, attitudes, and practices (n = 40)

Domain	Category	% (n)
Knowledge	Poor	75.0 (30)
	Good	25.0 (10)
Attitudes	Negative	7.5 (3)
	Positive	92.5 (37)

Domain	Category	% (n)
Practices	Poor	7.5 (3)
Practices	Good	92.5 (37)

Association between socio--demographic and obstetric variables and knowledge, attitudes, and practices

In the univariate χ^2 analysis, only education level (specifically secondary education) was significantly associated with higher knowledge scores ($p = 0.015$). No significant associations were observed for age, residence, employment status, husband's occupation, family type, obstetric characteristics, or healthcare access.

The full results of the associations between socio-demographic and obstetric variables and the three outcome domains (knowledge, attitudes, and practices) are presented in Table 4.

Multivariable analysis

A multivariable binary logistic regression model was performed to explore independent predictors of good knowledge among pregnant women. Variables with a p-value <0.20 in univariate χ^2 analysis were considered as candidates for multivariable modelling. However, given the limited number of outcome events (n = 10 women with good knowledge), the final logistic regression model was restricted to two variables to respect the events-per-variable principle. Education level and experience of pregnancy/ childbirth were therefore retained in the final model.

The results are presented in Table 5. After adjusting for experience of pregnancy, secondary education remained significantly associated with higher odds of having good knowledge compared to being illiterate (Adjusted OR = 6.72, 95% CI: 1.02–44.38, $p = 0.048$). Experience of pregnancy was not significantly associated with knowledge level in the adjusted model.

In the adjusted model, education level emerged as the only independent predictor of good knowledge.

Table 4. Association between socio-demographic and obstetric variables and knowledge, attitudes, and practices regarding maternal health problems during pregnancy (n = 40)

Variables	Statistical analysis p-values (df, Cramér's V^*)	Knowledge (good vs. poor)	Attitude (positive vs. negative)	Practices (good vs. poor)
Age groups	df = 2	0.526	0.884	0.995
Residence	df = 1	0.099	0.884	0.995
Employment status	df = 2	0.995	0.884	0.997
Education level	df = 2; **V = 0.463**	0.015	0.118	0.463
Husband's occupation	df = 3	0.313	0.884	0.994
Family type	df = 2	0.884	0.884	0.995
Husband's presence during pregnancy	df = 3	0.809	0.995	0.995
Pregnancy desired	df = 1	0.459	0.884	0.995
Number of pregnancies	df = 3	0.679	0.884	0.993
Number of children	df = 4; **V = 0.418**	0.998	0.884	0.998
Experience of pregnancy/ childbirth	df = 4; **V = 0.432**	0.995	0.884	0.997
History of pregnancy-related health problems	df = 1	0.180	0.884	0.995
Difficulty accessing healthcare	df = 1	0.141	0.884	0.995

*Cramér's V calculated only for statistically significant results in χ^2-tests; p-values < 0.05 are shown in bold.

Women with secondary education had higher odds of good knowledge compared with illiterate women (adjusted OR 6.72; 95% CI 1.02–44.38). This association persisted even after controlling for experience of pregnancy or childbirth. No significant association was found between experience of pregnancy and knowledge level.

Table 5. Multivariable logistic regression analysis of factors associated with good knowledge among pregnant women in Tiznit (n = 40)

Variable	Category	Adjusted OR*	95% CI**	*p*-value
Education level	Illiterate (ref***)	1.00	—	—
	Primary	1.85	0.22 – 15.44	0.570
	Secondary	6.72	1.02 – 44.38	0.048
Experience of pregnancy/ childbirth	Positive (ref)	1.00	—	—
	Neutral/ Negative	0.74	0.12 – 4.56	0.745

*OR: Odds Ratio; **CI: Confidence Interval; ***ref: reference category.

Discussion

This study identified a marked discrepancy between maternal knowledge and reported attitudes and practices among pregnant women attending public health facilities in Tiznit. Although three quarters of participants demonstrated poor knowledge of pregnancy-related health problems, most reported positive attitudes and appropriate practices. This divergence suggests that behavioural adherence during pregnancy may not necessarily depend on comprehensive health literacy.

The socio-demographic profile of participants was consistent with previous studies conducted in comparable settings, where pregnancies predominantly occur among young women and housewives.[1,2] Younger age may partially explain the limited knowledge observed. Women in early reproductive years may rely primarily on healthcare consultations or family guidance rather than accumulated experiential knowledge. Lower exposure to structured health education and limited health literacy in this age group may contribute to reduced awareness of pregnancy-related risks.[13] These findings highlight the importance of early, age-adapted antenatal education strategies.

Educational attainment emerged as the strongest determinant of knowledge. Women with higher education were significantly more likely to demonstrate adequate understanding of pregnancy-related health problems, consistent with evidence linking maternal education to health literacy and appropriate use of antenatal services.[14,15] Education enhances the ability to interpret medical information, recognise warning signs and engage in informed decision-making. However, the wide confidence interval in the adjusted model reflects the small sample size and warrants cautious interpretation of effect estimates.[16]

Despite limited knowledge, attitudes and practices were largely positive. Similar discrepancies have been reported in low- and middle-income countries, where antenatal attendance improves behavioural compliance without necessarily increasing conceptual understanding.[17,18] This phenomenon may be explained by the structure of antenatal care services. Direct counselling by midwives and healthcare providers may promote recommended behaviours through guidance and trust-based relationships rather than through deep comprehension. Evidence indicates that person-centred maternity care and effective provider–patient communication can significantly influence maternal behaviours and pregnancy outcomes.[19,20] In addition, social norms and family support may reinforce adherence to medical advice, even when formal knowledge remains limited.

Access to healthcare appeared relatively adequate in this sample, with most women reporting no major barriers, although a minority cited difficulties. Previous studies have shown that structural barriers such as transportation costs and service accessibility remain significant determinants of maternal healthcare utilisation in other contexts.[6] The relatively favourable access observed in our setting may partially explain the positive behavioural patterns reported.

Although obstetric variables showed some associations in univariate analysis, these did not persist after adjustment. Previous studies have documented associations between parity, gravidity and maternal knowledge,[4,5] yet such relationships may be mediated by educational level and exposure to structured counselling. The limited statistical power of the present study may also have obscured modest associations.

Overall, these findings suggest that improving maternal outcomes requires strengthening the educational component of antenatal care beyond routine clinical monitoring. The World Health Organization emphasises that health promotion during pregnancy should focus on improving women's understanding of danger

signs, nutrition and appropriate care-seeking behaviours.[14-16] Structured, culturally adapted and interactive educational interventions are therefore essential to bridge the gap between behavioural compliance and genuine health literacy.

Strengths and limitations

This study provides original, context-specific data on maternal knowledge, attitudes and practices in a Moroccan public health setting where limited local evidence is available. The use of a structured questionnaire allowed systematic assessment of KAP domains, and the instrument demonstrated good internal consistency (Cronbach's alpha between 0.8 and 0.9), supporting the reliability of the measurements. In addition, the inclusion of both socio-demographic and obstetric variables enabled exploration of potential determinants of maternal knowledge within routine antenatal care services.

However, several limitations should be acknowledged. First, the small sample size (n = 40) limits statistical power and reduces the precision of regression estimates, as reflected by the relatively wide confidence intervals. Second, the use of convenience sampling may limit the generalisability of findings beyond the selected facilities. Third, although the questionnaire showed good internal consistency, it was not externally validated in other populations, which may affect broader applicability. Finally, the cross-sectional design precludes causal inference between socio-demographic factors and knowledge levels.

Future studies using larger, multi-centre samples and externally validated instruments are recommended to confirm these findings and better inform targeted maternal health education interventions.

Practical implications and recommendations

Based on the findings of this study, several practical recommendations can be proposed to improve maternal and neonatal safety:

1. Strengthening antenatal education sessions with a focus on pregnancy danger signs, nutrition, and warning symptoms requiring urgent medical consultation.
2. Developing simplified and culturally adapted educational materials for women with low literacy levels, using visual and verbal communication tools.
3. Reinforcing individualized counseling during antenatal visits, particularly for young and multiparous women who were found to have lower knowledge levels.
4. Enhancing the role of healthcare providers in delivering structured health education rather than relying solely on routine consultations.
5. Encouraging family involvement, especially spouses, in maternal health education to support informed decision-making and timely care-seeking.

These targeted interventions are particularly important given the discrepancy observed in this study between low knowledge levels and generally positive attitudes and practices.

Conclusion

This study assessed the knowledge, attitudes, and practices related to pregnancy-associated health problems among pregnant women attending public health facilities in Tiznit, Morocco. The findings revealed a marked discrepancy between knowledge and behavior, with a high proportion of women demonstrating poor knowledge despite generally positive attitudes and good practices. This highlights a persistent gap in maternal health education, particularly in low- and middle-income settings.

Educational level emerged as a key determinant of maternal knowledge, with women having secondary education showing significantly better understanding of pregnancy-related health issues than those with no formal education. This finding is consistent with previous studies showing that maternal education plays a central role in health literacy and appropriate use of antenatal services.[15-17] In addition, although some obstetric factors showed associations in univariate analysis, only educational level remained independently associated with knowledge after adjustment, suggesting that repeated pregnancies do not necessarily lead to better awareness of maternal health risks.

Although most participants reported good attitudes and practices, the low level of knowledge remains concerning. Several studies have shown that attendance at antenatal care alone does not guarantee adequate awareness unless accompanied by structured and effective health education.[16,18] Poor recognition of danger signs during pregnancy may delay care-seeking behavior and increase the risk of maternal and neonatal complications.[19,20]

These findings highlight the urgent need to strengthen antenatal education programs through culturally adapted and easily understandable health messages.

Particular attention should be given to younger women, women with low educational levels, and multiparous women. Improving communication during antenatal visits, reinforcing individualized counseling, and involving family members – especially spouses – could significantly enhance maternal health literacy and promote timely use of healthcare services.[15,18,20]

Despite limitations such as the small sample size and the cross-sectional design, this study provides valuable insight into maternal health knowledge in a Moroccan context. Future studies using larger samples and longitudinal designs are recommended to better assess causal relationships and to evaluate the effectiveness of targeted educational interventions aimed at reducing preventable maternal and neonatal morbidity.

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Appendix 1. Questionnaire used for the assessment of knowledge, attitudes and practices (KAP)

The questionnaire consisted of three sections:

1. Section A – Knowledge: questions assessing awareness of pregnancy danger signs, antenatal care importance, nutrition, and common pregnancy-related complications.
2. Section B – Attitudes: items evaluating perceptions toward antenatal care, preventive behaviors, and healthcare utilization.
3. Section C – Practices: questions related to health-seeking behavior, hygiene, nutrition, and adherence to medical advice during pregnancy.

The questionnaire was administered in Arabic. For illiterate participants, questions were read aloud by trained staff and answers were recorded accordingly.

Questionnaire (English version)

Study: Pregnancy-Related Anxiety in Morocco

This questionnaire is part of a research study examining pregnancy-related anxiety among women attending antenatal care in Morocco. Pregnancy is a period marked by significant physical, emotional, and social changes, which may increase vulnerability to anxiety. This anxiety can be influenced by several factors, including social support, economic conditions, previous pregnancy experience, and the quality of care received within health services.

The purpose of this questionnaire is to explore the psychosocial and healthcare-related factors associated with pregnancy-related anxiety, in order to contribute to improving antenatal care and promoting maternal mental well-being.

Your participation is entirely voluntary.

All information collected will remain strictly confidential and anonymous, and will be used solely for research purposes.

Your decision to participate or not will not affect your medical care in any way.

Thank you for your valuable time and contribution to this study.

A. Sociodemographic Information

1. Age:
   ☐ 18–29
   ☐ 30 and above
2. Education level:
   ☐ None
   ☐ Primary
   ☐ Secondary
   ☐ University
3. Employment status:
   ☐ Housewife
   ☐ Employed
   ☐ Other: ...
4. Family structure:
   ☐ Nuclear
   ☐ Extended
5. Parity:
   ☐ Primiparous
   ☐ Multiparous
6. Current gestational age: ... weeks

B. Social and Partner Support

7. Do you receive emotional support during your pregnancy?
   ☐ Yes
   ☐ No
8. Who mainly supports you?
   ☐ Partner
   ☐ Family
   ☐ Friends
   ☐ No one

9. Does your partner accompany you to antenatal visits?
   ☐ Always
   ☐ Sometimes
   ☐ Never

C. Pregnancy-Related Anxiety

(*Scale: 1 = Not at all / 4 = Very much*)

10. I feel anxious about childbirth.
    1 ☐ 2 ☐ 3 ☐ 4 ☐
11. I worry about my baby's health.
    1 ☐ 2 ☐ 3 ☐ 4 ☐
12. I feel unprepared for motherhood.
    1 ☐ 2 ☐ 3 ☐ 4 ☐
13. I often feel anxious without a clear reason.
    1 ☐ 2 ☐ 3 ☐ 4 ☐

D. Health System and Care Experience

14. Do you feel your privacy is respected during ANC visits?
    ☐ Yes
    ☐ No
15. How would you rate healthcare staff attitude?
    ☐ Very good
    ☐ Good
    ☐ Fair
    ☐ Poor
16. Do you feel listened to and respected by healthcare providers?
    ☐ Yes
    ☐ No

E. Financial Constraints

17. Do you experience financial difficulties related to pregnancy?
    ☐ Yes
    ☐ No

Qualitive Interview Guide

A. Pregnant Women

1. How do you feel emotionally during your pregnancy?
2. What are your main worries or concerns?
3. Do you feel supported by your family or partner?
4. How do you experience antenatal care visits?
5. Do healthcare providers listen to and reassure you?
6. What could improve your psychological well-being during pregnancy?

B. Midwives

1. How do you perceive anxiety among pregnant women?
2. What are the most common contributing factors?
3. How do you address psychological issues during ANC visits?
4. What challenges do you face in providing psychological support?
5. What improvements would you suggest for antenatal care services?