

The effect of participation in pregnancy school trainings on perinatal comfort level

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ABSTRACT

Objective: This research aimed to investigate the impact of pregnancy school training on the perinatal comfort levels experienced by women.

Material and Methods: The research employed a case-control, quasi-experimental, descriptive, analytical, and relationship-seeking design. Conducted between June and December 2022, the study involved 64 pregnant women randomly selected from those who attended the hospital's registered pregnancy school training for 16 uninterrupted hours. These participants, who voluntarily joined the study, comprised the case group, contributing to a total sample size of 128 pregnant women. Data collection utilized a personal information form, developed by the researchers through a comprehensive literature review, and the Prenatal Comfort Scale (PCS). Statistical analysis was carried out using the Statistical Package for Social Science (SPSS) 20.0 package program.

Results: The educational status of the pregnant women and their spouses in the study group was higher than that in the control group (χ^2 : 14.040, $p=0.015$, χ^2 : 11.701, $p=0.013$), and there was no statistically significant difference between the two groups in terms of other descriptive characteristics. The analysis of the data showed that the women who attended pregnancy school trainings exhibited statistically higher rates of opting for planned/wanted pregnancies and normal births compared to the control group (χ^2 : 10.847, $p=0.001$; χ^2 : 3 4.696, $p=0.000$). Furthermore, more than half of the attendees at the pregnancy school were primiparous, leading to a statistically significant difference between the two groups (χ^2 : 8.708, $p=0.020$). In terms of PCS scores, the case group scored an average of 68.82 ± 8.13 , while the control group scored 61.07 ± 6.88 , demonstrating a statistically significant difference ($z=22.689$, $p=0.000$).

Conclusion: Participation in pregnancy schools demonstrated a positive impact on the overall comfort levels of the women in their third trimester of pregnancy.

Keywords: Comfort, education, pregnancy, pregnancy school.

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INTRODUCTION

Pregnancy is a process in which a woman prepares for motherhood both physiologically and psychologically. It encompasses numerous hormonal and physiological changes, where the line between illness and health becomes narrow. All these changes affect a woman's quality of life, comfort, and well-being. Comfort and well-being during pregnancy are universal necessities for women worldwide.^[1–4]

The transition to motherhood is crucial for the development of the maternal role, and it is important for this process to unfold with trust, satisfaction, and comfort.^[5] Comfort is a state of being free from stress and at ease, encompassing physical, mental, and social dimensions. Kolcaba^[6] describes the concept of comfort with a holistic perspective, defining it as the immediate experience of meeting basic human needs for relief, peace, and overcoming challenges. Comfort has always been a significant concept at the core of professional caregiving professions such as midwifery/nursing.^[7–9] Models/theories provide guidance on the purpose and execution of care, and comfort theory is one of them. Comfort theory suggests that individuals can achieve relief through physical, socio-cultural, psycho-spiritual, and environmental support to cope with problems and meet unmet needs.^[6,8,10,11] Analyzing the contemporary nursing literature, Kolcaba^[11] defines the concept of comfort in terms of levels and dimensions.^[7] Superiority among comfort levels is the ability of a woman to overcome the challenges she faces during pregnancy. Relief is defined as the alleviation of pain experienced by a pregnant woman with back pain through nursing interventions, leading to the easing of her discomfort. Relaxation is described as the comfort created by the educational interventions provided by a nurse to a pregnant woman experiencing fatigue in the third trimester. Nurses play a key role in helping mothers adapt to the changes during pregnancy and achieving comfort at every level through counseling/prenatal education provided during this period.^[12] The accessibility of pregnant women to these educational programs is crucial, and the establishment of pregnancy schools is highly important for continuity, content relevance to each pregnancy week, and sustainability. Recognizing this significance, the opening of pregnancy schools has been regulated by the government to ensure adherence to legislation.

A healthy pregnancy process is one of the fundamental goals of the Turkish Ministry of Health, aiming to provide higher quality, efficient, effective, and safe health services for maternal and infant health during the pregnancy and childbirth period. In line with this objective, the General Directorate of Health Services of the Turkish Ministry of Health issued a directive numbered 2014/28. This directive outlined the principles and procedures for the effective provision of services in pregnancy schools, pregnancy information classes, and childbirth preparation and counseling centers. The purpose was to conscientiously prepare and support expectant mothers in the mental, physical, and social aspects for childbirth and the postpartum period. These centers offer comprehensive services, including prenatal, childbirth preparation, and postpartum education for pregnant women, as well as childbirth preparation training for fathers.^[13]

These educational programs focus on preparing expectant mothers for the perinatal period, promoting healthy behaviors such as proper nutrition, and encouraging the cessation or reduction of smoking and alcohol use. In addition to elevating healthy behaviors, these

programs aim to provide accurate information and counseling, fostering an investment in fetal and newborn health. Services are designed to empower mothers with knowledge and skills, including preparation for childbirth and newborn care, contributing to the acquisition of the maternal role. The acquisition of maternal roles through these programs has positive effects on spousal and marital relationships. Furthermore, increased knowledge and comfort facilitate women's adaptation to maternal roles after childbirth and the mother-infant bond.^[4,9]

This study was conducted to determine the impact of the education provided in the pregnancy school on women's perinatal comfort levels. While reviewing the literature, studies related to postpartum comfort were found; however, it was observed that there was a limited number of studies focusing on pregnancy period comfort and its sub-dimensions. It is anticipated that our study will contribute to the literature by evaluating the comfort of women who attend pregnancy school during the perinatal period and provide guidance for midwives/nurses working in pregnancy education classes.

MATERIAL AND METHODS

Research Type

This study was designed as a case-control, quasi-experimental, descriptive, analytical, and relationship-seeking research.

Place and Time of the Research

The research was conducted at the Department of Gynecology and Obstetrics of our Hospital in Istanbul between June and December 2022. The selection of this particular hospital was based on the researchers' affiliation with the institution, the presence of a registered pregnancy school, and the hospital's status as a fully equipped A1 branch for women's obstetric care.

Sample of the Research

In the year 2021, a total of 185 pregnant women participated in the pregnancy school and completed the 16-hour training. The sample size for the study was determined using G*Power 3.0.10 based on known sample calculation, considering a 5% margin of error, 95% confidence interval, and 80% power, resulting in a determined case group of 60 pregnant women. The study was then conducted with a total of 128 pregnant women, consisting of 64 cases and 64 controls.

The inclusion criteria in the research were as follows:

- Proficiency in speaking and understanding Turkish,
- Being in the 3rd trimester of pregnancy,
- Voluntarily participating in the study,
- Additionally, for inclusion in the case group, being registered in the hospital's pregnancy school and completing 16 hours of uninterrupted training.

The exclusion criteria were as follows:

- Presence of any risky condition associated with pregnancy (for both the mother and the baby),
- Diagnosis of any systemic disease,
- Previous pregnancies with characteristics such as abnormal babies and/or loss.

The inclusion criteria for the case group involved 64 pregnant women who attended the hospital's registered pregnancy school for 16 uninterrupted hours and were randomly selected using a random sampling method. These women volunteered to participate in the study. In the control group, 64 pregnant women were included who received services from the hospital's antenatal clinics during the same time intervals. They were also randomly selected using a random sampling method, and these women volunteered to participate in the study.

The training provided to the pregnant women in the case group adhered to the standardized guidelines outlined in directive 2014/28 published by the Ministry of Health in 2014. It covered topics within the scope of the Pregnancy Information Class Program.^[12]

The topics covered in the education sessions week by week are as follows:

- Week 1: Reproductive organs and the formation of pregnancy, physiological and psychological changes during pregnancy, behaviors during pregnancy.
- Week 2: Signs of danger during pregnancy and necessary actions, high-risk pregnancies, common problems during pregnancy and suggested solutions, nutrition during pregnancy and nutritional support, pregnancy monitoring, routine tests and vaccinations, medication and the use of medical products during pregnancy.
- Week 3: The childbirth process, methods to reduce childbirth pain and facilitate delivery, postpartum period and its characteristics, physiological changes in the postpartum mother, psychological changes during the postpartum period, postpartum role and adjustment.
- Week 4: Postpartum behaviors, newborn feeding, mother-infant bonding in the postpartum period, postpartum contraception, father's education in childbirth preparation.

Data Collection Tools

For the collection of the research data, a personal information form developed by the researchers through literature review and the Prenatal Comfort Scale (PCS) were utilized.

Personal Information Form

The personal information form, prepared by the researchers in accordance with the literature, comprises 35 questions focusing on the following aspects related to pregnant women: descriptive characteristics, medical and obstetric history, participation in pregnancy and childbirth education, pregnancy check-ups, encountered issues during pregnancy, concerns and anxieties related to pregnancy and childbirth, birth plan, and the planning status of the birth companion.

Prenatal Comfort Scale (PCS)

The Prenatal Comfort Scale, developed by Nakamura et al.^[4] in Japan in 2011, aims to assess prenatal comfort.^[14] The original version of the scale consisted of 34 items, but it was later revised by the authors and shortened to 15 items.

The short version of the scale comprises 15 items and includes 5 sub-dimensions. The sub-dimensions and the items they contain are as follows: "Deepening relationships with the husband growing into fatherhood - Husband"; "Interactions by moving of the fetus - Fetus"; "Support from communications with the people around - People"; "Realization of becoming a mother and attachment to the baby - Mother"; "Changes in myself during the pregnancy - Myself." The scale consists of items rated on a six-point Likert scale. The Turkish version of the scale has a Cronbach's alpha of 0.815, indicating good reliability.^[4] For our sample, the Cronbach's alpha value of the scale was determined as 0.827.

The data were collected through face-to-face interviews, each lasting approximately 20–25 minutes, after obtaining approvals from the pregnant women by a midwife with a pregnancy education certificate from our pregnancy school.

Evaluation of Data

The statistical analysis of the data was conducted using the Statistical Package for Social Science (SPSS) 20.0 package program. Descriptive statistical methods such as percentage calculations, means, standard deviation, and median were employed for evaluating the mothers' sociodemographic characteristics and the scores they received on the Prenatal Comfort Scale (PCS). For other data, chi-square, Fisher's exact test, and Mann-Whitney U test were utilized to analyze the significance of differences between groups, two means, and categorical variables, respectively.

The Ethical Aspect of the Research

Prior to the study, ethical approval was obtained from the Non-Interventional Ethics Committee of our Hospital (approval date: 27.07.2022, approval number: 2022.07.245 decision number: 245). Written institutional permission was also obtained from the hospital. Written informed consent was obtained from the pregnant women participating in the study for data collection. The pregnant women included in the research were informed about the study, provided with detailed information, and their written consent was obtained using an informed consent form. In the study, participants were informed about the study and, by reading the information in the "Volunteer Consent Form" prepared according to the Declaration of Helsinki, written and verbal consents were obtained. Data were collected in a way that respected women's privacy.

RESULTS

It was observed that 53.12% of the 128 participating pregnant women were in the 26–34 age group, and the average age was 27.44±6.15. 35.1% of the women and 33.2% of their husbands were university graduates. Additionally, 69.5% of women were not working, and 56.25% stated that their income was equal to their expenses. Demographic characteristics are summarized in Table 1. In Table 1, it is noted that the education levels of pregnant women and their husbands in the case group are higher than those in the control group (χ^2 : 14.040, $p=0.015$, χ^2 : 11.701, $p=0.013$). However, no statistically significant difference was observed between the two groups in terms of other descriptive characteristics.

Table 1: Comparison of the case and control groups based on descriptive characteristics

Variables	Groups				χ^2	p
	Case group (n=64)		Control group (n=64)			
	n	%	n	%		
Age group					0.517	0.802
18–25 years old	15	23.4	14	21.8		
26–34 years old	33	51.5	35	54.6		
35–42 years old	16	25.0	15	23.4		
Educational background					14.040*	0.015
Illiterate	0	0.0	2	3.1		
Primary school	2	3.1	13	20.3		
Secondary education	8	12.5	15	23.4		
High school	25	39.0	14	21.8		
University	29	45.3	20	31.2		
Spouse's education level					12.701*	0.013
Illiterate	0	0.0	0	0.0		
Primary school	1	1.5	12	18.7		
Secondary education	11	17.1	15	23.4		
High school	28	43.7	21	32.8		
University	24	37.5	16	25.0		
Working status					0.332	0.701
Yes	21	32.8	18	28.1		
No	43	67.1	46	71.8		
Spouse's employment status					2.486	0.206
Yes	56	87.5	61	95.3		
No	8	12.5	3	4.6		
Income-expense status					0.000	1.000
Income is less than expenses	22	34.3	22	34.3		
Income is equal to expenses	36	56.2	36	56.2		
Income is more than expenses	6	9.3	6	9.3		
Social security status					1.976	0.241
Yes	56	87.5	50	78.1		
No	8	12.5	14	21.8		
The use of the internet for health literacy					0.000*	1.000
Yes	63	98.4	63	98.4		
No	1	1.5	1	1.5		
Residence					2.187*	0.335
Province	46	71.8	41	64.0		
District	17	26.5	23	35.9		
Village	1	1.5	0	0.0		

*: Fisher's Exact Test.

Table 2: Comparison of the case and control groups based on obstetric characteristics

Variables	Groups				χ^2	p
	Case group (n=64)		Control group (n=64)			
	n	%	n	%		
Pregnancy status					8.708	0.020
Primiparous	41	64.0	33	51.5		
Multiparous	23	35.9	31	48.4		
Your method of conception					1.360	0.220
With treatment	6	9.3	2	3.1		
Spontaneous						
Is your pregnancy planned?					10.847*	0.001
Yes	64	100.0	54	84.3		
No	0	0.0	10	15.6		
If planned, what is your preferred method of delivery?					34.696*	0.000
Vaginal delivery	63	98.4	20	31.2		
Cesarean section	1	1.5	25	39.0		
The date of your first prenatal visit for this pregnancy					12.933*	0.005
Before the 4 th week	39	60.3	26	40.6		
Between 5–8 weeks	23	35.9	23	35.9		
Between 9–12 weeks	2	3.1	10	15.6		
13 weeks and beyond	0	0.0	5	7.8		
Do you have concerns related to pregnancy and childbirth?					28.571	0.000
Yes	13	20.3	43	67.1		
No	51	79.6	21	32.8		
If yes, what are the reasons for your concerns?					10.645*	0.003
Not knowing what to expect during childbirth	0	0.0	10	23.2		
Fear of childbirth	0	0.0	9	20.9		
Concerns about the pain during childbirth	0	0.0	1	2.3		
Concerns about the baby's health	12	92.3	20	46.5		
Other	1	7.6	3	6.9		
What are your thoughts about the delivery room environment?					18.360*	0.000
Scary	5	7.8	23	35.9		
Noisy	1	1.5	10	15.6		
Other	58	90.6	31	48.4		
Would you like someone to support you during labor?					8.533*	0.006
Yes	64	100.0	56	87.5		
No	0	0.0	8	12.5		

*: Fisher's Exact Test.

The number of pregnancies was 2.12, the number of miscarriages was 0.8, and the number of living children was 1.2. Comparison of obstetric characteristics of the case and control groups is shown in Table 2. It was observed that the women attending the pregnancy educa-

tion class had significantly higher rates of choosing planned/intended pregnancy and normal birth as the preferred birth method compared to the control group (χ^2 : 10.847, $p=0.001$; χ^2 : 34.696, $p=0.000$). It was also noted that more than half of the pregnant women attending the

Table 3: Distribution of PCS scores according to the case and control groups

	Husband	Fetus	People	Mother	Myself	Total
Groups						
Case group	16.21±1.11	9.47±2.17	15.22±2.61	14.24±2.81	13.68±3.33	68.82±8.13
Control group	15.46±2.41	7.97±1.06	14.41±1.04	12.61±1.90	10.62±1.76	61.07±6.88
Statistics						
Z*	4.808	14.718	4.106	13.486	16.987	22.689
p	0.61	0.002	0.62	0.003	0.001	0.000

PCS: Prenatal Comfort Scale; *Z: Mann-Whitney U test.

pregnancy school were primiparous, and this caused a statistical difference between the two groups (χ^2 : 8.708, $p=0.020$) in Table 2. The women who attended the pregnancy school had significantly lower levels of anxiety related to pregnancy and childbirth compared to the control group. When examining the reasons for anxiety, it was found that the reasons related to coping with labor pain and/or knowledge deficiency were significantly higher in the control group, in Table 2. In the case group, 94% of the women expressed a desire to have someone with them during childbirth (85% being their partner), and this rate was significantly higher than the control group, creating statistical significance (χ^2 : 8.533, $p=0.006$). It was observed that the women who did not attend pregnancy education had more negative thoughts about the delivery room environment compared to the educated group (χ^2 : 18.360, $p=0.000$). The high anxiety levels and negative thoughts about the delivery room environment in the control group were associated with a lack of knowledge-related uncertainty.

The average PCS score was found to be 68.82±8.13 in the case group and 61.07±6.88 in the control group, with a statistically significant difference between the two groups ($z=22.689$, $p=0.000$) in Table 3. When examining the sub-dimension scores of prenatal comfort for the pregnant women in the case and control groups, it was found that in the case group, the Fetus, Mother, and Myself sub-dimensions were statistically significantly higher ($z=14.718$, $z=13.486$, $z=16.987$; $p=0.002$, $p=0.003$, $p=0.001$, respectively) in Table 3. While the scores for the Husband and People sub-dimensions were higher in the case group, this increase did not reach statistical significance.

DISCUSSION

In this study, the comfort levels of the third-trimester pregnant women who received and did not receive education from the pregnancy school were examined. Since there was no study specifically investigating the impact of attending pregnancy school on the comfort level of pregnant women in the third trimester, findings from studies that evaluated postpartum comfort and examined the contribution of pregnancy school education to anxiety, childbirth fear, and parental readiness were discussed. It was found that out of the 128 participants in our study, 53.12% were in the 26–34 age group, with an average age of 27.44±6.15. The educational level of the women and their partners who attended the pregnancy school was significantly higher than the educational level of the control group's prospective parents (χ^2 : 14.040, $p=0.015$, χ^2 : 12.701, $p=0.013$).

Yazıcıoğlu and Yavuz^[15] conducted a study to determine the impact of pregnancy school education on childbirth fear. In their research, the average age of pregnant women was found to be 27.13±5.07, and 52.4% of pregnant women were at least university graduates.

In the study conducted by Say and Çoban^[12] to determine the effect of attendance in the pregnancy information class on postpartum comfort, it was found that the education level of both mothers and fathers was higher, and that this difference created statistical significance between the two groups ($\chi^2=8.277$, $p=0.016$). Similarly, in the study by Yılmaz Esencan et al.,^[16] which aimed to evaluate the childbirth method, the first breastfeeding time, and skin-to-skin contact practices of pregnant women who attended the pregnancy education school, it was observed that women attending pregnancy education classes had higher education levels.

Akın et al.^[17] conducted a study to determine the impact of education provided in prenatal education classes on the fear of childbirth and readiness for childbirth. In this research, the average age of 121 participating pregnant women was 23.73±3.33, and 85% of the pregnant women had a high school education or above.

Aksakallı et al.^[18] found in their study that as the spouse's education level increased, mothers received higher levels of support, and that their participation rates in pregnancy education were higher.

Recent study results are similar to the literature in this regard. The increased desire of mothers with a high level of education to attend pregnancy schools can be explained by their awareness of the need for education due to the search for accurate information about pregnancy, childbirth, and baby care. Pregnant women with spouses with higher education levels were associated with more positive spousal relationships, better mutual understanding between spouses, and support for participation in education. In this study, it was observed that most of the pregnant women in the case group who attended the pregnancy school were primarily primiparous and had planned/intentional pregnancies, and this ratio was higher compared to the control group ($\chi^2=8.708$, $p=0.020$; $\chi^2=10.847$, $p=0.001$).

In the studies conducted by Yazıcıoğlu and Yavuz to determine the impact of pregnancy school education on childbirth fear, when questioned about the current pregnancy, 82.3%($n=102$) of participants stated that the pregnancy was desired/planned, and 79%($n=98$) mentioned that it was their first pregnancy.^[15]

In the study conducted by Akin et al.^[17] to determine the impact of education provided in prenatal classes on pregnant women's fear of childbirth and readiness for childbirth, it was found that more than half of the women attending the pregnancy school were primiparous, and that 100% of the pregnancies were intentional. In the study conducted by Turgut et al.^[19] to determine the knowledge levels of pregnant women who received education from the pregnancy school, it was found that 72.9% of those pregnant women were primiparous. Our study aligns with the literature in these aspects, showing a parallel relationship between primiparous and planned/intentional pregnancies, the desire of expectant mothers to participate in education, and the willingness to be prepared for every aspect of pregnancy, childbirth, and the postpartum period, as well as addressing knowledge gaps by seeking accurate information.

It is believed that the lack of knowledge and uncertainty experienced during the first pregnancy are additional factors that increase the demand for education. Especially for first-time expectant mothers who lack experiences with pregnancy and childbirth, hearing negative pregnancy/birth stories, and not being familiar with the delivery room environment make them more in need of accurate information and, therefore, education.

In our study, the scale used to assess the comfort levels of the third-trimester pregnant women is an evaluation tool that can receive a minimum of 6 and a maximum of 75 points. The average score obtained from the perinatal comfort scale by the 128 participants was 64.94 ± 13.88 , indicating a high level of comfort. The average score for those attending prenatal education was 68.82 ± 8.13 , while it was 61.07 ± 6.88 in the control group, and the difference between the two groups was statistically significant ($z=22.689$, $p=0.000$). The education and counseling services provided in prenatal classes aim to reduce uncertainties and anxieties and promote relaxation throughout pregnancy through supportive nursing interventions. Comfort, defined as a fundamental human need that all individuals aspire to achieve throughout their lives, is an intended outcome of nursing counseling, education, and care interventions.^[7] The concepts of stress, depression, anxiety, satisfaction, self-fulfillment, adaptation to pregnancy, attachment, or quality of life during pregnancy are among the factors that can both enhance and diminish comfort.^[20] The education and counseling provided in prenatal classes aim to alleviate and manage these processes, ultimately enhancing the comfort of women during pregnancy.

Özkan et al.^[1] conducted a study with 421 pregnant women in the third trimester to determine the comfort levels and influencing factors. The mean scores for the total Prenatal Comfort Scale (PCS) and its sub-dimensions, including Husband, Fetus, People, Mother, and Myself, were found to be 62.98 ± 8.28 , 15.23 ± 2.75 , 8.98 ± 1.36 , 12.90 ± 2.11 , 12.99 ± 1.98 , and 10.88 ± 2.87 , respectively. Univariate analyses revealed that variables such as age group, educational status, employment status, number of pregnancies, and planned pregnancy significantly influenced prenatal comfort. Logistic regression analysis identified multiparity as a variable that negatively affected prenatal comfort, with an odds ratio of 2.986 (95% CI 1.529–5.832) ($p=0.001$). The study concluded that the prenatal comfort level and its sub-dimensions were high among third-trimester pregnant women.

Nakamura et al.'s^[4] study indicated that comfort levels and sub-dimension scores in the later stages of pregnancy were high. Pregnant women with high comfort levels were reported to have better knowledge and practices related to infant care in the early postpartum period. The study also highlighted that nursing interventions during this period contributed to higher comfort levels in women, facilitating an easier adjustment to postpartum maternal roles.

In the study conducted by Akin et al.,^[17] aiming to determine the impact of prenatal education classes on pregnant women's fear of childbirth and readiness for childbirth, the scores obtained from the Wijma Delivery Expectancy/Experience Questionnaire version A (W-DEQ) were examined. The average score on the scale before education was 61.13, and after education, the mean score decreased to 30.83. There was a statistically significant difference between the scores before and after education ($p<0.05$). In the same study, before education, 14.0% of pregnant women experienced clinical fear, 43.0% severe fear, 21.5% moderate fear, and 21.5% low fear of childbirth. After education, fear levels were reevaluated, and it was found that 62.8% of pregnant women had low fear, 37.2% had moderate fear, and none experienced severe or clinical fear.

In the study, to determine the impact of childbirth preparation education on women's fear of childbirth, childbirth preferences, and readiness for childbirth, it was found that the mean scores for readiness for childbirth increased from 23.26 ± 5.55 before education to 20.63 ± 10.68 after education, and this increase was statistically significant. In women attending prenatal classes, a very high positive correlation was found between the fear of childbirth and readiness for childbirth after education ($r=0.912$, $p=0.000$).^[15]

In the study conducted by Yazıcioglu and Yavuz, the pre-education W-DEQ score for childbirth expectation was found to be 76.88. It was found that 40% of pregnant women ($n=50$) experienced clinical-level fear of childbirth. The post-education W-DEQ score was found to be 48.78. After education, the number of pregnant women experiencing clinical-level fear of childbirth decreased to 6 (4.8%).^[15]

In the study conducted by Yılmaz Esencan et al.,^[16] it was found that attending childbirth preparation classes increased awareness of vaginal birth, that the education created awareness of requesting and implementing skin-to-skin contact, and that there was a statistically significant relationship between the place of birth and the mode of delivery.

The results of our study show similarities with those studies in terms of the positive impact of education provided in prenatal classes on increasing pregnant women's comfort levels and having positive views on pregnancy and childbirth.

CONCLUSION

Evaluating the comfort level of pregnant women who receive prenatal education is important for determining the effectiveness of such education on the comfort level and its sub-dimensions and ensuring that pregnant women are better prepared for childbirth, postpartum, baby care, and the motherhood process. In this study, it was found that participation in prenatal classes increased the comfort level of third-trimester pregnant women. The mean PCS score in the case group was 68.82 ± 8.13 , while in the control group, it was 61.07 ± 6.88 , and the difference between the two groups was statistically significant

($z=22.689$, $p=0.000$). When examining the mean scores of prenatal comfort sub-dimensions for the pregnant women in the case and control groups, it was observed that the case group had significantly higher scores in the Fetus, Mother, and Myself sub-dimensions (respectively $z=14.718$, $z=13.486$, $z=16.987$; $p=0.002$, $p=0.003$, $p=0.001$). There was no significant increase in the average scores obtained from the sub-dimensions of Husband and People before and after education.

However, comfort includes the physical, psychospiritual, social, and environmental integrity related to meeting individual needs, being at peace, and coping with problems. It may be recommended to include more educational content in prenatal classes that will increase and support average scores in the sub-dimensions of Husband and People. Additionally, the participation of husbands and/or other relatives in the education is thought to contribute to their understanding of their roles.

Statement

Ethics Committee Approval: The Bahçeşehir Çam and Sakura City Hospital Ethics Committee granted approval for this study (date: 27.07.2022, number: 2022-245).

Author Contributions: Concept – AÖ; Design – AÖ; Supervision – AÖ; Resource – AÖ; Materials – AÖ; Data Collection and/or Processing – AÖ, BAH; Analysis and/or Interpretation – AÖ; Literature Search – AÖ; Writing – AÖ; Critical Reviews – AÖ.

Conflict of Interest: The authors have no conflict of interest to declare.

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