



International Journal of Public Health and Nursing (IJPHN)

VOLUME 1 ISSUE 2 (2025)



PUBLISHED BY
E-PALLI PUBLISHERS, DELAWARE, USA

Determinants of Model Mother Selection for Pregnancy Schools in Maternal and Child Survival Projects: Evidence from Northern Ghana

Mohammed Ali^{1*}, Rashid Bawumia Ali², Adam Abdul Fatahi³

Article Information

Received: October 17, 2025

Accepted: November 20, 2025

Published: December 29, 2025

Keywords

Ghana, Maternal Health, Model Mothers, Pregnancy Schools, Trust Networks

ABSTRACT

Ghana faces persistent maternal health challenges. This study examined Pregnancy Schools in eight Northern districts, analyzing how Model Mother selection approaches shape program effectiveness and maternal health outcomes through culturally grounded, community-based intervention strategies. Existing literature emphasizes peer credibility and cultural embeddedness as critical to maternal health success. Earlier studies highlighted literacy as a determinant of peer education. This study interrogates that assumption, revealing that trust and cultural acceptance exert stronger influence on health-seeking behavior and service uptake. A mixed-methods design was employed, combining quantitative surveys and qualitative interviews to evaluate 200 Model Mothers across eight districts. Stratified sampling ensured representation, and multivariate regression analysis assessed the impact of selection criteria on maternal health outcomes. Districts prioritizing trust and maternal experience (Talensi, Kasena Nankana, East Mamprusi, and Gushegu) recorded significantly higher antenatal care attendance ($\beta = 0.32, p < 0.01$) and skilled delivery uptake ($\beta = 0.28, p < 0.05$). In contrast, Mamprugu-Moaduri, Zabzugu, West Gonja, and Sawla-Tuuna-Kalba emphasized literacy, yielding weaker outcomes in antenatal care ($\beta = 0.05, p = 0.42$) and skilled delivery ($\beta = 0.07, p = 0.36$), both statistically insignificant. These findings indicate that technical knowledge alone does not predict influence, while trust-based social capital enhances program effectiveness. Trust and maternal experience emerged as key determinants of MM selection, surpassing literacy. The results validate community mobilization theories, challenge literacy-centered approaches, and provide evidence to guide maternal health programming in Ghana.

INTRODUCTION

Health literacy has grown to be recognized as fundamental to effective public health responses in low-resource settings, which often have limited access to formal health services. Health literacy allows communities to gain access to, understand, and implement health interventions, leading to improved maternal and child health outcomes (Nutbeam, 2008).

In sub-Saharan Africa, low health literacy rates remain a major barrier to maternal and neonatal mortality reduction. Despite improved maternal mortality rates overall, Ghana and particularly its Northern regions continue to experience higher maternal death rates as a result of limited access to skilled care, socio-cultural barriers, and inadequate health infrastructure (World Health Organization [WHO], 2023; Ghana Health Service, 2022). Community health personnel in the Ghana Health Service (GHS) working together with NGO field officers are also central to mobilization, sensitization, and awareness-making. However, their endeavors are constrained by cultural pushback, lack of trust in biomedical practices, restrictive gender norms, and logistical issues like poor roadnetworks and limited budgets (Adzitey *et al.*, 2024; Adatara *et al.*, 2020). The obstacles to maternal health services are strong and require culturally sensitive and innovative measures that

connect the health system to the community.

One of those programs is called Pregnancy Schools, which offer formalized training and peer guidance for new pregnant women. In these schools, one idea has developed: the Model Mothers. Model Mothers are respected women chosen as mentors and guides to pregnant women who provide a positive example of maternal social capital for health behaviors (CRS, 2020). Their roles as trusted intermediaries reflect the face of health officers, lower barriers to service utilization, and ultimately help community ownership of maternal health initiatives. But Model Mothers are not always recruited, despite their promise. Within the same community, organizations adopt different standards few emphasize literacy, while others emphasize leadership experience, and still others highlight cultural fit and community support. Without consistency, Pregnancy Schools may become ineffective in the long run. This means that the program's design and implementation also need to adapt as contexts change.

How Model Mothers are identified will influence the overall success of pregnancy schools. A well-integrated, culturally competent approach in selection and recruitment will not only enhance trust among mothers but also increase attendance at antenatal care appointments and enhance maternal care routines. Conversely, inefficient selection

¹ College of Community and Organizational Development, Walewale Campus, Ghana

² University for Development Studies, Ghana

³ Clinton Health Service Initiative, Ghana

* Corresponding author's e-mail: mohalim74@gmail.com

procedures may undermine program effectiveness (Ampofo *et al.*, 2020; Datiko *et al.*, 2019; Glenton *et al.*, 2013). Standardized for Model Mothers remain an important gap in maternal health programming.

The aim of this study has been to identify determinants of Model Mother selection for Pregnancy Schools and its effect on maternal health outcome in Northern Ghana. The ultimate goal is to identify the major factors associated with of Model Mothers to help optimize Pregnancy Schools and maternal and child health more generally.

Model Mothers as an Idea

The Model Mothers concept has been used by Catholic Relief Services, Ghana Program for almost two decades to cover almost all of its maternal and child survival work. Most often, model mothers participate in population health measures and encourage peer-to-peer learning and role modeling.

A model mother is one who has been consistently practicing recommended maternal/child health behaviors during pregnancy, childbirth, and early motherhood. With her own experience and position, she is seen as a woman that can be approached as a point of reference for other moms to practice similar habits. Model Mothers are one reason for believing that social change happens better when modeled by others rather than regulated by the authority. They stand as living testimony to the extent to which antenatal care, safe delivery, exclusive breastfeeding, and immunization, in addition to good diet, influence the health of mothers and children. They also make health education more accessible, more culturally sensitive, and more sustainable. Model Mothers are intermediaries between communities and health systems. They educate health workers on cultural barriers in their communities and encourage mothers' trust in formal health services. They also promote top-down and bottom-up health programs, and in the process, increase community ownership of health programs. This idea is particularly important in regions still experiencing significant maternal mortality and child health issues. Model Mothers offer some guidance on how to reduce maternal mortality, promote the survival of children, and enhance the national health approach by using local knowledge such as role models. They are a mix of living experience, peer support, and health promotion, and so form a vital part of community-based maternal health strategies.

LITERATURE REVIEW

Theoretical Framework

The study was premised on theories of community involvement and health behavior change. According to the Social Capital Theory, social networks of trust and reciprocity in communities can, in turn, be leveraged to facilitate collective action and enhance health (Putnam, 2000). Model Mothers live out this concept, applying influence not only based on social standing but also on maternal experience. Similarly, the Diffusion of

Innovations Theory illustrates how new practices circulate through social systems, and influence change can be influenced by opinion leaders (Rogers, 2003). Model Mothers are early adopters who role-model and disseminate positive maternal health behavior. The Community Health Worker (CHW) model offers a guide for how lay individuals can integrate health services by connecting formal health systems to communities (Glenton *et al.*, 2013). Together, these theories illustrate the need for Model Mothers to exist as culturally embedded peer educators whose efficacy is dependent on selection criteria.

Empirical Review

Evidence in literature underscored the need for maternal education and peer-led interventions in enhancing maternal and child health. In one study conducted in Ghana, maternal education was shown to decrease child mortality and improve health-seeking behaviors (Laari & Takahashi, 2019). In general, community-based health planning and services (CHPS) have mobilized local actors to improve maternal health outcomes (Bateima, 2025). Within these frameworks, peer educators have been effective at increasing antenatal care attendance and skilled delivery uptake (Kassim *et al.*, 2023). However, the choice of peer educators is heterogeneous. Some programs focus on literacy and leadership positions, while others are oriented towards cultural acceptability and trust in communities (Ampofo *et al.*, 2020). There is evidence from lay health worker programs that unreliable selection policies may affect program viability and effectiveness issues (Datiko *et al.*, 2019; Glenton *et al.*, 2013). In Ghana, even within the Pregnancy Schools, although improved, maternal education in Pregnancy Schools could lead to increased maternal health literacy among the members. The success of Model Mothers has been unequal because of unique organizational approaches to their recruitment and training.

Research Gaps

Despite the increasing emphasis on Model Mothers in maternal health programs, there are few studies examining the factors affecting their selection. The literature is quite limited; existing studies cover maternal education, CHW models, or gender patterns in general, yet seldom scrutinize the criteria for identifying Model Mothers for Pregnancy Schools. Empirical evidence of the interaction of sociodemographic characteristics (age, parity, literacy), community-level dynamics (trust, culturally accepted practices), and healthcare system influences (NGOs, training availability) in shaping selection outcomes is lacking. Moreover, there are not many studies that have quantitatively evaluated the effect of selection criteria on program effectiveness like antenatal care attendance or newborn care practices. However, such evidence may only be so definitive; therefore, it highlights the necessity of conducting research that combines qualitative knowledge with statistical analysis to formulate effective and sound

guidelines for Model Mothers.

Conceptual Framework

The conceptual framework of this study (Figure 1) describes a concept about the relationship between constructs and outcomes. Integrating theoretical ideas and empirical findings, it creates a model that links predictors of Choice of Model Mother to program outcomes. The determinants are divided into three categories:

1. Individual Level Determinants. For adults, they are also older by age to the extent of maturity and credibility, while parity provides an opportunity to gain hands-on and practical experience having had a child, thus increasing the relatable aspect. Literacy guarantees an understanding and transmission of health-relevant information to Model Moms, and marital status also ensures social stability and respectability within the community. Partner approval is vital in ensuring that the household holds the

Model Mother's support and endorsement, confirming that she can step in whole and with confidence. Together, these properties ensure the Model Mother is relatable, knowledgeable, and able to empower peers to follow the health behaviors that are recommended.

2. Community-Level Determinants. Trust is key from the community, where the Model Mother's credibility as an honest, trustworthy woman adds to her community perspective. When you have a cultural position, it helps ensure alignment with local beliefs, customs, and values that makes what she is teaching acceptable and appropriate. She can mobilize others through existing leadership positions, and she has strong ties in the social networks that expand her touchpoints to reach a broad range of stakeholders. Community nomination also gives legitimacy by signaling that her role is not imposed externally but arises from collective recognition; additionally, community acceptance builds her credibility

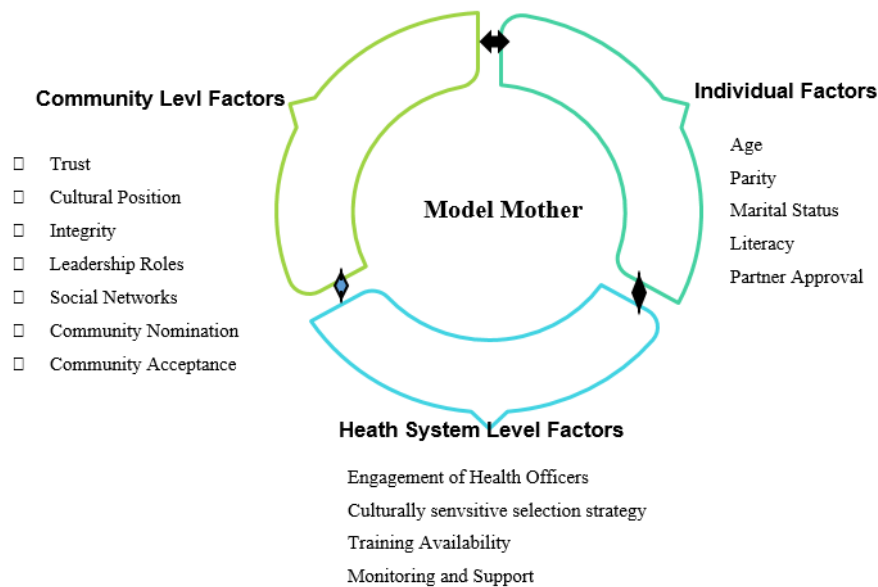


Figure 1: Conceptual Framework on the Determinants of Model Mother Selection
Source: Authors construct, 2025.

and ensures that her guidance resonates widely. Thus, these traits allow the Model Mother to be acknowledged and adapted to a role, and her guidance is more accepted across the community.

3. Determinants of health system-level. In the health system, the participation of health officers represents the formal endorsement of eligibility and support, and an NGO recruitment strategy facilitates the systematic and transparent identification of all candidates. Training is available, and it is well understood that Model Mothers need to possess the skills and knowledge to be effective in their occupation; however, with continued monitoring, they need support to ensure high-quality and consistent performance. Such characteristics embed the Model Mother within the healthcare system, where she is appropriately prepared, supported, and aligned to programme goals.

When these determinants are merged, they lead to the identification, with the right cultural competence and systemic help for Model Mothers. This congruence contributes to program achievement (e.g. increased antenatal care attendance, skilled delivery enrollment, and improved neonatal care competencies). The framework proposes that an improved and culturally sensitive selection strategy will yield the largest program impact, while an inconsistent, poorly designed protocol would limit program effectiveness

MATERIALS AND METHODS

Study Setting

The study was carried out in eight purposively selected districts of Northern Ghana, including Mamprugu-Moaduri and Bunkprugu (Northeast Region), Talensi and Kasena Nankana West (Upper East Region), Gushegu

and Zabzugu (Northern Region), and West Gonja and Sawla-Tuna Kalba (Savannah Region). Selection was made primarily on the basis of the existence of Model Mother-led Pregnancy Schools on-site, with support from governmental and non-governmental organizations (NGOs), and the districts' with high maternal and child mortality and morbidity rates. These contextual constraints further highlighted the importance of the setting for maternal health interventions.

Study Design

The study used a mixed-methods design, including both quantitative surveys and qualitative interviews. The methodology enabled the statistical examination of maternal health outcomes with the exploration of their contextual influences (Creswell & Plano Clark, 2011).

Study Population

The study population included: Model Mothers in Pregnancy Schools, Pregnant women attending the schools, Community health officers who specialized in maternal and child health, NGO field officers who supported maternal health programs, Community leaders who have a role in maternal health practices. Each group was added to reflect complementary perspectives: Model Mothers were focal because they run pregnancy schools and influence maternal health behaviours directly. Pregnant women offered first-person views of their experience and results. Community health officers gave a professional perspective on the delivery of service and maternal health. NGO personnel added details about the program's practice and sustainability. Community leaders were recruited to gain insight into social determinants of maternal health.

Sampling Strategy

The sampling methods adopted were multi-stage. Eight districts were purposively identified as having active Pregnancy Schools. Model Mothers were selected through the program records in every district. Pregnant women and health officers, NGO volunteers, and community leaders were also recruited using purposive and snowball sampling in order to gain a broad spectrum of perspectives.

Sample Size And Distribution

Quantitative Survey: A sample size of 200 Model Mothers was targeted using Cochran's formula to estimate the sample size as a measure of generalization (Israel, 1992). A total of 25 Model Mothers were conveniently selected and engaged per district.

Qualitative Interviews

Twenty-eight (28) comprehensive interviews were carried out, which were disseminated as follows: •eight (8) officers from each district health directorate (one per district); eight(8) NGO field officers (representing diverse organizations focused on maternal health), and Twelve

(12) Community leaders (based on potential influence and active participation in maternal health programmes). This distribution guaranteed representation from all relevant stakeholders as well as provided viability for deeper qualitative analysis.

Data Collection Methods

Structured questionnaires were filled for Model Mothers to gather quantitative data on socio-demographic characteristics, maternal health knowledge, attendance to antenatal services, delivery practices, and neonatal outcomes. In-depth interviews were made with health officers, NGO staff, and community leaders to provide multidimensional information on the functioning of pregnancy schools, challenges to maternal health, and community perspectives. Evidence of triangulation was carried out: document reviews of pregnancy school records as well as district health statistics.

Data Analysis

Quantitative data will be analyzed using SPSS. Frequencies, percentages, and measures of central tendency will be used for descriptive statistics on sociodemographic characteristics. Chi-square tests will investigate the relationship between categorical variables, while logistic regression will determine if there are predictors of Model Mother selection (Hosmer, Lemeshow, & Sturdivant, 2013). Multivariate regression analysis was used as a technique to examine associations between selection criteria and program outcomes, controlling for confounding variables. Qualitative data was transcribed and analyzed thematically using the software NVivo, per Braun and Clarke (2006) framework for thematic analysis. The triangulation of quantitative and qualitative findings added strength to the validity of the findings.

Ethical Considerations

Ethical approval by Institutional Review Board of Navrongo Health Research Center in Ghana (# NHRCIRB314) as part of a bigger research protocol. Also, permissions were obtained from the district health authorities in conjunction with leaders of the pregnancy schools. All participants provided informed consent and were reassured of voluntary participation and confidentiality. To protect participants' identities, the data were anonymized.

RESULTS AND DISCUSSION

This study investigated the determinants of Model Mother selection in Pregnancy Schools in eight districts of Northern Ghana. The quantitative survey included 200 Model Mothers, while 20 in-depth interviews were conducted with community health officers, NGO staff, and community leaders.

Socio-Demographic Characteristics of Model Mothers

Descriptive Statistics shows that most Model Mothers were between 30 and 45 years old, with four children

on average. Literacy ranged in terms of formal school attended; 58% of the individuals had attended primary school, 25% had attended secondary school, and

17% had no formal education. Model Mothers were predominantly married (82%), which mirrors cultural beliefs that prioritize married women as role models.

Table 1: Socio-demographic characteristics of Model Mothers

Demographic variables	Frequency (%)/Mean
Age Range	30 -45 years
Average Parity	4 children
Education	
Primary	58%
Secondary	25%
No formal Education	17%
Marital Status	82%

These revealed that Model Mothers are generally mature women who have a lot of experience of their own, and this adds trustworthiness to the results. Summary of the Model Mothers characterized are presented as Table 1. Qualitative interviews confirmed these findings. Model Mothers had a tendency to put emphasis on the role their lived experience played in the process of leading others. A 38-year-old Model Mother from the East Mamprusi district said, for example, “As I have had many children and lived through a number of childbirths, the younger women listen to me.” Likewise, a 42-year-old Model Mother from the Damongo district says, “They know I am married and have had children, so they trust what I have to say.” They illustrate that credible role is not just about formal training but also about the social recognition that a mother’s experience, age, and marital status counts, and district-level contexts determine the authority of Model Mothers over participants of pregnancy schools in their communities. The present findings are consistent with Social Capital Theory (Putnam, 2000), which considers trust and lived experience as central in mobilizing communities. Also, the prominence of married, multiparous women as role models in Ghana and other sub-Saharan African contexts reflects cultural norms where marital status and maternal experience confer authority in health issues. This conclusion is congruent with Social Capital Theory (Putnam, 2000) as it highlights trust and lived experience as cornerstones of community mobilization. Married, multiparous women act as credible role models in Ghana; more widely, mothers’ autonomy and influence are rooted in sub-Saharan norms in which power passes over to mothers. These results are aligned with other studies from Nigeria showing older, experienced mothers are found to be pivotal influences for community programs in maternal and newborn health interventions (Nasir *et al.*, 2022) and Ethiopia, where advanced maternal age and lived experience emerge as significant predictors of maternal health outcomes (Abebe *et al.*, 2025). But the majority (58%) with primary education stands in stark contrast to South Asia, where the literacy rate among health volunteers is higher, and highlights regional differences in educational status.

Community-Level Factors Influencing Model Mother Selection

Building trust in the community, having held leadership positions in earlier years, and spousal permission were some of the added major determinants of Model Mother selection. While other variables suggested different approaches, this study focuses on a review of those methods to evaluate models used by local nurses and field officers. Chi-square tests indicated significant associations between trust and selection ($\chi^2 = 15.6, p < 0.01$), leadership roles and selection ($\chi^2 = 12.3, p < 0.05$), and spousal permission and selection ($\chi^2 = 10.8, p < 0.05$). Beyond individual credibility and leadership experience, it also indicates that husbands’ approval was important for women to be willing to serve as Model Mothers. Interview data confirmed these statistical links. Women with a reputation for maintaining integrity and mobilization were more likely to be nominated, but spousal backing was frequently crucial. For example, one 40-year-old Model Mother from Mamprugu-Moaduri expressed, “My husband agreed that I should lead, and that gave me confidence and acceptance in the community.” A Bunkprugu participant added, “Even if the women trust you, without your husband’s permission, they will not choose you.” Credibility must take care of both personal qualities as well as household structures, and spousal consent validates the public participation of women.

Factors Affecting Model Mother Selection and Effectiveness Based on NGO And Health System

Logistic regression analysis indicated that NGO involvement in recruitment significantly increased the odds of selecting literate women (OR = 2.4, 95% confidence interval = 1.3–4.2), while government-led processes would prioritize cultural acceptance and communal nomination. Training availability emerged a significant predictor of effectiveness, with trained Model Mothers significantly more likely to describe increased antenatal care attendance among peers ($p < 0.01$). These numerical outcomes demonstrate a dichotomy between

technical aptitude and cultural legitimacy. By emphasizing literacy, NGO-driven approaches have the potential of excluding influential community women and the sustainability of the program, a problem documented with other lay health worker programs (Kassim *et al.*, 2023; Glenton *et al.*, 2013). Training, as necessary, is still inadequate without appropriate reference to culture, thus the necessity of an integrated approach.

The above findings were supported by qualitative interviews illustrating how women themselves identified the space between the two spheres: competence and legitimacy. “The NGO and health people wanted women who could read and write, but the community wanted someone they trusted,” said a 36-year-old Model Mother from Sawla-Tuuna-Kalba. A participant from Zabzugu likewise said, “The training helped me know what to teach, but without the elders’ blessing, people wouldn’t listen.” These accounts demonstrate that not only did literacy and training promote technical competence, but cultural legitimacy through trust, community nomination, and elder approval was also essential to acceptance and effectiveness. Collectively, these quantitative and qualitative findings indicate that technical abilities and cultural legitimacy must exist at the same time for maternal health leadership to be effective. These programs have a risk of sacrificing one to the other because of an inherent cost of sustainability, whereas integrated programs that have training that takes into consideration community acceptance would outperform this trend. Such a finding is expected to fill a significant research gap in the maternal health literature, and it suggests that household dynamics, especially spousal permission, significantly affect women’s leadership in maternal health projects.

Whilst maternal age and experience were noted by some in Nigeria as the most potent determining factors for maternal health interventions (Nasir *et al.*, 2022), advanced maternal age was also established as a predictor of maternal and neonatal outcomes in Ethiopia (Abebe *et al.*, 2025; Datiko *et al.*, 2019). Additionally, a recent Ugandan research showed that literacy and training are key elements for the effectiveness of community health volunteers (Lee *et al.*, 2025). However, few research studies addressed the relationship between household authority and community trust and programmatic priorities. In the present study, combining quantitative

findings (chi-square and logistic regression analyses of trust, leadership, literacy, training, and spousal permission) with qualitative voices (women’s discussion regarding elder approval, trust, and spousal consent), revealed that good maternal health leadership is the combination of technical skill and cultural legitimacy. This research contributes to the literature by proposing that the sustainability of the community-level programs depends on a mixture of programmatic (literacy, training) and social (trust, nomination, spousal approval) determinants approaches. The linkage of these dimensions reveals the need for interventions to be technically sound and socially legitimate. This advances our knowledge in re-characterising maternal health leadership not only as community based but as a mediation process in households, which has been neglected in previous works.

Relation between Model Mother Selection Criteria and The Program Outcome

Multivariate regression analysis across eight study districts demonstrated distinct variations in how Model Mothers were recruited and the consequent impacts of Pregnancy Schools.

In Talensi, Kasena Nankana, East Mamprusi, and Gushegu, Model Mothers were selected on the basis of experience and trust. These districts had higher antenatal care attendance ($\beta = 0.32, p < 0.01$) and skilled delivery uptake ($\beta = 0.28, p < 0.05$); therefore, women with lived maternal experience and community credibility were more capable of mobilizing peers. These findings are statistically significant and highlight the impact of culturally adapted selection strategies in promoting maternal health. In comparison, in Mamprugu-Moaduri, Zabzugu, West Gonja, and Sawla-Tuuna-Kalba, selection prioritized literacy over cultural acceptance. These districts had weaker outcomes; antenatal care attendance ($\beta = 0.05, p = 0.42$) and skilled delivery uptake ($\beta = 0.07, p = 0.36$) did not reach statistical significance. The non-significant positive regression coefficients suggest that this literacy-focused selection did not significantly improve maternal health outcomes. This is proof that technical skills alone do not ensure one’s influence on maternal health programs. Instead, the findings confirm that trust-based social capital and maternal experience remain stronger determinants for the effectiveness of

Table 2: Relationship Between Model Mother Selection Criteria and Maternal Health Outcomes

Districts	Model Mothers Selection Criteria	Select Maternal Health Outcomes		Signature Outcome
		Antenatal Care attendance	Skilled Delivery Uptake	
Talensi, Kasena Nankana, East Mamprusi, Gushegu	Trust & maternal experience	$\beta = 0.32, p < 0.01$	$\beta = 0.28, p < 0.05$	Significant improvements in ANC and skilled delivery
Mamprugu-Moaduri, Zabzugu, West Gonja, Sawla-Tuuna-Kalba	Literacy-focused	$\beta = 0.05, p = 0.42$	$\beta = 0.07, p = 0.36$	No meaningful improvements; outcomes not statistically significant

community mobilization, reduction in maternal mortality, and strengthening infant survival programmes. Table 2 shows the links between Model Mothers selection criteria and select maternal health outcomes.

Also, the results of this study are consistent with existing literature on community-based maternal health interventions in sub-Saharan Africa, emphasizing the need for peer credibility and cultural embeddedness as fundamental to the program's success (Kok *et al.*, 2015). Community trusted individuals often serve as intermediaries between the health system and the family, making uptake of services more probable and making it more likely to encourage health-seeking behavior in line with research on trust networks and other networks of association (Kassim *et al.*, 2023; Glenton *et al.*, 2013). However, the findings call into question previous thought on literacy and technical knowledge as being the main determinants of effective peer education. Although some studies have reported that literacy is a vital vehicle for the dissemination of health information (Perry *et al.*, 2014), relatively poor results in literacy-heavy districts indicate that there is an absence of acceptance and confidence in literacy without cultural trust. This research further adds district-specific evidence, demonstrating empirically that trust selection improves program effectiveness and promotes maternal health outcomes, providing novel perspectives toward maternal health programming in Northern Ghana in similarly settings and contexts.

Recommendations for Model Mother Selection Processes

The research uncovers a significant gap in the application of Model Mother selection standards. Though some organizations focus on literacy, others are more interested in how well a particular culture accepts the new technology, which creates uneven results even in the same district. There is evidence that consistent frameworks that integrate technical competence with community legitimacy are necessary. Culturally informed integration of trust, maternal experience, and training availability is more likely to provide lasting gains in maternal and child health. Summary of Findings and Discussion. Finally, this study implies that the performance of Pregnancy Schools is mostly based on the role that Model Mothers play. Selection approaches that incorporate community trust, maternal experience, and training in relation to gender have positive results for maternal health compared to those that focus only on literacy. This finding has practical implications for policymakers and NGOs, indicating that integrated and culturally sensitive selection strategies are critical in scaling and preserving Pregnancy Schools in Northern Ghana and elsewhere in sub-Saharan Africa.

CONCLUSION

The study aimed to examine the determinants of Model Mother selection in Pregnancy Schools within maternal health projects in Northern Ghana. The results have reinforced the view that the success of Pregnancy

Schools is strongly associated with the nature of the methods by which Model Mothers are identified. While sociodemographic characteristics age, parity, literacy, and marital status as determinants of credibility were critical, it was community trust and cultural acceptance that may have driven the selection and outcome of participation in the program. Community-level considerations were found to be important, with respect to women as agents of integrity, leadership, and maternal experience being most effective in the mobilization of peers. This was also influenced by health system factors such as government health officers, the recruitment strategy developed by NGOs, and the availability of training. Nonetheless, inconsistencies among organizations focusing on literacy in some while cultural legitimacy in others produced heterogeneous results, even within the same districts. Statistical evidence was consistent with strong, culturally sensitive selection, which was evidenced by greater attendance at antenatal care and skilled delivery, contrasted with less robust interventions that only focused on technical skills. Furthermore, the study builds on the theoretical constructs of Social Capital Theory and Diffusion of Innovations and adds to existing empirical research by integrating them in the context of maternal health interventions in Ghana. It notes that Model Mothers tend to perform optimally when integrated within community networks and with training. Most notably, the study indicates that there is a gap in standardized selection processes and a disconnect between technical capability and cultural legitimacy. Lastly, the future success of Pregnancy Schools and their contribution to community based maternal health programs may rest largely on the choice of Model Mothers. Strategies of selection based on community trust, maternal experience, and training availability enhance program delivery and sustainability outcomes. It is a necessity to have culturally grounded, evidence-based policies and practices for Model Mother selection by policymakers, health systems, Non-Governmental Organizations, and other health system actors to ensure that Model Mother selection is evidence-based and community-based. In this way, Pregnancy Schools could be scaled better, with greater capacity to be available both in Ghana and similar low-resource settings to further decrease negative maternal health outcomes and advance progress toward global health goals.

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