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FACULTY OF COMMUNITY AND HEALTH SCIENCES

RESEARCH REPORT

TITLE: A MODEL OF COMMUNITY ENGAGEMENT IN THE PREVENTION OF MATERNAL HEALTH COMPLICATIONS IN RURAL COMMUNITIES OF CROSS RIVER STATE, NIGERIA

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A THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR PHILOSOPHIAE IN THE SCHOOL OF NURSING, UNIVERSITY OF THE WESTERN CAPE, SOUTH AFRICA.

DECLARATION

I, Nsemo, Alberta David declare that the dissertation entitled: "A MODEL OF COMMUNITY ENGAGEMENT IN THE PREVENTION OF MATERNAL HEALTH COMPLICATIONS IN RURAL COMMUNITIES IN CROSS RIVER STATE, NIGERIA" is my own work and has not been submitted for any other degree or examination in any other university other than the University of the Western Cape. I have given full acknowledgement to the resources referred to in my study.

Name: Nsemo, Alberta David

Date: 2016

Sign…………

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DEDICATION

To my Lord and my God, this thesis is dedicated;

And to the memory of all rural women who due to lack of access to skilled birth attendance, lost their lives in the course of pregnancy, delivery or puerperium.

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ACKNOWLEDGMENTS

"Live your dreams with those people who mean something to you,

With those who have touched your life in one way or another,

With those who make you smile when you really need it,

With those that make you see the brighter side of things when life seem to be a failure,

And with those you want to tell how much their friendship, love and support is appreciated."

Above all, I give all glory to the Lord. He is worthy of my praise. My God made a way for me where there seem to be no way. He has made **something** out of **nothing.**

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I cannot mention all by name who must have contributed in one way or the other to my success in this program…

Please Accept my Gratitude.

ABSTRACT

Pregnancy-related poor maternal health and maternal death remain major problems in most Nigerian states including Cross River State. The acute impact of these problems is borne more heavily by rural communities where the majority of births take place at home unassisted or assisted by unskilled persons. These problems are due to a mixture of problem recognition and decision-making during obstetric emergencies leading to delayed actions. Every pregnancy faces risk, and prenatal screening cannot detect which pregnancy will develop complications. If the goal of reducing maternal morbidity/mortality is to be achieved, increasing the number of women receiving care from a skilled provider (doctor/nurse/midwife) during pregnancy, delivery, and post-delivery and prompt adequate care for obstetric complications has been identified as the single most important intervention. One of the strategies identified in many countries is engaging and working with individuals, families, and communities as partners to improve the quality of maternal healthcare. This strategy is thought to remove the barriers that dissuade women from using the services that are available, empowering the community members to increase their influence and control of maternal health, promote ownership and sustenance, as well as increase access to skilled care.

The aim of the study: The overall aim of this PhD study was to develop a model of community engagement to facilitate the prevention of maternal health complications in the rural areas of Cross River State, Nigeria. To develop this model, the study specifically sought to:

1. Understand the current situation in Cross River State by exploring the knowledge gap of women of child-bearing age (pregnant and new mothers) regarding obstetric danger signs, birth preparedness and complication readiness, delivery practices of women, the action of family/community members, and the role of community-based maternal health initiatives, if any, in emergencies, as well as explore participants' opinions on actions to be taken by the community to promote the utilisation of orthodox healthcare facilities by rural women of Cross River State (Phase 1).

2. Engage community members through a participatory approach (Photovoice) to highlight problems regarding pregnancy and birth practices, identify possible solutions,

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and make recommendations on communities' roles in the prevention of maternal health complications (Phase 2). The older women of the study communities were also engaged to verify and validate the findings from phases 1 & 2 analyses.

3. Develop a model of community engagement to improve maternal health literacy by increasing knowledge on early detection of obstetric complications, birth preparedness, complication readiness, and improved access to skilled birth attendance (Phase 3).

Methods: The study was conducted using a qualitative descriptive research approach that combined qualitative semi-structured interviews and focus group discussions within the Photovoice participatory approach. Purposive sampling was employed to select 20 participants, 10 each from the Idundu (Community A) and Anyanganse (Community B) rural communities of Akpabuyo Local Government Area of Cross River State, Nigeria. The participants comprised pregnant women and new mothers (babies aged 12 months and younger) who met the eligibility criteria. Data collection was by means of semi-structured interviews (Phase1), focused group discussions and Photovoice (Phase 2). Trustworthiness of the data was ensured by means of applying Guba's model of credibility, transferability, and authenticity. The ethical principles of respect for human dignity, beneficence, confidentiality, and justice were applied throughout the study. The Citizenship Healthcare and Socio-Ecological Logic models were used to direct the study. Permission was obtained from participants for all the phases of the study while approval for the study was obtained from the Senate Higher Degrees Committee of the University of the Western Cape and the Cross River State Ministry of Health Ethical Committee.

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Data was analysed using Tesch's method of content analysis. Based on the findings of Phases 1 & 2 of the study, themes emerged that were then validated by the older women in the study communities. The model was then developed by means of the four steps of the theory generation process. Step one was concept development that consisted of the identification, definition, validation, classification, and verification of the main and related concepts. Step two was model development consisting of the sub-steps, namely model guidelines and definitions. The communities' stakeholders were engaged at this phase to verify and validate the concepts, as well as contribute to the drafting of the model guidelines and the definitions. Step three was a model description whereby the

structure, definition, relation statements, and the process of the model were described. A visual application of the model that depicts the main concepts, the process, and the context was shown. Step four dealt with the development of guidelines for the operation of the model. A critical reflection of the model was done using Chinn and Kramer's five criteria for model evaluation.

Results: The study revealed that Idundu and Anyanganse's rural women have limited knowledge of obstetric danger signs and very few of them acknowledged the importance of hospital delivery. They also exhibited poor understanding of what birth preparedness and complication readiness entailed. There was a high preference for traditional birth attendant care during pregnancy and delivery with their reasons being belief and trust in traditional birth attendants, a long standing tradition to deliver with them, assumptions that orthodox healthcare is expensive, poor attitude of healthcare providers towards women, unavailability of 24-hour services in healthcare facilities, fear of hospital procedures and operations, communal living in traditional birth attendant's homes, spirituality in traditional birth attendant services, and the consideration of proximity to service points. These factors exacerbated the delays in seeking care and in referrals for skilled care in phases of emergency. The study also revealed that in the study communities, heavy household chores carried out by pregnant women is culturally accepted and seen as exercise to ease labour, there is lack of proper information regarding maternal and child health issues, men are sole decision-makers, they are ignorant of availability of free treatment in health centres, there is an ignorance regarding care of the new-born, and a lack of community structures to support women's health.

Based on the above findings, the women made the following suggestions towards finding a solution: improving maternal health literacy, increasing spirituality in service delivery, involving of husbands in antenatal care for proper information on maternal health issues, accessing community support through the use of community structures (town announcers, women groups, churches, etc.) with the purpose of emphasising facility delivery, constitution of influential groups to monitor the activities of pregnant women to ensure utilisation of skilled attendants, access to healthcare through free services and availability of providers, trust of health services, and traditional birth attendant training/traditional birth attendant facility collaboration. A total of eight concepts were identified from the concluding statements of steps 1 & 2, and used to

develop the Maternal Health-Community Engagement Model (MH-CEM). These were: maternal health literacy, spirituality in healthcare, integrated traditional birth attendants' role (value, training, and traditional birth attendants/hospital collaboration), trust in health services (by addressing previous experiences, attitude, and fear), improving access to healthcare, culturally acceptable care, husbands' involvement in women's health issues, and community support. These concepts formed the core components for the Maternal Health-Community Engagement Model which was developed as the main recommendation to address the core concepts. Central to this Model was the Community Engagement Group (CEG) which was established during the process of engaging the community stakeholders in validating the concepts and drawing up of the guidelines for the Model development.

Conclusions and Recommendations: It is believed that the activities of the Community Engagement Group may bring about improved maternal health literacy, a process for working with traditional birth attendants through training and re-orienting them to be promoters of facility delivery when appropriate, and a model for involving husbands, and indeed the entire community, in maternal health issues. Limitations were identified and recommendations for nursing practice, education, and research concluded the study.

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Key words: Community Engagement, Prevention, Maternal Health Complications, Rural Communities, Model, Birth Preparedness, Complication Readiness, Maternal Mortality, Skilled Attendant, Photovoice.

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LIST OF ABBREVIATIONS

MMR Maternal Mortality Rate

MM Maternal Mortality

BP Birth preparedness

CR Complication Readiness

PHC Primary Health Centre

ANC Antenatal Care

EmOC Emergency Obstetric Care

FANC Focused Ante Natal Care

WHO World Health Organization

UNICEF United Nation International Children Emergency Fund

TBA Traditional Birth Attendants

SBA Skilled Birth Attendants

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FGDs Focus Group Discussions

UNFPA United Nations Population Fund

NPLC National Population Commission

EmOC Emergency Obstetric Care

CEG Community Engagement Group

MH-CEM Maternal Health-Community Engagement Model

WDC Ward Development Committee

VHC Village Health Committee

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Around the world the birth of a baby is a major reason for celebration and societies expect women to bear children and honour them for their role as mothers. Yet, pregnancy and childbirth is a very dangerous journey in most of the developing countries (Ransom & Yinger, 2002). The majority of Nigerian people (women) live in rural areas where the burden of reproductive ill health is higher while the issue of health-seeking behaviour of these women is one of the most neglected maternal mortality research activities in the country (Osubor, Fatusi & Chiwuzie, 2006).

Every pregnancy faces risk, and prenatal screening cannot detect which pregnancy will develop complications (Abouzahr & Wardlaw, 2001). The high levels of maternal morbidity and mortality that are prevalent throughout the developing world, and indeed Nigeria, are as a result of many factors, including complexities of problem recognition and decision-making during emergencies leading to delayed actions and the acute impact is borne more by the rural communities (Gill, 2007). It is essential for women to have access skilled attendants during pregnancy, delivery, and after delivery, and prompt adequate care for obstetric complications if the goal of reducing maternal and mortality must be achieved (Graham, Bell & Bullough, 2001) .

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Health gains and healthy lives require more than just the provision of services but such services has to be well utilized, hence individuals and collective capacities cannot be ignored; working with individuals, families, and communities is considered a critical link in strengthening the continuum of care (World Health Organisation, 2000). Based on the health promotion approach as outlined in the Ottawa Charter (WHO, 2000), "engaging the rural communities in the defining, designing, planning, and taking collective action in issues that affect their health will contribute to the empowerment of

women, families, and communities by increasing their influence and control of maternal health, as well as increase access and utilisation of quality skilled care by women during pregnancy, delivery, and post-partum" (World Health Organisation, 2000).

Each year over half a million women die as a result of complications related to pregnancy and childbirth and the vast majority of these deaths are preventable (Shamshad, Aziz-Un-Nisa & Iqbat, 2003). While women in developed countries have only a 1:2,800 chance of dying in childbirth, women in Africa have a 1:20 chance with the lifetime risk greater than 1:10 (Freedman, 2005). According to the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Bank (WHO,UNICEF, UNFPA & World Bank, 2007), maternal mortality is a major public health problem in sub-Saharan Africa, where half (50.4%) of all maternal deaths occur, and the marginalised poor and rural women are the groups that are most affected. Improving maternal mortality has received recognition globally as is evidenced by the inclusion of its reduction of 75% between 1990 and 2015 in the Millennium Development Goals (MDG) (United Nations, 2004).

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Nigeria contributes approximately 10% of the global burden of maternal and child deaths and thus has one of the worst maternal health outcomes (UNICEF, 2008). The World Health Organisation ranked Nigeria as having the second highest number of maternal deaths in the world, with an estimated 37,000 maternal deaths (WHO, 2004). Nigeria is one of few countries where the maternal mortality ratio (MMR) has almost doubled in the 1990-2008 figures (Hogan, Foreman & Naghavi, 2010). In the rural areas, the MMR is very high as the majority of births takes place at home unassisted

and or assisted by unskilled persons thus women who develop complications rarely receive emergency services (Osubor, Fatusi & Chiwuzie, 2006).

Against this background, this study aimed to develop a model of community engagement in the prevention of maternal health complications in the rural communities of Cross River State, Nigeria.

1.2 THE RATIONALE OF THE STUDY

The study considers the following issues:

1.2.1 Risk of obstetric complications and the need for birth preparedness and complication readiness

All pregnant women faces risk of obstetric complications and prenatal screening does not identify all of the women who will develop complications and receiving care from a skilled provider (doctor/nurse/midwife) during childbirth has been identified as one of the most important stragegies in tackling such complications (Macro, 2005). However, the use of skilled provider in developing countries remains low according to the Demography and Health Survey (Macro, 2005). Ronsmans & Filippi, (2004), noted that there is some progress in the reduction of maternal mortality rate in urban areas, with little improvement in the rural areas. In response to this many African countries, including Nigeria have developed measures towards reducing maternal mortality (Ronsmans & Filippi, 2004).

Birth Preparedness (BP) and Complication Readiness (CR) are two key maternal health literacy strategies to promote the timely use of skilled maternal care during childbirth, and are based on the theory that preparing for childbirth and being ready for complications reduces delays in obtaining care (John Hopkins Program for International Education in Gynaecology and Obstetrics [JHPIEGO], 2004). The

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awareness of pregnant women and their family members regarding the danger signs enhances Birth Preparedness and Complication Readiness, improves early detection of problems, and reduces the delays in deciding to seek obstetric care (JHPIEGO, 2004).

There are three delays that influence the provision and use of maternal health care services to prevent maternal deaths: a) deciding to seek care if complication occurs; b) reaching care; and c) receiving care (Thaddeus and Maine, 1994 cited in Maternal Mortality in Context, 2004). The Maternal and Neonatal Health (MNH) programme of JHPIEGsO developed the Birth Preparedness (BP) and Complication Readiness (CR) matrix to address these three delays at various levels including the pregnant woman, her family, her community, health providers, health facilities, and policymakers during pregnancy, childbirth and the post-partum periods (Maternal Mortality in Context, 2004). The concept of Birth Preparedness and Complication Readiness includes: recognising danger signs, planning for a skilled birth attendant (SBA) and birth location, arranging transportation, and saving money in case of an obstetric complication (JHPIEGO, 2001).

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Birth Preparedness has been recommended as the best practice that has been adopted by several projects in many parts of the world including Nepal, India, Ethiopia, and Bangladesh (McPherson, Khadka, Moore & Sharma, 2006). Birth preparedness should reduce the three delays, commencing at community level and should link to improved access to skilled care (McPherson, Khadka, Moore & Sharma, 2006).

Over the last few years, the Federal Government of Nigeria has launched various health programmes in the different governmental tiers (including Cross River State) to curb the burden of maternal morbidity and mortality and to include Focused Antenatal Care (FANC) and skilled attendants at births (Ekanem, Etuk, Ekanem, & Ekabua, 2005). In

line with this, a midwife service scheme is one of the strategies, and most primary healthcare facilities have been upgraded to meet this challenge (Ekanem, Etuk, Ekanem, & Ekabua, 2005). A study in Calabar, Nigeria, revealed less progress in the rural areas in comparison to progress in the urban areas (Ekanem, Etuk, Ekanem, & Ekabua, 2005). This may be due to gross under-utilisation of healthcare facilities and delays in seeking skilled attendant by pregnant women in the rural communities of the which may be linked to unawareness of the danger signs of obstetric complications, deep-rooted traditions in birth practices, and lack of communities' involvement in healthcare service planning (Archibong & Agan, 2010).

1.2.2 Community engagement as a strategy to address problems of delay

The WHO suggested community engagement to strengthen partnerships as to address the problems of delay and to improve access to skilled attendants (Fleischer-Djoleto, 2004). According to Bloomfield & Cayton, (2009), "engagement entails involving people and communities fully throughout the process and activity to ensure their preference, interests, concerns in all aspects of decision including identifying solutions and developing alternatives." This has been supported by a review which showed that it is effective to engage community members in health care planning and decision-making if maternal survival must be improved especially in low-income countries and remove the barriers to maternal health care (AIHW, 2006). For example, in Burkina Faso, Ecuador, Bolivia, Peru, Guatemala and Honduras, Family Care International (FCI) through the "Missing Partner Initiative" engaged communities in various projects to improve the quality of and promote women's utilisation of maternal health services (FCI, 2013). Likewise in Ireland, an initiative was developed involving community mothers giving support to disadvantaged first-time mothers showed positive results as children in the intervention group were more likely to have received all of their primary

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immunisations (Blomfield & Cayton, 2009). This programme further influenced the development of a similar schemes in the UK (Blomfield & Cayton, 2009).

1.2.3 Innovative approaches to address gaps in research

In identifying this as an area that required further research in a country such as Nigeria, Photovoice has been identified as an innovative participatory action research (PAR) method that offers unique contributions to women's health especially in rural low-income settings. Photovoice has been proven to be effective in a variety of settings and with diverse populations and have been claimed to improve health services, enhance understanding of the community's needs (Rhoes, 2001), engagement of community through action and advocacy to enhance understanding of community needs, and improve maternal and child health services (Wang & Pies, 2004). Wang and Burris (1997) defined "Photovoice as a process by which people can identify, represent, and enhance their community through a specific photographic technique". Photovoice involves community members taking pictures, telling stories, and informing policymakers about issues of concern at the grassroots level (Wang, Cash & Powers, 2000). This method according to Wang & Pies,(2004), also enables people to identify community strengths and assets and their shared concerns as a basis for issue selection and action.

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1.3 PROBLEM STATEMENT

Pregnancy-related poor maternal health and maternal death are still a major problems in sub-Saharan Africa and it is assumed that most of these cases can be prevented when births are assisted by Skilled Birth Attendants (SBAs). Reviews highlight that Safe Motherhood programme packages of interventions to reduce maternal mortality include placing Skilled Birth Attendants within functioning health systems with the availability

of referral to emergency obstetric care services (Nyamtema, Urassa & Van Roosmalen, 2011). However, the availability of these services does not mean that they are utilised.

In Cross River State, Nigeria, only 34,890 of women attend labour by skilled attendants while the majority deliver at home, the situation as revealed in a study by Archibong & Agan (2010), is worse in the rural communities. This contributes to the high ratio of maternal mortality, currently being 1,513.4:100,000 live births in the state (Archibong & Agan, 2010). Despite some interventions by the federal and state governments, such as free maternal and child healthcare services and the National Midwives Service Scheme (NMSS), the majority of the women do not use these services (Ekanem et al., 2005). Findings from the same study showed that most women are aware of the existing healthcare facilities and the free services within their locations, yet they do not appear to be interested in utilising them. Study by Ekabua, Ekabua, Odusolv, Agan, Iklaki and Etokidem's (2011) identified lack of information on obstetric warning signs, birth Preparedness, complication readiness, women's limited autonomy in decision- making to seek healthcare, negative cultural beliefs and practices, and lack of community involvement in programme designing and implementation as factors that cause delays in seeking appropriate care, thereby hampering the abilities of rural women to participate fully in safe motherhood initiatives.

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Good knowledge of danger signs means that the predictable elements of the three phases of delay can be anticipated and prepared for with a birth plan for each pregnancy (Agarwal, Sethi, Srivastava, Jha & Baqui, 2010). It was hypothesised that the implementation of Birth Preparedness/Complication Readiness concepts that focus on individual, families, and communities could reduce at least the first two phases of delay (Ekabua, Ekabua, Odusolu, Agan, Iklaki & Etokidem, 2011). Ronsman and Graham (2006), observed that targeting of interventions to the most vulnerable rural populations

and poor people is essential if substantial progress is to be achieved in the reduction of maternal morbidity and mortality by 2015. In support of this, Fullerton, Killian & Gass (2005), emphasised that strengthening community mobilization efforts designed to reduce delays in transport to Emergency Obstetric Care referrals and to increase use of skilled services through community education on recognition of danger signs and early intervention has been identified as a key link towards improving maternal health through addressing the delays in seeking care and reaching health facilities. Accordingly, it has been demonstrated that active involvement by communities is critical to the success of interventions, and is best ensured if the initiative and responsibility for implementation comes from the community (Fullerton, Killian & Gass, 2005) . Literature has also highlighted the effectiveness in many countries of promoting community engagement as a means for healthcare planning to improve individual and community interventions. For example, a community engagement project by Care International project in Peru in South America and a women's non-governmental organisation (NGO) in India subsequently yielded increased women's utilisation of maternal healthcare (Freedman, 2001).

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Africa is known for communitarianism and mass mobilisation to address societal needs politically but none have been documented or located in the context of women's health that specifically addresses maternal mortality. The Ugandan Association of Women Lawyers initiated a community engagement initiative and made considerable progress in bringing local and national attention to the illegal practices of female genital cutting (Hawkins, 2005). In the traditional rural communities of Cross River State, Nigeria, men and older women often play a lead role, likewise solidarity mechanisms can be implemented to ensure both Birth Preparedness/Complication Readiness and utilisation of healthcare facilities for skilled attendance during pregnancy, delivery, and post-

partum. No such mechanism has been documented nor has a model been drafted to prompt such mechanism. Hence, the researcher aimed to develop a community engagement model which could function to facilitate the prevention and early detection of obstetric complications through the promotion of Birth Prepredness/Complication Readiness practices by community members themselves, to improve access to skilled birth at primary healthcare facilities (PHC) in the rural communities of Cross River State, Nigeria.

Against this background, this study aims to engage the community through the Photovoice participatory approach, in the development of a community engagement model, which will have the aim to facilitate the prevention of maternal health complications through promoting Birth Preparedness/Complication Readiness by the community itself, and the utilisation of healthcare facilities for skilled attendance during pregnancy, delivery, and after delivery in the rural communities of Cross River State, Nigeria.

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1.4 SIGNIFICANCE OF THE STUDY

This study is unique because though in various regions of the world, rural communities have been engaged in different ways to address various women health issues, but no community engagement model has been documented in Cross River State, Nigeria, despite the impact of maternal mortality in our rural communities.

This is the first study that utilises the Photovoice participatory approach in a low resource setting in Nigeria such as this, to engage community members in defining, planning, and designing an action towards promoting Birth Preparedness, Complication Readiness, and the utilisation of skilled attendants during pregnancy, delivery, and post-partum by the community members themselves. Hence, the development of a model of community engagement in the prevention of maternal health complications in the

rural communities of Cross River State, Nigeria. The study will generate future research at the post-doctoral level through the testing of the model.

1.5 SCOPE OF THE STUDY

This study was conducted in in the rural communities of Cross River State of Nigeria. The study focused on women of childbearing age, older women and other relevant community members in Cross River State.

1.6 STRUCTURE OF THE THESIS

The study is structured as follows:

Chapter 1 forms an orientation and introduction to the study. It includes the background, problem statement, rationale, significance of the study, scope of the study and how the thesis is structured.

Chapter 2 outlines the study and provides the aims and objectives of the study, the research questions, the definintion of terms and the theoretical ideologies underpinning the study.

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Chapter 3 entails a literature review that explores relevant aspects of maternal mortality and morbidity and strategies to address this.

In Chapter 4, the methodological approach to the study is described.

In Chapter 5 and Chapter 6 the data analysis results and discussion are presented.

Chapter 7 involves the data analysis results of the model development. Results are discussed and compared and conclusions are derived from the results.

In Chapter 8, the model is proposed.

In Chapter 9, the conclusions, limitations and recommendations and suggestions for further studies are outlined.

1.7 SUMMARY OF THE CHAPTER

This chapter has served to set the context of the study by providing an introduction and background to the principal issues under discussion, namely maternal and child health as well as highlighting the identified problem and the significance of the study. It also orientates the reader to the congruent proposed methodology to be used in the study, namely Photovoice. The aims and objectives of the study is described in the next chapter.

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CHAPTER TWO: AIMS AND OBJECTIVES OF THE STUDY

2.1 INTRODUCTION

This chapter provides an outline of the main aims and objectives of the study and the underlying theoretical underpinnings of the study.

2.2 AIM OF THE STUDY

The aim of this study was to develop a model of community engagement in the prevention of maternal health complications in the rural communities of Cross River State, Nigeria. The study which was conducted in three phases had the following objectives to attain the aim of the study:

Phase 1: Understanding the current situation in the rural communities of Cross River State:

1. to explore the knowledge gap of obstetric danger signs in women of child-bearing age (pregnant and new mothers) in the rural communities of Cross River State;
2. to explore Birth Preparedness (BP), Complication Readiness (CR), and delivery practices of women of child-bearing age in the rural communities of Cross River State; and
3. to explore the action of family/community members in emergencies and the role of existing community-based maternal health initiatives, if any, for rural women in Cross River State; and to make recommendations for community actions to address these issues.

Phase 2: Community engagement:

4. to engage community members (pregnant women and new mothers), through a participatory approach (Photovoice) to highlight problems regarding pregnancy and birth practices, identify possible solutions, and make recommendations on

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communities' roles in the prevention of maternal health complications in the rural communities of Cross River State, Nigeria; and

5. to verify and validate the findings from the interview and photovoice analyses with the older women of the two communities under study.

Phase 3: Model development:

6. to engage the community stake holders through a focus group discussion for concept validation and generation of guidelines for model development; and

7. to develop a model of community engagement for the prevention of maternal health complications in the rural communities of Cross River State, Nigeria.

2.3 RESEARCH OBJECTIVES AND QUESTIONS

The specific objectives of each phase of the study are discussed in relation to the questions that addressed them.

2.3.1 Phase 1: Understand the current situation

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Objective 1

To explore the understanding of women of child-bearing age (pregnant and new mothers) in terms of obstetric danger signs in the rural communities of Cross River State.

Research questions

i. *What are the knowledge and understanding of women in terms of obstetric dangers signs*

   a. *during pregnancy, delivery, and after delivery?*

   b. *home care delivery*

ii. *What is the knowledge and understanding of women in terms of importance of being attended to by skilled healthcare providers during pregnancy, labour, and after delivery?*

Objective 2

To explore birth preparedness (BP), complication readiness (CR), and delivery practices of women of childbearing age in the rural communities of Cross River State.

Research questions

i. *How prepared are women in terms of birth preparedness and complication readiness?*

ii. *What are the delivery practices of women of child bearing age?*

Objective 3

To explore the action of family/community members and the role of community-based maternal health initiatives, if any, in emergencies, and to explore participants' opinions on actions to be taken by the community to promote the utilisation of orthodox healthcare facilities by rural women in Cross River State.

Research questions

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i. What is the role of family members in obstetric emergencies?

ii. What is the role of community members in obstetric emergencies?

iii. What is the role of community based maternal health initiatives in obstetric emergencies?

iv. What actions are taken by the community to promote the utilisation of orthodox healthcare facilities by rural women in Cross River State?

2.3.2 Phase 2: Community engagement

Objective 4

To engage community members (pregnant women and new mothers), through a participatory approach (Photovoice) to highlight problems regarding pregnancy and birth practices, identify possible solutions, and make recommendations on

communities' roles in the prevention of maternal health complications in the rural communities of Cross River State, Nigeria

Research Questions

i. *What are the problems regarding pregnancy and birth practices that women see in their daily life*
ii. *What possible solutions can be suggested to address some of these issues*
iii. *What recommendations can me made on communities' roles in the prevention of maternal health complications in the rural communities of Cross River State, Nigeria*

Objective 5

To verify and validate the findings from the interview and photovoice analyses with the older women of the two communities under study.

Research questions

i. *Are the findings from phases 1 and 2 accurate?*
ii. *How are these findings related to your lives and practices in these communities?*
iii. *What actions can be taken to address these issues?*

2.3.3 Phase 3: Model development

Objective 6

To develop a model of community engagement for the promotion of Birh preparedness, Complication readiness and to improve access to skilled birth attendance for prevention and early detection of maternal health complications.

Research questions

- *What are the guidelines for model development*
- *What are the components of the model?*
- *What are the guidelines for operationalising the model.*

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These objectives were addressed through different steps in the model development process.

2.4 OPERATIONAL DEFINITION OF TERMS

The following terms have been operationalised for this study.

Term	Definition
Birth Preparedness	*Operational definition:* This refers to the preparation a pregnant woman makes towards having a safe delivery.
Complication Readiness:	*Operational definition:* The process of anticipating the action needed in case of an emergency and preparing for it. “The concepts of birth preparedness (BP) and complication readiness (CR) always go together. A woman is classified as “well birth prepared "or "complication ready", if she has accomplished three of the following practices: identified skilled health professional/s; saved money; identified transport; and has delivery kits/materials” (JHPIEGO, 2004:12).
Community	“The quality of holding something in common such as values, goals, needs or interests; a social bonding and an accompanying shared sense of self or identity; and the people of a certain district, neighbourhood or town" (Scott & Marshall, 2009:7) *Operational definition:* This In this study a community refers to a group of persons dwelling in the same area, sharing a common identity and interest.
Community Engagement	A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, making decisions about factors that affect their health, and taking actions to achieve change (Bruns, 2003). *Operational definition:* This In this study, community engagement refers to full involvement of community members in defining, designing, and proffering solutions to issues that affect their health, thereby gaining support. Note: In this study, community engagement will be used interchangeably with participation, involvement, and consultation.
Participation	*Operational definition:* This Communities are engaged as passive or active recipients of health services.
Mobilisation	*Operational definition:* This Communities are engaged to support health programmes through direction or facilitation by health professions or stakeholders

Empowerment	*Operational definition:* This Communities are engaged through a capacity-building process to plan, implement, and/or evaluate activities on a sustained basis to improve their health
Family Members	*Operational definition:* This In this study, family members refer to married men and women within each household that can make a significant contribution to decision-making during pregnancy, labour, and postpartum periods.
Knowledge/Awareness	Knowing the importance of pregnancy care and delivery care by a Skilled Birth Attendant, the danger signs of pregnancy, the location of health institutions and/or emergency obstetric care and existing community services for emergency (funds and transport) (Stanton, 2004). *Operational definition:* In this study it refers to knowing about the existence healthcare facility and the importance of being attended to by a skilled health professional during pregnancy and delivery, knowing the danger signs, and being birth prepared and complication ready.
Maternal Health Complication	*Operational definition:* This There is no precise definition of maternal health complications. In this study it refers to those life-threatening problems that could arise during a woman's pregnancy, childbirth, and up to six weeks after childbirth (puerperium or postpartum) that requires urgent intervention to save such life.
Maternal Morbidity	"Maternal morbidity includes physical and psychological conditions that result from or are aggravated by pregnancy and have an adverse effect on a woman's health" (WHO, 2004). *Operational definition:* This In this study it refers to serious disease, disability, or physical damage caused by pregnancy-related complications.
Maternal Mortality	Refers to "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (WHO/UNICEF/UNFPA/WORLD BANK, MME Estimates, 2004-2013). *Operational definition:* This In this study it refers to the death of a woman while she is pregnant or within 42 days of termination of pregnancy, regardless of the site or duration of the pregnancy.

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Model	"A model is an abstraction, a mental framework for analysis of a system. It involves simplified representations of real-world phenomena" (Powel & Connaway, 2004:60). *Operational definition:* This In this study it refers to a simplified description of a complex process used in analysing and solving problems or making predictions.
New Mothers	*Operational definition:* This This refers to mothers with babies 12 months of age or younger.
Obstetric Danger Signs	*Operational definition:* This The common, easily recognisable signs (even by a non medical personnel), of serious complications during pregnancy, childbirth, and postpartum. It is used interchangeably with maternal health complications in this study. The three most common key danger signs during pregnancy include severe vaginal bleeding, swollen hands/face, and blurred vision. Major danger signs during labour and childbirth include severe vaginal bleeding, prolonged labour (>12 hours), convulsions, and retained placenta. Major danger signs during the postpartum period include severe vaginal bleeding, foul-smelling vaginal discharge, and fever (JHPIEGO, 2004).
Prevention	The term 'prevention' is reserved for those interventions that occur before the initial onset of disorder. (Vermont Department of Health, 2015). *Operational definition:* In this study, prevention is the promotion of constructive lifestyles and norms that discourage ill health and death in pregnant women and mothers.
Orthodox Maternal Healthcare	*Operational definition:* This Modern healthcare services rendered to women during pregnancy, delivery, and puerperium.
Pro-TBA factors	*Operational definition:* This These are factors that bring about or favour the patronage of TBAs.
Pro-orthodox Healthcare Factors	*Operational definition:* This These are factors that bring about or favour the utilisation of orthodox maternal healthcare services by women.
Puerperium	*Operational definition:* This The period between the delivery of the placenta and six weeks after delivery. In this study, it will be used interchangeably with postpartum period.

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Skilled Birth Attendant (SBA)	Is defined as "an accredited health professional–such as a midwife, doctor or nurse–who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns" (WHO, 2006). *Operational definition:* This In this study, SBA refers to a medically qualified provider with midwifery skills (midwife, nurse, or doctor) who has been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications.
Traditional Birth Attendant (TBA)	A community-based provider of care during pregnancy and childbirth. TBAs are not trained to proficiency in the skills necessary to manage or refer obstetric complications. UNFPA Safe Motherhood Programme, (2007) in Canavan, (2009), states, "the term TBA refers only to traditional, independent (of the health system), non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period" A TBA is defined as "a person who assists a mother during childbirth and has acquired her skills by delivering babies herself or through apprenticeship to other TBAs" (WHO,1992). *Operational definition:* This In this study, TBAs refer to community-based traditional midwives who are not formally trained to proficiency but who provide care to women during pregnancy, childbirth, and puerperium.
Postpartum Period	A postpartum period (or postnatal period) is the period beginning immediately after the birth of a child and extending for about six weeks thereafter. Less frequently used are the terms 'puerperium' or 'puerperal period'. The WHO describes the postnatal period as the most critical and yet most neglected phase in the lives of mothers and babies; most deaths occur during the postnatal period. *Operational definition:* In this study it refers to the period after delivery of a placenta to six weeks after birth. In this study it will be used interchangeably with the term 'puerperium'.
Photovoice	"A participatory action research strategy by which people can identify, represent, and enhance their community through a specific photographic technique" (Wang & Burris, 1997; Lykes, Blanche,& Hamber, 2003).

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Operational definition: This In this study, Photovoice refers to a technique whereby people use a camera to capture images of their everyday life experiences in their communities. By telling stories about the photographs, they convey to others the context of their lives from their personal point of view.

2.5 THEORETICAL UNDERPINNINGS OF THE STUDY

2.5.1 Introduction

The conceptual framework refers to the relationship between concepts, guides the research, determines what concepts are important and explains the relationship between concepts (de Vos, Strydom, Fouche'& Delport, 2011). The conceptual frameworks of the Citizenship Healthcare Model, and the Socio-Ecological Logic Model provide the theoretical underpinnings of this study. However, Photovoice as a core participatory approach applied in this study is also highlighted to clearly show its link with the two models underpinning this study.

2.5.2 Citizen Healthcare Model

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The Citizen Healthcare Model is a way of engaging patients, families, and communities as co-producers of health and healthcare (Doherty & Mendenhall, 2006). According to the proponents, "it goes beyond the activated patient to the activated community, with professionals taking advantage of community organising skills for working with individuals and families who see themselves as builders of health in the community rather than mere consumers of health services" (Doherty & Mendenhall, 2006). Over the years, this model has been field-tested by the authors and their colleagues.

2.5.2.1 Origin of the Citizen Healthcare Model

The Citizen Healthcare Model emerged out of work across a variety of disciplines, moving beyond clinical collaboration to community collaboration (Doherty & Carroll, 2002). It emerged from the authors' professional backgrounds in family therapy, medical family therapy in family medicines settings, and collaborative family

healthcare with an addition of political theory in the form of the Public Work Model, contemporary community organising strategies, and community-based participatory research (Doherty & Carroll, 2002).

2.5.2.2 Principles of the Citizen Healthcare Model

The three principal orientating ideas of this model are:

Human beings as co-creators of the world: Public work is the sustained, visible, and serious effort by a diverse mix of ordinary people who create things of public significance (Doherty & Carroll, 2002). This contrasts to the provider/consumer conventional methods of American culture that renders people passive recipients of services rather than co-creators of important work (Doherty & Carroll, 2002)..

The importance of public life: The model emphasises the importance of the ultimate sphere of family and friends to live a full human life (Doherty & Carroll, 2002).

Democratic, rational power: The model stresses the development of relationship of mutual interest and collaborative energy to work on public solutions (Doherty & Carroll, 2002).

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The authors adopt community-based participatory research as the principal research tool for citizen healthcare projects (Mendenhall & Doherty, 2005).

Based on the above, the Citizen Healthcare Model centres on the core principles as discussed below.

Citizenship Healthcare Model: Core principles

1. The greatest untapped resource for improving healthcare is the knowledge, wisdom, and energy of individuals, families, and communities who face challenging health issues in their everyday lives (Doherty & Mendenhall, 2006).

2. People must be engaged as co-producers of healthcare for themselves and their communities, not merely as patients or consumers of services (Doherty & Mendenhall, 2006).

3. Professionals can play a catalytic role in fostering citizen initiatives when they develop their public skills as citizen professionals in groups with flattened hierarchies (Doherty & Mendenhall, 2006).

4. If you begin with an established programme, you will not end up with an initiative that is "owned and operated" by citizens, but a citizen initiative might create or adopt a programme as one of its activities (Doherty & Mendenhall, 2006).

5. Local communities must retrieve their own historical, cultural, and religious traditions of health and healing, and bring these into dialogue with contemporary medical systems (Doherty & Mendenhall, 2006).

6. Citizen health initiatives should have a bold vision (a BHAG—a big, hairy, audacious goal) while working pragmatically on focused, specific projects. (Doherty & Mendenhall, 2006).

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2.5.2.3 Action strategies for Citizen Healthcare

The Citizenship Healthcare Model process assumes the following steps, as identified by Doherty and Mendenhall (2006).

1. Consult the gatekeepers who must support the initiation of a project based on its potential to meet one of the goals of the healthcare setting and though, little or no budget may be requested, a small amount of staff time may be required to allow the project enough incubation time before being expected to justify its outcomes (Doherty & Mendenhall, 2006).

2. Identify a health issue that is of great concern to both professionals and members of a specific community (Doherty & Mendenhall, 2006). The issue must be one that a community of citizens actually cares about—not just something that we think they should care about, while the professionals initiating the project must be sufficiently passionate about issue to sustain their efforts over time (Doherty & Mendenhall, 2006).

3. Identify potential community leaders that are ordinary members of the community but who, in some way, have mastered the health issue in their own lives and who have a desire to give back to their community (Doherty & Mendenhall, 2006). Positional leaders who head community agencies are generally not the best group to engage at this stage, because they have institutional priorities and constraints (Doherty & Mendenhall, 2006).

4. Invite a small group of community leaders (three to four people) to meet several times with the professional team to explore the issue and to establish whether or not there is a consensus to proceed with a larger community project (Doherty & Mendenhall, 2006). These are preliminary discussions to establish whether or not a citizen healthcare project is feasible and to begin creating a citizen leadership group (Doherty & Mendenhall, 2006).

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5. This group decides how to invite a larger group of community leaders (10–15) to begin the process of generating the project (Doherty & Mendenhall, 2006). A major task of the small initial planning group is to decide on the criteria for expanding its membership and it is a necessary criterion that those invited should have leadership potential (Doherty & Mendenhall, 2006).

6. The full planning group implements the community organising process through the following steps: in-depth exploration of the community and citizen dimensions of the

issue; creating a name and mission; having one-on-one interviews with a range of stakeholders; generating potential action initiatives and processing them in terms of the Citizen Healthcare Model and their feasibility with existing community resources; and deciding on a specific action initiative and implementing it (Doherty & Mendenhall, 2006).

7. The following key citizen healthcare processes must be implemented:

- Democratic planning and decision-making at every step. This requires a disciplined process model and a vision of collective action that does not lapse back into the conventional provider/consumer model, but which does not control the outcome or action steps the group decides to take (Doherty & Mendenhall, 2006).
- Mutual teaching and learning among community members. Action initiatives consistent with the model first call upon the lived experience of community members, with the support of professionals, rather than recruiting community members to support a professionally created initiative (Doherty & Mendenhall, 2006).
- Creating ways to include new knowledge back into the community as all knowledge can become community property if there is a way for it to be passed on (Doherty & Mendenhall, 2006).
- Identifying and developing leaders. The heart of community organising is finding and nurturing people who have leadership ability, but who are not necessarily heads of organisations with agendas to protect (Doherty and Mendenhall, 2006).

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2.5.2.4. Examples of Citizen Healthcare projects

Partners in Diabetes (PID): Diabetic adult urban patients' health remained poor despite repeated focus groups and classes to impart elements of good diabetes management. There were complaints regarding noncompliance by patients and insensitivity to psychosocial and cultural/ethnic struggles on the part of the providers (Doherty & Mendenhall, 2006). William Doherty and other providers (Doherty & Mendenall, 2006) approached this challenge with a community-based participatory research project, using the Citizen Healthcare Model as a guiding framework. Fourteen adult patients and their spouses or significant others were engaged as collaborators in the design of supplementary services where their experiences and wisdom of living with diabetes were utilised and together with the providers, a citizen initiative that improved the lives of patients and families in the St. Paul community was established (Doherty & Mendenall, 2006).

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Mendenhall & Doherty (2003) submit that PID connects patients and families who have lived experience with diabetes to others who are struggling with the illness, for the purposes of support (Mendenhall & Doherty, 2003). The engaged patients and their support or significant others who were referred to as support partners, worked with the providers to design the project. They received training and were able to reach out to other patients, called members, who were struggling with their diabetes for some time (Mendenhall & Doherty, 2003).

Support partners commit at least two hours per week to the project and the whole group meets monthly to consult and address challenges. According to Mendenhall & Doherty (2003), a qualitative analysis of the PID project revealed that as a result of PID, the patients became more empowered to provide most of the care they needed themselves,

care took place outside of the health care institutions and people realised that healthcare happens in the real world on a day-to-day basis (Doherty & Mendenhall, 2006). The proponents commented that as support partners, participants increased partnership with providers and they became more aware of their potential to contribute as a result of their personal lived experience and the wisdom that they possessed as persons affected by diabetes (Doherty & Mendenhall, 2006). "Instead of providers designing a programme that patients then participate in (conventional model), PID evolved through the contributions of professionals and patients alike" (Doherty & Mendenhall, 2006:256).

The PID proponents highlight that every aspect of PID was approached in a collaborative and democratic manner as patients, their families, and providers shared responsibility for creating and implementing the new initiative, including designing the training, and establishing procedures for support partner/member connections. The initiative is now considering expanding since it has gained visibility with systems being developed to improving patient-centred care (Mendenhall & Doherty, 2003).

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ANGELS (A Neighbour Giving Encouragement, Love, and Support): Mendenhall utilised the ANGEL approach with providers in a south-eastern hospital in the United States, who were frustrated with their adolescent diabetic patients whose adherence to physical activity, blood sugar monitoring, and insulin administration was very poor despite efforts in conventional interventions and education. "Adolescents and parents worked democratically with providers throughout every stage of ANGELS' development – from initial brainstorming about its missions to the public visibility efforts, implementation, and ongoing problem-solving and maintenance" (Doherty & Mendenhall, 2006:258-259). Using the same approach, other community-based

initiatives were formed, for example the Department of Indian Work's Family Education and Diabetes Series (FEDS) (Doherty & Mendenhall, 2006).

2.5.2.5 The Citizen Healthcare model versus other Community–Oriented Primary Care (COPC)

Community-oriented Primary Care (COPC) is another model for identifying and addressing health problems in a community. The model tends to share the same phases as the Citizen Healthcare Model (Harper, Baker & Reif, 2001). However, a principal difference between the two models relates to the role of the professional (Doherty & Carroll, 2002; Mendenhall & Doherty, 2005). According to these authors, in COPC, the professional is central and hierarchical relationships exist; while communities help providers, the health of the community continues to rest ultimately on the providers (Doherty & Carroll, 2002; Mendenhall & Doherty, 2005). Despite its collaborative nature, it is still described as a type of service delivery to consumers of healthcare. Essentially, in COPC the providers' role is to use leadership to help communities in problem identification and solution-generation processes while in contrast, in the Citizen Healthcare Model, individuals and families are active producers and co-creators of action and change, hence they do not function in a consumer/patient role thus the model is less expert driven and is oriented to producing a sustained initiative (Boyte & Karki, 1996; Doherty & Carroll, 2002; Mendenhall & Doherty, 2005).

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2.5.2.6 Key lessons of the Citizen Healthcare Model

As outlined by Doherty and Mendenhall, (2006) the Citizen Healthcare Model is about: identifying transformation as a citizen professional, not merely about learning new skills; identifying and developing leaders in the community, not only about a specific issue or action; a sustained initiative, not a one-time event; and a professional who devotes too much time to the project is over-functioning and not using the model (Doherty and Mendenhall, 2006). .

2.5.2.7 Challenges of the Citizen Healthcare Model

The following setbacks of this model have been identified: citizen initiatives are often slow and messy, especially during the gestational period; a champion with influence is needed; until grounded in an institution's culture and practices, this initiative is quite vulnerable to shifts in the organisational context; the pull of the traditional provider/consumer model is very strong on all sides and hence democratic decision-making requires eternal vigilance; and the approach requires monitoring (Harper, Baker & Reif, 2002; Doherty & Carroll, 2002; Doherty & Mendenhall, 2006).

2.5.2.8 Application of the Citizen Healthcare Model within this study

In adopting the concept of Citizen Healthcare Model, the principles of the model were applied in the following way:

- Prior to engaging with the rural women and the community, the research team familiarized themselves with the community in order to understand the existing maternal birth practices in the context (the communities). This situational analysis is aimed at assessing the knowledge status of rural women regarding obstetric dangers, benefits of utilising orthodox healthcare facilities, explore Birth Preparedness and Complication Readiness status, understand the influence of husbands and families on decision-making, family/community support, and their opinions about community actions to promote utilisation of orthodox healthcare services for skilled care. Familiarising and planning with the community members on the teams' objectives, activities and events for the rural women and their community occured at this stage.
- The community women were identified, engaged in defining, designing, planning and taking collective action in issues that affect their health by themselves, through interviews, focus group discussions and photovoice. This

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contributes to the empowerment of women, families and communities, as well as increase their influence and control of maternal health in their communities. Ownership and sustenance of program is ensured while community members and team establish a collaborative relationship.

- Pregnant women and new mothers in the communities were engaged in the descriptive phase of the study via interviews to identify the problems and define the study focus. In phases 2 & 3, community members (pregnant women, new mothers, family members, community stakeholders) were fully engaged through the Photovoice participatory approach and qualitative focus groups in the generation of data and verification/ validation of the data, as well as participating in generating guidelines for the community engagement model design.
- The contrast in methodology is that while citizen healthcare employs educational sequences and mentoring through a community-based participatory approach, this study utilised the Photovoice participatory approach with some elements of participant training in Photovoice ethics, methodology, camera use, and photos to be taken.

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2.5.3 Photovoice

Photovoice (originally termed photo novella) has been referred to as a concept, an approach, an educational tool, a participatory action research method, a participatory action tool, a participatory health promotion strategy, and a process (Wang, 1999; Wang & Burris, 1997; Wang, Yi, Tao & Carovano, 1998). The varied language used to describe Photovoice shows that it can be adapted to many goals, an assortment of groups and communities, and a variety of public health issues. Wang and Burris (1997:369) define Photovoice as "a process by which people can identify, represent,

and enhance their community through a specific photographic technique". With this technique, people capture images of their everyday life experiences in their communities through the use of a camera and by telling the story behind a photograph, they describe life in their communities and thus convey to others the context of their lives from their personal points of view, hence Lykes, Blanche, and Hamber (2003) characterise Photovoice as a means of self-representation.

2.5.3.1 Photovoice foundations

The Photovoice technique lie in empowerment education, feminist theory, and documentary photography (Wang, 1999; Wang, 1997), which Wang and Burris (1997) connect, in turn, to health policy and health promotion principles. The empowerment and critical consciousness literature is described as originating with Freire (1970) and affirmed by Photovoice through health-education methods described by Wallerstein and Bernstein (1988). Friere (1970) proposed the accumulation of social equity through a process of educational empowerment and consciousness-raising among ordinary people, compelling them to be agents of policy change by using photography to reflect the realities of community life. Wang and Burris (1994) build on Friere's work by having the local people take the photographs themselves, photographs about which stories will be told. Photography, critical reflection, and dialogue can serve to reveal significant social and political issues (Wang & Burris, 1994). Feminist theory advocates that women become emancipated and made visible by acting instead of being the objects of action; feminists have objected to research methods that keep women in passive roles (Wang & Burris, 1997). In discussing the politics of feminist ethnography, Williams, Crabtree, O'Brien, Zyzanski, and Gilchrist (1999). suggest that research considers the complexities of women's lives through the eyes of both the researcher and the researched, in a manner that explores differences and acknowledges similarities.

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Photovoice addresses power inequalities by placing cameras not in the hands of the researchers, but in the hands of the research participants, thus investing them with authority and responsibility (Wang & Burris, 1997). Photovoice also has foundations in documentary photography, where visual images are used as an impetus for social change, by revealing the concerns and issues of specific individuals or groups. As described by Wang and Burris (1997), photographs are used in a similar manner, to generate a story that legitimises the contextual reality of the research participants.

Althogh photographs have been used in research for many years, by both physical scientists (such as astronomers) and social scientists (especially anthropologists), their primary purpose was to support findings collected in other ways (Wang & Burris, 1997). However, Photovoice is a special photographic technique whereby cameras are provided to study participants who are then asked to use the camera to record their real-life experiences (Wang, 2003). It is a participatory, qualitative, action-oriented method with three main goals: (a) to enable people to record and reflect on the community strengths and concerns; (b) to promote critical dialogue and increase understanding about important community issues; and (c) to reach policy-makers (Wang, 2003). As a data collection method, the idea of providing research subjects with cameras is relatively new (Wang, 2003).

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Some researchers consider the Photovoice method as having the unexpected benefit of empowerment, allowing participant photographers to express themselves in creative ways, and sometimes revealing a sophisticated understanding of the social determinants of their health and well-being (Ornelas, Amell, Anh, Tran, Royster & Armstrong-Brown, 2009). One consequence of this empowerment is a greater degree of community participation in problem-solving and information can be gained directly from the photographs, making it a particularly appropriate method for illiterate or semiliterate

groups (Ornelas,et al., 2009). Of course, it is important to be cognisant of the problems inherent in simply viewing photographs and gathering conclusions from them without benefit of the photographer's perspective (Ornelas et al., 2009).

Photographs can be viewed as tools to enrich and extend existing interview methodologies by providing information that cannot always be obtained through direct analysis (Harper, 2002). The author contended that this additional data might have a physical basis, explaining that "the parts of the brain that process visual information are evolutionarily older than the parts that process verbal information and thus, images may evoke deeper elements of human consciousness than do words (Harper, 2002). Essentially, the photographs can function as "starting and reference points" for discussions of both the familiar and the unknown. Also, it is not necessarily the obvious subject matter depicted that has importance, but sometimes why the photographer chose to film that activity, scene, object, or individual, rather than another (Haper, 2002). Each photographer and each viewer may attach a personal meaning to the image and the particular meanings might vary according to the level of knowledge of the subject matter depicted, or according to personal experiences that might be unrelated to the subject matter (Haper, 2002). Aditionally, the co-learning phenomenon is integral to this method since the dialogue is, for the most part, between equals. The researchers are both teachers and learners, as are the participants (Cheryl, Cooper & Susan, 2010).

2.5.3.2 Application of photovoice in maternal health programmes

Although Photovoice is becoming an increasingly common method for collecting data for a variety of purposes, both scholarly and commercial, articles describing the method for collecting health-related data in remote international settings are scarce (Wang, Burris, & Xiang, 1996). The first published health-related project using the Photovoice method in an international setting was conducted in Yunan, China, by Wang, Burris,

and Xiang (1996), with a focus on women's reproductive health and development. Subsequently, Photovoice has been used in a study of Ugandan nurses reflecting on their practice (Fournier, Mill, Kipp & Walusimbi, 2007), and a study of leisure experiences of older women with HIV/AIDS (Gosselink & Myllykangas, 2007). More recently, a sociological study of Mozambiquan rural farmer groups was conducted using the Photovoice methodology (Gotschi, Delve & Freyer, 2009). The method is commonly used among the poor, most disadvantaged, and historically oppressed populations in the world, and a common result of this oppression is what has been described as "learned helplessness," or "dependency thinking" (Carlson, Engebretson & Chamberlain, 2006).

Photovoice has also been used by village women to assess rural reproductive health needs in China (Wang, 1999; Wang, Burris & Xiang, 1996), by homeless children, men, and women to capture the essence of their everyday lives (Wang, Cash & Powers, 2000), by community members to reach policy-makers (Wang & Redwood-Jones, 2001), by research participants to evaluate the impact of social reform in New York City neighbourhoods (New York State Scholar Practitioner Team, 2002), by Mayan women in post-war Guatemala to reconcile differences and to promote community change (Lykes et al., 2003), by African American women to establish intergenerational connections between young homeless women and elderly housed women (Killon & Wang, 2000), and by elderly women to describe their everyday lives in the first 6 to 8 weeks post-hospital discharge (LeClerc, Wells, Craig & Wilson, 2002). When Photovoice was used with groups of women to assess and evaluate policy and public health issues, the participants increased their knowledge by creating a record of their own realities.

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In the same vein, Moffitt and Vollman (2004), in their study on picturing the health of Aboriginal women in a remote northern Australian community, used Photovoice with Tlicho pregnant women in order to better see, hear, and understand their everyday lives, and to promote dialogue on their health beliefs and health promotion practices. Similarly, Photovoice has been used by Chinese village women promoting reproductive health (Wang & Burris, 1997), young mothers and grandmothers establishing cross-generational links in Detroit (Killion & Wang, 2000), Black and Latino youth drawing attention to the HIV/AIDS epidemic in the San Francisco Bay area (May, 2001), and many others (Wang, Cash & Power, 2000; Lopez, 2002; Wang, Morrel-Samuels, Hutchison, Bell & Pestronk, 2004).

Five key concepts are intended to unite the ways in which diverse groups apply the Photovoice technique. These concepts include the understanding that: 1) images teach; 2) photographs can influence programs and policy; 3) community people ought to participate in creating and defining the images that shape healthful public policy; 4) the process requires that from the outset planners include policy-makers and other influential people to serve as an audience for community people's perspectives; and 5) Photovoice emphasises individual and community action (Wang, 1999).

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2.5.4 Socio-Ecological Logic Model

The Socio-Ecological Logic Model is the second conceptual framework to be used in the study. This model has been proposed to be used "to guide Photovoice planners and participants in planning activities that produce individual- and community-level changes" (Stark, Lovelace, Jordan & Holmes, 2010:629-636). The socio-ecological model gives a visual guide to Photovoice planners and participants to ensure that all parties are on the same conceptual page, increases the intentionality collective efforts

by using a simplified socio-ecological framework to capture the essential elements of the Photovoice process (Stark, Lovelace, Jordan & Holmes, 2010).

2.5.4.1 Background

Photovoice uses a Freirean-based process to engage people in observing and dialoguing about their communities; create a safe environment for critical reflection of why current realities exist; move individuals with increased level of critical consciousness towards action; and motivate the social power structures to initiate community change (Freire, 1970; Wang & Burris, 1997).

These components of the Photovoice process share a common core with Community Based Participatory Research (CBPR). Both CBPR researchers and Freireran practitioners agree that community members must actively analyse community issues to discover their root causes and to work towards change (Hann, Kean, Matutionis, Russell & Sterling, 2004). Similarly, the Institute of Medicine's report in Washington DC, on the future of public's health in the 21st Century argues that the health of populations and individuals is shaped by a wide range of factors in the social, economic, natural, built and political environments (Institute of Medicine, 2001). Accordingly, the Institute of Medicine (2002), submits that to improve population health, individuals and communities need to make changes in the broader society.

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This model proposes that the health of individuals is influenced not only by their attitudes and behaviours but also by community and social structures, and that there is "a reciprocal interplay among influences at individual, interpersonal, organisational, communal and larger societal levels of social ecology" (Strack et al., 2010:630). Wang and Burris (1997), the proponents of Photovoice, claim that Photovoice engages those community members whose voices are typically not heard in a participatory process to

identify, represent, and change their community through photography, dialogue, and action, with the goal of addressing root causes by targeting policy and systems changes. According to them, as a Community Based Participatory Research (CBPR) intervention, Photovoice brings together community members with community knowledge and passion, researchers with Photovoice knowledge and skills, experts with programme implementation skills and community and stakeholder connections (Carlson et al., 2006; Strack, Magill & McDonagh, 2004; Wang & Burris, 1997). Each partner brings unique strengths to the process and the core purpose is to communicate the intended relationship between planned activities, delivery processes, and targeted outcomes (Frechtling, 2007; Kaplan & Garrett, 2005; Kellogg Foundation, 2004).

2.5.4.2 Method and strategy

The Socio-Ecological Logic Model in Figure 1, illustrates the connection of activities and outcomes at each socio-ecological level: individual; interpersonal; organisational; communal; and societal. From left to right, the model identifies the Logic Model's common input and activity components leading to immediate and longer-term outcomes on the right. From the top to the bottom, the model depicts the levels of the socio-ecology, beginning with individual level activities and outcomes at the top and progressing down to the interpersonal, organisational, and communal levels' activities and outcomes (Stack et al., 2010) . According to the proponents, Stack et al. (2010), the key point here is that activities and outcomes at the lower socio-ecological levels (e.g. individual, interpersonal levels) are needed to achieve activities and outcomes at higher levels (e.g. communal levels).

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Within the Socio-ecological Logic Model, inputs refer to the resources needed to initiate and sustain the programme, and these resources are used to carry out activities ranging from individual actions, to group discussions, to community events. Activities

at each level are expected to result in an outcome. It is so sequential that short-term activities and outcomes lead to long-term activities and outcomes (Frechtling, 2007; Kaplan & Garrett, 2005; W. K. Kellogg Foundation, 2004).

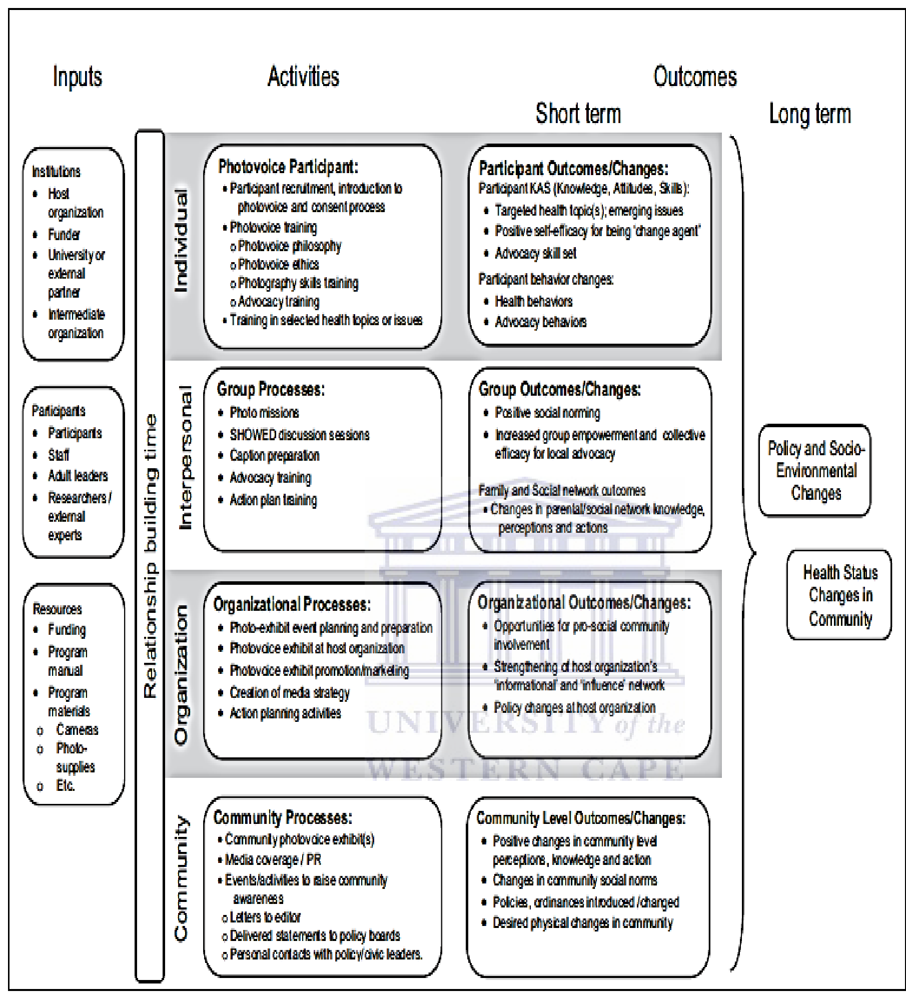

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FIGURE 3: Socio-Ecological Logic Model for guiding photovoice efforts

(Adapted from Strack et al., 2010)

Inputs refer to administrative support, programme resources and development steps needed for a successful project. Administrative support includes institutional partners and staff, programme facilitators and researchers, or external experts to inform programme design and evaluation. Programme resources include programme plans, funding, and Photovoice materials (e.g. cameras, photo supplies, photo-enlarging

resources). Programme facilitators or planners can use inputs from community members and the Photovoice literature to develop and customise a Photovoice programme (Carlson et. al. 2006, Strack et. al, 2004; Wang & Burris, 1997; Wang & Redwood-Jones, 2001

Because Photovoice is based on the principles of Community-Based Participatory Research (CBPR), facilitators should possess traits that foster trust and build rapport with community participants, they should also acquire skills to develop as mentors rather than top-down leaders, and they should be grounded in the Photovoice philosophy (Strack et al., 2010). Acordingly, the facilitators or planners must demonstrate cultural humility and a willingness to share power and resources, so as to maintain a strong respectful relationship, which is a key aspect of the Photovoice process (Wallerstein, Duran, Minkler & Foley, 2005).).

2.5.4.3 Individual level activities and outcomes

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The Photovoice process begins with activities and outcomes at an individual level. These include participant recruitment and introduction to the Photovoice process, structured Photovoice training (e.g. ethics, photography, and advocacy) and education regarding issues emerging from the project (e.g. health, tools, and resources) (Strack et al., 2010).

Short-term individual level outcomes include changes in participants' knowledge, attitude, skills, and behaviour regarding the targeted health issues. In Photovoice, participants share observations, have common experiences, and develop an emotional connection. Individual participants may start to consider themselves as community change agents (Carlson et al., 2006). Altman and Feighery (2004) predict that participants will be motivated to take action to change local conditions because of their

sense of efficacy for advocacy and the sense of community that develops through the Photovoice process.

2.5.4.4 Interpersonal level activities and outcomes

Participants may use their new knowledge and skills (individual level outcomes) to persuade others (interpersonal level activity) in their immediate environment to change (interpersonal level outcomes) (Strack et al., 2010).

Group activities include photo missions, SHOWeD discussion sessions, caption preparation, advocacy training, and action plans (Strack et al., 2010). Photovoice facilitators can use photo "mission" as a way to spark participants' exploration of photographic subject matter and help them become critical observers of their own community (Strack et al, 2004). As participants build confidence, facilitators should encourage participants to continue to observe and document their world through photography.

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Freire (1970), used listening surveys and pictures to represent community concerns and stimulate dialogue and analysis. In Photovoice, participants share photographs with the group, and with the help of facilitators, use SHOWeD, a Freirean-based process to discuss them. SHOWeD questions are designed to uncover root causes: what do you See here? What is really Happening here? How does this relate to Our lives? Why does this problem or concern exist? And what can we Do about it? After critically analysing the community problems and strengths identified through their photographs, participants craft captions to communicate their sentiments and observations. They discuss the ways of addressing the problem, or they may eventually develop public photography exhibits to engage others in action to address the problem. (Wang & Redwood-Jones, 2001).

2.5.4.5 Organisational level activities and outcomes

This includes planning, preparing, and holding Photovoice exhibits and planning actions together with the stakeholders to bring about community change. "Holding a Photovoice exhibit in the host community serves as a dress rehearsal for public exhibits and may stimulate organisational policy change" (Strack et al., 2010:634).

Action planning is a key component in preparing for long-term change. Facilitators work with participants to develop on action plan and a targeted local change strategy based on their images and root-steps of action planning; they choose actions and access the flexibility and likely effectiveness of each action. Finally, they identify potential community partners with similar interests with the aim of enlisting their help for specific actions (Strack et al., 2010:634). As the community becomes aware of the issues highlighted though Photovoice exhibits, the host community (organisation) builds relationships and increases its influence with other communities and policy-makers (Strack et al., 2010).

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2.5.4.6 Community and societal level activities and outcomes

This includes actions and outcomes outside the host community or organisation and immediate social network of Photovoice participants. One community team's work could influence other surrounding communities who may adopt the tool to effect change. For instance, several Photovoice efforts have successfully stimulated change at community and societal levels, and have influenced community leaders to address the needs of rural Chinese women (Wang & Redwood-Jones, 2001).

2.5.4.7 Photovoice evaluation

The socio-ecological Logic Model is useful for process as well as outcome evaluations because it identifies activities and possible changes at each level. Once planners agree on the desired activities and changes at each level, evaluators can identify

corresponding progress indicators (Guthrie, Louie & Foster, 2005) that can be used to monitor the causal links between activities and outcomes both within and between the socio-ecological levels. As Weiss pointed out in her work, collecting information on the hypothesised linkages or using a theory-driven evaluation approach, advances the understanding of programme design and function (Weiss, 1997).

To evaluate the hypothesised connections proposed by Strack et al. (2010), evaluators should ask the following questions:

Programme Fidelity:

- Was each element of the proposed Photovoice logic in place?
- Were attendance and the quality of programme elements sufficient for each activity?
- Were there sufficient physical and personnel resources available to carry out each activity (Strack et al., 2010:634-5)?

System-level change:

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- Did the Photovoice activities occur beyond the individual level?
- What progress or change occurred at each socio-ecological level?
- Was there adequate penetration and saturation of the Photovoice efforts within the target community?
- What barriers to carry out activities existed at each level (Strack et al., 2010:634-5)?

Causality:

- What intended and unintended outcomes were observed?
- Can causal relationships be drawn between processes and outcomes in each level?
- Did the processes and outcomes at one level influence those at higher levels ?

- Are there alternative explanations for observed changes (Strack et al., 2010:634-5)?

2.5.4.8 Merits of the Socio-Ecological Logic Model

The Socio-Ecological Logic Model highlights positive system change as a primary goal of the Photovoice method by:

- keeping both planners and participants on the same conceptual page and portrays the participants as 'agents' for social change (Strack et al., 2010);
- the model's flexibility can help participants strategise new tactics and outcomes as they discuss and define desired community changes (Strack et al., 2010);
- the model provides a framework for making planned activities with expected outcomes, and is useful in planning and evaluating the depth and intensity of the intervention; and when a change occurs, the model serves to guide questions about whether or not project activities were really responsible for the change (Strack et al., 2010) .

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2.5.3.9 Limitations of the Socio-Ecological Logic Model

There are some limitations underlying the implementation of a socio-ecological intervention such as Photovoice:

- Although Photovoice may contribute to systems level changes, changes in physical environments, social environments, and policies are complex and may require extended, long-term efforts for changes to occur (Guthrie, Louie & Foster, 2005, Reisman, Gienapp & Stachowiak, 2007); and
- Not all communities are able to achieve system level changes. Effective, sustainable changes will be more likely when advocacy strategies involve appropriate community members and are targeted to the community's readiness and capacity for change (Reisman, Gienapp & Stachowiak, 2007).

2.5.4.10 Application of Socio-Ecological Logic Model within the study

In adopting the socio-Ecological Logic Model for this study, inputs were derived from the following:

Administrative Support: Researcher, research assistants, model experts, analysts, gate-keepers, and permission from gaining entry processes.

Programme Resources: Funding, programme plan, Photovoice materials (cameras, photo supplies, photo-enlarging resources), and inputs from the descriptive phase (phase 1) of the study.

Individual-level activities and outcomes included: participant recruitment and introduction to Photovoice processes; training participants on Photovoice ethics, methodology, and photography; and educating them on project focus. This resulted in short-term individual level outcomes (knowledge and skill acquisition, behavioural and attitudinal change, empowerment, and development of confidence as change agents).

Interpersonal-level activities and outcomes resulted from the influence of the individual-level outcomes on others in their immediate environment to effect change. That is, after taking photos within their communities the Photovoice participants from the two communities met to discuss the photos through narratives and storytelling (FGD) to highlight the communities' problems regarding delivery practices and to suggest actions for solutions. They also interacted with the older women (grandmothers and mother in-laws from both communities) through FGD and photo exhibitions to validate their findings.

Organisational-level activities and outcome: Photos, findings, and decisions from the participants were shared with members from the broader community (older women in the communities, community stakeholders, representatives of women leaders, TBAs, leaders of women groups, religious leaders) for their information inputs and to draft

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guidelines for the development of the community engagement model to bring about community change in the prevention of maternal health complications through utilisation of orthodox healthcare facilities by women during pregnancy, delivery, and puerperium for skilled care. Thereafter, model experts were involved according to the themes that emerged for model development.

Communal- and societal-level activities and outcomes were achieved when the developed model is implemented to achieve the targeted outcome. Other communities could also adopt the model to affect similar changes within their communities.

For the purpose of this study, the Socio-ecological Logic Model was adopted until the development of a community engagement model, which was the purpose of the study. The implementation and evaluation of the community engagement model could be the focus of post-doctoral work and it will be available for other researchers to test.

2.6 Summary of the chapter

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This chapter provides the aims and objectives with specific reference to the concepts used in this study and the conceptual frameworks underpinning this study. In chapter three, an overview of the literature relating to the concepts in the proposed study, and the emergent arguments in support of the proposed model will be examined.

CHAPTER THREE: OVERVIEW OF LITERATURE

3.1 LITERATURE SOURCES

Various strategies were adopted to review the literature. Firstly, the major bibliographic databases were searched: Google Scholar, EBSCO Host, and Science Direct. Databases provided by the University of the Western Cape, Bellville, South Africa, which include but are not limited to the cumulative index of Nursing and Allied Health (GNAHL), journal storage (JSTOR), Pub Med, Blackwell Synergy, and Sage. All titles and abstracts of journal articles found were read for their relevance to the topic, and thereafter relevant articles were retrieved. A hand search was used in the articles that provided relevant information for further sources, such as books, journals, legislation, or policy statements. Experts who were consulted recommended further journal articles that in turn paved the way to yet other articles.

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3.2 INTRODUCTION

The aim of this study was to develop a model of community engagement in the prevention of maternal health complications in the rural communities of Cross River State, Nigeria. To this end this chapters presents an overview of the literature that is related to this concept, study definitions and theoretical underpinnings relevant to study. In addition, detailed literature review is provided as part of the discussions of the findings in Chapter 5 and Chapter 6.

3.3 MATERNAL MORTALITY

3.3.1 Global maternal mortality

Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, but not from accidental or incidental causes (WHO, 2004). The risk of a woman dying as a result of

pregnancy or childbirth during her lifetime is about 1:6 in the poorest parts of the world, compared with about 1:30,000 in northern Europe (Ronsmans & Graham, 2006). According to the same source, such a discrepancy poses a huge challenge to meeting the fifth MDG to reduce maternal mortality by 75% between 1990 and 2015 (Ronsmans & Graham, 2006). Some developed and transitional countries have managed to reduce their maternal mortality during the past 25 years, however, very high rates are still estimated in the poorest countries where further progress is jeopardised by weak health systems and the poor availability of data (Ronsmans & Graham, 2006). The authors further submit that maternal deaths are clustered around labour, delivery, and immediate postpartum periods with obstetric haemorrhages being the main medical cause of death (Ronsmans & Graham, 2006).

Each year, an estimated 529,000 maternal deaths occur and these deaths are not uniformly distributed throughout the world; obstetric risk is by far the highest in sub-Saharan Africa (WHO, 2004). In 2000, the MMR for sub-Saharan Africa was estimated to be nearly 1000 per 100,000 live births, almost twice that of South Asia, four times higher than Latin America and the Caribbean, and nearly 50 times higher than in industrial countries (Ronsmans & Graham 2006). These estimates confirm that most maternal deaths occur in sub-Saharan Africa. According to Mahler (1987), the lowest estimate of lifetime risk is nearly 1:30,000 for Sweden and the highest is 1:6 for Afghanistan and Sierra Leone. The comparison between the burden of maternal mortality in developed and developing countries has long been cited as the largest discrepancy of all public-health statistics (Mahler, 1987). In sub-Saharan Africa, only 46.55% of births are attended to by a skilled health professionals (34.2% and 39.6% in Eastern and Western Africa, respectively) (WHO, 2007).

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At the turn of this century, 189 countries endorsed the Millennium Declaration and signed up to meeting its eight goals. One of these–MDG 5–is to "improve maternal health" (Sachs & Mc Arthur, 2005). Evidence suggests that a reduction of 75% is achievable within a 25-year time frame (de Brouwere & Van Lerberghe, 2001). Reviewed sources posit that some industrialised countries halved their MMR in the late 19th century, mostly through the provision of professional midwifery care at birth, referral hospitals, free care, a supportive system, supervision, and information to confirm progress (Liljestrard & Pathmanathan, 2004). In sub-Saharan Africa, AbouZahr and Wardlaw (2001:560) confirm the unavailability of reliable trend data for countries with high levels of maternal mortality, and hence some investigators believe there is little to suggest any progress, except for Sri Lanka who documented a fall in maternal mortality from very high rates of more than 1500 deaths per 100,000 live births to 300 deaths per 100,000 live births over a 25-year period during the first half of the 20th century (Abouzahr & Wardlaw, 2001). This success was attributed to universal access to midwifery care, giving the hope that falls in maternal mortality are feasible.

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3.3.2 Maternal mortality in Nigeria

Nigeria has one of the highest maternal mortality ratios in the developing world (Ujah, Aisien, Mutihir, Vanderjagt, Glew & Uguru, 2005). Nigeria's maternal mortality indices are second to that of India, and maternal mortality is a critical indicator of maternal health and well-being in any country (Idowu, Osinaike & Ajayi, 2011). In 2000, the United Nations adopted the Millennium Declaration and the MGDs as a framework for comprehensive development. Hence, the task of improving women's health is one of the most important development issues facing Nigeria. According to

USAID (2008), in Africa the MDGs in maternal health cannot be met without significant improvement in the health status of Nigeria's women.

Official statistics reveal that Nigeria is the most populous country in Africa, with an estimated population of 129 million as at mid-2002. Nigeria is a multicultural society with over 300 ethnic groups, each with its cultural and traditional peculiarities and diversity (Idowu, Osinaike & Ajayi, 2011). According to Adegoke, Lawoyin, Ogundeji & Thomson, (2007), Nigeria bears a high burden of MMR, currently estimated at 800:100,000 live births. Several studies that have attempted to determine maternal death rates in Nigeria uniformly show high national levels, large urban-rural disparities, and wide variations across geographic regions (Shiffman & Okonofua, 2006). The National Planning Commission (NPLC) (2004) highlights the leading biomedical causes of maternal mortality as haemorrhage, sepsis, unsafe abortion, anaemia, malaria, toxaemia, and caphalo-pelvic disproportion.

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Additionally, the quality of maternal healthcare facilities in Nigeria is poor (Idowu, Osinaike & Ajayi, 2011). Fatusi and Ijadunola's (2003) study of 12 randomly selected states revealed that only 18.5% of facilities overall and only 4.2% of public facilities met internationally accepted standards for essential obstetric care. As such, approximately two-thirds of all Nigerian women and three-quarters of rural Nigerian women deliver outside of health facilities and without skilled attendance (NPLC, 2004). Therefore, conclusions could be drawn that the dismal state of Nigeria's health sector contributes to the diverse maternity outcomes. However, the WHO's ranking of Nigeria's healthcare system performance as one of the worst in the world in 2000 has prompted a major health sector reform plan now being supported by the World Bank, the African Development Bank, and DFID assistance (WHO, 2005).

In Nigeria, maternal mortality indices vary across regions, cultures, and settings, with the worst statistics recorded in remote rural communities. The MMR in northern Nigeria is among the worst in the country, and indeed the world, with over 1,000:100,000 live births in 2008, with a very low level and quality of maternity services. Doctor, Findley, Ager, Cometto, Afenyachs, Adamu, and Green's (2009) study revealed that only 26% of the women out of 6,882 women surveyed received antenatal care, and only 1,390 delivered in a facility with a SBA for their most recent pregnancy. The same source reported that most women had little or no contact with the healthcare system for reasons of custom, lack of perceived need, distance, lack of transport, and lack of permission (Doctor et al., 2009). According to these authors, the findings indicated that social influence is important in encouraging women to seek both antenatal and delivery care. "Existing informal social networks within the community can help in relaying back to the pregnant women and the community members how the health facilities have been improved" (Doctor et al., 2009) . The authors therefore recommended that information about birth preparations and recognising and knowing how to respond to danger signs could be integrated into the local social networks and groups, such as village women committees, since the study's findings exposed the fact that "women who made at least one kind of preparation for birth were more likely to deliver with a skilled attendant" (Doctor et al., 2009). Birth preparation is an important component of antenatal care and should be part of community based information networks to promote birth planning and preparation among all women (Onayade, Akanbi, Okunola, Oyeniyi, Togu, and Sule, 2010). A community study of maternal mortality in south western Nigeria (Ibadan) using the indirect sisterhood method developed by (Graham, Bell, and Bullough, 2001), for developing countries, revealed a high incidence of maternal mortality with a MMR of 7,778:100,000 live births

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(Adegeke, Campbell, Ogudefi, Lawoyin & Thomson, 2013). Women in Ibadan were dying more from pregnancy-related complications than from any other causes (Adegeke, Campbell, Ogudefi, Lawoyin & Thomson, 2013). Maternal death rates in Sagamu, Nigeria were 103 maternal deaths out of 5320 deliveries over a 10-year period (1988-1997) (Sule-Odu, 2000). This gives a MMR of 1,936:100,000, where 86.4% of the deaths were due to obstetric causes,10.7% were attributed to septic abortion, ruptured uteri (28.2%), eclampsia (12.6%), postpartum haemorrhage (12.6%), and puerperal sepsis (10.7%) (Sule-Odu, 2000).

An analysis on patterns of maternal deaths in a voluntary Agency Hospital in Abeokuta, Nigeria, revealed an overall high Maternal Mortality Ratio as related to preventable causes of haemorrhage, sepsis, anaemia, obstructed labour and eclampsia (Ariba, Inem, Biersack, Aina, Ayankogbe, & Adetoro, 2005). Likewise, in north-central Nigeria, a 17-year review of maternal mortality trends before and after the launch of the Safe Motherhood initiative in Nigeria conducted in University Teaching Hospital, Jos, revealed a high MMR of 740:100,000 in total deliveries (Ujah, Aisien, Mutihir, vanderjagt, Glew & Uguru, 2005). The greatest risk was recorded among young teenagers below 15 years and older women over 40 years who were either unbooked or illiterates and the direct causes of death were haemorrhage, (34.6%), sepsis (28.3%), eclampsia (23.6%), and unsafe abortion (9.6%) (Ujah, Aisien, Mutihir, vanderjagt, Glew & Uguru, 2005).

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In Anambra state, the services of traditional and local “reproductive health experts” are preferred and sought by women during pregnancy and birth (Izugbara & Afangideh, 2005). Such experts include family members, herbalists, spiritual leaders, and TBAs (NPC & ORC Macro, 2004). Reasons advanced for this preference by Igbo women were because they want privacy and cheaper rates (Izugbara & Agangideh,2005).

Additionally, beliefs in mystical forces (for example, complications may be regarded as consequences of committing abominable acts) and the supernatural aetiology of certain reproductive problems could also explain women's preferences for traditional attendants(Izugbara & Agangideh,2005). "The intersection of lower educational levels with cultural and religious beliefs, the highly fertility rate, and a high level of maternal complications in the region of poor obstetric outcomes is associated with both lack of financial resources to access and utilisation of maternal health services and lack of prenatal care" (Filippi, Ronsmans, Campbell, Graham, Mill, Borghi & Osrin, 2006).

It is estimates that 71% of the Nigeria population lives at or below US$1 a day, with the majority of them being rural dwellers, hence many Nigerian women do not seek care often because of lack of money to pay for such services (World Bank, 2006). It is also estimatd that about 37% of Nigerian pregnant women do not access prenatal visits, and 47% have four or more visits during pregncies (NPC and OPC Macro, 2004). Such inconsistencies in the utilisation of antenatal services increase maternal morbidity and mortality (NPC and OPC Macro, 2004). Cultural and familiar factors deter women from timely access to obstetric care and predispose them to risks and complications (Koblinsky, Matthews, Hussein, Mavalankar, Mridha, Anwar & Van-lerberhe, 2006).

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3.3.3 Maternal morbidity and mortality in Cross River State

Cross River State is a state in the Niger Delta region of Nigeria. The state covers a large area with a very difficult geographic terrain. It has a population of about 3,155,932 people, with a population growth rate of 2.9990, and 45.5% of the population are rural dwellers and about 22% is of the reproductive age (15-19 yrs) (National Population Census, 2009).

Available data for Cross River state shows that "the MMR is 831:100,000 live births" (Agan, Archibong, Ekabua, Ekanem, Abeshi, Edentekhe & Bassey, 2010). Accordingly, the very poor maternal health indices in the Cross River State has been attributed to poor antenatal, intra-natal and postnatal practices and to various socio-economic factors which expose women to adverse maternal health outcomes (Agan, Archibong, Ekabua, Ekanem, Abeshi, Edentekhe & Bassey, 2010). The fact remains that most of the deaths are preventable by simple, affordable and available interventions as well as attitudinal change, but the circumstances under which women become pregnant and deliver babies in the state remain a huge challenge as posit by (Archibong & Agan, 2010). According to the same source, community estimated rates of maternal mortality is lacking in Cross River State as available figures are institutional based and can be very high (Archibong & Agan, 2010).

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Apart from the common medical causes of death which include obstetric haemorrhage, eclampsia, sepsis, prolonged/obstructed labour, unsafe abortion, malaria and anaemia in pregnancy, HIV/AIDs in pregnancy and anaesthetic causes, social causes of maternal deaths include delayed referrals (Society of Gynaecology and Obstetrics of Nigeria, 2004). Same authors posits that, this problem is worsened by the activities of Pentecostal churches and "faith healers" who now conduct deliverances of their members in their churches (Society of Gynaecology and Obstetrics of Nigeria, 2004). "Faith healers have spiritual explanations for all normal and abnormal physiological and structural states, particularly in relation to pregnancy and labour and this contribute immensely to antenatal defaulting as well as negative perceptions about medical care" (Society of Gynaecology and Obstetrics of Nigeria, 2004). Most of these churches manage emergency obstetric cases, only to send them to the hospital to die when they are moribund, thus spiritual belief of people of Cross River State has a serious impact

on their health-seeking behaviour (Society of Gynaecology and Obstetrics of Nigeria, 2004).

Poverty is another major social cause of death in Cross River State as most people are unable to pay for health care service even when it is highly subsidised by government resulting in these patients ending up in the hands of unskilled birth attendants (Harrison, 2009). Same source highlighted that the attitude of some health care providers discourages pregnant women from seeking appropriate care by resorting to non-orthodox care, and in most cases present to hospital with avoidable complications (Harrison, 2009).

An analysis of clinical data desk reviews of published and unpublished material and interviews with policy-makers and service providers conducted by (Archibong & Agan, 2010), revealed that "although 75.6% of pregnant women in the state attend at least one antenatal visit, only 34.8% are attended to by skilled birth attendants when they are in labour"(Archibong & Agan, 2010). The same authors noted that the review of hospital-based maternal mortality rate in the Cross River State over an 11-year period (1999-2009) averaged 1,513.4:100,000 live births, with a types III delay being the leading social cause of death and 73.2% of these deaths resulted from cases referred by the rural communities (Agan et al., 2010).

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3.4 LINKAGES BETWEEN MATERNAL HEALTH AND NATIONAL DEVELOPMENT THROUGH THE MILLENIUM DEVELOPMENT GOALS (MDGS)

Maternal health is being considered a major determinant of the socioeconomic well-being of Nigerian women (Millenium Development Goal [MDG] Report, 2004). Accordingly, the National Health Policy adopts the primary health concept with the aim of establishing maternal health services for the provision of efficient and effective

services to every woman, mother-to-be, and mothers (MDG Report, 2004). As a result of the 1994 Cairo International Conference on Population and Development (ICPD), many countries around the world adopted the improvement of women's reproductive health as the key objective of governmental activities (MDG Report, 2004). Furthermore, maternal health questions have been raised in the context of women empowerment and gender equality issues as women cannot be economically empowered when their major health challenges are not being addressed (Gulma, 2008).

In Nigeria there is a tremendous delay in the progress towards improving maternal health care delivery systems (FOS/UNICEF, 2000; Shiffman, 2006). For instance, as at 1999 the national mortality rate was still at 704:100,000 live births with considerable regional variation (FOS/UNICEF, 2000; Shiffman, 2006). Several studies attempted to determine maternal death rates in Nigeria uniformly show "high national levels, large urban-rural disparities, and a wide variation across geographic regions" (FOS/UNICEF, 2000; Shiffman, 2006). Moreso, the quality of maternal health care facilities in Nigeria is poor, as a study of 12 randomly selected states revealed that "only 18.5% of facilities overall and only 4.2% of public facilities met internationally accepted standards for essential obstetric care" (Fatusi & Ijadunola, 2003). As such, greater number of rural Nigerian women deliver outside of health facilities and without medically skilled attendants present (NPLC, 2004). Hence, it can be concluded that the poor state of the health sector in the country contributes to these adverse maternal health outcomes (NPLC, 2004).

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In corroboration with this, in 2003, with support from the United Nations Population Fund, officials in the Federal Ministry of Health produced a study on the alarming state of obstetric care facilities across the country (Fatusi & Ijadunola, 2003). However, the WHO's ranking of the Nigerian healthcare system's performance as one of the worst in

the world in 2000, has served to awaken health and was in part what triggered a major government health sector reform plan, now being supported by a US$127 million World Bank loan and African Development Bank and DFID assistance (WHO, 2005).

The inclusion of maternal health in the MDGs has contributed to prioritisation of safe motherhood by the Nigerian states and based on this, the 5th MDG (MDG5) attributes the improvement of maternal health to the reduction of the MMR level of 1990 by 75% in 2015 (WHO, 2004). In response to the international consensus, the government established a presidential commission on the achievement of the MDGs and established an MDG office within the Ministry of the State and in 2005, and supported by the WHO, the government adopted a plan to attain the maternal and child health in MDGs (WHO, 2004). "In addition, this health sector reform invokes the MDGs as a basis for the commitment to maternal mortality reduction in Nigeria, as noted by (Osubor, Fatusi & Chiwuzie, 2006). For the fact that maternal mortality is difficult to measure, it was also suggested that by 2015, 90% of births should be assisted by skilled attendants as the proportion of births attended to by skilled health care providers is a key process indicator for the MDGs of improving maternal health and its target of reducing maternal mortality" (Osubor, Fatusi, & Chiwuzie 2006) .

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The review politics and programs for reducing maternal mortality in Cross River State, highlighted that large sums of money have been voted for the renovation of almost all primary health centres in the state which includes water supplies through borehole and light through solar panels and this is being strengthened by massive rural road construction by the state government to render rural dwellings more attractive for resident medical personnel to these areas (Archibong & Agan, 2010). The authors observed that the state is attempting to tackle type I and II delays in maternal death and that the State's Strategic Health Development plan has specific programmes for

maternal health which was harmonised with the National Health Plan in 2009 (Archibong & Agan, 2010). The state also has a blueprint for Primary Health Care that emphasises the provision of maternal health care at the grassroots level, was one of the first to buy into the National Health Insurance Scheme (NHIS) and has also signed the Memorandum of Understanding for the Mid-wife Service Scheme (MSS) which is currently functional with positive effects on maternal health (Archibong & Agan, 2010). In addition, the state is currently discussing the possibility of the University of Calabar Teaching Hospital's consultants utilising secondary health facilities to effect adequate coverage of maternal health issues (Archibong & Agan, 2010). In this regard, safe motherhood campaign programmes have been incorporated into the recently introduced Integrated Maternal, Newborn and Child Health (IMNCH) programmes aimed at improving maternal health (Archibong & Agan, 2010).

In 2008, the State House of Assembly enacted a law prohibiting child marriage and Female Genital Cutting with the hope of minimising the teenage pregnancy problem and recently, the state legislators has approved free antenatal, intrapartum, and postnatal care as well as free insecticide treated nets (ITNs) to all pregnant women provided by the Roll Back Malaria (RBM) programme (Archibong & Agan, 2010). The state also collaborates with UNICEF in implementing various reproductive health, child health, and immunisation programmes with the World Bank and USAID Africa being involved in various reproductive health programming systems in the state (Archibong & Agan, 2010). The WHO's RBM initiative is heavily involved in malaria prevention and treatment, while Global HIV/AIDS Initiatives Nigeria (GHAIN), is involved in the promotion of maternal health through HIV/AIDS prevention and treatment in the Cross River State (Archibong & Agan, 2010),

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The high maternal mortality in Cross River State has received attention from both the state executive and legislative arms through their regular condemnation of unacceptably high figures and a general emphasis on health manpower development (Archibong & Agan, 2010). Accordingly, a Legislation is underway from the State House of Assembly to make birth and death registration mandatory from ward to state levels for the generation of appropriate statistics (Archibong & Agan, 2010). Despite all these governmental efforts, the health sector is still poorly funded while the state's free maternal health care programme still records a very low uptake by the rural poor women (Archibong & Agan, 2010), .

3.5 RISK PERIODS OF MATERNAL MORTALITY

Findings from studies by Hurt and Ronsmans (2002), revealed that most maternal deaths seem to occur between the third trimester and the first week after delivery. In support of this, data from Matlab, Bangladesh shows that maternal mortality rates are more than 100 times higher on the first day after birth and 30 times higher on the second day after birth and these findings provide strong support for strategising professional care during pregnancy, delivery, and post-delivery (Hurt & Ronsmans, 2002) .

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Women remain at increased risk of death for some time after childbirth thus maternal deaths have conventionally been defined as those occurring up to 42 days postpartum (Pradhan, West & Katz, 2002). Recently a new category has been proposed to include late deaths up to one year postpartum as there is evidence that risk of death is increased for up to six months postpartum (Hurt & Ronsmans, 2002). Mortality rates can also be especially high after an abortion or still-birth (Hoj, da Silva, Hedegard, Sandstrom & Aaby, 2003). In Bangladesh, for example, pregnancies ending as abortions or stillbirths accounted for more than half of maternal deaths within the first week after the end of the pregnancy, and 50% within the first six weeks according to (Hurt & Ronsman,

2002). This data has implications for the timing of postpartum care and the duration that women should routinely have access to skilled care after birth (Hurt & Ronsman, 2002).

3.6 CAUSES AND DETERMINANTS OF MATERNAL HEALTH CHALLENGES IN NIGERIA

Women who become pregnant in developing countries face a risk of death due to the fact that trained personnel do not attend births with few backup services for high-risk pregnancies with poor transport network limiting easy access to health care services, and malnutrition is endemic among pregnant women (Idowu, Osinaike & Ajaji, 2011).

3.6.1 Poverty

Poverty is also identified as a major cause of maternal mortality, since it prevents many women from getting proper and adequate medical attention due to their inability to afford good antenatal care (Idowu, Osinaike & Ajaji, 2011). It also results in malnourishment in pregnant women who are susceptible to illness, pregnancy complications, and maternal death (Idowu, Osinaike & Ajaji, 2011). "Where infant and child mortality is high, birth rates are also high, increasing the stress on women's bodies and trapping them and their children in a cycle of poor health and nutrition" (Lanre-Abass, 2008). Also, taking time to rest and eating a balanced diet, both of which are essential to safe pregnancy, are absent (Lanre-Abass, 2008).

3.6.2 Educational status

Findings from numerous studies on maternal health care and mortality conducted in developing countries show a positive association between maternal education and maternal health care studies (Falkingham, 2003; Ogujuyigbe & Liasu, 2007). According to the authors, schooling imparts literacy skills, which enable pupils to process a wide range of information and stimulate cognitive development (Falkingham, 2003; Ogujuyigbe & Liasu, 2007). As Graczyk (2007) posits, that lack of education can

also affect health when it limits young women's knowledge regarding nutrition, birth spacing, and contraception. Before a woman decides to seek care, she must be able to recognise the signs and symptoms that indicate the need for care (Graczyk, 2007). Furthermore, lack of educational opportunities might lead to poor understanding of health-related matters, and therefore, many women may not be familiar with different diseases and their presentation (Graczyk, 2007).

3.6.3 Culture

Culture influences health behaviour on so many levels by influencing the way illness is perceived and acted upon in Nigeria (Erinosho, 2005). Cultural factors which include gender norms, child marriage, early pregnancy, nutritional taboos, particularly during pregnancy and certain birthing practices exert great negative impacts on the health of women (Erinosho, 2005). These factors also condition the number of children they want and how they want their births spaced as women do not always get the support they need to fulfil their reproductive intentions (Erinosho, 2005). Therefore cultural restrictions limit choice and beliefs about appropriate behaviour can reduce access to health information and care and impair its quality (Erinosho, 2005).

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3.6.4 Belief System

It has been argued that perception of illness is affected or influenced by different belief systems in societies (Igun, 1988 as cited in Erinosho, 2005). The magic-religious belief systems do influence how people perceive diseases and for this reason, quite a significant number of patients utilise the services of various traditional healers before seeking care from modern health workers and facilities (Igun, 1988 as cited in Erinosho, 2005). Accordingly, most religious believers emphasise their faith's healing power, due to this fact, most pregnant women seek to patronise mission homes in other to be protected from evil during delivery facilities (Igun, 1988 as cited in Erinosho, 2005).

According to Dr. Isaac Owolabi, the Oyo State Commissioner of Health, about 36,000 expectant mothers die annually from avoidable complications before and after birth in the mission homes, mostly as a result of lack of qualified personnel (Erinosho, 2005). In Nigeria, Islamic religious practice severely restricts women's interaction with men and strangers, hence hampering their access to professional healthcare facilities (Erinosho, 2005).

3.6.5 Gender Role

Sex discrimination affects women's lives in one way or another in almost every country, particularly in the deprived sectors of each society (Idowu et al., 2011). However, its negative impact on women's lives is greater in the developing world (Idowu et al., 2011). Mothers cannot just take health decisions because she has a unified budget with her husband over which she has some rights and which will meet the costs of healthcare, this also connotes a cultural value of male dominant roles in patriarchal societies like Nigeria ((Igun, 1988 as cited in Erinosho, 2005). This reduces the promptness with which medical assistance is obtained anytime an illness is suspected during pregnancy, therefore because of their heavy household duties, women cannot afford to be sick themselves (Idowu et al., 2011).

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3.6.6 Age at Marriage

Child marriage is one of the cultural factors that work against women because when a mother is still young she is inclined to fall prey to ideas of childbearing and child care because she has no experience (Ufford & Menkiti 2001 in Idowu, Osinaike, & Ajayi, 2011) . Age also determines the physiological readiness of the mother as highlighted in the 1999 Nigerian Demographic and Health Survey (DHS), as adolescents suffer disproportionately from complications related to childbearing because their bodies are not yet fully developed (Ufford & Menkiti, 2001 in Idowu, Osinaike, & Ajayi, 2011).

Galadima, the regional manager of the Abuja-based Society for Family Health (SFH) in Abdul'Aziz, (2008) also affirmed that a woman should not start having children too early in life because if a woman's body is not ready to receive pregnancy, the likelihood of complications is increased.

3.6.7 Economic Status

Various studies have documented that a woman's position in the household largely determines her range of acceptable reproductive options (Falkingham, 2003; Ogujuyigbe & Liasu, 2007). Women's status is a broad concept that encompasses multiple facets of access to (and control over) material resources (including food, income, land and other forms of wealth) and to social resources (including knowledge, power and prestige) within the family, in the community and in society at large (Idowu, Osinaike & Ajayi, 2011). Financial barriers often prevent local people from being able to arrange transportation as vehicles in Nigerian rural areas are scarce and in poor condition, therefore, the cost of arranging emergency transportation can be challenging (McIntyre & Hotchkiss, 1999 cited in Izugbara & Ukwayi, 2004). Mothers who were dependent on their husbands were not able to respond immediately to any health-related problems concerning their children and also themselves (McIntyre & Hotchkiss, 1999 cited in Izugbara & Ukwayi, 2004). Lanre-Abass (2008) noted that user charges during a time of deepening poverty have become a great barrier to access for many Nigerian women who are not educated and economically empowered (Lanre-Abass, 2008). According, accessing money for treatment was the problem most commonly reported by Nigerian women of all backgrounds and there exist a strong negative correlation between both levels of education and wealth quintile (Lanre-Abass, 2008) .

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3.7 BARRIERS TO UPTAKE OF MATERNAL HEALTHCARE SERVICES IN RURAL COMMUNITIES

3.7.1 General barriers

Personal factors, such as lack of knowledge of a condition and its consequences, are associated with a person's denial of symptoms pointing to a condition, and of people often trying to manage the symptoms rather than accessing appropriate health services (Tod, 2001 & Lavender, 2007). Furthermore, it was noted that in most community studies, social and cultural norms and attitudes of particular communities are strongly related to personal factors, since the attitudes and patterns of coping are community specific (Tod, 2001 & Tran, 2008). Thomas (2005) and New (2006) identified the cultural insensitivity of service providers which was further supported by evidence from other studies that cultural ignorance and underlying beliefs among many health professionals, which could have significant impact on the services they provide (Lavender, 2007) .

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Low levels of knowledge and awareness of risk factors, causes, and treatment for given conditions was observed among those failing to take up services (Tod, 2001). Likewise, problems that communities encounter in trying to obtain information in their own language also limits knowledge about particular conditions and the services available to them. The same source indicated that knowledge might be a contributor to behavioural change (New, 2006).

Lavender (2007) posit that expectations of health services formed from past experiences can pose as barriers to further accessing services, for example having experienced culturally insensitive service and/or professional negative attitudes and being blamed could form specific barriers to individuals Lavender (2007). Negative experiences may affect access and engagement of service by the community (Lavender, 2007).

The fit among personal, social, cultural, economic, and system-related factors can promote access to primary health care services among individuals, families, and communities to have a timely, needed, continuous, and satisfactory health service (Blomfield & Cayton, 2009). The above suggests that to address these barriers people need to be reached where they already are, and engaged with in an attempt to change the norms and attributes that lead to low uptake of service (Ansari, 2007). Additionally, engagement is needed to ensure that services adequately take account of cultural sensitivities so that this does not pose an additional barrier to uptake of services (Blomfield & Cayton, 2009) .

3.8 THE CONCEPT OF THREE PHASE DELAY

Almost 90% of maternal deaths occur in developing countries (Carroli, Rooney & Villar, 2001), and while many women die because they do not receive the appropriate medical care, a significant percentage die because they do not access that care fast enough (Carroli, Rooney & Villar, 2001). In most cases this is due to the fact that pregnant women, their families, and the community in general do not know about the danger signs and symptoms that occur during pregnancy, labour, or the puerperium (Carroli, Rooney & Villar, 2001). Delays by women with obstetric complications in reaching and accessing care are the main cause of maternal mortality (Kabakyenga, Ostergren, Turyakira & Peterson, 2012).

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A three delay model was presented by Thaddeus and Maine (1994) to explain the chain of factors responsible for the high maternal morbidities and mortalities in low-income countries (Figure 2) (Thaddeus & Maine.1994). The first delay is by the individual, the family, or both, in making a decision to seek care (Delay I), and is due to socio-economic or cultural factors, which include women's status, decision-making, poor understanding of complications and risk factors in pregnancy, previous poor experience

of healthcare, acceptance of maternal death, and financial implications (Thaddeus & Maine.1994). The second delay is occasioned by women failing to reach the healthcare faculties due to physical accessibility, cost of transportation, adverse road conditions, mountainous terrains, and rivers (Delay II), and the third delay is when women take time to receive appropriate and adequate care once they reach the health faculty due to poor facilities, lack of medical supplies, inadequately trained staff, poorly motivated supplies, and inadequate referral systems (delay III) (Thaddeus & Maine, 1994).

Gabrysch and Campbell (2009) have used the three phase delays model in their review report to group the determinants of delivery service use into sociocultural, perceived need, and economic and physical accessibility (Gabrysch & Campbell, 2009). Accordingly, Kabakyenga (2012) noted that studies on women's autonomy (which is a socio-cultural factor), and health knowledge (which is the perceived need group) have produced mixed results across populations both within and across countries regarding the use of maternal healthcare in relation to funding and the organisation of health services (Say & Raine, 2007). Therefore, the authors recommended that, there is a dire need for context-specific studies to help design interventions to reduce the three delays and consequently reduce maternal morbidity and mortality (Say & Raine, 2007) .

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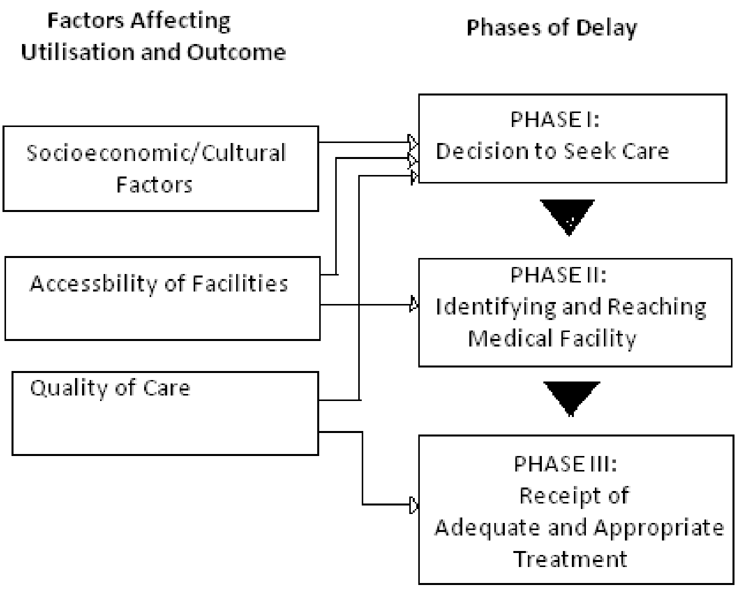

FIGURE 4: Three Phase delays model

Source: Thaddeus and Maine (1994)

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3.9 HEALTHCARE-SEEKING BEHAVIOUR OF NIGERIAN WOMEN

The three phase delays model has subsequently been used to inform a comprehensive approach to birth preparedness (BP), with prevention and management as integral components of the plan (Canavan, 2009). According to same authors, the elements of birth preparedness have been promoted by WHO, UNFPA, and other international agencies as part of maternal health strategies with the shift from TBA training and risk-screening towards access to skilled attendance, including emergency obstetric care, as a means of decreasing maternal mortality (Canavan, 2009). The causes of these delays are common and predictable, so in order to address them, women, families, communities, providers, and the facilities that surround them must be prepared in advance and ready for rapid emergency action (Maternal and Neonatal Health [MNH] Programme, 2004).

Osubor, Fatusi, and Chiwuzie's (2005) study on maternal health-seeking behaviour and associated factors revealed poor maternal health-seeking behaviour with a high

preference for Traditional Birth Attendants who are unskilled to respond to emergency obstetrical conditions (Osubor, Fatusic & Chiwuzie, 2005). The reasons advanced included greater accessibility, better interpersonal relationships, lower cost, greater convenience, and freedom to use traditional birthing positions, which has also been documented in other studies (Fatusi & Ijadunola, 2003).

The low level of utilisation of postnatal services, and poor acceptance of modern family planning methods are indications of poor reproductive health behaviours and pose as challenges to reducing the high level of maternal mortality in Nigeria (Fatusi, 2004). Perception and knowledge of the community members in Nigeria regarding maternal health problems play a role in their care-seeking behaviour (Fatusi, 2004). For instance study by Osubor, Falusi & Chiwuzie, (2005) found that local beliefs, such as those that link pregnancy-related problems to witchcraft and other supernatural causes, ignorance regarding warning signs in pregnancy were noted among community women, as some respondents attributed bleeding episodes and swollen feet to normal conditions experienced during pregnancy (Osubor, Fatusi & Chiwuzie, 2005) . Such misguided opinions and folklore are likely to result in a delay in seeking medical attention on time (Fatusi, 2004). Same source posits that, when spiritual factors were linked to a particular problem, community and family members often believe that such conditions cannot be handled by orthodox medical practitioners, such people are taken to traditional healers and Traditional Birth Attendants rather than orthodox health facilities in most Nigerian communities. (Fatusi, 2004).

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Various studies have reported the issue of cost as playing a role in poor service utilisation in Nigerian communities. In a study of the Ologbo community, Nigeria, it was noted that the official cost of the orthodox service was higher than what many of the people in the community could afford, given their socio-economic level and this

was reported as preventing community members from fully utilising those services (Osubor, Fatusi & Chiwuzie, 2005). However, as Thaddeus and Maine (1994) noted, while cost might constitute a reason for the delay in seeking healthcare, people pay a higher premium for quality (Thaddeus & Maine, 1994). Osubor et al. (2005) recommended that availability of care providers on a regular basis and interpersonal relationships with clients, are some of the factors influencing care-seeking behaviour. On the other hand, same study revealed that the existence of a health facility with large numbers of trained health professionals is not sufficient in itself, rather, efforts to improve the maternal health status of Nigerian women, particularly in rural areas, would entail examining and understanding the sociological context of health behaviour within the communities, as well as analysing issues relating to services delivery (Osobur et al, 2005).

3.10 STRATEGIES TOWARDS REDUCTION OF MATERNAL MORTALITY THROUGH BIRTH PREPAREDNESS AND COMPLICATION READINESS

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Four strategies are discussed below, namely health education, skilled birth attendants, training of TBAs, financial motivations and community engagement.

3.10.1 Heath education and counselling on birth preparedness

Health education is discussed in detail as part of the Model in Chapter 7.

3.10.2 Skilled birth attendants and efforts to reduce maternal mortality

The term 'skilled attendant' refers to an accredited health professional–such as a midwife, doctor or nurse–who has been educated and trained to proficiency in the skills needed to manage uncomplicated pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns (WHO, 2006). Studies reveal a clear association between the proportion of births attended to by skilled health personnel and maternal mortality (de Bernis,

Sherratt, AbouZahr & Van Lerberghe, 2003). The proportion of births by Skilled Birth Attendants is a key indicator for the MDG5 of improving maternal health and its target of reducing maternal mortality (de Bernis, Sherratt, AbouZahr & Van Lerberghe, 2003).

Skilled birth attendance is one of the strategies aimed at reducing maternal and newborn mortality as having a Skilled Birth Attendant (SBA) at every birth together with an enabling environment has shown to reduce maternal morbidity and mortality (Starrs, 2006; Starrs, 2007; de Bernis et al., 2003). However, in most low-income countries, the majority of women deliver at home without any skilled attendance or with the assistance of family members, friends, or Traditional Birth Attendants (Darmstadt, Lee, Cousens, Sibley & Bhutta, 2005). The situation is further aggravated by the fact that most healthcare facilities that offer comprehensive emergency care services are located in urban areas, some distance away from the rural areas where the majority of the population live (Darmstadt, Lee, Cousens, Sibley & Bhutta, 2005).

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Recent research demonstrates that delivery by an Skilled Birth Attendant serves as an indicator of progress towards maternal mortality worldwide, whereby estimates between 13%-33% of maternal deaths could be averted by the presence of a Skilled Birth Attendance (Graham et al., 2007). Furthermore, studies have shown that the proportion of deliveries assisted by Traditional Birth Attendants is extremely variable within and across countries, being the highest in rural areas (Sibley & Sipe, 2004). Several studies points out that there is no improvement in the Maternal Mortality Rate (MMR) where Traditional Birth Attendants (TBAs) are the main providers of care to pregnant women (Sibley, Sipe & Koblinsky, 2004). In 1999 WHO explicitly stated that "there is no reason to believe that TBA training can contribute to MMR reduction in isolation" (WHO, 1999). This was amply demonstrated in a study in Pakistan where

TBA interventions led to a decrease in perinatal mortality but did not lead to a significant reduction in the MMR (Jokhio, 2005).

The study found that TBA training was linked to outreach and facility-based care, resulting in a statistically significant reduction of 30% of perinatal mortality (Jokhio, 2005). There are confounding factors associated with such positive evidence, as it can be attributed to other social and economic factors that evolved concurrently with the provision of skilled birth attendance and improvements in referral systems (Jokhio, 2005).

Sibley and Sipe (2006) posits that if there could be 90% coverage of Skilled Birth Attendants in developing countries, interventions for pregnancy, labour, and post natal care up to 24 hours after birth would result in a 15-30% reduction in maternal and newborn mortality (Sibley & Sipe, 2006). Same authors thus advocate for urgent research on effects of community-based interventions that reduce maternal deaths (Sibley & Sipe, 2006).

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Through its Safe Motherhood Research Programme, the Quality Assurance Project (QAP) implemented three studies between September 2001 and July 2002 in Benin, Rwanda, Ecuador, and Jamaica, to explore the competencies of Skilled Birth Attendants in countries with high Maternal Mortality Rates (MMRs) (Boucar, Bucagu, Djibrina, Edson, & Burkhalter, 2004). "The phase I of the study examined the competency of SBAs using checklists and assessment tools piloted by the project team with a total purposive sample size of 166 health providers, phase II of the study measured Skilled Birth Attendants performance and the relative contribution to performance of different enabling factors in the work environment, and the third study examined causes of hospital delays (third delay) in providing obstetric care (Boucar, Bucagu, Djibrina,

Edson, & Burkhalter, 2004). According to the authors, Phase 1 of the study focused on: (i) competency of skilled providers; (ii) enabling environment and influence on performance of providers; and (iii) third delay at hospital level, where observation checklists were used to ascertain the time and motion for women admitted and the treatment intervals, and in a subsequent phase, revised instruments were adapted to conduct a larger scale study in Nicaragua (Boucar, Bucagu, Djibrina, Edson, & Burkhalter, 2004).

Instruments were developed to measure provider competencies using the universally agreed clinical standards and definitions focusing on diagnosis and management of the three direct causes of maternal mortality, namely pre-eclampsia/eclampsia, haemorrhage, and sepsis, knowledge levels were also assessed with written tests, and skills were assessed using anatomical models and materials from the Maternal & Newborn Health programme (Boucar, Bucagu, Djibrina, Edson, & Burkhalter, 2004). Results showed correct knowledge in 62% of the questions across all cadres of skilled providers, while auxiliary nurses (community midwives equivalent) were correct in 51% of the questions with demonstrated low knowledge on sepsis (9%), third stage labour management (16.7%), and use of a partograph (52%) (Boucar, Bucagu, Djibrina, Edson, & Burkhalter, 2004). As was observed by the same study, such low scores is indicative of the poor level of healthcare provided to women in pregnancy and such variations in competency levels are also suggestive of wide disparities across a heterogeneous group of providers who are classified as Skilled Birth Attendants (Boucar, Bucagu, Djibrina, Edson, & Burkhalter, 2004). Furthermore, there is a great concern over the watered-down approach to skilled birth attendance as expressed by (Harvey, Blandon, McCaw-Binns, Sandino, Urbina, Rodriguez & Djibrina, 2007). Skill scores were generally lower than knowledge level scores, which suggest that

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knowledge levels alone are no guarantee of correct procedures being performed and such disparities between knowledge and skill levels are also confirmed by monitoring studies conducted in Yemen, whereby quality assurance studies demonstrated that 40% of health facility staff trained in emergency obstetrics; follow-up assessments showed alarmingly low levels of knowledge and even lower skill levels among known Skilled Birth Attendants (Harvey, Blandon, McCaw-Binns, Sandino, Urbina, Rodriguez & Djibrina, 2007).

Chowdhury, Botlero, Koblinsky, Saha, Dieltiens and Ronsmans (2007) conducted a study on MMR determinants in Matlab, Bangladesh using 30 years of cohort data (1976-2005), with the objective of determining effective strategies for the reduction of maternal mortality through the assessment of the contributions of interventions, such as skilled attendance at birth. Trends in MMR and interventions were examined in two adjacent areas over a 30-year period, analysing cause of death and socio-demographic determinants (Chowdhury et al., 2007). The authors used routine data collected via household surveys (interviews with families to determine cause of death of women aged 15-49) and health information by International Research Centres (Chowdhury et al., 2007). The result revealed a notable fall in the MMR over the 30-year period (68% in intervention areas and 54% in government areas), despite the low uptake of skilled attendance at birth and this was attributed to improved access to Emergency Obstetric Care (EmOC) with midwives facilitating access, and notable increases in the provision of caesarean sections (Chowdhury et al., 2007). Overall, the authors advocate for investment in midwives and EmOC while also acknowledging a wider socio-economic determinants namely female literacy, and improved financial access for the poor. They also considered poverty reduction as essential to sustain the success achieved (Chowdhury et al., 2007). The authors therefore conclude that posting trained and well-

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equipped midwives at the village level, who have access to an effective chain of referral, can improve maternal survival (Chowdhury et al., 2007).

The methodology and approach used in the Bangladesh studies acknowledge that wider economic and social determinants had a major influence in the reduction of MMR, including women's education (Chowdhury et al., 2007) . "The key characteristics of the population included a predominantly Muslim area, tradition restricts women from seeking care outside the home, hence, the majority of deliveries are home-based, and it is a largely agricultural rural area with a poor economic status; trained midwives are present at health centre level with basic obstetric care, and referral for emergency services, and the proportion of births attended to by a skilled provider via government services was very low (Chowdhury et al., 2007). A major recommendation from this study is that an intra-partum care strategy at health centre level can reduce maternal mortality, subject to referral services through the availability of Skilled Birth Attendants working within a district health system with adequate Emergency Obstetric Care provision (Chowdhury et al., 2007).

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Carlough and McCall (2005) explored the use and measurement of skilled birth attendance in Nepal and their implications for maternal well-being with the focus on the shortage of skilled attendants in rural areas that, when combined with cultural and economic barriers, means that trained attendants are not available for most deliveries (Carlough & McCall, 2005). Accordingly, untrained maternal and child health workers or village volunteers are the most accessible cadre of health worker available to the women in a remote rural villages in Nepal, with only 9% of births taking place within a health facility and 11% by skilled attendants as noted by the authors (Carlough & McCall, 2005). In efforts to respond to this major gap in accessing basic and emergency obstetric care, maternal and child health workers underwent six weeks training in basic

Emergency Obstetric Care in order to expand the provision of basic services (Carlough & McCall, 2005). In Nepal, following an extended study on the overall clinical skills and competencies of the basic cadres of skilled attendants, findings showed a range of barriers and constraints which can adversely affect the performance of the Skilled Birth Attendants (SBAs) and these included limited support for Skilled Birth Attendants at family and community levels, lack of transportation and emergency funds for referral, cultural and financial barriers to seeking obstetric services at all levels, and lack of quantity and quality facilities providing comprehensive Emergency Obstetric Care, low capacity among providers in health facilities, and national policies that preclude health workers from performing the tasks they are qualified to perform (Borghi, Ensor, Neupane, Tiwari, 2006). However, results demonstrated that the providers Maternal and Child Health Workers who received refresher training were significantly more competent than the control group who had not experienced maternal health refresher training (Borghi et al., 2006). This led to the exploring of the wider determinants of maternal mortality further in order to identify how the health system needs to interface with other systems to address the gaps that exist (Borghi et al., 2006).

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Another equally concerning issue is that of the identification of risk pregnancies and timeous emergency obstetric referral (Stanton, 2006). A huge disparity exists between rural and urban populations in accessing life-saving interventions (Ronsmans & Filippi, 2004). Also of concern are the socio-economic disparities whereby maternal mortality has a clear poverty gradient across developing countries (Stanton, 2006). Same author observed that inequalities are associated with education level, gender, and livelihood opportunities, which are shown to have a significant effect on survival rates during the reproductive years (Stanton, 2006).

A Bangladesh study by a local NGO partnership for home-based Skilled Birth Attendant care showed significant inequities in access to services, with inequities being primarily linked to a woman's education, income, distance to nearest hospital, and area of residence (Anwar, 2007). The author also observed that facility-based service resulted in higher inequities than home-based care, hence the strong recommendation for further research to understand what the poorest women consider to be the main factors that limit access to care, such as cost and quality of care as dependent variables. (Anwar, 2007).

Stanton's (2006) Indonesian study assessed the extent to which village midwife programmes improved access to professional delivery care among the poorest people using two key indicators of: (i) percentage of births attended to by a trained provider; and (ii) percentage of caesarean sections (as a proxy for access to emergency obstetric care) (Stanton, 2006). The study showed that while Indonesia's strategy to increase skilled attendance (through investment in training and deployment of midwives) met with success in reaching the poor, skilled care was reported to have reached more than 40% of the poorest in rural areas (Stanton, 2006). Similarly, higher fees at hospitals have increased the costs for the poor, which creates barriers to accessing health facility care (Stanton, 2006). On a positive note, the author conclude that the strategy of a midwife in every village has reduced socioeconomic inequalities (Stanton, 2006).

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WHO (2006) indicated that solving the problem of the shortage of human resources will require long-term changes, but 'task shifting' (delegating clinical functions to less specialised health workers) has been recommended as an interim measure in a number of places (WHO, 2006; Mavalankar, 2002; Bergstrom, 2005). For instance, paramedics conducting caesarean sections, the shifting of anti-retroviral treatment, education and dispensing services from physicians to mid-level clinicians, and from nurses to

community health workers, as such practices have been shown to be feasible, acceptable and are associated with favourable outcomes (Bergström, 2005; Rana, Rajopadhyaya, Bajracharya, Karmacharya & Osrin, 2003).

3.10.3 Training of traditional birth attendants (TBAs)

While swings between advocating for community-based or facility-based care in the context of maternal and newborn health exists, it is evident from conclusions of studies that trained TBAs can contribute to reductions in both maternal and perinatal mortality (Jokhio, 2005).

Training of birth attendants is discussed in detail as part of the Model in Chapter 7.

3.10.4 Financial motivations to increase access to maternal services

The maldistribution of health workers call for a number of strategies to attract staff . Willis-Shattuck, Bidwell, Thomas, Wyness, Blaauw, and Ditlopo (2008), identified a number of strategies to address the problem of unwillingness of highly trained personnel to reside in rural and remote areas. These included incentives such as financial rewards, career development, continuing education and recognition, and these have been tested in other communities (Willis-Shattuck, Bidwell, Thomas, Wyness, Blaauw, & Ditlopo, 2008). In their systematic review, Butterworth, Hayes, and Neupane (2008) noted that isolated financial incentives are insufficient and that a range of initiatives to improve motivation is essential to address these factors (Butterworth, Hayes, & Neupane, 2008).

Another type of incentive to health workers was established in Afghanistan where a cash payment was given to community health workers who brought women to facilities for childbirth (Butterworth, Hayes, & Neupane, 2008). Accordingly, Devadason, Elias, John, Grahacharya, and Ralte (2008), noted that a similar large-scale intervention to increase delivery rates in health facilities has also been introduced in India, though the

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effective of such interventions is yet to be established (Devadason, Elias, John, Grahacharya, & Ralte, 2008). The concern is that such incentives can lead to altered behaviours and self-interest amongst health workers, leading to a mistrust between care providers and those seeking care (Tibandebage & Mackintosh, 2005; Hu, Tang, Liu, Zhau, Escobar & de Ferranti, 2008). For example, women may suspect that they are being taken to a clinic or hospital to increase the health worker's income, rather than because of real clinical need care (Tibandebage & Mackintosh, 2005; Hu, Tang, Liu, Zhau, Escobar & de Ferranti, 2008).

Storeng, Baggaley, Ganaba, Quattara, Akoum, and Filippi (2008) highlighted that uptake of skilled care at delivery shows the widest poor–rich gap. Suggestions include funding the provision of maternity care adequately through fee exemptions and waivers, voucher and cash-transfer schemes, loans, and healthcare insurance (Gwatkin, Wagstaff & Yazbeck, 2005). Richard, Witter, and DeBrowere (2008), also observed that most of these efforts are currently implemented on an experimental basis or are on a small scale, and evidence regarding the benefits and disadvantages of such interventions remains limited (Ensor & Ronoh, 2005).

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Knowledge transfer is a process where learning is shared, replicated, or used to scale-up interventions, create value, and improve effectiveness, although the best way to do this is not clear as posit by (Mitton, Adair, McKenzie, Patten, & Waye, 2007). Same source commented that 'policy advocacy' is on 'appreciative enquiry' (asking staff supportive questions about their problems to find solutions), and this appeared to improve motivation, quality of services, and reflective practice (Mitton, Adair, McKenzie, Patten, & Waye, 2007). Despite the perceived benefits, concerns regarding these practices include their resource-intensive nature, the need for highly skilled

facilitators, committed leadership, and almost evangelical enthusiasm (Mitton, Adair, McKenzie, Patten, and Waye,2007).

3.10.5 Community engagement as a strategy to improve maternal health literacy

3.10.5.1 Community engagement

As the main aim of the study was to develop a community engagement model, the concept of community engagement, community engagement groups and the principles of collaboration, partnership and dialogue ares discussed in detail as part of the Model in Chapter 7.

3.10.5.2 Community engagement in maternity services in developing countries

The Malawian initiative which was based on a successful project in Nepal that sought to engage with local women's groups to identify the major maternal and newborn problems in their communities, and to develop community-driven strategies to address these had significant success with 30% fewer newborn deaths and 80% fewer maternal deaths (Blomfield & Cayton, 2010; Rosato et al., 2006). Likewise, another community engagement initiative in rural Malawi, in which the Health Foundation was involved found that although studies had suggested that women did not have a comprehensive awareness of the problems that affect them, when channelled through women meeting and collectively discussing these issues, the process enabled women to clearly identify their maternal health problems, recognise their importance, and generate the motivation to address them, thus women's own perceptions of their problems could form a vital resource for communities and policymakers (Rosato, Laverack, Grabman, Tripathy, Nair & Mwansambo, 2008).

Although there are many barriers to take-up of services in developing countries, such as financial costs and the availability of services, there are nevertheless common

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barriers underlying low take-up rates (Costello, 2004) . The Malawian study operated on the premise that improving preventive and care-seeking behaviours, increasing knowledge, and changing attitudes was necessary, rather than providing information and delivering programmes at a health facility level for which there is little evidence of effectiveness (Costello, 2004). Rosato et al. (2006) observed that it is more effective to build upon what already exists where the people are in their communities, rather than design initiatives that do not take this into account thereby not utilising the capacities and potential resources already available in the communities (Rosato et al., 2006).

Blomfield and Cayton's (2010) Report for Health Foundation on community engagement noted that being pregnant does not make one a member of a community, hence women are pregnant within their communities, family and friends, locality, faith, or ethnic community, so it is particularly important to identify the authentic community with which individuals identify if a community engagement strategy is to have any hope of succeeding (Blomfield & Cayton, 2010).

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3.10.5.3 Reviews of effectiveness of community-based interventions in the reduction of maternal mortality

In developing countries, most of the maternal, perinatal, and neonatal deaths and morbidities occur at home (Ensor & Cooper, 2004). Reasons advanced include poverty, poor health status of women, illiteracy, lack of information regarding the availability of health services/providers, lack of control on household resources and decision-making authority, poor antenatal and obstetric care both within the community and health facilities, absence of a trained attendants at delivery, inadequate referral systems for Emergency Obstetric Care (EmOC), inadequate or lack of transportation facilities, and absence of/poor linkages to health centres within the communities (Ensor & Cooper, 2004). The majority of maternal and neonatal deaths could be prevented with early

recognition and proper implementation of required skills and knowledge (Ray & Salihu, 2004).

Soon after the Alma-Ata Declaration, arguments for selective rather than comprehensive primary health care dominated, and it was then recognised that community participation was important in supporting the provision of local health services and in delivering interventions at a community level (Rosato et al., 2008). Same authors posits that community participation has long been advocated to build links at improving maternal and child health, and there are several trials that have evaluated the role of women's groups on maternal and neonatal health (Rosato et al., 2008). In the Makwanpur trial, Nepal implemented a participatory learning cycle in which problems were identified, prioritised, and relevant interventions selected and implemented, and results evaluated, by developing women's groups and this yielded a reduction in maternal mortality by 88% and neonatal mortality by 30% (Azad, Barnett, Banerjee, Shaha, Khan, Rego & Costello 2010; Tripathy, Nair, Barnett, Mahapatra, Borghi & Rath 2010). It has also been proposed that a significant proportion of these mortalities and morbidities could also be potentially addressed by developing community-based intervention packages which should also be supplemented by developing and strengthening linkages with local health systems (Azad et al.,2010).

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A review to assess the effectiveness of community-based intervention packages in reducing maternal and neonatal morbidities and mortality and improving neonatal outcomes as well as the impact of different strategies such as home visitation, home-based care, community support groups/women's groups etc., on the reported outcomes, found encouraging evidence in integrating maternal and new-born care in community settings through a range of strategies that work, many of which can be packaged

effectively for delivery through a range of Community Health Workers (CHWs) (Lassi, Haider, & Bhutta, 2010).

The use of bicycles, motorcycles, and boats in villages; communication aids such as radios and mobile phones; and pre-negotiated arrangements and community loan funds to reimburse taxi drivers and private car owner's fuel costs have been recommended to address transport and referral problems (Mugasa, and Peron 2003). Jahn and DeBrouwere (2001), Krasovec (2004), and Lalonde, Okong, Mugasa, and Peron (2003) noted that the obstetric helpline described in India has built on these experiences by bringing together many of these separate components into one package with positive outcome (Mugasa & Peron, 2003; Jahn & DeBrouwere, 2001; Krasovec, 2004; Lalonde, Okong, Mugasa,& Peron, 2003).

Reviews by Hussein, Newlands, D'Ambruoso, Thaver, Talukder, and Besana (2010), on identifying practices and ideas to improve the implementation of maternal mortality reduction programmes highlighted the need for high-quality scientific evidence as the basis for any knowledge base as well as the need to consider field experience, innovation, and common sense in implementing any programme for maternal mortality reduction interventions (Pablos-Mendez, Chunharas, Lansang, Shademani & Tugwell, 2005). The same source posits that the practices and ideas identified in this study were generated through experience and the understanding of local needs, innovative practices and was responsive to needs of the people (Pablos-Mendez, Chunharas, Lansang, Shademani & Tugwell, 2005).

Sustainability is another criterion of good practice and this refers to the likelihood of activities or benefits continuing after initial inputs have been withdrawn (OECD, 2007). Conversely, indications of sustainability included uptake of learning from projects into

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larger-scale programmes, and the implementation of projects and programmes in collaboration with governments as highlighted by (Mitton, Adair, McKenzie, Patten, and Waye, 2007). However, it is important to find out whether health personnel themselves experienced benefits from the interventions, or adopted them as part of their routine practice (OECD, 2007). According to Hussein, Braunholt, and D'Ambruoso (2008), undue haste to 'scale-up' initiatives needs to be tempered by experience of how to implement actions that are known to work by starting small and learning from experience. Also as noted by Hussein, Braunholt, and D'Ambruoso (2008), considering the sustainability of interventions is important, so new ideas or innovations need to be seen in context as the same solution will not fit all situations (Hussein, Braunholt, & D'Ambruoso, 2008). Finally, even if some practices and ideas have not been proven to be 'good', sharing the experiences of how others have overcome constraints is important and it is through this mechanism of knowledge transfer that common sense approaches can evolve to become evidence-based strategies (Hussein, Braunholt, and D'Ambruoso, 2008).

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3.10.6 Strategies by the government of Cross River State, Nigeria

In Cross River State, Nigeria, large sums of money have been voted for the renovation of almost all primary health centres in the state, including those in the study setting according to Archibong & Agan, (2010). The upgrades include water supplies via borehole and light via solar panels, which is being strengthened by massive rural road construction by the state government in an attempt to render rural dwellings more attractive and thereby attract the habitation of these areas by medical personnel (Archibong & Agan, 2010). The implication is that the state is attempting to tackle type I and II delays in maternal deaths (Archibong & Agan, 2010). According to same authors, regarding the existing policies on maternal health, the Cross River State

Strategic Health Development Plan has specific programmes for maternal health. This plan was harmonised with the National Plan in 2009 (Archibong & Agan, 2010).

The state has a blueprint for primary healthcare that emphasises the provision of maternal health care at the grassroots level, and it is also on record that the state was one of the first to buy into the National Health Insurance Scheme (NHIS), and has also signed the Memorandum of Understanding for the Midwives Service Scheme (MSS), and the state funds the programme including accommodation of the midwives (Archibong & Agan, 2010). The authors also highlighted that the state currently has a total of 64 midwives deployed by the Federal Government of Nigeria under the MSS scheme and these programmes (NHIS and MSS) are currently functional and have made positive influences on maternal health (Archibong & Agan, 2010). Moribund obstetric emergencies that usually emanate from primary health centres to the teaching hospital have greatly reduced, and this has apparently contributed to the reduction trend in the maternal mortality rate (Archibong & Agan, 2010). The state has effective family planning facilities spread across the state, so in this regard, safe motherhood campaign programmes have been incorporated into the recently introduced Integrated Maternal and Child Health (IMNCH) programmes aimed at improving maternal health (Archibong & Agan, 2010).

Accordingly, the high maternal mortality rate in the state has received attention by both the state executive and legislative arms through regular condemnation of unacceptably high figures and general emphasis on health manpower development and Legislation is underway from the State House of Assembly to make birth and death registration mandatory from ward to state level. There is also a renewed effort to employ more medical doctors and midwives (Archibong & Agan, 2010). The impact of free maternal health care has not been felt yet since some centres still claim they operate as fee for

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service, the average cost of antenatal services in the state is N8, 000.00 (55.2 USD), while an average delivery costs N5, 000.00 (35.0 USD) while the average caesarean section cost is N18, 000.00 (125.0 USD) (Archibong & Agan, 2010). These figures as posit by the authors are averages of costs in both the teaching hospital and state general hospital. Despite these minimal charges, the patients are most reluctant to utilise healthcare services (Archibong & Agan, 2010).

3.11 SUMMARY OF THE CHAPTER

The chapter has provided an overview of the literature review that guided the researcher in the project. Several concepts were discussed to include: maternal morbidity and mortality; barriers to uptake of healthcare services by community mothers; the concept of three phase delays; health seeking behaviour of community women; the concept of birth preparedness and complication readiness; the role of Skilled Birth Attendants in the reduction of maternal mortality; community engagement; and the concept of Photovoice. Factors supporting the need for and benefit of community engagement in the prevention of maternal morbidity and mortality in the rural communities were also discussed. Several examples of successes of different strategies in various regions were highlighted. Findings in the literature were used to formulate the instruments for data collection. The next chapter provides an overview of the methodology.

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CHAPTER FOUR: METHODOLOGY

4.1 INTRODUCTION

The purpose of this chapter is to describe and justify the research methodology used to generate the answers to the research questions. The research design, research setting, sampling technique, research instruments, data collection techniques, and cleaning of the data are described (Blanch, Durrheim & Painter, 2006).

The overall aim of the research was to develop a model of community engagement for the prevention of maternal health complications in rural communities in Cross River State, Nigeria. The study had three phases consisting of five studies. Each phase and research instrument used will be described separately but the common elements such as the qualitative data analysis procedures and the ethical consideration is disussed collectively at the end of the chapter.

4.2 STUDY APPROACH

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The study was conducted using a qualitative descriptive approach that combined qualitative semi-structured interviews and focus group discussions within the Photovoice participatory approach. Using a participatory method with a qualitative approach results in the investigation of phenomena, typically in an in-depth and holistic fashion (Polit & Beck, 2012) and the investigations are conducted without the manipulation of the researcher.

Qualitative research is concerned with a subjective exploration of reality from the perspective of the person experiencing the phenomenon (Fouché & Schurink, 2012). It is based on a naturalistic inquiry, which implies that the experiences of the participants and their interpretation thereof will be studied in their natural state (Patton, 2002).

In this study the researcher using the qualitative approach method is able to explain the relationships between the social, cultural, political, physical environments, and the individual by analysing the stories they tell (Parse, 2001). The research delves in-depth into the complexities and the process of the participants' real life experiences (Creswell, 2007) and is designed to provide a complete and accurate description of a particular situation, social setting, or relationship (Schurink & Fouche in De Vos, 2011).

Photovoice has a Participatory Action Research (PAR) approach which is considered democratic, equitable, liberating, and life-enhancing qualitative inquiry that remains distinct from other qualitative methodologies (Koch & Kralik, 2006). PAR is a process of engaging with a community to systematically collect and analyse data for taking action through practical knowledge (Gills & Jackson, 2002). Ideally, as noted by Koch & Kralik (2006); McNiff & Whitehead, (2006), the purpose of PAR is to bring about social change with a specific action or actions as the main goal (Koch & Kralik, 2006). PAR has a cyclical process of fact finding, action, reflection, and leading to further change (Minkler,2000). Consequently, participants are not subjects of research, but rather, are active contributors to research who participate in all phases of the research process (Chander & Torbet, 2003; Kelly, 2005). A simple PAR cyle has initial steps, plus planning, acting and review cycles (Kelly (2005) (Figure 3). The essential initial step is conducting a community assessment, finding a community partner in the context of available community resources and ethical approval (Kelly,2005). The next step is the planning cycle which involves a balance between presenting ideas developed from a formal community assessment and working with community groups on the creation of actions (Kelly, 2005:69). During the review cycle, the participants and researcher collaborates to assess the process of the research and the outcome of their efforts (Kelly, 2005). In this cycle, the group determines how to share the data (Kelly, 2005).

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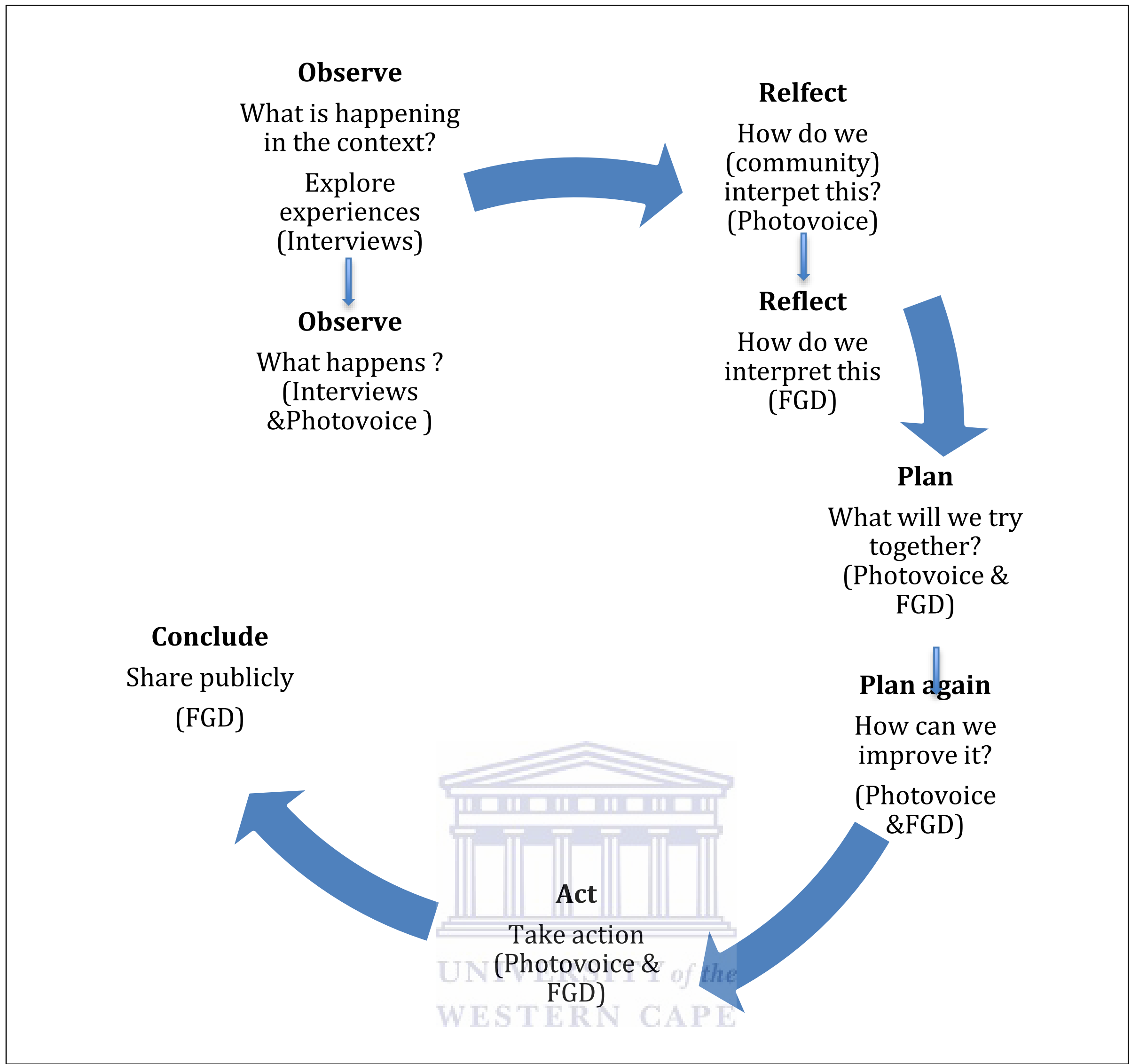

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FIGURE 3: Participatory approach throughout study

The initial observation phase of this study (Figure 3) explored the experiences of the participants regarding knowledge of obstetric danger signs, birth practices, and experiences within their communities. These experiences were explored, described and reflected on by means of qualitative interviews and Focus Group Discussions through the use of Photovoice (a qualitative participatory action research data collection tool combining photography and participants' narratives) in the observation and the reflective phases to create descriptive evidence of everyday health realities.

Photovoice employs a participatory strategy through which people can identify, represent, and enhance their community through a specific photographic technique. It

enables people: (1) to record and reflect their community's strengths and concerns; and (2) to promote critical dialogue and knowledge about personal and community issues via large and small group discussions of their photograph. Photovoice was developed by Wang and Burris in 1997 to enable Chinese village women to photograph their everyday health and work realities. The application of Photovoice is characterised by participatory analysis using the three-stage process: 1) selecting; 2) contextualising; and 3) codifying. The Photovoice strategy in this study gave participants an opportunity to photograph their health realities regarding birth practices and experiences in order to voice their felt health needs towards developing a community engagement model for the prevention of maternal health complications in their rural communities for positive change.

In the planning and action phase, a model was developed using qualitative focus groups. Focus group discussion (FGD) is a way of collecting qualitative data, which involves engaging a small number of people in an informal group discussion (or discussions), focused around a particular topic or set of issues (Wong, 2008; Wilkinson, 2004). This informal group discussion is usually based on a series of 'scheduled' questions and the researcher generally acts as a 'moderator' or 'facilitator' for the group by posing the questions, keeping the discussion flowing , and enabling the group members to participate fully (Wilkinson, 2004). By so doing, as posit by Morgan, (1988), the group members interact with one another, exchange ideas and comments on each other's experiences and views, which is the 'hallmark' of focus group methodology. According to Wilkinson, (2004), obtaining high-quality gocus group data depends upon an effective moderator and a well prepared session.

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4.3 PARADIGM AND ASSUMPTIONS OF THE STUDY

4.3.1 Research paradigm

Paradigms are sets of beliefs and practices that are shared by communities of researchers and that regulate inquiry within disciplines (Weaver & Olson, 2006). The various paradigms are based on the approaches used in conceptualising and conducting research and their contributions towards disciplinary knowledge construction. The authors further noted that to accomplish the task of developing nursing knowledge for use in practice, there is a need for a critical, integrated understanding of the paradigms used for nursing inquiry (Weaver & Olson, 2006).

The study focused on the development of a community engagement model for the prevention of maternal health complications in the rural communities of Cross River State, Nigeria.The underlying paradigms for the study was interpretive and participatory paradigms.

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To engage participants actively in the process of identifying and developing a community model, a participatory paradigm, based on critical social theory, inspired by the writings of Marx, Habermans, and Freire, according to (Maguire, 1987; Lutz, Jones & Kendall, 1997) was used with elements of the interpretive approach in the initial phases of the study. In this phase, the interpretive paradigm which includes mutual recognition between the researcher and the research participants was central to this study as it is congruent with phenomena which are studied through the eyes of people in their lived situations.

The participatory paradigm includes feminist, grassroots, and emancipatory movements which is concerned with countering operation and redistributing power and resources. This is essential in a community based model where the research becomes a means of

taking action and a theory for explaining how things could be (Maguire, 1987). Various researchers explained that this philosophy embodies a dynamic educative process, an approach to social investigation, and an approach to take action to address a problem or to engage in socio-political action (Gillis & Jackson, 2002; Kock & Kralik, 2006; Marshall & Rossman, 2006; Morris, 2002).

The PAR approach was used as a framework throughout the study, with the interpretive approach guiding Phase 1 of the study. The theoretical underpinnings of both these two paradigms were specifically applicable since they both emphasise active participant engagement, collaboration and engagement in defining health issues of common interest and designing programme to address them.

4.3.1.1 Interpretive paradigm

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In Phase 1 of the study, the interpretive paradigm is applied. In this approach, the researcher is not objective and separate from the study, but act as a participant observer who engages in the activities and discerns the meanings of actions as they are expressed within specific social contexts (Polit & Beck, 2012). In the study this was done through the use of a qualitative explorative descriptive approach with qualitative semi-structured interviews and focus group discussions during the Photovoice study. This resulted in the investigation of phenomena, typically in an in-depth and holistic fashion (Polit & Beck, 2012).

Interpretive approaches rely on naturalistic methods, which implies that the experiences of the participants and their interpretation thereof will be studied in their natural state (Patton, 2002). The research delved in-depth into the complexities and the process of the participants' real life experiences and was designed to provide a complete and

accurate description of a particular health situation. The use of Photovoice becomes a natural vehicle to then move from exploration and description to action.

4.3.1.2 Participatory Action Research paradigm

Photovoice has a Participatory Action Research (PAR) approach which is considered democratic, equitable, liberating, and life-enhancing qualitative inquiry that remains distinct from other qualitative methodologies (Koch & Kralik, 2006). Through Photovoice the community members were recruited and engaged to systematically collect and analyse data for taking action through practical knowledge, with the aim of bringing about social change with a specific action or actions as the main goal. Consequently, participants are not subjects of research, but rather, are active contributors to research who participated in all phases of the research process (from phases 1 to 3). Using the participator approach, the essential initial step was conducting a community assessment, finding a community partner in the context of available community resources and ethical approval (Kelly, 2005). The next step was the planning cycle which involved a balance between presenting ideas developed from a formal community assessment and working with community groups on the creation of actions (Kelly, 2005:69). During the review cycle, the participants and researcher collaborated to assess the process of the research and the outcome of their efforts (Kelly, 2005). The group then determined how to share the data publicly. The entire process of the study was strictly directed by the two conceptual framework (Citizenship Healthcare Model and Socio-Ecological Logic Models).

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4.3.2 Assumptions underlying research

"Assumptions are basic principles that are accepted as being true on the basis of logic and reasoning without being verified or proven" (Polit & Hungler, 1997:640).

Assumptions function as essential background beliefs that underlie other decisions in the research process (Mouton, 1996). In this study, it is assumed that:

- Participants' concerns are not isolated from their context and communities and there is wisdom in communities that informs the understanding and the interpretation of the data and the decisions and actions to take.
- Participation or engagement of community members promote empowerment and ownership, and ensures sustainability of the recommendations from the study.
- Qualitative descriptive contextual research design is most appropriate for studying human experiences. Perceptions of such experience have to be as they are actually lived by the individual and the community.
- Purposive sampling method is most suitable to select information-rich source participants who will most benefit the study.
- Photovoice as a participatory strategy will help people identify, represent and enhance their communities through a specific photographic technique. It will promote critical dialogue and knowledge about personal and community issues through large and small group discussions of their photographs.
- Participants' stories and narratives around the photos will enable people to reflect on their lives and communities regarding the study focus to serve as agents of authentic change (Carlson et al., 2006).

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4.4 RESEARCH SETTING

The Akpabuyo Local Government Area (LGA) is one of 18 LGAs that make up Cross River State, Nigeria. It was created out of the former Odukpani LGA on the 27th Day of August 1991 as the 14th LGA in Cross River State, and the 589th LGA in Nigeria.

The wet season is experienced from March until October. November marks the beginning of the dry season with December and January as the driest months. The wet season is far longer than the dry season by a ratio of 2:1.

4.4.1 Historical background of the Akpabuyo Local Government Area

Akpabuyo is predominantly an Efik migration and expansion area. Efik rural areas or plantations cover the whole hinterland. These rural settlements constitute the farming community of all the "7 Efik clans" (Essien Efik Itiaba). Creek Town (Obio Oko or Iboku Esit Edik), Adiabo, Old Town (Obutong), Duke Town (Atakpa), Henshaw Town (Nsidiung), and Mbiabo (Eket Etoiko) make up the seven clans. Of these, Old Town, Duke Town, Henshaw Town, and Cobham Town have their parent stock in Calabar, and are also represented in Akpabuyo (Charles, 1996).

The Akpabuyo LGA is bounded by Calabar Municipality and the Calabar South LGA to the west, Akamkpa LGA in the north, Bakassi LGA in the south, and an international boundary with the Republic of Cameroun on the east. Akpabuyo is situated between latitude 4.47'N and 5.00'N and longitude 8.25E and 8.37E. It is a territory harnessed by a series of river tributaries. The watershed tends to divide Akpabuyo into two parts, with villages lying on either side of the river to enjoy and exploit the economic benefits of the river.

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4.4.2 Ethnic group/social life

The ethnic groups are the Efiks, Quas, and Efuts, and over the years the Akpabuyo LGA has witnessed migrant settlers from the Anang- and Ibibio-speaking people of the present Akwa. Some of these immigrants have influenced the thought patterns of Akpabuyo people, and the dominant culture and beliefs of the traditional Akpabuyo people are significantly upheld.

The people are of “Efik” stock and share their culture with that of the “Old Calabar dynasty” (Charles, 1996). They are highly religious people, and are predominantly Christian (of diverse sects). Within the communities, traditional religious practitioners of the “Ekpe and Obon cults” are not uncommon. Here, the Ekpe cult, as elsewhere in the “Efik clan”, has a dominant influence on the community’s social life. It wields enormous influence, even among Christians. It is still regarded as an embodiment of the social/cultural norms within the community. The belief in the community is that the contravention of any Ekpe or Obon norms may lead to ill-health (including child birth complications), and when not properly atoned for, may result in death. Thus, the Ekpe are considered to be sacred by members of the community.

4.4.3 Economic life

The vast landmass of the Akpabuyo LGA provides agricultural opportunities for the community. Akpabuyo is described as the “Efik” plantation (Inwang Efik) (Charles, 1996). The people’s agricultural life revolves around land and they have a subsistent economic life. In most cases, their agricultural methods are primitive. The Akpabuyo’s economic life is occupied mainly with the production of key cash crops such as palm oil/kernel, palm wine, and kola nuts. The production of foodstuffs such as cassava, yam, plantain, pepper, corn, and okra is common. Fishing is common among the people living along the adjoining river, while the local stream provides a source for drinking water and other domestic chores. Cow, goat, sheep, and chicken farming (though at subsistence level) are noticeable in the community.

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4.4.4 Population

The Akpabuyo LGA is one of the LGAs situated in the South-South geopolitical zone of Cross River State. It has 271 villages comprised of 22 clans (Source-Secretary Traditional Rulers Council). The estimated population is 31,134 people. It is sub-

divided into 10 political wards and five health districts (PHC Dept). The five health districts have the following projected populations, as shown on Table 1.

TABLE 1: Health district and projected populations

District	Population
District 1	25,280
District 2	24,256
District 3	18,948
District 4	26,618
District 5	26,288

Source: PHC Dept. Akpabuyo LGA

4.4.5 Clan structure/administration

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The administrative structure in Akpabuyo is similar to that of most other Efik clans. The Efiks are socially organised into "Ufok" (House). To an Efik, one must belong to "a House" (Charles, 1996). Charles (1996) further asserts that an Ufok is a "unit of social grouping, a corporate but dispersed group, and members of whom trace their descent to a common ancestor or ancestors". Each Ufok under the Efik tradition is headed by "Etubom". An Etubom is elected from the royal and illustrious sons of the Ufok. A village is a conglomeration of three to four Ufok (Houses).

The administration of the Idundu and Anyanganse clans rests with the clan heads that sit in council with all heads of the villages in the clans. The clan heads delegate responsibilities to the village heads and equally mentor the exercise of such delegated authorities and powers. The clan heads runs a secretariat for easy administration of the communities and information dissemination on all issues (including health matters). New and innovative health issues and ideas to be implemented in the clan have to be precisely explained to the clan head-in-council. The clan head-in-council will explain

such new ideas to the entire community and will solicit their co-operation. The clan authority is often (in most cases of health campaigns) saddled with the responsibility of mobilising the community for participation.

4.4.6 Healthcare delivery in Akpabuyo Local Government Area

Healthcare delivery in the Akpabuyo LGA is linked to the healthcare delivery of the Cross River State in general. The Ministry of Health formulates and implements all health policies for the state, and liaises with the Federal Ministry of Health for the implementation of international and national health programmes. The Local Government is linked directly to the Primary Healthcare Department of the State Ministry of Health. The Hospital Management Board posts doctors to the Local Government Councils as primary healthcare coordinators, while primary healthcare directors in each LGA are directly in charge. There is only one general hospital/secondary health facility (St. Joseph Hospital, Ikot Ene) in Akpabuyo LGA, and it is located in the Ikot Ene community. The hospital was transformed from a mission hospital built by the medical missionaries under the supervision of the Catholic church. It serves as a referral point for the entire LGA and its environs. The hospital has an equipped maternity unit for ANC and deliveries. It has a functional theatre for the management of obstetric complications. There is a functional blood bank and a resident medical doctor who is knowledgeable in obstetric cases.

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4.4.7 Alternative maternal healthcare

There are a variety of alternative treatment sources available in the local communities in Akpabuyo LGA, including the communities under study (Idundu and Anyanganse). These sources include traditional healers, herbalists, spiritual healers, diviners, and TBAs. Among the sources listed above, there is a high preference for TBAs and spiritualists to attend to antenatal care and deliveries in the communities. A recent

community survey revealed that most women in these rural communities consult the TBAs before seeking orthodox care during antenatal care and deliveries, even though they have access to orthodox medical facilities. The strategic role of TBAs should be explained further that since the TBAs are contacted first, and they decide when and where orthodox medical services should be sought by women with childbirth complication(s) (Charles, 1996).

Various reasons have been advanced for rural dwellers' patronage of TBAs. The proximity of the TBAs to the members of the local communities, especially in areas without access to orthodox medical care, is important. This benefit of accessibility is further enhanced by the exorbitant cost of transportation. The cost of medical care in orthodox health institutions is not only exorbitant but also ever-increasing and thus is not easily affordable for the low-income communities, who form the bulk of the studied population. Another facilitator of using TBAs, is the barrier to seeking out orthodox healthcare due to bureaucratic procedures, which is not clearly defined but must be strictly followed. For instance, allowing different medical staff to attend to a patient tends to discourage community members, especially during delivery when the women's privacy is considered to be highly encroached

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Over the years TBAs have become trusted members of the community where they operate due to their receptive attitude of women during antenatal care and childbirth. The trust garnered over the years is also influenced by their perceived aetiology of childbirth complications, which is linked to intuition of extraneous forces (supernatural forces and/or witchcraft), fate, and vows. The treatment given is usually in the form of atonement, which, in most cases, is carried out by the TBAs.

Whatever the opinion on TBAs may be, they occupy a very important position in the dispensation of maternal care in our rural communities. The majority of the interviewed TBAs in the study communities stated that they became birth attendants as a result of responding to “a divine-call” to save women during deliveries. Accordingly, most TBAs combined their traditional midwifery with spiritual healing. A pregnant woman attending antenatal care must mandatorily abide by the prescriptions and prohibitions of the TBA. In most TBA houses, fasting and abstinence is recommended during ANC, while herbs and medieval roots are taken orally and/or as an enema. This method of treatment is meant to purify the pregnant women, to ward-off evil spirits, and to facilitate safe delivery. In the event of childbirth complications, time is spent on prayers and administration of herbs orally.

TBA’s only make referrals subsequent to failed trials of traditional remedies. Any loss of life at the TBA house is accepted as fate, what was meant to be, infidelity on the part of the victim who had not confessed, or God’s design. Payment for services rendered could be made in instalments or in kind. Some debts are allowed to be carried over to the next pregnancy. Some pregnant women claim some TBAs lock the pregnancy spiritually, only to unlock it when labour commences to facilitate delivery. This practice is to ensure that the pregnancy remains intact and unharmed until the expected time of delivery.

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4.4.8 The selected communities for the study

The communities of Idundu and Anyanganse were purposively selected for this research study, based on their records of low utilisation of PHC services for delivery, as shown in Tables 2 and 3 (Akpabuyo LGA PHC Records).

TABLE 2: Anyanghanse maternity records, January 2012-December 2013

Year	Months	Antenatal	Delivery	Postnatal
2012	January	21	4	37
	February	11	6	30
	March	14	4	24
	April	6	4	20
	May	14	6	31
	June	21	9	28
	July	22	8	16
	August	26	8	24
	September	2	7	40
	October	0	7	46
	November	17	6	22
	December	15	5	31
	Total	169	74	349
2013	January	24	5	28
	February	42	6	36
	March	21	8	35
	April	21	4	43
	May	19	5	28
	June	17	5	28
	July	20	2	28
	August	8	2	40
	September	16	6	32
	October	12	5	30
	November	9	2	26
	December	11	3	30
	Total	220	71	384

Source: *PHC Maternity Records, Akpabuyo LGA*

TABLE 3: Idundu PHC maternity records, January 2012-December 2013

Year	Months	Antenatal	Delivery	Postnatal
2012	January	41	4	56
	February	78	4	80
	March	20	8	71
	April	21	2	55
	May	36	8	52
	June	40	6	48
	July	41	6	52
	August	78	5	42
	September	28	6	66
	October	39	8	60
	November	47	7	52
	December	40	9	49
	Total	509	73	683
2013	January	51	14	60
	February	50	12	58
	March	52	11	59
	April	61	11	66
	May	64	9	69
	June	60	6	64
	July	56	10	58
	August	55	9	60
	September	50	8	60
	October	51	11	61
	November	44	4	49
	December	48	14	714
	Total	642	119	384

Source: PHC Maternity Records, Akpabuyo LGA

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The Anyanganse community has a health post manned by a senior CHEW, while the Idundu community has a PHC, headed by a qualified senior nurse/midwife with a medical doctor who visits the centre 3x a week. Doctors on national youth service assignment are sometimes posted there. The PHC in Idundu is well-equipped to attend to referred cases from the surrounding health posts. Only complicated obstetric cases are referred to St. Joseph Hospital, Ikot Ene, or the General Hospital in Calabar.

4.5 RESEARCH STUDY OUTLINE

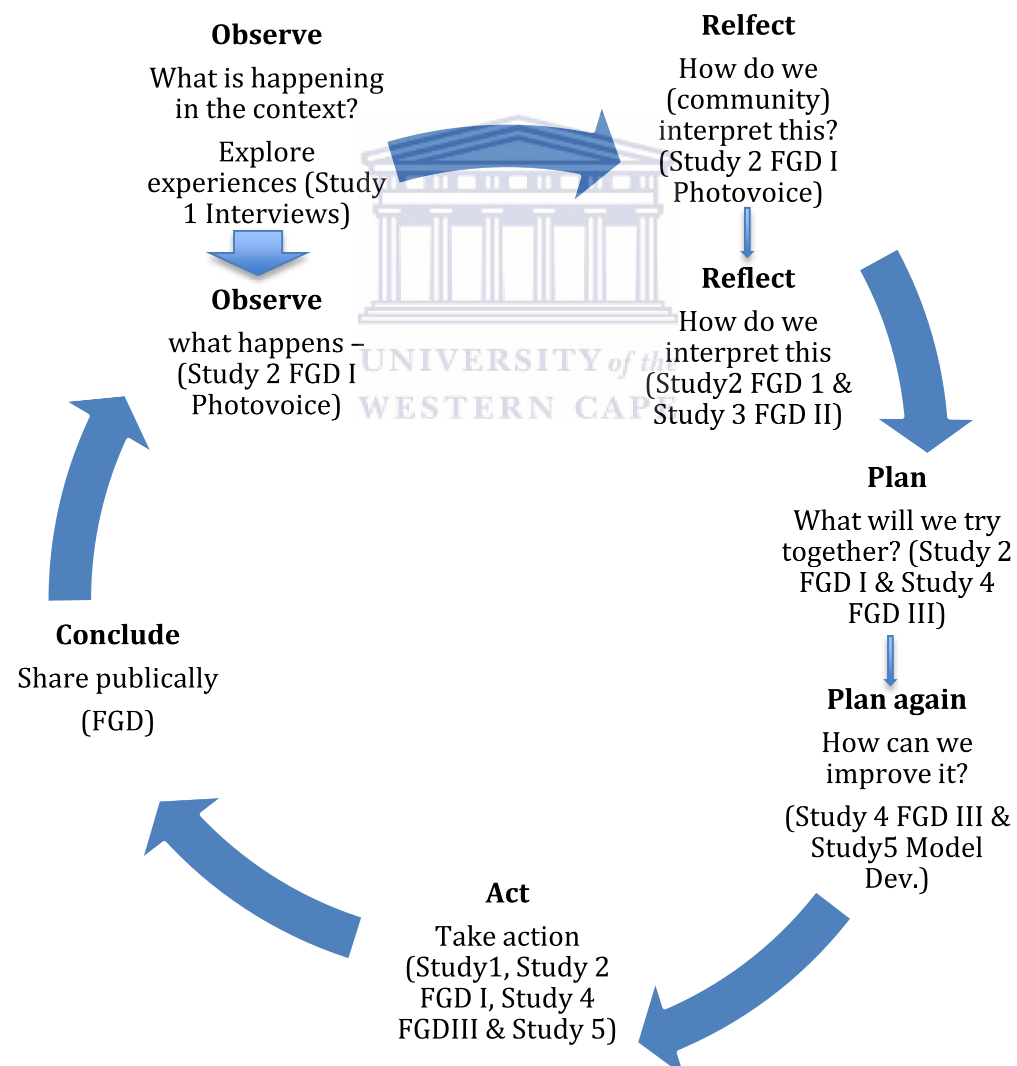

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FIGURE 4: PAR showing the various studies

The study has three phases, consisting of five (5) studies addressed through six objectives. The study uses the PAR cycles overall and at the same time forming the basis for the Model Development (Figure 4). The *Observe* and the *Reflect* phases in the PAR process included both Phase 1 and Phase 2 which aimed to explore the participants experiences and to observe and reflet on what happened.

Table 4 provides a summary of the phases and studies as they relate to the PAR cycle and the Model Development.

TABLE 4: Summary of the phases of the research

OBJECTIVES	PHASES AND STUDIES	MODEL DEVELOPMENT	PAR CYCLE
PHASE 1: Understanding the current situation in the rural communities of Cross River State			
To explore (1) the knowledge gaps and understanding of the obstetric danger signs in women of child-bearing age (pregnant and new mothers) (2) their perceptions on birth preparedness, complication readiness and delivery practices and (3) the perceptions of the actions of family/community and the maternal health initiatives in emergencies in terms of utilisation of orthodox health services.	**Study 1:** Qualitative semi-structured interviews with pregnant women and new mothers (n=20 - 10 each from the two communities under study). Qualitative data analysis using Tesch's 8-step coding method; Identification of themes and categories and literature support of findings. Verification with member checking with both groups were conducted using field notes for agreement	*Concept development*	**Observation**
Phase 2: Community engagement using Photovoice			
4) To explore and validate: the perceptions of mothers through a participatory approach about the problems experienced in pregnancy (birth preparedness, complication readiness and utilization of healthcare facilities for skilled attendance during pregnancy, delivery and puerperium); and	**Study 2:** Qualitative Focus Group I (FGD1) for community engagement, narratives, identification and validation of concepts with same 20 participants from Study 1, now using Photovoice • *Establishing Photovoice Group*: Recruitment of participants and orientation and training of participants.	*Concept development and identification*	**Observation & Reflection**

OBJECTIVES	PHASES AND STUDIES	MODEL DEVELOPMENT	PAR CYCLE
to identify possible solutions involving the community in the prevention of maternal health complications through improved utilization of health care facilities for skilled attendance during pregnancy, delivery and puerperium.	Field notes were taken (n=20). • *Photovoice Training*: Camera-sharing and training. Audio recording of meeting and field notes were taken (n=20). • *FGD I*: Discussion of photos was conducted with participants from Study 2 (n=15). Focus Group discussions were recorded and transcribed and analysed using Tesch's eight-step coding method to identify key themes and categories. This was verified through an independent coders and supported by literature and verification through member checking.		
(5)To validate the concepts identified in the study with the older women of the two communities under study.	**Study 3**: Qualitative Focus Group Discussion (FGD II) to provide feedback and validate the findings from Interviews and Photovoice with older women in the community (n=14 participants). Qualitative data analysis and validation of themes and field note agreement analysis.	*Concept identification*	**Reflection & Action**
Phase 3: Model Development			
(6) To develop a model of community engagement for the promotion of Birh preparedness, Complication readiness and to improve access to skilled birth attendance for prevention and early detection of maternal health complications.	**Study 4: Qualitative Focus Group Discussion (FGD III)** • Classification and validation of themes and concepts. • Generating guidelines for model development	*Verification of concepts through , definition, validation, classification* *Identifying the relationships between concepts*	**Planning & Action**
	Study 5: Model Development Synthesis of all findings by the researcher	*Model description* *Guidelines for the operationalization or implementation of the model*	**Action**

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4.6 PHASE 1: UNDERSTANDING THE CURRENT SITUATION IN THE RURAL COMMUNITIES OF CROSS RIVER STATE

This phase comprised of study 1, addressing objectives one to three (see Table 4) using qualitative semi-structured interviews.

4.6.1 Study 1:Semi-structured interview with study participants

The objectives of this study were to:

- to explore the knowledge gap of women of childbearing age (pregnant and new mothers) regarding obstetric danger signs in the rural communities of Cross River State, Nigeria;
- to explore Birth Preparedness, Complication Readiness and delivery practices of women of childbearing age in the rural communities of Cross River State; and
- to explore the action of family/community members and the role of community-based maternal health initiatives, if any, in emergencies, as well as to explore the opinions of women on actions to be taken in the community to promote utilisation of orthodox healthcare facilities by rural women in Cross River State, Nigeria.

4.6.1.1 Study method

Qualitative semi-structured interviews with pregnant mothers and new mothers.

4.6.1.2 Participants

The study included 20 purposively selected women of reproductive age who met the inclusion criteria of being pregnant at any given gestational age or women who have recently given birth (babies within 12 months of age). Women of non-reproductive age (below 12 years and above 49 years) were excluded. The participants comprised an equal number of participants (10) from each of the two communities under study

(Idundu and Anyanghanse). Entry was gained into the community through the community women leaders who identified the participants in their communities based on the inclusion criteria for the study.

4.6.1.3 Sampling

Non-probability sampling known as purposive sampling was used. This type of sampling is based on the judgment of the researcher (Brink, 2012:141). The aim of is to choose individuals who will most benefit the study. It was assumed that the selected participants having had pregnancy and delivery experiences will form a rich source of information to meet the focus of the study.

The first step in the sampling were to purposively select the two communities. The Akpabuyo Local Government Chairman was visited through the PHC co-ordinator, for the purpose of obtaining permission for the study and intimating him of the study aims and objectives. Through the PHC Coordinator, the researcher was able to access the PHC facilities register to identify those communities that least utilise the Primary healthcare facilities for delivery. From there, the choice of the two communities under study (Idundu and Anyanganse) was made.

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The second step of the sampling process was to purposively select the participants. Visits to the clan heads of the two communities were made for their approval of the study. The clan heads introduced the community women leaders to the researchers, to assist in identifying the pregnant women and the new mothers in their communities for the study. A brief meeting was held with the two women leaders to re-emphasise the aims and the process of the study, their roles and the category of women to be identified to suit the purpose of the study (pregnant women and new mothers whose babies are within 12 months of age), 10 from each of the two communities giving a total of 20 participants.

4.6.1.4 Research instrument

Semi- structured interview was used to elicit information using an interview schedule. The interview schedule (Appendix 1a) was developed using the guiding principles from Birth Preparedness/Complication Readiness matrix adapted into community Maternal and Newborn Health programmes (JHPIEGO, 2004), and questions were in sections to address the three phase delays to obtaining skilled care (Thaddeus & Maine, 1994).

4.6.1.5 Data collection and analysis

The data collection process for this study was done in participants' homes. This venue is both private and allowed for the out of sight voice recording of the face-to-face interview. The interview was approximately 45 minutes to an hour long. Field note taking was done alongside therefore allowing for the highest possible reliability of data (Polit & Beck, 2012:543). Data was collected until data saturation was achieved; this means that both emergent themes developed and continued until no additional information was provided (Brink, 2012:141). The data was analysed using standard qualitative data analysis techniques (see 4.9).

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4.6.1.6 Member checking and verification

Member checking was done using two groups consisting of the participants (one group in each community) to provide feedback of interview analysis and to verify identified themes with participants from study 1. A week after the completion of the interviews, the 20 pregnant women and new mothers from the two communities used in study 1, were grouped into two groups (n=10 in each community) in their town halls and were given verbal feedback on the analysis of the findings from study 1 using the themes that emerged. This process lasted for about 50 minutes and field notes of agreement were taken.

4.7 PHASE 2: COMMUNITY ENGAGEMENT USING PHOTOVOICE

The objectives of this phase were to:

- explore the perceptions of mothers through a participatory approach about the problems experienced in pregnancy (birth preparedness, complication readiness and utilization of healthcare facilities for skilled attendance during pregnancy, delivery and puerperium) (OBSERVE & REFLECT); and
- to identify possible solutions involving the community in the prevention of maternal health complications through (ACT).

Photovoice participants were engaged through photovoice to photograph the everyday health realities that depict their birth practices and experiences and to tell stories regarding the photos taken to bring about solutions and positive change.

This phase was conducted in two studies, Study 2 and Study 3.

- Study 2 was the Photovoice Focus Group (FGD I) with the photovoice participants (n=15). The purpose of FGD I was the identification and discussion of the photographs and to verify the themes that emerged from the photovoice process (member checking).
- Study 3 was focus group discussion (FGD II) with older women in the community (n=14). The purpose was the validitation of the themes of the Interviews and the Photovoice FGD I by an external group of older women.

4.7.1 Study 2: Community engagement (Photovoice)

4.7.1.1 Participants

The participants for Study 2 comprised the photovoice participants recruited for Study 1 namely; 20 pregnant women and new mothers from the two communities (A & B).

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Though 20 participants consented and participated, only 15 participants took part in the Photovoice FGD I. The Photovoice FGD I was preceded by the group recriutment and training in Photovoice and photography and was followed by member checking and verification by the group of the key themes that emerged from the photovoice process.

4.7.1.2 Photovoice methods

The following are the nine-step strategy to mobilise community action through the use of Photovoice:

1. Selection and recruitment of a target audience of policy-makers or community leaders who can make decisions that can improve the situation. This may include city council members and other politicians, journalists, physicians, administrators, researchers, business people, and community leaders with the power to make and implement participants' recommendations and their primary role is to serve as a group with the political will to put participants' ideas into practice.

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2. Recruiting a group of Photovoice participants of Seven to 10 people to allow for practical ease and in-depth discussion. Projects in which women take photographs could provide an opportunity to gain comparative generational perspectives on community issues that affect women and it should be noted that step 1 and step 2 are interchangeable in sequence; women participants could come together first and then decide upon their primary intended audience/s (Wang & Redwood-Jones, 2001).

3. The Photovoice methodology is introduced to participants, a group discussion is facilitated about cameras, power, and ethics. Firstly, Photovoice concept and method is introduced with emphasy on the aim to influence policymakers and

community leaders, the responsibility and authority conferred upon the photographer wielding the camera, an ethic of giving photographs back to community people to express thanks, and how to minimise potential risks to participants' well-being. Hence, questions to be discussed include: What is an acceptable way to approach someone to take his or her picture? Whether you ought to take pictures of other people without their knowledge? When would you not want to have your picture taken? To whom might you wish to give photographs, and what might be the implications? (Wang & Redwood-Jones, 2001).

4. Obtain informed consent. The first session of Photovoice training emphasises the safety and the authority and responsibility that are concomitant to using a camera, thus facilitators must consider how participants' vulnerability may be further modified by their social class, access to power (or lack thereof), health concerns, and other factors. Facilitators should explain the written informed consent form, which ought to include a statement of project activities and significance, specific potential risks and benefits, the voluntary nature of participation and freedom to withdraw at any time for any reason, and the understanding that no photographs identifying specific individuals will be released without separate written consent of not only the photographer, but also the identified individuals (Wang & Redwood-Jones, 2001).

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5. Pose initial theme/s for taking pictures. Participants may wish to brainstorm together regarding the themes that they can focus on to enhance community health, and then determine individually what they wish to photograph. Or, they may be given a specific project theme such as birth practices. For subsequent rounds of picture-taking, participants can generate specific, related ways of

thinking about what to photograph in terms of open-ended questions (Wang & Redwood-Jones, 2001).

6. Distribute cameras to participants and review how to use the camera. The choice of camera can be guided by facilitators' and participants' preferences and practical considerations.

7. Provide time for participants to take pictures. Participants should agree on a specified time to turn in their images over to a facilitator for developing and/or enlarging, such as one- three week after the initial workshop, and then to meet again to discuss their photographs (Wang & Redwood-Jones, 2001).

8. Meet to discuss photographs and identify themes. The next three stages– selecting photographs, contextualising or storytelling, and codifying issues, themes, or theories–occur during group discussion. Firstly, each participant may be asked to select and talk about one or two photographs that s/he feels is most significant, or simply likes best. Secondly, participants may frame stories about–and take a critical stance toward–their photographs in terms of questions spelling the mnemonic 'SHOWeD':

   - What do you See here?
   - What's really Happening here?
   - How does this relate to Our lives?
   - Why does this situation, concern, or strength exist?
   - What can we Do about it?

   Third, participants codify the issues, themes, or theories that arise from their photographs. Given that Photovoice is well-suited to action-oriented analysis

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that creates practical guidelines, participants may particularly focus on issues. The number of Photovoice rounds will depend on factors that include facilitators' and participants' preferences, overall project scope and budget, and other practical considerations (Wang & Redwood-Jones, 2001).

9. Plan a format with participants to share photographs and stories with policy-makers or community leaders. Facilitators and participants typically plan a format such as a Powerpoint slide show or an exhibition to amplify participants' photographs, stories, and recommendations to policy-makers and community leaders. The above outline provides a brief methodological overview (Wang & Burris, 1997; Wang & Redwood-Jones, 2001).

4.7.1.3 Photovoice community engagement group establishment

Photovoice Community Engagement was done in two steps, namely the recriutment of the Photovoice Group (community engagment) and Photovoice training.

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Establishing the Photovoice Group: The recruitment and engagement of the Photovoice Groups' participants was the first step with the two groups based on the selected communities (A & B) being invited to attend a meeting about the Photovoice study in their respective community town halls. Informed consent was obtained from the 20 participants to become the Photovoice participants and the first meeting of the group was held. During this meeting they were oriented to the Photovoice study. This included training on what Photovoice is, Photovoice ethics, study methodology, camera usage, and types of photographs to take. Audio recording and field notes were taken during this group meeting.

Training in Photovoice: Three days after the first meeting, follow up group meetings in the respective group town halls were scheduled to share cameras, review camera

usage, review on the kind of photos to take based on study focus, and a repeat of Photovoice ethics. Participants were given three weeks to take photos. In this study, photos were to be of the following areas in the communities: where women seek care during pregnancy; family support; Birth Preparedness; Complication Readiness practices; places that women utilise for delivery; common complications encountered by women during pregnancy, delivery and after delivery; actions of family/community members in emergency situations; and the roles of community-based maternal healthcare initiatives, if any. An audio recording and fieldnotes of the meeting were done.

4.7.2 Photovoice Focus Groups

Two Focus Group Discussions (FGD I and FGD II) were held under phase 2 of the study. FGD I aimed to select, group and tell stories/ narratives around the photos taken, and FGD II aimed to validate the findings of FGD I and the interviews from Study 1.

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4.7.2.1 Focus Group I (Photovoice narratives)

***Design*:** Qualitative focus group discussion to discuss, reflect and recommend actions to be taken.

Study venue: Community Hall.

Participants: Photovoice participants from the two communities under study (n=15). Five of the participants sent in their cameras earlier for printing of their photos through their community woman leader with verbal excuses of inability to be present at the session due to some unforeseen family challenges which were not disclosed.

***Research instrument**:* A focus group guide was used which included the following instructions based on the recommended Photovoice guidelines (Wang & Redwood-

Jones, 2001). The following questions were posed to start the FGDs using the acronym SHOWeD).

- What do you See in these photos?
- What is really Happening?
- How does it relate to Our lives?
- Why does the situation Exist?
- What can we Do about it?

Data collection: Three weeks later, an FGD I was conducted, drawing participants from communities A and B (n=15, 8 & 7 espectively). FGD I was held to check photograph quality, select and group photos, and to discuss issues around the photos through storytelling and narratives. Two days earlier, cameras were returned to the facilitator (researcher), through the community women leaders, for development of the photo films and printing. This method enabled people to reflect on their lives and communities in terms of the study focus via the dual voice of visual and spoken narratives, serving as agents for authentic change (Carlson et al., 2006). The researcher simultaneously recorded the discussions. Field notes were also taken and triangulation of analysis was built into the data collection process, thus allowing for the highest possible reliability of data (Polit & Beck, 2012). Participants codified themes from issues that arose from the photos.

Data analysis: Photos were grouped and categorised while in the FGDs participants told stories and narratives about each photograph, which was recorded alongside the note-taking. After the initial translation and transcription of the recorded narratives, data was analysed following Tesch's eight-step method of coding (Bruce, 2000), as described in 4.9.

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4.7.2.2 Member checking and verification

Member checking was done with the photovoice participants to provide feedback of the photovoice analysis and to verify the identified themes. A week after the completion of the photovoice, participants were gatherered in the townhall and given verbal feedback on the analysis of the findings and the themes that emerged from study 2 FGD I. The verification group discussion lasted about 50 minutes and field notes of agreement were taken.

4.7.2.3 Study 3: Focus Group II: Verification of study findings by the communities' older women

Study 3 aimed to verify the findings from Phase 1 and Phase 2 (Study 1 and Study 2) through a qualitative focus group discussion (FGD II) with the older women selected from the two communities under study.

4.7.3 Study method

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Qualitative participatory approach using a focus group discussion (FGD II).

***Participants*:** Participants included a different group (older women from the two study communities) who were selected and engaged through FGD II to verify the findings of Phase 1 and Phase 2 (Study 1 and Study 2). Older women (mother-in-laws and grandmothers) drawn from the two communities under study, representatives of Photovoice participants and women leaders from the two communities were selected, totalling 14 participant across the two communities.

***Sampling*:** Purposive sampling was conducted with the selection based on these older women having daughters and/or daughters in-law who are either pregnant or nursing a baby.

Research instrument

Focus Group Schedule (Appendix 1d) containing the FGD guiding questions and the key themes identified from the validated interviews and Photovoice (FGD I).

Data Collection

The FGD II was held in Community Town Hall. Participants were given verbal feedback on the analysis of the findings from the validated interviews and the validated Photovoice FGD using the themes emerging from these studies. FGD II lasted about 50 minutes and was run through focused group discussions focusing on each theme. The discussions were tape-recorded and field notes were taken.

Data Analysis

The data was analysed using standard qualitative data analysis techniques (see 4.9) and the field notes were checked for agreement of all the participants on the findings shared which was tape- recorded and notes taken.

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4.8 PHASE 3: MODEL DEVELOPMENT

The aim of this phase was to develop a model of community engagement for the promotion of maternal health knowledge of Birth Preparedness, Complication Readiness, early detection of obstetric complications, correction of negative assumptions against orthodox healthcare services, positive healthcare attitude, and to improve access to skilled birth attendance for prevention of maternal health complications in rural areas of Cross River State, Nigeria.

This phase was done through two studies (Study 4 and Study 5). Study 4 is a qualitative study using a focus group discussion (FGD III) to identify the key concepts for the model and to generate the guidelines for the model development (Study 5).

4.8.1 Study 4: Focus Group Discussion (FGD III: Concept validation and generating guidelines for model development)

The community stakeholders were involved to contribute in the first step of the model development process, which is the validation of concepts developed from the findings of study Phases 1 & 2 and to draw up the guiding principles for the model development.

4.8.1.1 Study methodology

A qualitative participatory approach using a modified focus group approach.

Participants

The participipnts for FGD III included the clan heads and women leaders from the two communities, representatives of Photovoice participants, religious leaders, leaders of women's groups, TBAs, heads of healthcare facilities within the study communities, and Ward Development Committee (WDC) and Village Health Committee (VHC) members (n=20). The selection inclusion criteria was based on members and leaders of influential groups within the communities and those whose services in the community has a direct link with the study focus.

Sampling

Purposive non probability sampling was used based on the fact that the selected participants were the community gate-keepers who were influential and heading one important group or the other in the community. Their positions had a direct link with the study focus.

Research instrument

Focus Group Schedule (Appendix 1e) containing the key themes identified from the validated interviews and the validated Photovoice FGD. In addition, instruction for recommendations for guidelines for development of model was included.

***Data Collection**:*

FGD III was held in the Chief's Palace. This FGD was designed to share with the community stakeholders the findings generated from the analyses of the data from study Phases 1 and 2. The provision of such was for their information, verification of data, and concept development and definitions. It was hoped that once themes and concepts were established and confirmed by the participants and stakeholders, a guideline for model development would be drawn. The FGD lasted an hour.

Data Analysis

The data was analysed using standard qualitative data analysis techniques – see 4.9 and member checking was done through field notes which were checked for agreement of all the participants on the findings shared, which was tape- recorded and notes taken.

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4.8.2 Study 5: Model development

The process of model development included four steps:

1) Concept development: the identification, definition, validation, classification, and verification of the main and related concepts (Walker & Avant, 2005).

2) Model development: the model guidelines and definitions (Walker & Avant, 2005). These were validated by the responses from the stakeholders during the FGD III (Appendix 13).

3) Model description: the structure, definition, relation statements and a process description of the model (Walker & Avant, 2005). The structure is described according

to the following sub-headings: overview of the model, context, purpose and assumptions on which the model is based (Walker & Avant, 2005)..

4) The development of guidelines for the operationalisation or implementation of the model in the rural communities is developed (Walker & Avant, 2005)..

4.8.2.1 Study method

Synthesis was used as the approach to model development because the data that emerged from Phases 1 & 2 needed to be connected theoretically. The synthesis assisted the researcher in the interpretation of the data (Walker & Avant, 2005).

4.8.2.2 Concept development

Concept synthesis and development began with raw data, which in this study were from Phases 1 & 2 of the study. The data was classified into categories and themes and were clustered. Clustering involves comparing each classification category with each other (Walker & Avant, 2005). These were done by the researcher and independent coder (supervisor). Once the clusters were discovered they were examined for hierarchical structure. Clusters that appeared similar were combined to form a higher order concept.

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Concept synthesis is a strategy for developing concepts by means of different forms of empirical evidence (Walker & Avant, 2005). There are three approaches to concept synthesis: qualitative, quantitative and literary (Walker & Avant, 2005). The qualitative and literary approaches to concept synthesis were found suitable for this study, since this study had generated concepts using a qualitative approach. Literature reviewed assisted in identifying similarities and differences.

4.8.2.3 Concept definition, validation, and verification with literature

The new concepts were then defined and validated during the FGD III with the community stakeholders (Appendix 13) and empirically by means of literature to establish whether or not the concept can be empirically supported. The identified

concepts were also defined by means of dictionary definitions and subject definitions, and their defining attributes were used to clarify the concepts in terms of their relevance to the study (Walker & Avant, 2005). The concept was then described in a theoretical definition using the theoretical underpinnings of the study, and finally the researcher determined whether or not the new concept fitted into existing theory (Walker & Avant, 2005).

4.8.2.4 Classification and verification of main and related concepts

In this study the researcher employed statement synthesis to specify relationships between two or more concepts. The purpose of statement synthesis was to develop from the phenomena one or more statements that exist between the concepts (Walker & Avant, 2005). From there, guidelines were drafted for the model development. In generating guidelines for the model development, the researcher made use of the six vantage points of surveying activity as listed by Dickoff, James, and Wiedenbach (1968), and also used it to develop the questions that guided the FGDs with the community stakeholders.

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- Agents: Who or what performs the activity?
- Recipients: Who or what is the recipient of the activity?
- Framework: In what context is the activity performed?
- Terminus: What is the end point of the activity?
- Procedure: What is the guiding procedure, technique, or protocol of the activity?
- Dynamics What is the energy source for the activity?

The steps above are used as a checklist when describing a particular situation or problem, and to provide direction for the activities or strategies required to address the problem. The survey list is used to identify the agent who carries out the strategies, who

the recipients of the strategies are, and in what context the strategies will be carried out. The responses from the community stakeholders during an FGD V (Appendix 13) validated this. The survey list assisted the researcher to identify what dynamics are required for activities to take place as well as the procedures that are required to guide them. The terminus or the end point of the activity was to ensure that community engagement measures are in place to prevent maternal health complications by promoting utilisation of SBAs during pregnancy, delivery, and post-partum in rural communities of Cross River State of Nigeria.

4.8.2.5 Model description

Theory is a "creative and rigorous structuring of ideas that projects a tentative, purposeful and systematic view of phenomena" (Chinn & Kramer, 2004:91). Thus the following questions were used as guides in the description of the community engagement model that was developed for the prevention of maternal health complications in the rural communities of Cross River State, Nigeria:

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1. *What is the purpose of this model (Chinn & Kramer, 2004)?*

This question is important since it specifies the context and situations to which the theory applies. The question can then be asked: Why was this model formulated?

2. *What are the concepts of this model (Chinn & Kramer, 2004)?*

This question identifies the ideas that are structured within the model. Concepts must be examined for quantity, character, emerging relationships, and structure (Chinn & Kramer, 2004). This is important because their quantity and character form an understanding about the purpose of the model (Chinn & Kramer, 2004).

3. *How are the concepts defined (Chinn & Kramer, 2004)?*

This question clarifies the meaning of the concepts within the model (Chinn & Kramer, 2004). Concepts may be defined explicitly or implicitly, and thus it is important to ascertain whether the definitions are consistent with implicit or explicit definitions. Can general language meanings be accepted as the intended meanings? Are the definitions general or specific?

4. *What is the nature of the relationships (Chinn & Kramer, 2004)?*

This question addresses how concepts are linked together. The theoretical purpose and the assumptions are ascertained from cues in the way that the relationships emerge (Chinn & Kramer, 2004).

5. *What is the structure of the model (Chinn & Kramer, 2004)?*

The structure of the theory gives overall form to the conceptual relationships within it.

6. On what assumptions does the model build (Chinn & Kramer, 2004)?

This addresses the basic truths taken to underlie theoretical reasoning. To uncover the assumptions, the question that needs to be asked is: What is the researcher taking as an accepted truth? (Chinn & Kramer, 2004).

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4.8.2.6 Guidelines to operationalise the model

Deliberative application and validation involves using “empiric knowledge to guide practice and practice-oriented approaches that contribute to empiric knowledge development” (Chinn & Kramer, 2004:145). There were three sub-components in the deliberate application of the model that was used in this study, they included:

- Selecting the clinical setting: The setting for deliberative application for this model is the rural communities. It is also applicable in the teaching and learning situations of nurses and other healthcare providers.

- Determining outcome variables for practice: The outcome variables for this study ensured that a model of community engagement for prevention of maternal health complications in rural communities of Cross River State, Nigeria, will promote the utilisation of SBAs by the community's women during pregnancy, delivery, and post-partum.
- The model that was developed was not implemented or tested in this study since this was beyond the scope of this study. Guidelines were developed to operationalise the model.

4.9 QUALITATIVE DATA ANALYSIS

Data analysis involved data reduction, organisation and subsequent interpretation using themes (Burns & Grove 2003:479).The researcher translated and transcribed the tape-recorded interviews, then read and re-read the interviews in their entirety, reflecting on the interviews as a whole. Then, she summarised the interviews; keeping in mind that more than one theme might exist in a set of interviews. Once identified, the themes that appeared to be significant and concepts linking, were written down and entered on computer (Morse & Field, 1996).

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4.9.1 Description

The descriptive stage is more critical in qualitative studies. It is the initial phase whereby the researcher becomes familiar with the data (Burns & Grove, 2003). "In this study the researcher replayed the tape after the interview to listen to voice, tone, pauses and responses as well as to the entire content" (Burns & Grove, 2003:380). The information on the tape was translated and transcribed word for word including pauses, exclamations, laughter or crying (Burns & Grove, 2003).

After transcribing the researcher replayed the tape to correlate the information for accuracy (Streubert, Speziale & Carpenter, 2003). To uncover the meaning of the experiences, the researcher read the interview transcripts several times. The researcher explored personal feelings and experiences that might influence the study and integrated this understanding into the study – this is called reflective thought" (Burns & Groove, 2003:382).

Codes and coding were used as a way of indexing or identifying categories of data. The purpose of coding is to facilitate the retrieval of data segment by coding category. A category system was invented and applied to the data gathered. Several categories or codes could be identified within the data recorded for any given participant (Brink, 1999:192). The categories with the greatest priority to the study participants were identified and later compared with those of other participants so as to determine the final theme.

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Analysis goes beyond description because data is transformed and extended (Burns & Grove, 2003). In this process there is identification of essential features and description of interrelations among them. The researcher identified themes and patterns from the data. Coding was also used to expand, transform and re-conceptualise data, providing opportunities for more diverse analyses. Memos were also used to record insights or ideas related to notes, transcripts or codes. The researcher recorded any ideas that emerged, even if they were vague or not well thought out. Memos were given titles and dates (Tesch, 1990).

4.9.2 Interpretation

Interpretation focused on the usefulness of the findings for clinical practice or moved toward theorising. The researcher identified any relations between categories that could

be used to formulate tentative propositions. These tentative propositions were recorded and sorted into categories (Burns & Grove, 2003).

4.9.3 The data analysis process

The researcher used Tesch's proposed eight steps in data analysis:

(1) The researcher carefully read through all the transcriptions, making notes of ideas that came to mind (Tesch, 1990; de Vos, 2002; Bruce, 2010).

(2) The researcher selected one interview and read it to try to get meaning in the information, writing down thoughts coming to mind (Tesch, 1990; de Vos, 2002; Bruce, 2010).

(3) After going through the transcripts, the researcher arranged the similar topics in groups by forming columns labelled major topics; unique topics; and leftovers (Tesch, 1990; de Vos, 2002; Bruce, 2010).

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(4) The researcher then abbreviated the topics as codes and wrote the codes next to the appropriate segment of the text. The researcher then observed the organisation of data to check if new categories or codes emerged (Tesch, 1990; de Vos, 2002; Bruce, 2010).

(5) The researcher found the most descriptive wording for the topics and converted them into categories (de Vos, 20021; Bruce, 2010).The aim was to reduce the total list of categories by grouping topics together that relate to each other. Lines drawn between the categories indicated interrelationship of categories (Tesch, 1990; de Vos, 2002; Bruce, 2010).

(6) A final decision was then made on the abbreviation of each category and the codes were arranged logically (Tesch, 1990; de Vos, 2002; Bruce, 2010).

(7) The data material belonging to each category was put together in one place and preliminary analysis performed (Tesch, 1990; de Vos, 2002; Bruce, 2010).

(8) Recoding of the data was done (Tesch, 1990; de Vos, 2002; Bruce, 2010).

4.10 VALIDITY AND RELIABILITY OF QUALITATIVE RESEARCH

The model for trustworthiness in qualitative data, which must be maintained, is that identified by Guba (1981) in Lincoln and Guba (1985). The model describes the following criterion credibility, dependability, confirmability, transferability, and authenticity.

***Credibility**:*Polit and Beck (2012:584 -585), Lincoln and Guba (1985), viewed credibility as the overriding goal of qualitative research. Credibility refers to confidence in the truth of the data (Polit & Beck 2012). The study needs to be believable and steps need to be taken to demonstrate this. The following strategies were used to ensure the credibility of the study:

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Observational notes were taken during interviews to strengthen data; Description of the interview process and techniques used during the interview and FGDs i.e. (probing) as well as member-checking; and training of participants on Photovoice processes. This means that when transcribed, the data were given to the participants to validate the findings, and the validation of the data were independent through an external coder.

Dependability: Brink,Van der Walt, & Van Rensburg, (2012) states that the term dependability refers to the stability of the data over time. The researcher keeping accurate records of all steps followed in the conduct ensured dependability in this study and this was done in a manner whereby it was possible to retrace all the research steps.

Confirmability: Confirmability refers to "objectivity or neutrality of the data obtained" (Polit & Beck, 2012:723). Confirmability ensures that the data reflects the participants' voice and not the biases of the researcher (Brink, et al., 2012). Confirmability, was ensured by audiotape recordings of the interviews and Photovoice as well as researcher's own notes based on the interviews and Photovoice. This enabled the researcher and an external coder to confirm each interview and the themes elicited from the interviews.

Transferability: Transferability refers to "the ability to apply the findings in other contexts or to other participants' (Brink,et al., 2012:173). It is the responsibility of the researcher to provide sufficient descriptive data in the research report to enable others to evaluate the applicability of the findings to other contexts (Lincoln & Guba, 1985). Transferability, in this study, was enhanced by giving a dense description of the research topic. Purposive sampling increased transferability since the sample criteria are specified and information rich participants are chosen. The presence of similar responses by participants increased transferability.

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Authenticity: According to Polit and Beck (2012:720), authenticity refers to "the extent to which researchers fairly and faithfully show a range of different realities in collection, analysis and interpretation of data". Authenticity was ensured by using quotes from the participants' interview to describe their experiences in the final report. This enabled the reader understand the real experience of the phenomenon as it lived. The researcher sometimes used the participants' own wording to describe a particular phenomenon.

4.11 ETHICAL CONSIDERATIONS

The following clearances, permissions, consents, and approvals were obtained before the commencement of the study:

- ethical clearance from the Senate High Degrees and Senate Resesarch Committee of the University of the Western Cape, South Africa;
- ethical approval from the, Ministry of Health, Cross River State, Nigeria;
- approval from the Chairman, Akpabuyo LGA of Cross River State, Nigeria;
- permission from the community gate-keepers, community heads, and the women leaders; and
- informed consent was obtained from the participants for all phases of the study.

4.11.1 Ethical principles

All the participants at the different phases of the study were assured of anonymity, their right to withdraw at any time during the study without any punishment or prejudice, and confidentiality of the information obtained since all data will be kept in a safe place under lock and key for five years after the result is published and the software data is secured by a personalised password.

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Right to self-determination: The ethical principle of respect for persons was adhered by ensuring that the research participants had the right to self-determination. The researcher respected the rights of the individual to decide whether or not to participate in the study, without any risk of penalty or prejudicial treatment (Brink et al., 2012).

Right to privacy: Privacy means that the participant determines the environment and circumstances under which personal information is shared (Brink et al., 2012). This study was conducted in private homes. No data was collected from participants without their consent throughout this study.

Right to autonomy and confidentiality: The participant had the right to expect that data they provided be kept in the strictest confidence. For the purpose of this study it was impossible to maintain anonymity between the researcher and the participants, thus confidentiality procedures was implemented (Polit & Beck, 2012). During the study the researcher did not share any information gathered from the interviews and Photovoice without the authorisation of the participants. The interview and FGDs notes were kept in a password-secured computer and a locked cupboard. Identifying information was restricted to the researcher and supervisor. The data will be destroyed five years after publication. When reporting, the researcher provided only general descriptions and slightly distorted identifying information. This was done in order to safeguard identities (Polit & Beck, 2012).

Right to fair treatment: The right to fair treatment is based on the ethical principal of justice, and it maintains that each person should be treated fairly and receives what is duly owed to them (Brink et al., 2012). Participants in this study were accorded fair selection and treatment (Polit & Beck, 2012:155).

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Right to protection from discomfort and harm: In research with humans, harm and discomfort can come in many forms, and it is therefore vital that the researcher protects the participants from unnecessary risks of harm or discomfort (Polit, 2012:153). The researcher paid close attention and was particularly sensitive when interviewing individuals and engaging them in FGDs. The researched planned for any potential harm by trying to anticipate potential problems associated with the process. This was also taken into consideration during the Photovoice processes.

Obtaining informed consent: Informed consent means that the participants have adequate information about the research and therefore have the ability to consent or

decline participation (Polit & Beck, 2012). In accordance with the International Conference of Harmonization, the research study proposal was reviewed by the Ethics Committee of the University of the Western Cape and only upon receipt of their approval was any study-related activities performed. Ethical approval was obtained from Cross River State Ministry of Health, Nigeria as well as permission from the chairman of the Akpabuyo LGA. Permission was also obtained from the clan heads of the study communities and the participants. Written informed consent was obtained from participant, a spoken explanation was provided, and the researcher answered any questions put forth by participants.

4.11.2 Photovoice and ethics

Wang and Redwood-Jones (2001) highlight a set of ethical considerations specific to researchers employing Photovoice methods and these were strictly adhered to throughout the Photovoice process: (1) individuals have a right to privacy in both private and public spaces; (2) participants need to understand and identify contexts in which consent is needed; (3) the safety of participants must be considered as photographs produced can cause embarrassment. In addition, a) participants will give consent for participating in the study; b) participation will be free and voluntary; c) participants will be informed of the nature and intention of the study in their language of choice; d) the participants will be informed of their right to withdraw from the process at any stage of the project; and e) participants will be assured of confidentiality and anonymity regarding any information provided (Wang & Redwood-Jones, 2001).

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The Photovoice participants were trained on Photovoice processes, ethics, camera use, and the kind of photos to take. Consent was duly obtained. The research study proposal was reviewed by the Ethics Committee of the University of the Western Cape and only on approval did the study-related activities began. Permission for the study was

obtained from the Cross River State Ministry of Health Ethical Committee and the Akpabuyo LGA's chairman.

Informed consent was obtained from study participants for all the phases of the study.

Focus Group participants, model experts, research assistants, and secretarial staff also signed confidentiality-binding forms.

During each phase all the study participants were assured of anonymity, their right to withdraw at any time during the study without any punishment or prejudice, assurance that the information would be handled in a confidential manner, and assurance that data would kept in a safe place under lock and key for five years after the result is published and that software data would be secured with a personalised password.

Additionally, Photovoice participants were advised of the ethical considerations specific to visual methods, which include:

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- an individuals right to privacy in both private and public spaces;
- the need to understand and identify contexts in which consent is required before photo-taking;
- participants' confidentiality, since photos may cause embarrassment among those photographed and result in retaliation towards the participants;
- there may be the need for researchers to intentionally or unintentionally direct the kind of images produced;
- participants should own the prints and negatives they produce to prevent commercial exploitation and appropriation;
- photos taken should be developed by the researcher and should not be shared with anyone but the researcher; and

- digital copies of the images will remain on the researcher's password-protected computer until data analysis is completed, where after it should be destroyed.

There may be the need to include visual data into research reports. Anticipating this, an exception was built into the consent process requesting the use of certain photos that may reflect member-checked themes. Photos requested should meet the following criteria:

- images should be devoid of people;
- images should be focused on events or objects that may include people who could be easily anonymised without altering to the photographic meaning; and
- any illegal photographs that participants documented should not be reproduced. (Wang and Redwood-Jones, 2001)

4.12 SUMMARY OF THE CHAPTER

In Chapter Four, the research methodology was discussed step-by-step, with reference to the overall qualitative approach and the three phases leading to the development of a community engagement model for the prevention of maternal health complications in rural communities of Cross River State, Nigeria. Steps to ensure rigour and ethical considerations were discussed. The data analysis, results, and the initial interpretation of the data will be discussed in the next chapter.

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CHAPTER FIVE: FINDINGS OF PHASE 1: UNDERSTANDING THE SITUATION

5.1 INTRODUCTION

This chapter reflects the findings from the analysis of phase 1. The purpose of the phase was to explore and validate the knowledge gaps and understanding of the obstetric danger signs in women of child-bearing age (pregnant and new mothers). This phase represents the initial engagement with the study group participants (pregnant women and new mothers) and was conducted in two studies, the qualitatitive interviews (PAR cycle observation) and focus group discussions (PAR cycle REFLECTION). Initial interpretation and discussion of the data are conducted in organised logical steps that permits the drawing of themes to address the objective of this phase. A theme represents a level of patterned response or meaning from the data that is related to the research questions at hand (Braun & Clarke, 2006) and eventually provides an accurate understanding of the "big picture".

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5.2 PARTICIPANT DESCRIPTION

There were 10 participants from each of the two communities (Communities A & B), 20 in total. These participants were part of all the phases (Table 5).

TABLE 5: Participants demographics

Demographics	Idundu (Community A) (n=10)	Anyanghanse (Community B) (n=10)
State: Pregnant	6	2
New mothers	4	8
Age: 15-24 years	5	3
25-34 years	3	7
35-45 years	2	0
Marrital Status: Single	2	2
Married	8	7
Widow	0	1
Occupation: House Wives	3	2
Farmers	2	3
Traders/Business	3	5
Workers	2	0
Total	10	10

5.3 STUDY 1: QUALITATIVE INTERVIEWS TO EXPLORE AND VALIDATE THE KNOWLEDGE GAPS AND UNDERSTANDING OF THE OBSTETRIC DANGER SIGNS

Study 1 addresses three objectives, namely to explore and validate the birth preparedness, complication readiness and delivery practices of women of child-bearing ages; the roles and action of family/community members and community-based maternal health initiatives in emergencies; and the perceptions of the participants on the actions that could be taken to encourage the rural women to utilize healthcare facilities for skilled care for the prevention of maternal health complications.

5.3.1 Central story from study 1

The central story line from the interviews were that the participants had a low level of knowledge on maternal health issues, a high patronage and usage of TBAs with low knowledge of benefits of health services. These patterns were strongly underscored by the cultural patriarchal society with a strong influence and control on maternal health issues by the husbands, strong matriarchal support of pregnancy and its ramifications but a lack of community based structures to support women in pregnancy and child birth.

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5.3.2 Objective 1: Knowledge gaps and understanding of the obstetric danger signs

Objective 1 was assessed by posing three key interview questions, namely:

- What are the signs/symptoms that are considered to be dangerous during pregnancy, delivery, and after delivery?
- What is the importance of being attended to by skilled healthcare providers during pregnancy, labour, and after delivery?
- What are the dangers of home delivery?

The following themes emerged based on the analysis of the data generated and transcriptions from the in-depth interviews: Participants had limited knowledge of obstetric danger signs; only moderate knowledge on benefits of hospital care; a high recognition on the importance of immunisation; and only moderate knowledge of the dangers of home deliveries (Table 6).

TABLE 6: Themes and sub-themes emerging from study objective 1

Themes	Sub-themes
1. Limited knowledge of obstetric danger signs	• Knowledge of only a few danger signs • Knowledge is centered around waiting at home for abnormal signs • Knowledge is the role of the care giver
2. Moderate knowledge of of benefits of skilled care in hospitals/health Centres	• Some knowledge on the benefits of skilled health care • Knowledge is influenced by previous experiences • Role of hospital in providing and health education • Recognition of importance of role of hospital to provide immunisation
3.Moderate knowledge of dangers of home delivery	• Some awareness of TBA lack of knowledge and skills for emergency interventions; • Lack of receiving immunisation for baby when attending a TBA • The possibly unsanitary environment of home delivery

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5.3.2.1 Theme 1: Limited knowledge of obstetric danger signs

Three sub-themes emerged from this theme, namely limited knowledge of obstetric dangers with knowledge of only a few danger signs; knowledge is centred around waiting at home for abnormal signs and this not seen as their role to have knowledge of obstetric dangers.

Limited knowledge of obstetric danger signs: Contributions from the respondents indicated that women in rural communities have limited knowledge of obstetric danger signs and symptoms during pregnancy, delivery, or after delivery. Some of the women

interviewed affirmed not knowing and being unable to mention any of the key danger signs.

"I don't know!"

"I have no idea".

About 12 out of the 20 respondents could mention only one or two correct signs and symptoms related to obstetric dangers. Among the key signs mentioned was bleeding, swollen legs (oedema), high fever, severe vomiting, paleness (anaemia), weakness, severe lower abdominal pain, liquid drainage, prolonged labour, and retained placenta though the words used to describe these dangers were often tacit and simplistic.

> *"if she is not well sometimes water starts entering her, also she has to go to hospital or sometimes since she started pregnancy she has been sickly.".*

> *"[The] problem was that since when that pregnancy started I was really sick, I was sick, real sick. Whatever I put in my mouth, I will vomit, It did me somehow, somehow in my body, was really sick".*

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> *"[W]hen it is time for me to born the baby, water used to come out first before, but in this particular child, it was blood that came out first, blood came out plenty that I said God what could cause this? I went and told somebody who advised me to come to the hospital, I was told that it was labour. So that particular sign made me to know that… that is not the normal kind of labour... Blood to come out because I have never seen before".*

> *"I think those kind of signs that someone can see that can be bad signs during pregnancy… sometimes, one can notice bleeding … I think that is a bad sign or water coming out of a pregnant woman's body, she has to rush to see a doctor".*

> *"Those signs that can occur that can take a woman's life are excessive profuse bleeding can occur, labour could start without the baby moving in the belly, labour can last up to one week. Those kinds of things can take one's life".*

> *"One of the dangerous signs during pregnancy that can cause danger is bleeding from the body and if the bleeding should continue without doctor or whatever …it's miscarriage, then the second one is fever, as in when the person is having fever …fever comes up very strongly or she has lower abdominal pain or*

waist pain like that so there are bad signs. Then swelling of the face and legs also contribute".

"[W]hat I know myself is that if a woman is pregnant and she looks pale and her lips looks pale it shows that there is no blood and is something that she should go to the hospital".

Knowledge is centred around waiting at home for abnormal signs: During the interviews it emerged strongly that the knowledge is centred round waiting at home until there is an abnormal or painful irritation at which time they then visit caregiver.

"This one is not my first pregnancy the first one, it was in fact I suffered and before I put to birth they do operation. So I suffered then when I was in labour, it took me one week... I suffer, I cry! Then later on they took [referred] me to hospital. They said I should do operation".

Knowledge is the role of the caregivers: One participants also felt that it was not her duty to know the danger signs since she was not a caregiver and that they would normally submit themselves to the professional examination of the caregivers.

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"I cannot know, I cannot know since I am not a TBA."

Discussion

Before a woman decides to seek care, it is important that she must be able to recognise the signs and symptoms that indicate the need for care, however our study found limited knowledge of danger signs. This has been confirmed in other studies with similar populations as highlighted by Pembe, et al., (2009) and Hasan and Nisar's (2002) whose studies in low-income countries show that knowledge of obstetric danger signs among rural women in Nigeria was deficient. Kabakyenga, Ostergren, Turyakira & Peterson (2012) observed that the delay by women with obstetric complications in reaching and accessing care (Phase 1: delay in seeking care) is the main cause of maternal mortality. Women's autonomy and health knowledge regarding risk factors have been significantly associated with this "Phase 1 delay" (Kabakyenga et al, 2012).

Reasons for this low knowledge may be lack of educational opportunity leading to poor understanding of health-related issues. An explanation is also provided by Tod (2001) and Lavender (2007) who found in their study that low levels of knowledge and awareness about risk factors, causes, and treatment for given conditions were observed among those failing to take up services. Lavender (2007) believed that personal factors are associated with both personal denial of having a condition in the face of symptoms and often trying to manage the symptoms rather than accessing health services. New (2006), added that problems of communities to obtain information in their language could also limits knowledge about particular conditions and the services that are available to them thus contributing to this low knowledge.

An important reason identified with low knowledge of maternal health problems relate to the community's perceptions of the problems. Several studies in Nigeria have highlighted that community members' perception and knowledge of maternal health problems and how this play an integral role in their care-seeking behaviour. Osubor, Falusi, & Chiwuzie's (2005) found that local beliefs, such as those that view pregnancy-related problems as being associated with witchcraft and other supernatural causes, deter women in seeking skilled maternal care in hospital/clinics. In addition, warning signs in pregnancy, such as bleeding episodes and swollen feet, were seen by some women as being normal in pregnancy and these opinions and folklore were likely to result in delays in seeking medical attention timeously (Osubor et al., 2005). Furthermore, when family and community members consider spiritual factors as being responsible for a particular problem, they often consider that orthodox medical practitioners won't be able to manage such problems (Osubor et al., 2005). Falusi (2004) supported by noting that in most Nigerian communities, women that present

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with such problems are taken to traditional healers and Traditional Birth Attendants rather than orthodox health facilities.

Limited knowledge of obstetric signs is a health risk which needs to be addressed, especially in low income countries where the risks associated with pregnancy is higher. Engaging the community in improving health literacy is one strategy which has been suggested. Stevens (2000) stated that women, their partners, and their communities need to be educated on obstetric danger signs so that they can seek appropriate care from skilled providers timeously (Stevens, 2000). Similarly, Doctor et al. (2012) asserts that some of the antenatal counselling information regarding birth preparation and recognising and knowing how to respond to danger signs could be integrated into the local social networks and groups, such as village women's committees. Nutbeam (2000) also emphasised the importance of health literacy for community women in the development of context-specific health knowledge and the self-efficacy necessary to put that knowledge into practice in ways that enable people to have greater control over their health and health-related decisions. A Health Foundation community engagement initiative in rural Malawi, found that although studies have suggested that women as individuals did not have a comprehensive awareness of the problems that affect them, this capacity was accessed and channelled through women meeting and collectively discussing these issues (Rosato, Laverack, Grabman, Tripathy, Nair & Mwansambo, 2008). The authors felt that the women's own perceptions of their problems could form a vital resource for communities and policy-makers and that this process could enable women to clearly identify their maternal health problems, recognise their importance, and generate the motivation to address them (Rosate et al, 2008).

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5.3.3.2 Theme 2: Moderate knowledge of benefits of skilled care in hospitals/ health centres

Four sub-themes emerged from this theme, namely, some knowledge about the benefits of skilled health care; the role of hospitals to provide health education; knowledge being influenced by previous experience and the recognition of the importance of hospitals in providing immunisation.

Some knowledge about the benefits of skilled health care: Some of the participants could not state any benefits because they had never accessed antenatal or postnatal care provided by orthodox health facilities. Contributions from other participants indicated that most women in the rural communities are knowledgeable about the basic advantages and benefits that accrue to mother and child in the hands of a skilled healthcare provider at a certified health facility.

> *"I know, because it helps the woman on the day of delivery. The woman will not have problems, and the baby also will not have problems. You will have your baby free and peacefully, no bad sickness will enter your baby's body".*

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Some key benefits mentioned by the participants include: Not picking up infections; laboratory tests; availability of drugs and emergency equipment to conduct Caesarean section operations or prevent the likelihood of bleeding. However, according to them, these benefits are only provided at the general hospital level and not at the Primary Health Care (PHC) level as at PHC level, referrals are always made.

> *"I know ... those benefits that goes with attending hospital are that when you go to the hospital, nurses, doctor will know and test the body to know what the problem is and also gives you drugs that respond to that problem".*

> *"Importance is that in the hospital here ... there are many things that nurses, they can do for you that the other person cannot do because when you go to native doctor, the only thing I used to*

see, they will cook something inside the pot, maybe when you want to put to bed you bleed … the blood will come out before the baby, you can die but in hospital maybe when you. They know that you are weak, they can use drip, and that drip will give you the strength that the baby will come outside".

"The benefit that is in the hospital is that when you deliver your baby, that first day you deliver, they will come and give injection because there are some our women that deliver, and they don't remove Odon [Tetanus] from their body so when they see that you have your baby, they bring themselves in, they carry their hands and touch that baby so that things will harm the baby bringing death to that baby".

"Benefits that accompany women who deliver in the hospital is that hospitals looks after them in terms of injecting them and giving drugs and in looking after the women and the babies they deliver. They look after them in the hospital [rather] than in the house".

However, it was also noted that though some of the participants have accessed either antenatal or postnatal care and hence have good knowledge of some essential services obtainable, they also affirmed that they have never nor will (their current pregnancy) deliver at a hospital.

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"In my own opinion in that [re]spect, is that because of how the world is like this now [changes mood, becomes sombre] *some people decides to go to TBA to deliver their babies, but I usually encourage people to go to hospital ... so that they can check their body and I also encourage those who wish to deliver in hospital to go, but for me ... I wont tell lies here ... I have never deliver[ed] in hospital and will never ... [I] prefer to deliver with TBA*".

Knowledge is influenced by previous experience: It was observed that contributions from the women were strongly associated with their experiences at government health facilities at one time or the other.

"The benefits that accompanies somebody that goes to the hospital to deliver are that you can go to that hospital to deliver… For example like this my own when I went to the clinic, I was brought to the clinic, when labour became too difficult, they transferred me that I should go to general hospital…

Labour still was very difficult; they then sent me to teaching hospital. So there, they put me drip so that it can give me power so that I can push out the baby when it's time for me to born my baby".

"Because Hospital is good, if you have your baby. There are some TBA's places that collect from you more than ten thousand but if hospital, if you register in the hospital, they will not collect from you as much as a TBA would, they make it easier for you because it is under the government ... the problem is that, some things the TBA does not know, but if they bring you to the hospital, the hospital will help".

Role of hospital in providing health education: The provision of health education and knowledge was acknowledged by some respondents as some of the benefits of attending hospital.

"I know because those things ... you will have knowledge about those things you never knew about. Like me… the children I used to born, after delivery, people ... they will teach me how I am to stay, while in the TBA house ... those friends that deliver their babies with the TBA, they don't used to tell them any knowledge they gain from there, but if it is in hospital, like health centre, Anyanganse I used to attend, they used to teach us knowledge, upon knowledge on how a woman should stay or how to take care of her baby".

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Recognition of the importance of the role of the hospital to provide immunisation: Participants voiced a high recognition of the importance of immunisation. From the responses, it became obvious that rural women give high preference to immunisation and the health of their babies. The study revealed high patronage of immunisation services, even by those who do not utilise antenatal and delivery services. This may partly be due to the fact that immunisation services are given wide publicity in the communities and even by the TBAs, and it is almost mandatory for those who are due for it. Some responses were captured verbatim as thus:

"When she is pregnant and goes to the hospital, it will be good because they will [inject her immunisation and give her small drugs that she will use and take. From there when she use ... the drugs will be good to her and she will then see benefit, she will see some improvement in her body".

> *“One good thing I know when you keep going to the hospital, they will give you immunisation and will not allow you to be sick and will also, when your baby is born, it will be healthy”.*
>
> *"Aunty, she will surely have problems because she was not going to inject immunisations and was not going to receive other treatments to meet up, problems can reach her anytime".*
>
> *"Why I decided to deliver in the hospital is because I used to receive immunisation in the hospital until the day I was to deliver, saying that when that day reaches I will deliver freely without anything happening".*

Discussion

Our study found moderate experiential knowledge of the benefits of skilled care in hospitals. This is supported by the findings from Okafor, Sekoni, Ezeiru, Ugboaja, and Inem (2014) in a qualitative study on orthodox versus unorthodox care which found that when rural women seek care during pregnancy and childbirth in Nigeria, they experience the conduction of regular check-ups and investigations (BP, weight checks, ultrasound scans, and urine and blood tests), better management of postdate pregnancy and prolonged labour, and immunisation of the newborn, all of which are their reasons for choosing orthodox care.

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However, there is ongoing concern about the low uptake of orthodox health care and the need to improve this, especially around the recognition of obstetric danger signs. Sibley et al., (2004) showed that several studies confirmed there has been no improvement in Maternal Mortality Rates (MMRs) where TBAs are the main provider of care to the pregnant woman. De Bernis et al. (2003) also found an association between the lower association of maternal mortality and births attended to by skilled health personnel. Starrs (2006); Starrs, (2007); and De Bernis et al. (2003) concluded that skilled birth attendance is one of the strategies aimed at reducing maternal and newborn mortality and the proportion of birth conducted by Skilled Birth Attendants

(SBA) is a key indicator for MDG 5 of improving maternal health and its target of reducing maternal mortality.

5.3.2.3 Theme 3: Moderate knowledge on dangers of delivering at home

Three sub-themes emerged from this theme, namely, some awareness of TBA lack of knowledge and skills for emergency interventions; lack of receiving immunisation for baby when attending a TBA and the possibly unsanitary environment of home delivery.

Some awareness of TBA's lack of knowledge and skills for emergency interventions: Only one respondent (who was just delivered of a baby by a TBA) confirmed not having any knowledge on the likely dangers associated to home deliver or TBA-assisted home delivery. According to her:

> "*I have no idea*".

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Contributions from most of the participants indicated that they were aware of the likely complications and implications for carrying out deliveries at home or at a TBA home. The participants highlighted lack of knowledge and skills in emergency situations was also highlighted. Unavailability of emergency equipment for use by the TBA in the event of emergencies such as retained placenta and bleeding was noted.

> *"...also the mother too they don't give that mother treatment too. Bleeding used to happen to a woman too who delivers at home, without help ... from there she may die".*

> *"Problem ... problems that can befall them when ...they go to TBA is No.1 ... they can deliver without the placenta coming out . No.2 ... they can labour with suffering for long without delivering. Then when you go to the hospital, ... the nurses and the doctors will test you and know all the problems ... all those small problems since when you were pregnant from one month to seven months onwards, they will give you drugs ... because TBA only knows enema without knowing what the problem is inside one's body".*

"Those bad things that can happen to a woman who goes to the goes to receive treatment …and not go to the hospital, she then goes to TBA to deliver her baby, then the placenta refuse[s] to come out or it remains and this TBA does not know the type of leaves ... to give to this woman for the placenta to come out. It is there that the mother used to die and the baby lives or mother dies".

A participant highlighted why access to maternal care by a TBA rather than a professional birth attendant poses a danger. She claimed that a TBA helps the pregnant woman to have an easy delivery because TBAs uses local herbs and palpations to ease labour pains, unlike the orthodox hospitals who rather inject and conduct a CS on the mother; this according to her, scares many pregnant women away from hospitals.

"the problems that could follow such a woman… because there are many things are there that a TBA can [do] ... there are leaves, if labour is difficult that they can take and give you ...you chew ... so that you deliver fast because some ... of these our women are afraid that when they go to the hospital and labour is too difficult they will take them to theatre and operate them, there are problems, and problems that women fear about operation, fear small knife".

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Lack of baby receiving immunisation when attending TBA: The main reason offered to justify the limitations of the TBA was that the baby is not likely to receive antibiotics (in their own words "immunisation") immediately after birth.

"She will surely have problems because she was not going to inject immunisations and was not going to receive other treatments to meet up, problems can reach her anytime".

"The problem that can happen to them is that as they are delivering that baby at their home ... delivering at home without giving that baby immunisation that first day, that the baby is born".

"Those bad signs that can happen to women who deliver at home are that you can deliver that baby at home ... because you did not attend anti-natal in the hospital, they don't give you injection".

Possible unsanitary environment of home delivery: Another sub-theme that emerged was the untidy and uncomfortable delivery room for mother and child.

> *"The place she sleeps to delivers is not good, sometimes the treatment given to her at home is not good with that baby, maybe that baby can have problem".*
>
> *"Some problems used to affect them, also Nwanga [yawning] can happen to them. Secondly, also that can ... bad person can come in ... somebody who had delivered a baby and suffers from [akpa] comes in and touch the baby, and the baby dies, that is not good".*

Discussion

Our study found moderate knowledge by the mothers on the dangers of home delivery, though there are some preference for the attendance to TBAs.

While it is recognised that TBAs can and do provide emotional and social support to the mother and can provide key health education messages, women rely on TBAs where there are no Skilled Birth Attendants available or where they cannot afford the cost of professional services (Ogunjobi, 2015). However, according to several studies, TBAs are not an acceptable substitute for Skilled Birth Attendants (SBAs) at birth (WHO, 2007). Imogie (2000), Ofili and Okojie, (2005), and Titaley, Hunter, Dibley, and Heywood (2010) all describe a typical TBA as an illiterate person who may lack the potential to recognise birth complications. TBA-provided maternal health services on their own are believed not to be safe and it has not contributed to a decrease in maternal mortality (Ofili & Okojie, 2005). Several studies as observed by Sibley et al. (2004) point to the fact that there has been no improvement in Maternal Mortality Rates where TBAs are the main provider of care to pregnant women. This may be due to some practices of TBAs as shown by the findings from a study on the assessment of the role of TBAs in maternal healthcare in Nigeria, which revealed that the infection control

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methods employed by the TBAs was found to be poor (Ofili and Okojie, 2005). According to Imogie, Agwubike, Aluko (2002), Traditional Birth Attendants (TBAs) are very much in short supply of modern facilities and most times are forced to use whatever is available which are often substandard. Ebuhi & Akintujoye (2012), in her study revealed that respondents acknowledged that complications could arise from TBA care. Likewise, findings from studies by Oshonwoh, Nwankwo & Ekiyor, (2014), revealed that majority of the provided services by TBAs are unhygienic as only very few of them use any form of personal protective devices or equivalents in the course of their duties.

In 1999, WHO explicitly stated “there is no reason to believe that TBA training can contribute to MMR reduction in isolation” (WHO, 1999). This was amply demonstrated in a study in Pakistan where TBA interventions led to a decrease in perinatal mortality but did not lead to a significant reduction in the Maternal Mortality Rate (Jokhio, 2005). Therefore, some studies, such as those of Sibley and Sipe (2006) and Pyone et al. (2014), suggested that in low resource settings, training and re-orientating TBAs to change their roles from recognition of “at risk” women and referrals for skilled obstetric intervention to that of companion and promoter of facility-based maternity care including delivery, can improve healthcare access for women, and can result in an increased number of women receiving skilled maternity care. Similarly, in a systematic review of strategies adopted to reduce the MMR, Campbell, Graham, & Lancet Maternal Survival Series Steering Group (2006), concluded that a comprehensive package of services is required with a continuum of care approach from Birth Preparedness, including Ante Natal Ccare, to delivery interventions, postpartum care with intra-partum care identified as the most critical phase when complications can

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occur and therefore should be managed by qualified health professionals (Skilled Birth Attendants).

5.3.3 Objective 2: To explore the perceptions on birth preparedness, complication readiness, and delivery practices of rural women

The second objective which was to explore the perceptions of the participants on birth preparedness, complication readiness and delivery practices was assessed through the following questions:

- Preference for delivery: Where do you have babies or intend to have them, and who attends? Provide experiences and reasons for your choice.
- What preparations do you make for emergencies, i.e. transport, money, blood donors, etc.
- What are your common cultural practices and preferences?

Using the questions addressing the second objective, the following themes emerged based on the analysis of the data generated and transcriptions from the in-depth interviews that were conducted: There was a high preference for TBAs; there was some understanding of skilled care and prompt interventions in hospitals; there was a poor understanding of what Birth Preparedness entails; and the strong influence of cultural practices and beliefs (Table 7).

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TABLE 7: Themes and sub-themes emerging from study objective 2

Themes	Sub-themes
4. High patronage of and preference for TBAs	• Negative perceptions and experiences of healthcare services. • Financial position of the family • Past positive TBA delivery experience and positive reception by TBAs • Friends and family members' experiences of TBAs

	• Husbands' or influential family members' overriding decisions as to where to give birth • High consideration of proximity to place of birth • Concept of giving birth through natural inducement • Combination of spirituality in TBA services
5. Understanding of skilled care and prompt interventions in hospitals	• Good care of mother and baby • Safety of their babies through cleanliness and immunisation • Positive experiences of hospitals • Education on birth preparedness • Provision of prompt emergency care
6. Poor understanding of Birth Preparedness and complication readiness	• Poor preparation for emergencies • Reliance on TBAs for delivery dates • Preparation for non-emergency baby provisions • Reliance on husbands for financial arrangements • Reliance on God for provision during pregnancy
7. Strong influence of cultural practices and beliefs relating to pregnancy	• Beliefs that certain food can affect the pregnancy • Beliefs that cerain practices can affect the pregnancy

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5.3.3.1 Theme 4: High patronage of and preference for traditional birth attendants

Most of the participants (16 out of 20) maintained that generally, the women in their communities' preferred place of delivery is at the TBA's homes and churches.

> *"they go to TBA"*
> *"this community prefer TBA's house more".*

These participants maintained that they have been and would continue to access child delivery services from a TBA. Some of the contributions from particpants include:

> *"I deliver in a TBA house... They are three, two boys, one girl".*
> *"In the house of a TBA"*
> *"I delivered in a TBA's Place"*
> *"No! this is not my first pregnancy. The other pregnancy, I delivered in a TBA's house. This is not the second but the third I delivered in a TBA's house and not in the hospital".*

"All my children, I deliver with a TBA not home. I don't have experience about delivery in the hospital".

Only four of the participants maintained that they have been accessing maternal care and child delivery at their different PHCs or the general hospital.

"In the hospital".
"Teaching hospital".
"In the hospital".
"I used to deliver in the hospital. All my children I deliver in Ediba health centre".
I delivered ...at the teaching hospital".

Regarding the preferred place of delivery for their current pregnancies, most of the pregnant women (six out of eight) affirmed that they would be having their babies in a TBA home.

"In the house of a TBA".
"This one? ...since I have never delivered .... in a hospital before, I will deliver in a TBA's place".

This affirms the strong values, attachment, and influence the TBAs command in the lives of many rural women and their spouses. Some of the participants did not openly state their preferred birthing place and were reluctant to state the actual place where they would give birth. This may be due to concerns that their responses might be considered disappointing or out of fear of being reprimanded (observed and recorded on the field notes during the interviews with evidence of gestures (fidgeting and restlessness).

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"Mummy, even if it happens in the hospital, I will deliver there because I have registered and all my things are intact in the hospital. If in case it happens in a TBA's place, I will also deliver there with TBA".

"Me I don't know ... oh! Because it can happen at night that I cannot reach the hospital Oh! ... hmm Um! sometimes it can happen in the farm, it can happen at home where there is no transport to take you to hospital , that is why where it will be to deliver, that is where I will deliver".

"I have no idea but my sisters like delivering in the hospital..."

"I will deliver in the TBA or in the Idundu health centre, why because the other hospital is far".

Only four out of the 20 respondents interviewed preferred the hospital.

"In the hospital! Where I come from, we believe in hospital, their place too, they believe in hospital, then because why….TBA only does things at home, she doesn't have what government has".

"There are benefit[s] ... if you deliver in the hospital, the baby will be given help, will be given injection, the baby will not be sickly, some sickness like measles will not do him and other kind of terrible sicknesses will not affect the baby. There are benefits".

The researcher established that even among those few community members who cited the hospital as their preferred place for birth were really not convinced of their assertion, and it is possible that they were trying to impress the interviewer so that their communities would not be seen in bad light (as observed in their non-verbal expressions during the interviews).

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"Some people go to hospital, some go to church and some to TBA... TBA's place is where people like going most I think it is due to lack of knowledge that makes them go to TBA".

"Most women… ehm! Some women likes going to deliver with a TBA some likes going to deliver in the hospital".

"Some they went to hospital, some they used to deliver in their home, some churches...".

The participants' high patronage and preference for TBAs is in accordance with Osubor et al.'s (2005) whose study in rural Nigerian communities on maternal health-seeking behaviour and associated factors revealed a pattern of poor maternal health seeking behaviour with a high preference for TBAs who may lack skills to respond to emergency obstetrical conditions.

In analysing the reasons for the high patronage and preference of TBAs, eight (8) sub-themes emerged, namely: negative perception and experiences of health care services,

financial position of family, past positive delivery experience and receptive treatment of TBAs, friends and family members' experiences, husband and influential family members overriding decisions, proximity of TBAs, giving birth through natural inducement, and the combination of spirituality and TBAs' services (Table 8).

Negative perceptions and experiences of health care services: One of the main reasons for attending TBAs in preference to health services was the negative assumptions held on health care services. These included: first place of birth is safe", healthcare facilities are expensive, health providers have negative attitudes, and the non-availability of 24-hour services.

A concerning issue that arose from the participants was the issue of negative perceptions and experiences at health services. These included reporting feeling abandoned, and the health facility's caregivers showing general apathy towards a pregnant woman in labour. This was especially felt once it has been established that she is a referred case from a TBA or that she is not registered with a PHC.

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> *"Aunty, pains ...They used to put, they put hands inside my body and checked if the baby ... was lying well... After[wards] the clinic people wrote a referral note that I should go to general hospital, so when I went, they said I did not register. First they asked me to lie on the bed ... they removed urine from my body… Then secondly, they said the baby does not reach to be born yet, they also said I should do exercise and I did exercise and I finished I went back and they again put hand and checked saying that the time does not reach at all for the body to be born. So… that they will not look after me that I should go to teaching hospital. Even bed was there, but they did not allow me to stay saying there is no space but there is bed. Then, secondly, they said that they were instructed not to attend to anybody brought here that did not register. All through that night I suffered, received pain with baby in the belle, I was not happy. Even with the baby's thing that I took there including my things that I carried there, so that they use in delivering me, they said it should be taken outside, so those things were removed. I was not happy. I went back, when I went back, I told the big woman in our clinic [Idundu clinic], what happened and she was not happy Eh eh! The [referral] I was given, it was not the matron that gave, but the nurse who were there gave me, saying ... that*

is how they use to give any one they refer... They saw it but refused to use it but this is the same letter I took to teaching hospital and they attended to me".

Financial position of family: Another major issue was the financial position of the family, the following comments from participants were noted:

> *"Aunty; [She paused and laughed] I don't have money, oh! it is because of money that I say wherever it happen, there I will deliver".*
>
> *"What I would like to share with others… that is … or if labour starts … or pain in the lower abdomen… Or … maybe that where she intended going to … hospital like that ... she walks there … or that money is going to be too much, then they can now tell her….Let's go to TBA's place because they don't collect much money as others collect".*

Past positive TBA delivery experiences and positive reception by TBAs: Past positive TBA experiences and the place where the participants delivered their babies first, also played a role in the decision.

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> *"the reason is since from the first pregnancy they brought me to deliver with a TBA, that is why, I am used to a TBA's home ... because I have seen the benefit, also she has been giving me something and I have seen the benefit".*
>
> *"Yes… because the TBA use to give me something to meet up the month, when my month is complete, I will go there and stay until it is the day I deliver."*

The place where a pregnant woman delivered her first baby is a significant determinant in deciding where they will go for subsequent deliveries.

> *"The reason I like TBA's Place is because the TBA's place that I attended in my first pregnancy and delivery I received treatment from TBA and it was good with me, that is why I like delivering with the TBA".*

Also in contrast to the negative experiences at health services reported by the participants, the positive treatment the participants had received in their previous experience with TBAs also played an important role in deciding where to plan for the next birth. This can be seen by the statement from a participant below:

> *"Experience that I have [in a TBA home] when it started it pained me but not much. It pained me and tortured me… I went to the TBA's place and stayed and stayed there and delivered my baby, there was no problem* [in low tone]*… They took good care of me..."*

Friends or family members' experiences and stories of attending TBAs: From participants' narratives, some women's decisions regarding the place of birth is greatly influenced by the stories and tales about pregnancy and delivery experiences told by relatives and friends.

> *"Oh! I used to hear from my grandmother and my friends that … some it could be that yawning (Syncop) can start and in the hospital, they will rush and give injection, sometimes they say injection is not good, some say that leaves in the bush is better than to give injection, and so that is why I say sometimes home is better than hospital because of that reason".*

Husbands' or influential family members' overriding decisions as to where to give birth: In addition, the role of the husband or other influential family members in the decision process for delivery was also noted.

> *"None, me my husband used to say I should go to the TBA's place and receive treatment, also I myself likes it because the TBA also gives me something and is good with me."*
>
> *"Mummy is not that on my own … because like my husband, it … can happen like that and he … may decide to take me to a TBA, but I keep telling him I want to deliver in the hospital and [he] keeps saying TBA's place".*

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High consideration of proximity of service point to where they live: There was a high consideration of the proximity of the TBAs to where they live. This was specifically relevant with emergency deliveries as a result of a delivery not being planned or occurring abruptly at night.

> *"[smiling]Aunty, TBA's place is nearer to me oh!"*
>
> *"Aunty; it is not that people don't pay at TBA, but am talking concerning means of how to transport one to the hospital. At night you may not see transport to take you to the hospital. It is why I say wherever is nearer to me, that is where I will deliver".*
>
> *"The benefit I have seen is that ... if I go to the hospital, or the hospital is not close to me ...if I go to the hospital to deliver the baby, and there is nobody to assist me, to bring things to me ... then the reason I go to deliver in a TBA's place which is close to my house".*

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The concept of giving birth through natural inducements (such as herbs rather than injections, sedatives, or operations): Most of the participants (those that patronise TBAs) highlighted issues regarding how labour and the delivery period is usually less painful, less stressful, and shorter than what they have either experienced (those that have patronised both TBAs and hospitals) or heard from friends and family members. They linked this to the herbs administered by the TBA to reduce the size of the baby in the womb and hence vagina tear during delivery is either eliminated or reduced.

> *"Oh! I used to hear, some it could be that yawning (Syncop) can start and in the hospital, they will rush and give injection, sometimes they say injection is not good, some say that leaves in the bush is better than to give injection, and so that is why I say sometimes home is better than hospital because of that reason".*

Combination of spirituality in service delivery in TBA homes: Other reasons include the mainstreaming of religious psychosocial support–prayers for maternal and childcare by caregivers. As one participant noted:

"Here we believe in God … the prayers and fasting in TBA houses help us …a… lot when we are pregnant and during delivery. It protects us from evil eyes… I mean our enemies harming us and our babies".

Discussion

A high proportion of women in this study access maternal health services from TBAs, and generally women in the study communities have high preference for TBAs. In support of findings our, the result of a study carried out in a rural Local Government Area in Ogun State, Nigeria, confirmed that almost two-third of the respondents had visited a TBA (Ebuehi & Akintujoye, 2012). Similar to our study their sources of information about TBAs were mothers, family members, and friends (Ebuehi & Akintujoye, 2012).

Access: The patronage of TBA-provided maternal healthcare by pregnant women is seen as a response to the failed health system that is more pronounced in the health inequality suffered by rural women (National Population Commission [NPC]) & Inner City Fund International Macro [ICF Macro], 2009). Although, there has been some increase in health system expansion in Nigeria, only 31% of births are assisted by a skilled healthcare provider while only 35% of women deliver their babies in health facilities (NPC & ICF Macro, 2009).

Perceptions of the care provided in TBAs and orthodox health services: Previous studies carried out in Nigeria also reported similar findings to our study that, many rural Nigerian women rate the quality of services rendered by TBAs to be higher than services offered by orthodox health facilities (Fatusi & Ijadunola, 2003). In this study the traditional beliefs of the communities' women is that the TBAs possess special skills in providing preventive and curative services to pregnant women and newborn babies (Fatusi & Ijadunola, 2003).

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Negative perceptions of medical procedures also play a role with the birthing procedures that the women perceive as complications (episiotomy and Ceasarean Section) are one of the reasons they prefered TBA-assisted deliveries and are usually done for optimal maternal and foetal outcome (Okafor et al., 2014). This is comparable to the practice of women in Tajikistan where some women prefer to deliver at home because they perceive available medical services to be of low quality and unsafe (Falkingham, 2003). This also is corroborated in the findings of a study in Nigeria that revealed that some of the women did not like going to the orthodox health facilities because these centres administer drugs and injections and the women would rather have the TBA-administered herbal concoctions (Okafor et al., 2014).

Good interpersonal relationships: Our study also supported the reasons provided by Falusi & Ijadunola (2003) which were greater accessibility, better interpersonal relationships, lower cost, greater convenience, and freedom to use the traditional birthing position (Falusi & Ijadunola, 2003). Similar findings were reported in a Ghanaian study, where the women reported that TBAs were more considerate and provide more compassionate care (Addai, 2000). Women in rural Guatemala were also less likely to deliver in medical settings because of the lack of social support from orthodox healthcare providers compared to that offered by traditional midwives (Glei & Goldman, 2000). As TBAs are accessible when they are needed, TBA-assisted maternal health services are part of the community providing social support, and they serve as a source of pregnancy care and childbirth for pregnant women. Moreover, among the sampled population of TBA users in Nigeria, 52.4% asserted that TBAs provide compassionate care (Ebuehi & Akintujoye, 2012). A study in the Afar Regional State of Ethiopia also asserts that TBA-provided maternal healthcare is very popular with the sampled population because TBAs provide social support, cultural

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competence, and psychological support for the mothers and babies (Yousuf, Mulatu, Nigatu & Seyum, 2010). Also supporting these reasons, and this has not changed over time, is the notion that childbirth, being a natural phenomena, should be welcomed by a pregnant woman's family, and childbirth is better handled by people who are culturally-acceptable and viewed as experts in child delivery and who are easily accessible to pregnant woman because of the convenience of home delivery (Isenalumbe, 1990).

Previous experiences with health services and TBAs: The expectation of health services formed by past experiences can prove a barrier to accessing services in the future is also important (Lavender, 2007). Having experienced a culturally insensitive service and/or negative attitudes by professionals and a sense of being blamed form specific barriers to individuals, and negative experiences and may have a detrimental impact on access and engagement with services by other members of a community (Lavender, 2007).

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Osubor et al. (2005) stated that provider-related factors, such as regular availability and interpersonal relationships with clients are some of the factors influencing care-seeking behaviour. One of the reasons for this may be the misdistribution of health workers linked to the unwillingness of highly trained personnel to reside in rural and remote areas (Osubor et al., 2005). According to Osubor et al. (2005) this problem could be addressed through incentives such as financial rewards, career development, continuing education, and recognition.

Financial cost of health services: Evidence has shown that out-of-pocket expenditure in poorest countries (Nigeria inclusive) is two to three times the total expenditure of government (WHO, 2005). According to the participants in this study, the cost of accessing care from TBAs was ranked to be cheaper and therefore more affordable than

that of orthodox health facilities. This is similar to findings in West Java province in Indonesia (Titaley et al., 2010) and southeast Nigeria (Fatusi & Ijadunola, 2003) where some TBAs allow payment over a period of time, while others accept payment through a barter system. In a paper presented by Abigail Imogie in Edo State of Nigeria in 2000, it was indicated that TBA-provided maternal health services is free from inhibiting factors of prohibitive hospital fees, illegal fees, and bribery (Imogie, 2000). Imogie's position regarding cost is supported by Murakami and Nagaosa's (2003) Bangladesh study involving interviews and with 60 women who had given birth in the last 3 months, 48 husbands, and 43 mothers-in-laws which showed that TBA-provided maternal health services was chosen by the respondents because of their low cost (Murakami et al., 2003). This has not changed since the 90s when Isenalumbe (1990) reported that TBAs are sources of succour to pregnant women because their services are financially affordable unlike the orthodox medical service.

Proximity: Distance to health facilities is linked with utilisation of maternal health services (Omotor, 2011), and the context in which modern maternal healthcare has been accessible to rural people in Nigeria is low (Abdulraheem, Olapipo & Amodu, 2012). Because TBAs are well known in their communities and live in the community where they practice (Itina, 1997), it is possible for the TBAs to have easy access to the people for whom they provide healthcare. Titaley et al. (2010) assert that some women prefer home delivery because it gives them the opportunity to do their household chores and also to take care of other household members.

Studies have proven that some pregnant women still patronise TBAs even if and when modern health facility is in close proximity and that accessibility can be explained by more than physical proximity alone (Imogie 2000; Titaley et al., 2010). This can also be seen in other countries for example Bangladesh where through investment healthcare

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facilities have been made more accessible but the evidence shows that TBAs are still very prevalent (Rowen, 2009).

In summary, the difficulties women face in accessing health facilities may seem to have led many into forming distrust in modern maternal healthcare, hence the reliance on maternal healthcare provided by TBAs. Despite affordability, accessibility, and cultural acceptability of TBA-provided maternal healthcare, which is further enhanced by its high patronage, evidence has shown that many of its practices have an adverse effect on the health of mothers, in contrast to modern healthcare (Imogie, 2000).

5.3.3.2 Theme 5: Understanding of skilled care and prompt interventions in hospitals

The four women who expressed their preference for modern healthcare facilities were observed to be those who had utilised such services at one time or the other during pregnancy or delivery. Their reasons for preferring hospitals, which emerged as five (5) sub-themes, included: Good care of the mother and baby, safety of their babies through cleanliness and immunisation: positive experiences in hospitals; education on birth preparedness; and provision of prompt and emergency care.

Good care of mother and baby: Women who patronise hospitals affirmed receiving good health care for both the mother and the baby.

> *"I used to tell them that home delivery is not good".*
>
> *"Delivery in the hospital, it is good because after delivery, they take good care of your baby".*
>
> *"They can take the baby from the mother and go and put ... madam, I don't know how they call that place. Then they will give that baby injection, immunisation, and also give the mother injection. Giving birth at home, sometimes you can give birth at home and you start bleeding so much, the TBA may not be able to endure. Hospital is good because they will give you injection, give you tablets, look after both the baby and mother too".*

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In addition, they reported the assurance of being received after being referred from a PHC unit than a TBA, and the availability of equipment to manage likely emergencies.

> *"because one, …when you have pregnancy, when you come to register, they will register you, they will take care of you till that time will come, that you will put to birth, that is why I like to go there, then anytime you have maybe you have headache, anytime you come to them, they will take care of you that is why I so much like hospital".*

Safety of babies through cleanliness and immunisation: Some of the women highlighted their childbirth experiences in respect to a clean environment, being assured that their babies would receive proper medical attention (drugs and vaccines) immediately after birth,

> *"Why I like hospital is because I have benefitted from the nurses, I have also benefitted from doing … and taking care of babies, because when you have trust in hospital when pregnant, they will tell you how to take care of your baby, then hospital, hospital will make all my baby's things to be very clean".*

> *"Why I decided to deliver in the hospital is because I used to receive immunisation in the hospital until the day I was to deliver, saying that when that day reaches I will deliver freely without anything happening".*

Positive eperiences of hospital: Some of the respondents expressed their easons for preferring hospital delivery based on their previous positive experiences in hospital. Some verbatim responses captured includes thus;

> *Why I say so…..is that hospital is good, like me because I take example from myself. when I was pregnant, I went to the health centre at Idundu, my stomach was very big, people used to say that I will deliver twins. So, I went to the hospital and did scan and I saw that hospital is good. They also looked and told me what is my problem and I also took it the paper to them. I then know that if something disturbs you and you go to the hospital that the whites can make you know even doctors can make you know".*

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> *"It would have been good for a woman to go to the hospital when she is pregnant, because they will look after her, take good care of her, check her, she goes for check up, they will advice her, give her dates to be coming for check ups. They check her well well, whenever she has problems they give her some drugs, so they take care of her well, so it is good for one to go to hospital when pregnant."*

Education on birth preparedness: An important aspect mentioned by two participants were the provision of education on birth preparedness and the benefit of this for all future pregnancies as well.

> *"The main reason that I want to deliver in the hospital is that I like hospital due to how in the hospital they look after somebody. Secondly, in the hospital, I have been given a list for me to use at home to prepare for hospital delivery".*

> *"I have derived a lot of experience about delivery and nursing a baby, one is that ... because the first time I had a baby, I had no experience. The second one I delivered, I had experience concerning caring for baby, personal hygiene, washing baby's thing very clean and taking good care of the baby. Immunising my baby whenever due".*

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Provision of prompt and emergency care: One participant specifically highlighted the importance of interventions in case of emergencies.

> *"That...that it's because labour can pain you til ... after when you have the baby, after having the baby....., you can become breathless and die. That is the reason. So I see that the hospital is better than a TBA's place that is why I started going to the hospital".*

Discussion

Several studies collaborate the above findings. Okafor et al. (2014) found that the reasons for choosing orthodox care include regular check-ups and investigations (BP, weight, ultrasound scan, and urine and blood tests), better management of postdate pregnancy and prolonged labour, and immunisation of the newborn. De Bernis et al. (2003) observed an association between the proportions of births attended to by skilled health personnel and maternal mortality, and according to them the proportion of births

by skilled health personnel is a key indicator for the MDG 5 of improving maternal health and its target of reducing the MMR.

Sibley & Sipe (2006) estimates that with 90% coverage of Skilled Birth Attendaants present in developing countries, interventions for pregnancy, labour, and postnatal care up to 24 hours after birth would result in a 15-30% reduction in newborn mortality, with improvements in maternal health. Though skilled birth attendance is one of the strategies aimed at reducing maternal and newborn mortality (Starrs, 2006; Starrs, 2007; de Bernis et al., 2003), Darmstadt et al. (2005) assert that in most low-income countries especially those in the sub-Saharan region, the majority of women deliver at home with the assistance of family members, friends or TBAs and most healthcare facilities that offer comprehensive emergency care services are located in urban areas (Darmstadt et al., 2005).

5.3.3.3 Theme 6: Poor understanding of birth preparedness and complication readiness

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Five (5) sub-themes supported theme 6 which is the poor understanding of birth preparedness and complication readiness. These themes are: Poor preparation for emergencies (transport, money, and blood); Preparation for baby things (not emergency related); Reliance on TBAs regarding delivery dates; Reliance on husbands for financial arrangements and Reliance on God for provision

Poor preparation for emergencies: Preparation of emergencies include arranging transport, financial arrangements and ensuring that blood for blood transfusion would be available. Contributions from the participants affirm that most of the women did not make any preparations or arrangements regarding transportation in the event of any emergency or ease of mobility in terms of the expected date of delivery (EDD).

"I don't use to prepare myself but I know that when the day reaches, God will do his will".

"I did not do".

Regarding arrangements for a blood donor in case it is needed, contributions from the participants showed that there were usually no preparations for a blood donor put in place by the women or their family members as part of preparations towards a successful delivery. Most of the participants maintained that they never made such arrangements prior to their deliveries. Some of their responses include:

"No"

"I did not do"

"Yes I know that it is possible for a woman putting to birth to require blood. No I have not made any arrangement for blood"

A few participants maintained that their husbands are usually prepared as donors, while others stated that money is usually provided by their husbands for blood to be procured at the hospital, thus implying that the few respondents whose husbands made money available for blood are those few who access care at the Primary Health Centres or hospitals.

" I think they can take blood from my husband. It can be bought from the hospital".

"I have never made preparation concerning blood but I have made preparation ……….. Firstly, I used to buy pampas and keep, buy pad that I will use and baby's things and keep for the day baby will come"

"no,…… if so, we can get blood from my husband, or buy in the hospital"

Most of the participants reported that no specific planning were routinely done regarding delivery dates and that they continued about their daily domestic and business routines, even if they had information on their delivery dates.

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"Aunty;…….I have not really decided on a particular place to deliver yet, that is why I am saying whenever it happens and wherever, I will deliver there"

Preparations for non-emergency baby provisions:

The participants reported that the primary issue of concern in preparation is for the baby whereby the baby provisions need to be bought before the delivery of the baby. According to them:

"I have to keep money knowing that labour can start anytime unexpectedly, buy things and keep those things to be used in taking care of the baby, I have to prepare, buy them and keep in place so that when that day comes, I can bring them to hospital"

"Yes…I used to do because when you go to TBA's house, TBA will not tell you to buy baby's things and keep, TBA will not tell you that, but when you go to the hospital, they will always tell you to be prepared in case labour starts unexpectedly in the mid-night".

"Preparations that I used to make when am pregnant concerning my baby…saying my time has gone far…from there I stand and consider that my time has gone far…., it is for me to enter and start buying baby's things like clothes or powder, I buy baby's things and keep, so that if baby is delivered now, they can bath and use those things on it, use soap on the baby and powder the baby, so that if somebody comes to visit or carry the baby, the person can do that".

Reliance on TBAs for delivery dates: There is strong reliance on delivery dates to be provided by the TBAs. This information is known to usually be speculative and unempirical information (based on palpation examination of a pregnant woman). Hence the pregnant participants reported having to prepare and leave their homes and family members in their eighth month to live in the TBA home until she delivers her baby.

"Yes……., because the TBA use to give me something to meet up the month, when my month is complete, I will go there and stay until it is the day I deliver. Nothing used to happen"

Reliance on husbands for financial arrangements: A strong sub-theme that emerged were the reliance on the husbands for financial arrangements such as money in the event of any emergency during pregnancy or delivery. Contributions from all the participants interviewed revealed that the women strongly rely on their husbands to provide the financial requirements for their pre- natal, delivery and post- natal care and that they do not concern themselves with the burden of saving money for their delivery.

> *"I prepared the preparations I made was….it used to be that when the father of this baby gives money, I will buy baby's things and keep them. I will also follow and buy small small things, buy like food thing ... when the time to deliver drew near, I bought food stuffs, so that when I deliver, so I will have what to eat".*

> *"No, when the time comes my husband will have the money; God will provide the money for us. When that time come, because my husband is working".*

> *"preparation is that as I am pregnant, I have started buying my things and keep, my husband has not yet given me money to buy things and keep but when it is time he will buy what he wants to buy, he will give me money to start buying baby's things and keep small small".*

> *"I prepared ... the preparations I made was….it used to be that when the father of this baby gives money, I will buy baby's things and keep them. I will also follow and buy small small things, buy like food thing ... when the time to deliver drew near, I bought food stuffs, so that when I deliver, so I will have what to eat"*

Reliance on God for provision during pregnancy: Many of respondents maintained that they relied on God to provide at delivery, hence leaving everything related to the birth to faith.

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"God will do his will".

"nothing will happen".

"I don't use to prepare myself but I know that when the day reaches, God will do his will".

Discussion

Similar to our study, studies conducted in sub-Saharan countries report low rates of birth preparedness (Hiluf & Fantahun, 2007; Moran, Sangli, Dineed, Rawlins, Yame'ogo, & Baya, 2006; Mutiso et al., 2008 & Hailu et al. 2011).

According to JHPIGO (2001) birth preparedness and complication readiness are interventions that address these delays by encouraging pregnant women, their families, and communities to effectively plan for births and deal with emergencies, if they occur. The concepts of birth preparedness and complication readiness include identifying a trained birth attendant for delivery, identifying a health facility for emergency, arranging for transport for delivery and/or an obstetric emergency, and saving money for delivery (JHPIGO, 2001). The Prevention of Maternal Mortality Programme (1987-1997) found that inadequate funds and transport were key causes of delay in deciding to seek care and in reaching facilities (JHPIEGO, 2004).

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The Maternal and Neonatal Health (MNH Programme, 2004) posits that the cause of the delays in taking decisions in emergency situations are common and predictable, and in order to address them, women, families, communities, providers, and the facilities that surround them must be prepared in advance and ready for rapid emergency action. High levels of birth preparedness have been shown to be strongly associated with increased levels of use of skilled birth attendants (Moran et al., 2006; Mutiso et al., 2008; Hailu et al. 2011). There is evidence from rural Nepal (Mc Pherson et al., 2006), Burkina Faso (Moran et al., 2006), and Ethiopia and India (Fullerlen et al., 2005 &

Kumas et al., 2008) that promoting birth preparedness and complication readiness improves preventive behaviour, improves a mother's knowledge regarding dangers-signs, and leads to improvement in care-seeking during obstetric emergency.

In corroboration with these findings, Doctor et al. (2009) suggested that social influence is important in encouraging women to seek both antenatal and delivery care and that existing informal social networks within the community can help in relaying to the pregnant women and the community members the extent to which health facilities have been improved. Doctor et al. (2009) recommended that messages regarding birth preparations and recognising and knowing how to respond to danger signs could be integrated into the local social networks and groups, such as village women committees. Birth preparation needs to be a consistent element of antenatal care and should be incorporated into community-based information networks to promote birth planning and preparation, even among women who don't attend antenatal care (Onayade et.al, 2010). In a similar study by Agarwal et al. (2010) on birth preparedness and complication readiness among women in India, findings highlighted that maternal literacy and availing of antenatal services were and important predictors of birth preparedness, and birth preparedness was positively associated with skilled birth attendance.

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Part of birth preparedness is having a birth plan and involving partners in the pregnancy care process. Evidence from studies have shown that the women who had a birth plan were more likely to be accompanied by their spouses to health facilities and were more likely to report more support from spouses in looking after children or in assistance with household chores during pregnancy (Agarwal, 2004). The findings are similar to those from a study in northern Uganda (Tweheyo et al., 2010), which found that several men were actively involved in birth preparedness and complication readiness when

their spouses were pregnant or in labour. In this study, men who were knowledgeable of antenatal services, obtained health information from a health worker, and whose spouses utilised skilled delivery during their most recent pregnancy were more likely to accompany their spouses to antenatal care. This finding suggests that providing information to male partners of pregnant women attending antenatal might increase their involvement and participation (Tweheyo et al., 2010).

Lastly, a major factor effecting birth preparedness is finances. Financial barriers often prevent local people from being able to arrange transportation. In Nigerian rural areas, vehicles are scarce and in poor condition and the cost of arranging emergency transportation can be daunting (McIntyre & Hotchkiss, 1999 cited in Izugbara & Ukwayi, 2004).

These findings reinforced the widely held notion that birth preparedness and complication readiness should be promoted during pregnancy in settings where deliveries in the home are common (JHPIEGO, 2001). While improving knowledge and helping mothers to prepare for birth and emergencies, efforts are also required to address the barriers that hinder skilled birth attendance and the use of health facilities for delivery (Agarwal, 2004).

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5.3.3.4 Theme 7: Strong influence of cultural beliefs and practices relating to pregnancy

Two sub-themes related to this theme emerged, the belief that certain foods can affect the pregnancy (specifically resulting in a large baby) and that certain practice can affect the pregnancy or the child.

From the contributions of the participants regarding their community's common cultural practices relating to pregnancy, delivery, and after delivery, it was concluded

that there were no generally held practices and enforceable cultural norms related to pregnancy.

> *"No….o! I have not heard such laws".*
> *"Such laws are not there in my community!"*

Beliefs about certain food affecting pregnancy: However, people are driven by perceptions and myths that are not necessarily traceable to a generally acceptable cultural practice but are observed by some individuals independently in the communities. A number of participans mentioned beliefs about certain foodstuffs (pap, tea, garri, beans, and pork meat) which may affect the mother (stomach pains) or result in the baby being to big. Examples of these are:

> *"Aunty, in my place, there is no law! If there is anything people used to…when they have babies that say, they will not use, somebody like me when I deliver baby, I am never fast in eating garri because it gives problems in the stomach so…".*

> *"I don't know of such laws in my community. But on my own, what I know about they said I should not drink tea, should not drink ogi (pap). Eh…Because baby was big ... they said I should not eat what is sweet".*

> *"... then in my place we have, they say 'don't eat beans'! They say if you eat ... drink custard or Akamu, it will make the baby to be large inside your tummy".*

> *"There is none like that. Laws that are there when a woman is pregnant… They say she should not eat beans, not drink tea should not eat some things that can make a baby big in the belle, so that on the day of delivery, it may not be difficult things and things that makes baby big".*

> *"There are such laws when I went to the hospital, I was told different things I should eat and those I should not eat, such things I did not eat. They used to tell me that I should not drink tea… much of tea, should eat fruit, small fruit like that and things that are light ... I don't know because like in my first son, they said I should not eat that the baby was too big inside my belly".*

> *"There is none like that. Laws that are there when a woman is pregnant… They say she should not eat beans, not drink tea*

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> *should not eat some things that can make a baby big in the belle, so that on the day of delivery, it may not be difficult things and things that makes baby big".*

Belief that certain practices can effect pregnancy: There are a number of practices that were mentioned as taboo. These included not wearing red cloths after birth, ensuring that one's mother is present at the hospital before giving birth for fear of having miscarriage, not allowing persons with odon (tetanus) to visit the child, or an unmarried girls living with a man who must have sex or to visit a newly circumcised male child on the account that there will be delayed healing. Below are some direct comments from participants:

> *"Yes now! Like in my place, hmm! When, when you have pregnancy, they will say….., when somebody have put to birth. Maybe your mother is not there where you born, they say don't go there ... when you go to that place you will miscarriage ...".*

> *"It is not there ... where I come from. It is only there where my baby's father come from only. There is no law in my place only in my baby's father place. Eeh! What is in my baby's father place is that you don't use…you don't use red thing, anything that is red, also you don't eat things like pork, you don't eat ... different kind of meat that he counted... So there are many many laws in his place, you can't even count. Because ... his place, it is forbidden to eat those things, so one has to act according to how their laws is".*

> *"When one delivers newly, she must not be quick to eat…there are no laws ... like when a baby is born newly, they don't always allow people to visit, like a person with odon (tetanus) should not visit the baby until everything is healed in a baby's body. That is the kind of belief we have in this place"*

Discussion

Evidence shows that modern maternal healthcare is aligned with the socio-cultural realities of pregnant women in Nigeria (Imogie, 2000). A specific example of this is the reliance of Nigerian women on TBAs for assistance and advice during pregnancy because their services are seen to be culturally acceptable (Babalola & Fatusi, 2009 &

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Ebuehi & Akintujoye, 2012). Tod (2001) and Tran (2008) noted that in most community studies, social and cultural norms and attitudes of particular communities are strongly linked to personal factors, since many of the attitudes toward and patterns of coping were community-specific.

5.3.4 Objective 3:To explore the perception on the role of the family/community and maternal health initiatives in emergencies, and suggestions on actions to be taken to promote utilisation of orthodox health services

To address the third objective to explore the perceptions of the actions of family/community and the maternal health initiatives in emergencies in terms of utilisation of orthodox health services, the following questions were asked:

- Decision regarding birth plan and place of birth: Who takes decisions in the family regarding the place of birth?
- Family support: What are the supportive roles of family members during pregnancy, delivery, and after deliver?
- Community support: What roles do the community play in emergency situations during pregnancy, labour, or postpartum?
- Community engagement: What can be done by the community members to promote delivery in facilities for the prevention of maternal health complications?

Three (3) themes and four (4) suggested actions emerged based on the analysis of the data generated and transcriptions from the in-depth interviews conducted. The themes were the strong influence of husband in decision-making about place of birth; Family support for women during pregnancy and nursing periods; the absence of community structure supporting women in emergencies (Table 8).

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The recommended actions included: education of women on maternal health issues; husbands/community involvements in maternal healthcare issues; developing motivational healthcare services; and community awareness (Table 9).

5.3.4.1 Theme 8: Strong influence of husbands in decisions determining place of birth

Three (3) sub-themes supported the theme of the influence of the husband on the decisions determining the place of birth, namely: the husband determined the place of delivery, the husband bears the financial responsibility for the delivery and the patriarchal role of the husband

Husbands are the key decision-makers about place of delivery: Addressing the question of who is responsible for determining the place of delivery, most of the participants (16 out of 20) maintained that their husbands were the key decision makers as to where, when, and how a pregnant woman would register for antenatal, delivery, and postnatal care for her and her baby.

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TABLE 8: Family/community role themes and emerging sub-themes

Themes	Sub-themes
8. Strong influence of husbands in decision-making about place of birth	• The husbands are the key decision-makers about the place of delivery • The husbands bear the financial responsibility of delivery • The patriarchal role of the husband
9. Family support for women during pregnancy and nursing periods (house chores and care of other children)	• Assistance by immediate family members during pregnancy, delivery, and nursing periods • Assistance by their husband during pregnancy, delivery, and nursing periods
10. Absence of community structures supporting women in emergencies	• Lack of existing community based maternal care initiatives • Support groups are strictly for their members

"none ... me ... my husband used to say I should go to the TBA's place and receive treatment, also I myself likes it because the TBA also gives me something and is good with me."

"All of them wants hospital, husband… all the children I deliver in the hospital, even my husband goes to hospital, me too I go to hospital, any small fever that comes, we talk about hospital".

"*My husband used to carry me because I used to register in the hospital, my husband used to take me to the hospital and also bring me to the TBA's place.*"

Only a few (two out of 20) of the participants (pregnant women) affirmed the person responsible for determining their birth plans and place of birth to be their mother in law, sister in-law, or their own mother (pregnant woman's mother):

"My husband's sister and my mother in-law said I should deliver in the hospital, I also accepted delivering in the hospital...".

"In fact, my mother is a TBA, she decides that she has to take care of my pregnancy and delivery,…. Me and my husband trusts her care"

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Three of the participants admitted to being the person responsible for determining the birthplace.

"Is myself o! even my husband".

" Where am from, nobody decided for me ... where to deliver, where I want to deliver, that is where I will go".

"Is not my husband that says, my mother-in-law is dead, my father-in-law is dead. So am the one that likes going…".

Hence, many participants willingly relinquish the birth preparations and determining the birthplace to others and do not consider it as significant in their roles.

Husband bears financial responsibility for the delivery: The husband also was reported to have the main financial responsibility for both money and transport.

> *"As I came and register in the hospital, it was my husband that gave me money to come and register, my baby's things too, it is my husband that wants to buy, am not the one to buy".*
>
> *"My husband used to carry me because I used to register in the hospital, my husband used to take me to the hospital and also bring me to the TBA's place".*

The patriarchal role of the husband: Another sub-theme that emerged was the strong patriarchal model of the family where the husband's decision was seen as final and not to be challenged.

> *"Hmm! Because I am under somebody I had decided delivering in hospital but wherever he says, I will stand by that since because I will cross my hand over his head since he is the head of the house".*
>
> *"Like in my own during my first pregnancy. My husband really warned that he does not like home delivery. That anytime it happens and he not around when I get there I should call him that he will come".*
>
> *"like my husband decided that I should deliver in the hospital and no more at home".*

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Discussion

The key theme that strongly emerged here is the patriarchal role of the husband. Other studies in Nigeria also showed similar trends. A study in Nigeria also showed that half the women surveyed said they did not have spousal permission to deliver in a facility (Onayade et al., 2010). The men's approval or disapproval of pregnancy care was linked primarily with difficulties of access and the costs involved (Onayade et al., 2010).

Women's status is a broad concept that enbodies access to and control over material resources (including food, income, land, and other forms of wealth) and to social resources (including knowledge, power and prestige) within the family, in the community, and in society at large (Idowu et al., 2011). Gender discrimination affects

women's lives in almost every country, with the negative impact being greater in the developing world (Idowu et al., 2011). This results in women not always receiving the support they need to take health decisions as cultural restrictions limit their choices (Idowu, et al, 2011). The reasons for this has not changed over time, as the cultural value of the dominant male role in patriarchal societies such as Nigeria still impact on mothers' decisions for promptness of medical assistance due to unified budgets with their husbands (Jegede, 1998 in Erinosho, 2005). In

addition, due to heavy household duties, women cannot afford to be sick themselves (Idowu et al., 2011).

A woman's relationship with her family and her status within her family unit is critically associated with her ability to seek healthcare services and any programme needs to work with men as well to address these issues.

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5.3.4.2 Theme 9: Family support for women during pregnancy, delivery and nursing periods (house chores and care of other children)

Regarding the supportive roles of mothers-in-law and other relatives during pregnancy, childbirth, and nursing periods, all the participants maintained that they receive adequate support and care from their mother in-laws and other family members when they are pregnant.

> *"Like my mother-in-law, she's very, very caring. So when I went to her place because we are not from the same place with my husband, she takes care of me, she give me all my needs, she will……, sometimes when I sit down, she will ask me…."Cecelia what is the problem, are you annoyed?" I will say "No mummy I am not annoyed, it's because of my condition". She will say "Please don't do face like this". No! The woman is very, very good to me. She takes care of me very well."*

"My mother in-law used to help me when I have a baby, she will cook food and bring to me that same day, bath my baby and bath me".

Two sub-themes were identified as areas where participants were supported by other women during pregnancy, labour and nursing periods were the assistance by immediate family members by caring for other children when mothers are in labour, preparing food, assisting in household chores and looking after the baby and the mother and asssistance by the husband in the same chores.

Assistance by immediate family members during pregnancy, delivery, and nursing periods: Participants reported getting the basic attention and support from immediate and extended family members, which, from observations during the interview, were based on both interpersonal relationships and cultural value systems that are still very much accessible in rural communities. This is not unconnected to the traditional African family setting of extended family relationships and support offered during significant occasions in family life.

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Pregnant women in rural communities attract all the necessary support they can from all family members and neighbours.

"My mother is there".

"My senior sister. All those children are in Lagos now".
"My mother will look after my children for me".

"If labour start now, it is their father's sibling that look after them for me".

Relatives care for other children when mothers are in labour and mothers and babies are cared for by other women: bathing the mother, bathing the baby carrying the baby baby care advice and providing reminders for drug adherence.

"During pregnancy and delivery, they used to……if I go out and leave the children behind, they [husbands relatives] look after

them knowing that they are their brother's children. They take care, giving them things, bathing them ... when am not around".

According to the participants, family members also render basic domestic chores like boiling water, fetching water, and washing clothes,

> *"They use to help me and also boil water and bath me and also help carry they baby and also take good care of the baby".*
>
> *"They used to render help to me and also sometimes carry cloths and wash for me. If I cannot do something, they assist, they carry that thing and do. They use to assist me like that and not leave everything for me to do "…also assist me with baby*
>
> *"Like when I was pregnant they used to .... because I am living alone, fetch water for me, sweep for me and also help in other small small things like when I delivered they will help and bath the baby and also wash my cloths saying it is not good for me to start working yet,[un] til am strong".*
>
> *"My husband's sister gives me cloths and also renders some help since my mother-in-law is not there, my father-in-law is not there. They are my mother-in-law, they are my father-in-law".*
>
> *"Since I used to be pregnant, he used to give ... all of them gives me a great help, that is why I used to get pregnant every now and then .....They used to give me happiness in the house, whatever you are doing, they will help you, they don't allow things to overpower you, then when you have the baby too, they will be doing great things for me and also help me always".*

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Assistance by their husband during pregnancy, delivery, and nursing periods: Regarding the care of other children left at home and the roles of husbands during delivery and nursing periods, participants affirmed that the men in rural communities support their wives during pregnancy by rendering services such as fetching water, carrying the baby, waking up early to boil water, caring for the other children while his wife is in hospital, cooking, and providing the financial means to take care of both mother and baby after delivery.

"He used to help fetch water, cook for me even when I deliver newly, he does not allow me do anything until the baby is about 2 months before he allow me do something. He fetches water for me, early in the morning he wakes early to help me, I will take care of the baby, sometimes my mother takes care because his mother does not quickly come, the mother is in their village".

"My husband helps me as God gives him the ability especially as my mother in law had died".

"My husband used to assist me since it is not a man's duty whatever he can, he used to assist me. My mother is person who really assist me".

"My husband looks after them ... yes my husband".

"I don't have anybody that takes care of my ... that looks after my children for me… I look after them alone. …Those I leave at home? Their father looks after them".

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Discussion

The findings concur with the findings of Mutiso et al.'s (2008) which found that in Kenya 43% of mothers were accompanied by spouses during antenatal care and 69% during labour while 42% of the spouses remained at home looking after the home and children. A quarter of spouses were reported to assist with household chores during the antenatal period (Mutiso et al., 2008). Where a mother had a high level of birth preparedness, they were more likely to be accompanied by their spouses to health facilities and were also more likely to report more support from spouses in terms of childcare or assistance with household chores during pregnancy (Mutiso et al., 2008). This research's findings are similar to those from a study in northern Uganda which found that men who were knowledgeable of antenatal services, obtained health information from a health worker, and whose spouses utilised skilled delivery at their pregnancy were more likely to assist or support their spouses (Tweheyo et al., 2010).

This finding suggests that providing information to male partners of pregnant women attending antenatal care might increase their involvement and participation. Prenatal male involvement has been associated with positive outcomes for the mother and baby, including higher birth preparedness and complication readiness (Iliyasu et al., 2010 & Odimegwu et al., 2005). Unfortunately, in most studies, male partner involvement in maternal and child health is still low in many sub-Saharan African countries.

5.3.4.3 Theme 10: Absence of community structures supporting women in emergencies

Two sub-themes were identified, namely the lack of community based structures and where they did exist they were exclusive.

Lack of community-based maternal care initiatives: In terms of the existence of community-based maternal care initiatives that are responsive to the concerns of pregnant women and nursing mothers in communities, especially during emergencies, most of the participants affirmed that there were no voluntary community-based groups assuming the responsibility of caring for pregnant women at the community.

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> *"None"*
> *"There is none!"*
>
> *"I have no idea!"*
>
> *"No".*
> *"Madam, I have not seen. In my community, there is none".*

According to the participants, care for pregnant women is the responsibility of the pregnant woman's immediate and extended family members to provide, hence, at the central community level there is no known social community group assuming this responsibility, except in some case the church:

> *"In my place, there is no group than church, no organisation than church. We all rely on church, then nothing happens to anyone of us unexpectedly".*

Suppot groups strictly for members: Where a few of the participants did confirm the existence of a group in their community, it was observed that these were social clubs whose loyalty and responsibility is to care for their members (including pregnant women), hence, rendering care services as contained in their constitution to their members or family members only and not the general community.

> *"There is none ... unless it is ... the community members cannot render help unless it is the group you belong that will have love to assist whenever they hear you have problems before they carry you there. These groups that acts as contribution group, if they have love, they will carry you saying that you are their member, full member of theirs before they do it. As you used to see them do to people".*

> *"Such group exist but am not a member. They call "NKA IBAN". As I don't belong, is because my ability is not up to that. They sometimes contribute money if it is the turn of a particular member, they contribute and give her gifts, household items".*

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> *"We have such in where I come from in Mfamosing 1. Great [f]ine ladies ... Women they are ... If it happens they help members ... Great [f]ine ladies".*

Discussion

Community engagement enables individuals and organisations within the community to take collective actions that are aimed at improving their conditions. Bhutta et al. (2008) and Bhutta and Lassi (2010) noted that in order to improve maternal survival in low-income countries there is need to up-scale community-based interventions linking families and facilities for care at birth (Lee et al., 2009). Community engagement is seen as essential in maintaining this continuum of care from communities to heath care facilities.

Lassi et al.'s (2010) review to assess the effectiveness of community-based intervention packages in reducing maternal and neonatal morbidities and mortality and improving neonatal outcomes and the impact of different strategies (home visitation, home-based care, community support groups/women's groups.) on the reported outcomes, provides encouraging evidence that the benefits of community-based strategies may extend across the continuum of maternal and newborn care. The most successful packages were those that emphasised involving family members through community support and advocacy groups and community mobilisation and education strategies, provision of care through trained Community Health Workers via home visitation, and strengthened proper referrals for sick mothers and newborns, hence, the links between strong communities and good health are becoming more and more evident (Lassi et al., 2010). In line with this review, Doctor et al. (2012), in their study on using community-based research to shape the design and delivery of maternal health services in Northern Nigeria discovered that social influence is important in encouraging women to seek both antenatal and delivery care. The programme takes steps to improve the quality of maternity services through existing informal social networks within the community which can help in relaying information to pregnant women and the community (Doctor et al., 2012). In addition, antenatal counselling knowledge regarding birth preparedness and recognising and knowing how to respond to danger signs could be integrated into the local social networks and groups, such as village women's committees (Doctor et al., 2012).

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Examples of these programs include a Health Foundation community engagement initiative in rural Malawi which found that although studies had suggested that women as individuals did not have a comprehensive awareness of the problems that affect them, these problems could be addressed through women meeting and collectively discussing these issues (Rosato et al., 2006).

A Canadian study undertaken by Church, Wanke, Saunders, Pong, Spooner, and Dorgan, (2001), provides insight into the nature, extent, and impact of citizen participation on policy and service outputs in 17 community health centres across the country. Findings from the study showed that community health centres with locally elected boards were more likely and able to take on advocacy roles and activities for their communities and were "an important source of developing and enhancing community capacity through leadership development" (Church et al, 2001). This research also found that citizen participation in community health centre decision-making had led to improved programmes and services, and that in the range of programmes and services, strong representative community governance structures offer meaningful opportunities for citizens to become better informed of the complexities of healthcare decision-making while enabling local community concerns to be heard and considered in programme planning meeting the needs of the community (Church et al, 2001). Local community engagement, where issues are defined and managed by the community in a comprehensive approach, will have a sustainable positive impact on health (Weinstein et al., 2006).

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Rosato et al. (2006) observed that the key challenge is to channel this effectively and build upon what already exists where the people are in their communities, rather than design initiatives that do not take this into account and thus do not utilise the capacities and potential resources already existent in the communities. According to Rosato et al. (2006), the Malawian initiative was based on a successful project in Nepal that sought to engage with local women's groups to identify the major maternal and newborn problems in their communities and to develop community-driven strategies to address these. The initiative had significant success with 30% fewer newborn deaths and 80% fewer maternal deaths than in the control areas (Rosato et al., 2006). Mathur et al.

(2005) assert that community mobilisation approaches gave young women the confidence and skills to articulate their reproductive health concerns and demand services, increased young men's understanding of maternal care, improved husbands' willingness to support their wives' maternal care needs, and fostered better intergenerational communication and support between mothers-in-law and daughters-in-law. Furthermore, in working with local healthcare providers, peer networks, and key adults, the community mobilisation approaches enhanced the availability of quality sources for reproductive health information, counselling, and services for young married women (Mathur et al, 2005).

5.3.4.4 Action recommendations: Women's opinions on actions to be taken by the community to promote facility deliveries

Participants' opinions were solicited on ways of engaging the community to motivate pregnant women to utilise orthodox maternal healthcare services and facilities for the prevention of maternal health complications. Four (4) key action recommendations emerged (Table 9), namely: The education of husbands and wives on maternal health issues; husbands/community involvement in maternal health issues; Motivational healthcare services through free maternal and child healthcare and occasional gifts for mother and babies in the clinics, Spirituality in service delivery; and Increased community awareness.

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TABLE 9: Action recommendations and sub-themes

Action Themes	Action Sub-themes
A. Education for women and husbands on maternal health issues	• Education for women and husbands on maternal health issues
B. Husbands/community involvement in maternal health issues	• Husband involvement and education
C. Motivational healthcare services	• Free healthcare services • Occasional gifts for mothers and babies • Spirituality in health services
D. Increase community awareness on maternal health issues	• Community sensitization and education on maternal health services

Recommendation 1: Education of husbands and wives on maternal health matters

Few participants championed using important members of the community, doctors, religious centres and spiritual heads to mobilise and educate the men and their wives on the benefits of accessing professional/qualified healthcare services as people in the rural communities were not aware of policies and free maternal and child care services being operational at the state and national levels, hence they continuously require enlightenment and motivation to access these services.

> *"Am saying that the doctors, all big people should come together ... when they come together, they should call all the women in the community together and tell them that the hospital is better than TBA's place, they should also educate them and when they are well informed, they will decide to start going to the hospital".*

> *"I think they should be sending letters out to different churches to tell women to be going out to hospital. Some of them think hospital money is always too much. I think they should be sending letters to churches to tell them if any woman is pregnant, she should go to collect money because it is due to lack of knowledge. They think that hospital used to collect money. That is what I think in my idea".*

Recommendation 2: Husbands and community involvement in maternal health issues

Some participants suggested that the involvement of their husbands in issues of maternal health would be useful as their husbands were the breadwinners and the bearers of the financial burden of healthcare, determined the place of delivery, and because of their assumption that orthodox healthcare was expensive, most of them prefer the TBAs, leaving their wives have no right to refuse.

> "*The clan head should call ... they should ring bell ... and call all men out to chief house ... tell them to allow their wife go to hospital when pregnant and put name. If not so, they will not allow us go, they say money is too much".*

Recommendation 3: Motivational Healthcare Services

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According to most of the participants, for pregnant women and mothers to access care at the primary or secondary healthcare facilities, services should be provided at no cost or minimal cost for both mother and child, provide occasional gifts and be spiritual.

Though, a few of the participants maintained that most of the women are already used to and prefer the TBAs, and that no incentives or education provided, would change women's opinions on this.

> *"I cannot know oh! What could be done, I cannot know –o! Because we have been used to delivering with the TBA.*

Free health services: Most of the participants were of the opinion that health services should be free:

> *"I think, it should be that as we come to the hospital, [it] should not collect money, sometimes if somebody y… is sick they take her to the hospital, they should not collect money, or they collect a little money because sometimes money is the reason why they don't like coming out to the hospital. When*

they bring, as they bring here, because some people, their babies can be sick and they don't have money and when they bring to the hospital, they should not wait for money before attending to the babies. Some people who don't register in the hospital, maybe they used to pay money but since I have not had a baby before, I wouldn't know".

"Eh! Government should help them maybe they will change, they will…… they will change their lives so that they will……maybe anytime they want to put to bed, they will come to the hospital. Maybe some there, they don't have money that is why that they are afraid to come to the hospital. I don't know for them… ... like myself I don't like to… Mma…..my own is that anyone that wants to put to birth should come to hospital and deliver that ... to help yourself and your baby inside".

"The government ... should render help for pregnant women, the government should give pregnant women drugs free, treatment free, so that they can be healthy, the baby in the womb can be healthy too ... they give rugs in hospitals ... because there are some woman who likes hospital and some who don't like hospital to deliver. They will say "Since they were born, their mother never gave birth to them in hospital and they too will have their babies at home". Is not everybody ... because I am not in their minds to know, I only know myself".

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"In my ... own thinking ... I would suggest that they should give advice, the line of advice I mean. ….In some hospitals, there is how somebody goes to deliver and the hospital bill will be too big. So I want to say they should bring down hospital costs. Like now that it is free [in Cross River state], but women don't go, it is because some of them do not know about that".

"If true true government say hospital is free for women, then why...why... they are always telling us ... pay money for this, for that?"

Provision of occasional gifts for mothers and babies: This is closely followed by significant number of respondents who maintained that gift items like mother care kits and Long Lasting Treated Nets (LLTN), when provided, would motivate more women to attend health centres.

" *In my own side, government should do something about it and also look after women, like in the general hospital I went*

> *to, they gave mother gifts, I am sure that if sometimes mothers are given gifts mothers will be happy and would attract them to go and deliver in the hospital that is my own idea"*

> *"I… to me, in my neighbourhood, as I am going back ... or going to hospital I used to call home that I am in the hospital, I also used to tell them what happens in the hospital whenever am discharged home, then there was once I was given mosquito net in Ediba, I took it and showed around to my people and they were all happy that anytime they are pregnant, they will join me to know where I used to attend clinic and receive treatment. They use to think that I attend Idundu clinic. It is only now that I don't have transport to go to Ediba health centre, that I now attend clinic in Idundu health centre".*

Spirituality in health services delivery: A few participants mentioned the issue of spirituality (prayers and fasting) in healthcare services, which is one strong reason as to why TBAs enjoy significant patronage. They observed that if the orthodox healthcare facilities took spirituality seriously and introduced this aspect into the services they render, then the rural women would be motivated to utilise the services.

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> *"…In my own opinion in that aspect is that because of how the world is like this now ... some people decides to go to TBA to deliver their babies, because there prayers and fasting will protect women from bad people (enemies), but I usually encourage people to go to hospital – o! So that they can check their body and I also encourage those who wish to deliver in hospital to go. I used to encourage some people".*

Recommendation 4: Increasing Community awareness

Some particpants suggested creating awareness about maternal health issues by educating the entire community as most people were not aware of the benefits of hospital services and they instead remained faithful to their old negative assumptions and traditions. They noted that these are the same people who keep discouraging women (their relatives) from utilising hospital services. They felt that if the community were well informed, they may change their attitudes.

> "*….for me I believe if the community announcers, women groups, churches are used to pass on good information about how the hospital works and the importance of women going there when pregnant for good care, then the whole community will start knowing the good good things in our hospitals".*

> *"...in this community everybody knows about immunisation. When the immunisation time comes, the clan head will use the town announcer to announce and even markets will not sell. Churches will make announcements, even meeting groups. Then why can't the same method be used to let everybody know about the good of women going to hospital to deliver".*

> *:….even this free treatment for mothers and their babies, am just hearing from you. We don't know about it…the people don't know. Everybody still think that it is still the way it used to be money, money, money. That is why we do not go. No information at all".*

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Discussion

Evidence from several studies have supported the above recommendations.

Education for women and husbands: Graczyk (2007) posits that lack of education can affect health when it limits women's knowledge about proper nutrition, the importance of rest and exercise, and birth spacing. Accordingly, before a woman decides to seek care, she must be able to recognise the signs and symptoms that indicate the need for care (Graczyk, 2007). Low levels of knowledge and awareness about risk factors, causes, and treatment for given conditions was observed among those failing to take up services (Tod, 2001). Furthermore, as pointed out by New (2006), problems of communities to obtain information in their own language also limits knowledge about particular conditions and the services available to them. Caroli, Rooney, and Villar (2001) observed that while many women die because they do not receive appropriate medical care, a good percentage die because they do not access that care timeously. This is due to the fact that pregnant women, their families, and the community in

general lack knowledge of the danger signs and symptoms that occur during pregnancy, labour, or the puerperium (Kabakyenga, 2012).

In support of this, Ronsmans and Filippi (2004) emphasised that information, education, and counselling plays a vital role in the prevention of maternal death by making the pregnant women and their partners aware of the sequence of events, from late recognition of danger signs through to delays in seeking care, to delays in receiving prompt care.

An appropriate programme of health literacy or behaviour change communication, such as implementing a birth plan, can circumvent this sequence. Actions to improve health literacy are focused on developing context-specific health knowledge, and the self-efficacy necessary to put that knowledge into practice in ways that enable people to exert greater control over their health and health-related decisions (Nutbeam, 2000).

Free health services: According to Izugbara and Agangideh (2005), reported that Igbo women in Eastern Nigeria, choose traditional rural therapeutic destinations for obstetric services because they want cheaper rates. NPC and OPC Macro (2004) asserted that many women in Nigeria do not consistently seek care often because of the lack of financial resources to pay for such services. Poverty is a major social cause of death in Cross River State as most people are unable to pay for healthcare services even when it is highly subsidised by government (Harrison, 2009). Also a large component of healthcare is provided in private fee-for-service centres leading to slow progress towards improving maternal healthcare delivery systems in Nigeria (Federal Office of Statistics (FOS)/UNICEF, 2000; Shiffman & Okonofua, 2006). Lanre-Abas (2008) also identified poverty as a major cause of maternal mortality as it prevents many women from accessing adequate medical attention due to inability to afford good antenatal care. User charges coming at a time of deepening poverty, have become a great barrier to

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access for many Nigerian women who are not educated, and economically disempowered (Lanre-Abas, 2008). In the case of the study of the Ologbo community by Osubur et al. (2005), the official cost of the service was higher than what most of the people in the community could afford.

Gifts at health services: On the aspect of 'gifts" as a source of motivation for the women, in Cross River State all pregnant women are given free Insecticide Treated Bed Nets provided by the Roll Back Malaria programme. In maternal health care, Mama Kits are already given free to all pregnant women registering for antenatal care. These are all are measures implemented by the government to encourage women and to motivate others who are not registered in the orthodox healthcare facilities, in the bid to promote uptake of skilled birth attendance (Archibong & Agan, 2010).

5.4 Verification and member checking

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Member checking was conducted with participants from both communities (A&B) to present the findings phase 1 study 1(interview) and to verify the themes and recommendations identified. The 10 themes and the 4 action recommendations (Table 10) were presented to the groups and the fieldnotes from this group meeting showed that participants verified and agreed on the emerging themes from their interviews.

5.5 Conclusion statements of the themes and sub-themes from the phase 1 (interview) of the study

The following concluding statements from the interview phase (1) of the study are highlighted below:

1. **Maternal health literacy** is low with low birth preparedness, complication readiness and knowledge of complications hence there **is a need to identify a strategy to improve maternal health literacy in the community**

2. There is low knowledge of the dangers of home delivery and only some experiential knowledge of benefits of skilled care and skilled birth attendants and there is a need **to improve access and attendance of these services**
3. There is a strong preference and patronage of TBAs based on access, culture and cost and any strategy to be developed should look **to integrate the role of the TBA within an overall collaborative model of maternal health care**
4. Communities continue to function in a traditional cultural way with strong cultural values and patriarchal roles influencing maternal health literacy and care and **ways to include the husband in the planning of maternal care should be identified**
5. The community does provide some support (though there is an absence of formal structures for this) for the pregnant women and community **sensitization would increase the community's role as a resource for maternal health literacy.**

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TABLE 10: Verified and validated themes, sub-themes and actions from study Phase 1

Objectives	**Themes**	**Sub-Themes**
To explore (1) the knowledge gaps and understanding of the obstetric danger signs in women of child-bearing age (pregnant and new mothers)	1. Limited knowledge of obstetric danger signs	• Limited knowledge of obstetric dangers with knowledge of only a few danger signs • Knowledge is centred around waiting at home for abnormal signs • Knowledge is the role of the caregiver
	2. Moderate experiential knowledge of benefits of skilled care in hospitals/health Centres	• Some knowledge on the benefits of skilled health care • Knowledge is influenced by previous experiences • Role of hospital in providing health education • Recognition of importance of role of hospital to provide immunisation
	3. Moderate knowledge of dangers of home delivery	• Some awareness of TBA lack of knowledge and skills for emergency interventions; • Lack of receiving immunisation for baby when attending a TBA • The possibly unsanitary environment of home delivery
(2) their perceptions on birth preparedness,	4. High patronage of and preference for TBAs	• Negative perceptions and experiences of healthcare services. • Financial position of the family

Objectives	Themes	Sub-Themes
complication readiness and delivery practices		• Past positive TBA delivery experience and positive reception by TBAs • Friends and family members' experiences of TBAs • Husbands' or influential family members' overriding decisions as to where to give birth • High consideration of proximity to place of birth • Concept of giving birth through natural inducement • Combination of spirituality in TBA services
	5. Understanding of skilled care and prompt interventions in hospitals by previous users	• Good care of mother and baby • Safety of their babies through cleanliness and immunisation • Positive experiences of hospitals • Education on birth preparedness • Provision of prompt emergency care
	6. Poor understanding of Birth Preparedness and Complication Readiness	• Poor preparation for emergencies • Preparation for non-emergency baby provisions • Reliance on TBAs for delivery dates • Reliance on husbands for financial arrangements • Reliance on God for provision during pregnancy
	7. Strong influence of cultural practices and beliefs relating to pregnancy	• Beliefs that certain food can affect the pregnancy • Beliefs that cerain practices can affect the pregnancy
(3) the perceptions of the role of family/ community and the maternal health initiatives in emergencies in terms of utilisation of orthodox health services.	8. Strong influence of husbands in decision-making about place of birth	• The husbands are the key decision makers about the place of birth • The husbands bear the financial responsibility for delivery • The patriarchal role of the husband
	9. Family support for women duing pregnancy, delivery and nursing periods (caring for other children and doing household chores)	• Assistance by immediate family members during pregnancy, delivery, and nursing periods • Assistance by their husband during pregnancy, delivery, and nursing periods
	10. Absence of community structures supporting women in emergencies	• Lack of community based maternal care initiatives • Support groups are strictly for their members
Action Recommendations	A. Education for husbands and wives on maternal health issues	• Education for women and husbands on maternal health issues

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Objectives	Themes	Sub-Themes
	B. Husbands/community involvement in maternal health issues	• Husband involvement and education
	C. Motivational health services	• Free healthcare services • Occasional gifts for mothers and babies • Spirituality in health services
	D. Increase community awareness on maternal health issues	• Community sensitization and education on maternal health services

5.6 SUMMARY OF PHASE 1 OF THE STUDY

There is clear evidence from these findings that the rural women in the study settings had limited knowledge of obstetric danger signs, moderate knowledge on the role of the hospital, and some knowledge on the danger signs of home delivery. Generally there is poor understanding of what Birth Preparedness and Complication Readiness entails among the rural women, as their focus was rather more on preparations for the baby's provisions.

The study findings also revealed a high preference for TBAs by the community women as a result of negative experiences and assumptions about orthodox healthcare services, past delivery experiences and that of friends and family members, proximity to place of delivery, receptiveness of health care providers, spirituality and cost of the TBAs' services. Skilled care and prompt interventions in hospitals were acknowledged among the few women who had at one time or another accessed hospital services.

Common cultural practices and beliefs regarding early visiting after delivery, and the intake of certain foods during pregnancy and after delivery was observed along with strong cultural influences of the husband on decision making and the absence of community structures supporting women in emergencies.

The above themes highlight the need for the following: maternal health literacy and community sensitisation; to improve community women's knowledge on maternal health matters, Birth Preparedness and Complication Readiness; and education to

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correct some negative assumptions and perceptions about orthodox health care services. In addition, these findings denote the need for husband and community involvement in maternal health issues and community sensitisation.

The action themes that emerged from the participants' suggestions on actions to be taken to promote utilisation of orthodox healthcare services by rural women were: educating women and husbands on maternal health issues; husbands/community involvement in maternal health issues; motivational healthcare services: and increasing community awareness. These further confirm the need for maternal health literacy and husband and community involvement in maternal health issues, and emphasise the need for motivation and spirituality in health service delivery.

This phase of the study is in line with the steps of the Citizenship Healthcare Model proposed by Doherty and Mendenhall (2006), which was adopted to guide this study. The proponents highlight that every project should be approached in a collaborative and democratic manner, and that the knowledge, wisdom, and energy of individuals, families and communities who face challenging health issues in their everyday lives could be tapped by engaging them as co-producers of healthcare for themselves and their communities, not merely as consumers of services. In this study, pregnant women and new mothers in the communities were engaged in this descriptive phase (1) of the study through interviews to identify the problem, suggest actions, and define the study focus.

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CHAPTER SIX: FINDINGS AND DISCUSSIONS OF PHASE 2: COMMUNITY ENGAGEMENT (PHOTOVOICE) AND VALIDATION

6.1 INTRODUCTION

This chapter presents the analysis of phase 2 of the study which aims to address objective 4 to explore the perceptions of mothers through a participatory approach about the problems experienced in pregnancy (birth preparedness, complication readiness and utilization of healthcare facilities for skilled attendance during pregnancy, delivery and puerperium) and to identify possible solutions involving the community in the prevention of maternal health complications through.

This phase was conducted through two studies. Firstly, a qualitative focus group (FGD I) with the participants from Study 1 (recruited as photovoice participants), was conducted using Photovoice for community engagement through narratives around the photos taken to explore the problems experienced in pregnancy, delivery and after delivery and identification of key themes as well as the possible solutions. This was followed by member checking to validate the emerging themes from photovoice analyses. In addition, a focus group with older women (OWG) FGD II, was held with 14 older women from the study communities, to further validate and confirm the discussions of the findings from the Photovoice, (see responses in appendix 13) FGD11. The results of these 2 focus group discussions (FGD I and verification by OWG-FGD II), and the themes that emerged are presented where appropriate.

6.2 STUDY 2: PHOTOVOICE FGD I

6.2.1 Photovoice participants

All the 20 pregnant women and new mothers from the two study communities who participated in the Phase 1 of the study, were recruited as Photovoice participants (See 4.7.1.1 for description of participants). Though all 20 participants were trained and

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participated in taking photographs, only 15 individuals participated in the FGD. The 15 participants were nine new mothers and six pregnant women between the ages of 15 to 45 years, 8 from the Community A and 7 from Community B.

6.2.2 Photovoice process

After participants were recruited, orientated to Photovoice ethics and methodology and trained, all 20 participants participated in camera sharing and education on the kinds of photos to take based on the study focus and were given three (3) weeks to take photos.

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Photo 2: Pregnant women and new mothers during Photovoice FGD.

Source: Fieldwork, 2014

The cameras were earlier turned in for the printing of the photographs. A FGD was held in Community A with the 15 participants. The five persons who could not attend due to family reasons had sent in their cameras earlier for the printing of their photos. A total of 10 photographs were selected and used for the discussion by the Group.

As the photographs were being passed between participants, each participant gave a short description of what they could see in the photographs. Using Wang and Redwood-Jones' (2001) Photovoice guidelines, the discussion was facilitated by posing the following questions:

- What do you **S**ee in these photos?;
- What is really **H**appening?;
- How does it relate to **O**ur lives?;
- Why does the situation **E**xist?;
- What can we **D**o about it?

The first four questions explored the current situations of pregnant women and possible reasons for their situations, and the last question addressed possible future community actions that could possibly address their current situations.

6.2.3 Member checking and verification of FGD1

Member checking and verification was done to provide feedback from photovoice FGD 1 analysis and to verify identified themes with photovoice participants.

A week after the completion of the photovoice FGD1, the 15 pregnant women and new mothers from the two communities that participated in study 2 FGD I, were gathered in the town hall and given verbal feedback on the analysis of the findings and the themes that emerged from study 2 FGD I. The verification group discussion lasted about 50 minutes and field notes of agreement were taken.

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6.3 STUDY 3: FGD II (OLDER WOMEN)

6.3.1 Participants of older women's group (OWG) FGD II

Fourteen (14) participants from the 2 communities under study comprising older women (mother-in-laws and grandmothers n=8), representatives of photo voice participants (n=4) and women leaders (n=2) participated in the the FGD.

6.3.2 FGD process

The participants were asked to verify the concepts identified in Study 2 by asking the following questions: What are your opinions about these findings? What aspect of the findings do you agree or disagree? What are your contributions towards these? How do these findings related to your lives and practices in these communities? What do you think can be done?

6.4 PHASE 2 FINDINGS: THEMES EMERGING FROM PHOTOVOICE

During the FGD I the 10 pictures selected out of the printed pictures, examined and grouped for discussion under two headings, namely "Domestic activities and healthcare practices of pregnant women" (Figure 5), and "Attitude and access to healthcare services by pregnant women and nursing mothers" (Figure 6). The themes and sub-themes are presented according to these headings. The themes that emerged from the Photovoice FGD I and the verification and validation through FGD II by the OWG will be presented and discussed together. More detail of these findings can be found in Appendices 9 &10.

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6.4.1 Domestic activities and pregnant women's healthcare practices

Photographs 2, 3, 4, 5, and 6 (Figure 5) illustrate the domestic activities and healthcare practices of pregnant women. Based on the analysis of the data generated and transcriptions from the narratives of Figure 5 photos, four (4) themes with sub-themes and three (3) actions emerged (Table 12).

6.4.1.1 Theme 1: Cultural practices impacting on maternal health

Domestic chores were dominant in all the photographs and there was a strong identification that it is culturally acceptable that it is the woman's job to do all things and not to expect any assistance. Two sub-themes supported this theme, namely heavy

household chores carried out by mothers is culturally accepted and Cultural respect for men

<table>
<tr><td> </td><td>Mother with baby working on farm (Photo 2): The first photograph discussed was that of a young mother weeding on her farm with her 1 year-old baby secured on her back. She was engrossed in her farm work when the photograph was shot.</td></tr>
<tr><td> </td><td>Pregnant woman sweeping (Photo 3): The second photograph discussed under this category was that of a pregnant woman wearing a tunic, broom in hand, and bending down sweeping the floor within her compound.</td></tr>
</table>

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	Pregnant woman carrying wood (Photo 4): The third photograph was that of a heavily pregnant woman wearing a long tunic and carrying a big bunch of firewood on her head. She was possibly going home after fetching firewood from the farm.
	Pregnant mother shopping (Photo 5) The fourth photograph was that of a young pregnant girl standing at a major (tar) roadside holding a shopping bag in her hand. She was wearing a skirt and a short T-shirt that didn't cover her abdomen.
	Pregnant mother shopping (Photo 6) The fifth photograph is that of a pregnant woman with a red gown, shopping bag in hand at the meat sellers' stand in the local community market.

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FIGURE 5: Domestic activities and healthcare practices of pregnant women (Group 1 photographs)

Source: Fieldwork, 2014

TABLE 11: Themes, sub-themes, and actions emerging from storytelling and narratives of photos on domestic activities and healthcare practices of pregnant women

Themes	Sub Themes
1. Cultural practices impacting on maternal health	• Heavy household chores carried out by mothers is culturally accepted • Cultural respect for men and subscription to traditional male and female roles
2. Lack of adequate information about maternal and child health issues	• Strenuous work by pregnant women is seen as exercise to reduce prolonged labour • Lack of awareness about the health impact of strenuous household chores • Attitudes about appropriate clothing during pregnancy
3. Poverty	• Working to raise money for family • Lack of money for appropriate clothes
4. Lack of help and support for pregnant women	• Lack of help and support from husband • Traditional male and female roles
ACTIONS IDENTIFIED THROUGH PHOTOVOICE	
A. Recognising and Strengthening the role of men to support women during pregnancy	• The husbands are best placed to provide this support • Challenges in addressing cultural norms and roles
B. Strengthen the role of community to support women during pregnancy	• The extended family can also provide support • Community sensitisation on maternal health issues
C. Improve maternal health education in terms of domestic activities and pregnancy	• Need for education on self-care

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Sub-theme 1: Heavy household chores carried out by mothers is culturally accepted

Observing the participants, it was deduced from the facial expressions and contributions that the photographs depicted common occurrences in the community. Amusement and acceptance was visible in the participants' body language and facial expressions as they shared what could be seen in the photograph as culturally normal behaviour. All participants confirmed that the stories and tasks being carried out by

pregnant women depicted in the photographs on display were an accurate reflection of what women do in their homes whether or not they were pregnant.

> *"It's my friend carrying her baby on the back and doing her work in the farm beside their house ... she is weeding the farm ... this is exercise o! But also punishment for the baby ... as she is carrying the baby on her back like this is a punishment to the baby because the baby's head is facing the ground and the sun is also hitting on the baby". (Photo 2)*
>
> *"Yes it's me that snap the picture ... it's my sister...she is pregnant and sweeping the compound ... she is in her husband's house; it's she that sweeps it every morning ... even before she became pregnant ... it's a big compound". (Photo 3)*
>
> *"The woman in this picture is our neighbour and she is my friend ... she is pregnant and we use to go to the farm together to fetch firewood which we use to cook for the house ... she is 6 months pregnant and I snapped this picture as we were coming back from the farm". (Photo 4)*
>
> *"For me what I can see in this picture is a girl who is pregnant holding a bag; its like she is going to the market...standing by the road waiting for transport" (Photo 5)*
>
> *"I can see a pregnant woman with some other people ... its a market ... where they are selling meat ... the pregnant woman is trying to buy meat ... she is wearing a gown". (Photo 6)*

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Sub-theme 2: Cultural respect for men and subscription to traditional male and female roles

In discussing the reasons why, the situations in the photographs exist, women felt that these roles were strongly culturally prescribed as women's roles and that these roles were not the husband's roles. Even when the husbands and other relatives assume certain tasks such as taking care of the older kids, paying the medical bills, providing funds for baby shopping and washing clothes (usually the husband's clothes), these are done merely to assist the women. The participants stated that most husbands were not interested or openly willing to take up the more tedious tasks and chores that are societally demeaning or are usually ascribed to women, such as sweeping, fetching

water, fetching firewood, and farming. Reasons suggested for this was that this may be due to men fearing being labelled a weakling.

> *"Ah! Whether you are pregnant or not you must prepare food for your husband".*
>
> *"Me I use to do everything in the house ... go to the farm ... fetch water with my pregnancy and nobody use to help me.*
>
> *"Even if they help you they feel its help o! After, you will come and take over ... my husband use to help me like to carry the children but when I come back I will take over.*
>
> *"It is lack of help that is supposed to be rendered ... so till she goes and come back from the farm she and her children will not eat ... so you see"*
>
> *"You must do your work in the house as a good wife o! ... Nobody will support you if you say its because you are pregnant ... ehen! Are you the first woman? ... So we must sweep the house ... we stay and take care of the house ... you are supposed to do what your husband say because he is the one that will pay the money ... yes you can tell him your own but if he says this is where you will go that is it".*

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Participants' contributions illustrate that women subscribed to these female roles in the community. All the participants maintained that generally women accorded the roles child-bearer and helpmates to men by ensuring that men are comfortable and satisfied both sexually and domestically by carrying out the household chores.

> *"Ahh! ... Aunty even if your husband want to help you he will not want to do it because of his friends or family people so they will not say he is soft ... woman wrapper".*
>
> *"How can you expect your husband to be the one to sweep your house if people see it they will take you to be a bad wife".*
>
> *"I will not like it if my husband is sweeping the house ... people will say I am a bad wife allowing my husband to sweep and fetch water ... I like it ... it is part of exercise like the nurse tell us to be walking around so that delivery would be easy".*
>
> *"It is my duty as a woman to fetch firewood and go to the market whether I am pregnant or not ... a man cannot be going to the market for you all the time because you are pregnant".*

"Whether you are pregnant or not you have to eat ... you still do all those work you normally do ... you must sweep your house in the morning ... your husband will out and you are at home ... it is only you and the children ... it is not bad; it is part of exercise like they tell us in hospital".

It is my duty ... it is the woman's duty to cook, fetch firewood and take care of the house ... without she going to get the firewood she would not be able to cook and eat ...sometimes there is food in the house but there is no firewood to cook ... so it is the woman job.

Discussion: The finding is not uncommon in Africa and is corroborated by a study in Tanzania which pointed out the relationship between lack of a birth plan, low skilled delivery at available health units among rural women in Tanzania and the heavy house hold chores of women (Magoma, Requejo, Campbell, Cousen & Filippi, 2010). A further implication of the heavy household duties are that women cannot afford to be sick themselves and the cultural value of male dominance reduced the promptness with which medical assistance is obtained anytime an illness is suspected during pregnancy (Magoma, Requejo, Campbell, Cousen & Filippi, 2010).

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6.4.1.2 Theme 2: Lack of adequate information about maternal and child health issues

Three (3) sub-themes supported this theme, specifically strenuous work as exercise to ease labour, the lack of awareness about the health impact of strenuous household chores, and uninformed attitudes about appropriate clothing during pregnancy.

Sub-theme 1: Strenuous work on pregnant women is seen as exercise to reduce prolonged labour

According to the participants, and as captured in the photographs, the pregnant women's practice of taking on the tasks is also with the intention of exercising their

bodies to facilitate quick and smooth delivery during labour and may relate to women desire and willingness do anything to minimise labour pain.

> *"I can see a woman, she is pregnant and sweeping the house ... she is bending down and sweeping ... ... this woman is doing exercise and this exercise she is doing is good with her body ... it makes it less on her ... its not good for a pregnant woman to be lying or siting down always ... this exercise that she is doing is good for her; it will make it light on her". (Pic 3)*

> *"I see a pregnant woman carrying a big firewood on her head ... she is laughing ... this is exercise as am seeing ... if she finish doing exercise she would now go and bath after sweeping ... because sweat will be coming out of her body and make her feel light and it's a good thing". (Pic 4)*

Most community women religiously perform these hard domestic tasks because they have been told by healthcare givers to regularly exercise instead of being idle during pregnancy, and that exercise helps to reduce prolonged labour and undue stress on the baby. The concept of *"exercise to reduce prolonged labour"* affirms that women in the communities are open to and interested in activities geared at reducing their pain during labour and the stress inflicted on their babies during delivery.

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> *"The reason why this pregnant woman is going to the market is she need help but she also need to walk to the market so that it will be light on her".*

> *"...And it's a form of exercise ... the woman is exercising ... it's not good to stay one place when you are pregnant; that's what they tell us at clinic ... so, its exercise".*

> *"The woman (TBA) that used to deliver me say when you go to the farm walk about do your work you are exercising your baby will be active and come out fast without wasting time when you are giving birth".*

Sub-theme 2: The lack of awareness about the health impact of strenuous household chores

Contributions from participants affirmed that most women were unaware of possible health impacts or risks of carrying out some of the strenuous tasks on themselves and their babies. Those that had slight knowledge of the likely risks did

not have any option as they had no assistance and in some cases there may be no food for the family, hence the willingness to cheerfully carry out their tasks.

> *"I don't think it's bad ... for me o! ... It is like exercise for the body ... every day we must eat so we must go to the farm and do work at home ... nobody will do it for you except when you have born you will rest small.*
>
> *"We work; we do work; very hard work like farm ooo! Some people born for farm self and we rush them home ... but if they don't go there will be no food in the house and hunger will come for us ... your husband go vex with you".*

Sub-theme 3: Attitudes about appropriate clothing during pregnancy

Photograph 5 specifically stimulated a discussion on the correct clothing to wear during pregnancy. From the contributions it is affirmed that participants knew that it's a good practice for pregnant woman to wear loose clothing and to participate in light exercise that assists in keeping mother and child healthy. The photograph of a pregnant teenage girl was however frowned upon, not because the participants considered the possible health implications for the girl, but from a moral angle, namely that the girl was too young to be pregnant, she brought shame to the family, and was not knowledgeable regarding the suitable clothing to wear during pregnancy.

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> *"Secondly, the clothes that she is wearing is not good for a pregnant woman to wear ... the clinic that we use to go [to], they use to tell us that we should not wear tight clothes because as it is tight on you its also tight on the baby inside the belly ... you should wear clothes that would be free on your body". (Pic 5)*
>
> *"I snapped this picture because I see this girl as a very small girl and she is pregnant ... she is living in our place with her parents and she is pregnant like four months now ... she is waiting to take a bike when I snapped the picture ... she wants to go to the market ... the clothes she is wearing is too short and tight and its not good". (Pic 5)*

Discussion: In support of the above findings**,** Osubor et al. (2005) noted that Nigerian community members' perception and knowledge regarding maternal health problems play a role in their self-care. Also, the findings are in accordance with the findings of Mutiso et al.'s (2008) Kenyan study, which revealed that the families who were knowledgeable about maternal health issues were more likely to report more support from spouses.

6.4.1.3 Theme 3: Poverty

Poverty was experienced and explained by the photographs showing women working and the photograph of the young pregnant girl wearing inappropriate clothes. Thus, two (2) sub-themes emerged in support of this theme, namely working to raise money for the family and lack of money for appropriate pregnancy attire.

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Sub-theme1: Working to raise money for the family

Contributions from most of the participants affirmed that there is little or nothing that can be done to effect changes in the work women did while pregnant as it was culturally acceptable for pregnant and non-pregnant women to perform domestic chores and there is no other person but her (the wife) available to perform such chores. Their argument from the participants were that it was the woman's responsibility to support her home (the man) in performing household tasks as there was a need to alleviate the high level of poverty experienced by families. They commented that the woman had to carry out those tasks to ensure the next meal for herself and children.

> *"Nothing o! It is part of our culture ... the man is the head we [referring to the women] here, we are supposed to support and go to our farm to work so we can eat".*

> *"We work, we do work; very hard work like farm ooo! Some people born for farm self and we rush them home ... but if they*

don't go there will be no food in the house and hunger will come for us ... your husband go vex with you".

Sub-theme 2: Lack of money for appropriate pregnancy attire

Participants' responses also indicated that lack of money played a role in photograph 5 in which the pregnant woman was wearing tight and short clothing. They commented that this was likely to be as a result of lack of money to purchase the appropriate attire suitable for pregnancy.

> *"Some husbands do not give their wives money for new gowns that is free during pregnancy because of no money. Their wives keep managing old ones".*

> *"Women like this, sometimes they have no help or money to change clothes. Government should also help by providing materials to pregnant women especially those who attend antenatal, to encourage them and motivate others".*

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Discussion: Poverty plays a major role in access and quality of maternal health services. Lanre-Abass (2008) stated that poverty prevents Nigerian women from accessing ANC, having the time to rest, and eating balanced diets, all of which are essential to safe pregnancy.

6.4.1.4 Theme 4: Lack of help and support for pregnant women

Lack of help and support for pregnant women may make it difficult to access and receive adequate care. The theme of lack of support emerged strongly and was supported by two (2) sub-themes, namely lack of support from husband and traditional roles of males and females.

Sub-theme 1: Lack of help and support from husbands

According to most participants, the lack of support and help from the husband resulting in women, whether pregnant or not, perfoming all basic tasks at home was responsible for most women being prevented from accessing correct and first-hand information on their pregnancy and any health concerns they may have. The particiapants stated that women may not be aware of the benefits of child immunisation and free ANC services in the State as they were always busy on the farm (bush), at the stream, or in the kitchen. They were thought to be engrossed in their domestic work, hence they don't have the time to access such information.

> *"Hah hah hah, is it when you are always going to the farm that you will know what is happening? ...My husband goes to the farm too but go to work in Calabar ... he tells me things ... what to do and I support him.*

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Even when men (husbands) want to either take total responsibility or assist their pregnant wives in certain tasks, they can't because fears and concerns of being seen as a "woman wrapper" by other community members, including women.

> *"Ahh! ... Aunty even if your husband want to help you he will not want to do it because of his friends or family people so they will not say he is soft ... [a] woman wrapper".*

Sub-theme 2: Traditional roles of males and females

This was compounded by the cultural roles of males and females with the men (their husbands) being the ones that go out, socialise more, and listen to the news. The information received from their peers were also traceable to men (husbands) as women were more dependent on their husbands for correct information regarding maternal care and childcare, and may not have the opportunity to access information first hand. According to the participants, this is a major reason why they depended on and trust

what their husbands say regarding the place of birth and whether or not they should present their babies for immunisation.

> *"Ahh! As a woman am supposed to go to the market to buy things to cook for the family ... what is there? It is my own to give birth and it's the man's own to provide the money ... to take care of the children ... he is the head of the house so if he says he does not want immunisation what can I do? ... Although I have heard it is good but people will blame me for disobeying my husband".*
>
> *"It make us not to know what is happening outside ... like news ... it is what our husband tell us that is final ..."*

Discussion: Cultural roles played a major role in the help and support the participants received. Erinosho (2005) observed that culture influences health behaviour on so many levels. For instance, cultural factors such as gender norms deter women from getting the support they need to fulfil their reproductive intentions, limits their choices and reduces their beliefs regarding behaviour, all of which reduces their access to health information and care and impairs its quality (Erinosho, 2005).

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6.5 ACTIONS FROM DOMESTIC ACTIVITIES AND HEALTHCARE PRACTICES OF PREGNANT WOMEN

Three (3) action recommendations to improve the impact of domestic chores and hard work on women were identified by the participants: recognising and strengthening role to support women during pregnancy; strengthening the role of the community in supporting the pregnant women; and improving maternal health education in terms of domestic activities and pregnancy.

6.5.1 Recommendation 1: Recognising and strengthening the role of men in support of pregnant women

In the context of these photographs and the need to provide domestic support for pregnant women, a few of the participants suggested the need for the men (the husband) to be positioned in the forefront as a recognised helper to his pregnant wife and that this

should be backed by the community. Two (2) sub-themes supported this recommendation, namely that the husband was best placed to provide this support but that there were challenges in addressing cultural norms and roles.

Sub-theme 1: Husbands are best placed to provide support

The participants argument was supported by the fact that the man was the closest person to the pregnant woman and the father to her unborn child, In addition, they believed that his assistance would attract that romantic and soothing relief to the pregnant woman.

> *"They (the government) should help us to let our husband to understand ... that too much work is not good ... our husband is supposed to help us and be petting us ... but no help".*
>
> *"Ehen; yes now! They used to tell us at the hospital we should come with our husband so he will understand what we are going through ... because they [referring to husbands] are the ones that are supposed to understand; ... is in not them that put it [referring to pregnancy] inside? ... If they can teach them so they will not be ashamed to be assisting us when we are pregnant it will help.*
>
> *"Except they will tell our husband to be helping us ... but some of the men are good o! They help their pregnant wives they stop them from going to the farm like my husband he use to pet me ... does not allow me to do hard work when I am pregnant".*

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Sub-theme 2: Challenges in addressing cultural norms and roles

During the discussions and from the use of words by the participants, the researcher observed that most of the women tried not to refer to their own husbands directly as examples, preferring to use words such as "the men", "them", or "our husbands" when contributing to the discussion. This is linked to the cultural respect for men in the society and the depersonalisation of the problem by the shifting of blame factor (as in*; it's a general problem*) and not trying to link the issue to what is obtainable in their homes.

However, contributions from most of the participants confirmed that there was little or nothing that can be done to effect change since it is part of the cultural norm for the woman, whether pregnant or not, to perform all domestic tasks under the premise that there is no other person but her (the wife) in the house who can perform such tasks. Their argument was that it is the woman's responsibility to support her home (the man) in performing those tasks and to help reduce the high level of poverty, hence the woman would have to carry out those tasks to be sure of the next meal for herself and children.

> *"Nothing, oh! It is part of our culture ... the man is the head, we [referring to women] here we are supposed to support and go to our farm to work so we can eat".*

The above findings corroborate the responses from FGD IV with the older women group (OWG) in the communities to validate these findings:

> "*Hmmmmm! Pregnancy is not a sickness; it does not stop any woman from doing her duties. It is even better for her health and that of her baby. If she sits back at home, she is a lazy woman. Who will do it for her…is it her husband? No ... it is not like that here" (OWG).*

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Discussion: The suggested action would be beneficial as men who are supportive and helpful to their pregnant wives appeared to be more knowledgeable of ANC services and may seek health information from a health worker (Tweheyo et al., 2010). Similarly those men whose spouses utilised skilled delivery during their last pregnancies were more likely to accompany their spouses at ANC (Tweheyo et al., 2010). According to Iliyasu, Abubakar, Galana, and Aliyu (2010) and Odimegwu et al. (2005), prenatal male involvement has been associated with positive outcomes for the mother and baby, and includes more ANC visits, participation in high-risk behaviour reduction, and more Birth Preparedness in case of pregnancy complications. This recommendation suggest that strengthening the role of men to support women in pregnancy through providing information to male partners of

pregnant women attending ANC might be beneficial an increase their involvement and participation. However, addressing the cultural male and female roles remains a challenge.

6.5.2 Recommendation 2: Strengthen the role of the community to support women during pregnancy

Two (2) sub-themes supported this recommendation, namely the role of the extended family in providing support and the need for community sensitation on maternal health issues.

Sub-theme 1: The role of the extended family in providing support

A second recommendation from the participants was that other family members such as the woman's mother, mothers-in-law, and brothers- and sisters-in-law could also provide support during pregnancy.

> *"There is need to provide any kind of help to her ... from her husband, brother in-laws, mothers-in-law and the woman's siblings ... by taking care of the baby when she wants to go out"*
>
> *"It is lack of help ... if she has somebody she would have keep that baby before going to the farm ... she needs help ... if there was someone to help to go and get the firewood it would have been good they would have been helping her with something in the house".*
>
> *"Sometimes, though it is a form of exercise, someone or a relation or even an in-law, should assist the women so that ... that they can rest".*

Sub-theme 2: Community sensitisation on maternal health issues

However, the participants identify that such support and engagement would require a robust education and advocacy programming to community leaders and men generally at the local, state, and federal government levels. Hence, the caregivers and health

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service providers should shoulder the responsibility of education and campaign for domestic support of pregnant women by the men.

> *"That is why I think nurses and government should be the ones to come here and educate the men and women. Tell them what they should know about pregnancy and delivery and how to help or support them".*

Discussion*:* The role of the extended family in support of the pregnant women is an important community resource that could be tapped. The community also could be approached to discuss solutions to obstacles in accessing this needed care (Portela & Santarelli, 2003). In order to involve decision-makers in the community and reach women who do not receive ANC, a complementary process of dialogue and building partnerships with the community, based on the principles of a reciprocal relationship, may be useful in certain contexts in order to discuss maternal and newborn health needs and to support the importance of skilled care for births (Portela & Santarelli, 2003).

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6.5.3 Recommendation 3: Improve maternal health education in terms of domestic activities and pregnancy

Most of the participants maintained that it is the pregnant woman and not the husband that requires education regarding what kind of domestic and economic chores and tasks she should not be engaged in while pregnant. To improve maternal health education for mothers about domestic activities the participants identified the importance of focusing on the responsibility of the women herself and the need for education on self- care.

> *"See…. to me I think it is we the woman that should be educated on the kind of work we should not be doing when we are pregnant ... like me now they told me it is not good for me to be bending down to sweep the floor as I am pregnant and I don't use to do it ...my husband cannot force me ... it is my younger sister that is staying with us that use to sweep".*

Discussion: Improving the health literacy of women in terms of maternal health education is an important recommendation. People who have better developed health literacy will have the skills and capabilities that enable them to engage in a range of health-enhancing actions including personal behaviours as well as social actions for health (Nutbeam, 2008). This may endow them with the ability to influence others in healthy decisions such as participating in preventive behaviours or utilising healthcare facilities for skilled care (De Walt et al., 2004).

6.6 PREGNANT AND NURSING MOTHERS' ATTITUDE AND ACCESS TO HEALTHCARE SERVICES

Photographs 7, 8, 9, 10, 11, 12, and 13 (Figure 6) were grouped together as the showed the attitude towards maternal health care and the issues impacting on access to healthcare services of pregnant women in the communities. Based on the analysis of the data generated and transcriptions from the narratives of Figure 6 photos, ten (10) themes and sub-themes and seven (7) action recommendations emerged (Table 12).

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6.6.1 Theme 5: Men are sole decision-makers regarding place of delivery

When reflecting on what is really happening, contributions from participants affirm that men most often determine the delivery place for the women, but only a few of them accompany a woman to the health facility. The theme was supported by two (2) sub-themes namely: some men escort their wives to the delivery place; and the men bear the financial burden of the cost of healthcare (Table 12).

TABLE 12: Themes, sub-themes, and actions emerging from storytelling and narratives of photos on pregnant and nursing mothers' attitude and access to healthcare services (SHOWeD) in Figure 6

Themes	Sub Themes
5. Men are sole decision-makers regarding place of delivery	• Men escort their wives to the birth place for various reasons • Men bear the financial burden of healthcare services
6. High preference for TBAs	• High patronage of TBAs by the community women • Communal living in TBA homes • Spirituality in TBA homes • Physical proximity to service point • Confidence in TBAs as a first choice • Past experience ad belief that first place of birth is safe • Poverty and low cost of TBA services
7. Low preference for orthodox healthcare facilities	• Lack of knowledge about availability of free healthcare for women and children in healthcare facilities • Past experiences of negative attitude of healthcare providers • Fear of health facility injections and operations • Absence of healthcare providers on duty at night • Perceived costs of health services
8. Poor knowledge of maternal and child care in TBA homes	• TBA's lack of knowledge on proper delivery procedures and care • Lack of education on care of the newborn
9. High recognition of importance of immunization	• Utilisation of immunisation services by women • High level of community involvement in awareness-creation on benefits of immunisation
RECOMMENDATION ACTIONS IDENTIFIED FOR ACCESS AND ATTITUDES	
D. Free treatment in healthcare facilities	• 'Free' treatment should be free in the real sense • Community involvement in raising awareness of free health services
E. Involvement of husbands in ANC	• Men as sole decision-makers should be involved in ANC • Challenges in addressing cultural norms and roles
F. Spirituality in service delivery	Strong faith in prayers and fasting to God during pregnancy for protection should be integrated in health service delivery
G. Community support	• Influence of community heads through levies and sanctions to emphasise importance of utilisation of healthcare facility

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	• Constitution of influential women group to monitor the activities of pregnant women in the community • Use of community structures such as village announcers, churches, women groups, community heads, etc. in emphasizing facility delivery
H. Motivation to attend health services	• Receptive attitude of care-providers • Occasional gifts to women who utilise orthodox facilities to encourage them and motivate others • Availability of 24-hour services
I. TBA training and facility/TBA collaboration	• Knowledge and skills for proper delivery practices of mother and childcare. • TBA/Facility collaboration

	Pregnant woman with a young man (Photograph 7): The photograph presented for discussion shows a young man walking very closely behind a young pregnant woman holding a head tie and a nylon bag firmly behind her waist. The pregnant woman walks quickly into a thatched house, and in front of them is another pregnant woman making phone call with a travelling bag and a cooler on the floor next to her foot directly in front of her.
	Traditional birth attendant house (Photographs 8 & 9): The photograph discussed depicts seven women, five of which are seated on three beds placed at the corner of a mud houseroom with a thatch roof. The sixth woman is standing with a book in her left hand and she is talking to one of the women in the room. The seventh pregnant woman is seated on the floor with a baby of about two years old sitting close by; two of the five women sitting on the beds are holding newly delivered babies in their arms, while the other three women on the beds are pregnant. Clothes hung on the walls of the room,

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while well-folded sleeping floor mats were placed in the corner of the room.

A prayer altar is always evident in a TBA's delivery room (*Photograph 9*)

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***Baby delivered (Photographs 10 & 11)*: ** The photographs show a baby who has recently been delivered and the mother on the bed in a mud houseroom. The mother is lying down next to her baby on the bed; the bed is littered with sanitary towels and tissue papers stained with blood and fluids. The room looks dark and confined, and there are with rubber containers and piles of clothes all over the room.

A popular TBA in the community standing in front of her delivery room with a gloved hand shortly after taking the delivery shown in photograph 10

<table>
<tr><td> </td><td>Mother feeding baby (Photograph 12): The photograph depicts a young woman with wrapper tied around her torso with her brassiere visible on her bare shoulders. She is standing with a baby feeding bottle filled with pap in her left hand and a stainless steel plate filled with pap in her right hand and raised to her mouth. Her head is bent and she is using her tongue to lick the corners of the plate. A baby of about three days old is lying on the bed wrapped in cloths.</td></tr>
<tr><td>
</td><td>Waiting at the clinic (Photograph 13): The photograph shows a big hall with health-related posters on the walls and a total of 13 women; all but one are seated on benches, five of them are pregnant and eight of them are carrying babies. They all appear to be engrossed and are looking away from the camera.</td></tr>
</table>

FIGURE 6: Attitude and access to healthcare service (Group 2 photographs).

Source: Fieldwork, 2014

Sub-theme 1: Some men escort their wives to the birthplace for various reasons

When asked what they could see in photograph 7 *(Pregnant woman with a young man)*, some of the women's comments were as follows:

> *"The picture is my friend and her husband; she and her husband was coming to the TBA home ... she was having labour pains so she is walking fast and her husband is following her at the back.(Photograph 7)*

> *"I see a pregnant woman and a man walking towards a ... a thatched house it's like a TBA house because there is another pregnant women standing outside making phone call ... I see a bag and cooler on the floor beside the pregnant woman making phone call ... there is a small boy standing and looking at the first pregnant woman and her husband". (Photograph 7)*

> *"To me what I can see here is that a woman who is pregnant is being escorted to a TBA home by her husband ... the other pregnant woman is like making phone call to her family or husband to give them message". (Photograph 7)*

It was interesting to note that most of the participants commenting on this photograph linked the man in the photograph to be the husband to the pregnant woman. This finding was encouraging as it affirmed that the role of the man could be strengthened during pregnancy and that the utilisation of orthodox healthcare facilities can also be made possible by reaching out to and convincing more men to participate in antenatal visits with their pregnant wives to promote facility delivery.

However, the reasons for men escorting their wives to the birthplace were less clear; with at times this decision seemed to reflect men's involvement in determining the place of delivery for the women and ensuring that their decisions are followed.

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> *"Ahh! My husband use to follow me o! ... he goes with me sometimes to the clinic ... when I born this baby ... he use to go with me ... and when I was there I use to see some men come with their wives also; some of them like and to make sure their wives goes to exactly where she was asked to go because some will not go".*

Sub-theme 2: Men bear the financial burden of the cost of healthcare services

The participants when reflecting on the men being the sole decision makers commented that as the financial responsibility for the medical bills was mostly the sole responsibility of the men, this strongly influenced their decision to support access affordable healthcare services. This has been identified as the reason most men select

the TBA as the birth place. From this fact it is evident that the primary concern for the men is not of quality services but the most affordable service available.

> *"The normal thing is that it is the man would take care of all the money the hospital so sometimes they usually prefer places that are not expensive ... see that is why many of them prefer us to born in the TBA place".*
>
> *"We are women; it is anywhere my husband say I should go and deliver that I will go because it is him that will give me money ... even if I want to go to general hospital at Ikot Nakanda, if he say no ... I cannot ... no money; we are suffering".*

From the discussions it was apparent that there is a strong belief linking quality healthcare service delivery at the community primary health centres to high financial cost, which according to the participants, is not available to the men (husbands) in the community. Hence the women's justification that delivering at a TBA's home is a direct alternative to quality maternal and child healthcare.

During the FGD I1 to validate the above findings, the OWG commented thus;

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> *"It is the husbands that struggle to pay this money, so they want their wives to go to where they can pay. It is them that decide. So… I think that the men should be informed about all these things we are trying to do ... and .and ... I mean let them understand why it is good for their wives to register and deliver in hospitals. If not so, even when the women know the use and wants to go, if the oga say no… they won't go".*

Discussion: The participants confirmed that life in the communities basically revolved around the man being considered the family's sole decision-maker. Patriarchy is an integral part of the societal life in these communities and continues to facilitate male dominance in all matters, Women have little choice but to follow the sometimes unilateral decisions made by the men or influenced by the men in terms of where a pregnant woman must deliver of her baby. This situation has ultimately created low confidence in most of the women in terms of taking proactive initiatives regarding their

healthcare seeking behaviour. This was supported by Onayade et al. (2010) who observed that men's approval or disapproval of pregnancy care was linked primarily with difficulties of access and the costs involved, which were sometimes to do with the use of healthcare services. The authors identified this as a priority area to work with men to address these assumptions (Onayade et al., 2010).

6.6.2 Theme 6: High preference for TBAs

As in the interviews, in observing photographs in the group, a high preference for TBAs was confirmed. The reasons for this were supported through six (6) sub-themes. Specifically they is high patronage of TBAs by the community women, communal living in TBA homes, physical proximity to service point, prayers and fasting in TBA homes, confidence in the TBAs, past experience and beliefs that the first place of birth is safe and financial reasons.

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Sub-theme 1: High patronage of TBAs by community women

In observing photographs 8, 9 and 10, high patronage of TBAs were confirmed. The participants commented on the large number of women in the TBA house. It was interesting to note that no reference was made to the size of the room or their comfort.

> *"Ma, this is the picture I snapped inside the common room of a TBA home at Idundu....the number of pregnant women and women that give birth there is usually very plenty ... on this picture we have some of the women that have already delivered with their babies and the pregnant women in that room ... the women in labour pain are either standing or moving around in the room as mma (the TBA) have instructed ... by the corner of the room although I did not capture it on this shot, is a table altar where we (the pregnant women) use to pray for ourselves and family". (Photograph 8).*

> *"In the picture are women seating down like they are waiting for their turn ... like about 7 women some are pregnant and some are*

not pregnant and may be relatives staying around their women in labour as to help; some of the women are carrying their newborn babies ... it is a TBA home; yes it is a TBA home they are inside a TBA home. (Photograph 8).

From the content of this photograph (Photograph 8) and contributions by participants, it is evident that TBA homes continue to receive good patronage by community women. The women are at ease with the conditions inherent in TBA homes. Their family members are allowed to support their pregnant relations by rendering one form of assistance or another. Children from home are occasionally brought in to see their mothers. There is also a food preparation area and spiritual support (Photograph 9).

Sub-theme 2: Communal living in TBA homes

Participants' observations of photograph 8 denote the importance and the joy derived from communal and free living in rural communities.

"I see mothers, pregnant women, relations all in one room in a TBA home. Staying all of them very happily even as the room is very tight and hot. Some of them are sitting on the floor".

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"On the photo, women with their newborn, pregnant women and relations are all in a tight room in a TBA house. Some sitting on the mat on the floor. They don't even mind".

"Our women are always happy being together. The TBA is friendly and welcomes everybody"

The fact that family members of the pregnant woman can prepare food for the pregnant woman in the TBA's home and that communal sharing of things like food, prayers (Photograph 9), toiletries, family life discussions take place in the TBA home provides pregnant woman with a home-from-home feeling and attribute to the high patronage of TBAs. When asked how this relates to their lives, the participants' responses were again confirming the enjoyment:

"Every one of them is happy to be together. This cannot be allowed in the hospital".

"The women feel free here than hospitals. Because in the hospital they don't allow relations. Even the visiting time is very short. If it is hospital nurses will be shouting at them as they are sitting on the mat on the floor".

"Your people like your sister or your sister in-law can come to the place prepare food for you ... even in the hospital they will not agree; you cannot even try it ... I like it ... she will massage you; tell you when you will born and you will born ... we use to pay o! ... give her foodstuff like yams, cassava ... she also tell us to do test; immunisation".

Sub-theme 3: Spirituality in TBA homes

The regular prayers and fasting organised for pregnant women in the TBA's homes also encourages women to patronise TBAs. As seen in photograph 9, a prayer altar is always an aspect of the TBAs delivery rooms. From the women's narratives it was confirmed that every TBA clinic or delivery room has an altar at one corner. This is used for regular prayers and fasting with pregnant women and mothers and they are a strong force that endears women to the services of the TBAs since they strongly believe in God's protection throughout their course of pregnancy.

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According to participants' contributions, most women tend to feel spiritual and religious during pregnancy, hence their preference to access birth delivery services from TBAs since most of them apply spiritual programmes such as prayers, prophecies, visions, and food fasting to psychologically prepare each pregnant woman for delivery.

"For me aunty if you ask me, you see the TBA will pray with and you give you fasting to do ... when you come all the women come together to pray at the altar ... yes now! She has an altar in the house everybody comes together we pray". (Photograph 9).

This service is usually not provided at the health centres, hence the higher preference of pregnant women in TBA homes. In support of this, during FGD I1 to validate the findings of the study the older women confirmed this;

"Mma Nurse, It will not be easy ... to stop women going to TBAs at all at all. Because these women are very good ... many are prophetess, they pray for women, fast for women ... in fact they have a way of locking your pregnancy so that it does not come out

*till it is time. Hospital people don't know all these, prayers and fasting is very important. We believe in God and it is God that helps us. Nurses do not have much time for fasting and prayer with women unless ... they will start doing something about this. If not so, I know that our women will still go to TBAs and churches even after registering in health centres" (*OWG).

*"Nurse, we trust in God here! Without God it will not work for us. Prayers and fasting makes us belief God will help the woman deliver safely. So please we want fasting and prayers in our hospital. In fact, they should be calling prophets and prophetess to pray for the women, so that any bad thing coming can be stop" (*OWG).

The participants' discussion of photograph 9 above revealed the strong religious inclination of the community's women.

"This is a TBA house. Where women go to deliver. At the corner is where they set up a table for prayers. Pregnant women are taken through prayers and fasting in TBA homes. Can see many women here ... some have delivered and some pregnant and waiting to deliver".

"[Babies crying] I see a prayer altar and women in a room. Some with their babies ... some pregnant".

"I see a prayer corner in a TBA home for pregnant women and this place is set aside for prayers and fasting for pregnant women".

When asked how this relates to their lives, the participants offered the following:

"Mma, see ... I don't play with my God ... o! Anything done without putting God will never work out. Here ... em, in the villages here, there are many evil eyes after you, ...especially when pregnant. If you don't cover yourself with prayer and fasting, hm, hm! they will kill you and your baby. TBAs take us through prayers and fasting every week, some even see spiritual things and prophesy...and tell you what to do. I can't stop going to them ... o!

"Some of the TBAs see spiritually. During fasting and prayer, they prophesy and do some assignments to ward off evil manipulation on the pregnant women that would have caused them to die or their babies to die".

"Pregnant women needs prayers ... o! They really need prayers and fasting because this is a trying period, that is why they ask people to be praying for them too when they will be fasting and praying for God to see them through".

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> *"This means that women like a place of prayer like this so that God will protect them to go through pregnancy and delivery without dying".*
>
> *"Most TBAs are prophetess. They combine fasting and prayers with their work that is why God is helping them to help women in this community".*

On the reason why the situation exists, the participants emphasised beliefs on some supernatural forces and attack from enemies.

> *"Prayers and fasting is one of the things that move them come to TBA to deliver. God is everything. And during pregnancy you have to surrender yourself to God. The world is bad and enemies attach more during pregnancy and delivery".*
>
> *"Fasting and prayer is what help us. We all rely on God who can do everything and protect us from harm during pregnancy and delivery".*

In validating this finding, the older women in the FGD I1 commented thus:

> *" It will not be easy ... to stop women going to TBAs at all at all. Because these women are very good…o! Many are prophetess, they pray for women, fast for women ... in fact they have a way of locking your pregnancy so that it does not come out till it is time. Hospital people don't know all these, prayers and fasting is very important" (OWG).*

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Discussion: Spirituality is an important part of the culture of the women. Most religious people emphasise the healing power of faith, and thus most pregnant women patronise mission homes in order to be protected from evil during delivery (Erinosho, 2005).The spiritual belief of people of Cross River State has a serious impact on their health-seeking behaviour (Harrison, 2009). Faith healers have spiritual explanations for all normal and abnormal physiological and structural states, particularly in relation to pregnancy and labour, and hence contribute immensely to poor utilisation of antenatal services and negative perceptions about medical care (Harrison, 2009). On the aspect of pregnant women and their relatives feeling more at home at the TBA homes, WHO, (2007), supported that various studies have confirmed that TBAs do play an important role in traditional

societies in the course of their services by the provision of emotional and social support to pregnant women and their relatives.

Sub-theme 4: Physical proximity to service points

The situations in the pictures and participant contributions affirm that many pregnant women–in the communities access ANC and other healthcare services at the TBA homes. One of the reasons provided by the participants is the proximity of the TBA. TBAs are physically closer to them either in the form of relatives, friends, or neighbours, while the health centres are usually situated far from their homes and sometimes don't have health personnel available.

> *"Sometimes labour starts at night and there is no transport to go to the clinic that night.....most TBAs live close to us, some are our relations. When it happens like that…we enter the closest place and born our baby"*

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The fact that pregnant women leave their own homes and go to the TBAs home a few weeks prior to their delivery dates affirms some level of Birth Preparedness in terms of addressing the issue of transportation at the onset of labour.

Discussion: Proximity is a major consideration of use of TBAs. Titaley et al. (2010) assert that some women prefer home delivery because it affords them the opportunity to perform their household chores and also to take care of other members of their households. The United Nations (2004) documented that poor transport networks in developing countries, especially in rural areas, do not allow easy access to medical care that is often located in cities, thus making the TBA more accessible. The Prevention of Maternal Programme found that inadequate funds and transport were the key cause of the delay in seeking care and reaching facilities, and in Nigerian rural communities, vehicles are scarce and in poor condition, making the cost of arranging emergency

transportation very challenging. (McIntyre & Hotchlass 1999 cited in Izugbara & Ukwayi, 2004).

Sub-theme 5: Confidence in the TBAs

Confidence in the TBAs is one of the sub-theme supporting this theme. Participants' comments on photograph 10 showing the delivery theatre of a TBA depicts the absence of a clean and disinfected environment, a proper delivery bed, lighting system, oxygen, drip stand, shock vest, and other items normally expected in a delivery room. However, the environment appeared not to deter the participants thus revealed that there is high patronage of TBAs which indicates the confidence the women have in TBAs, irrespective of the high-risk situations that pregnant women and their babies are exposed to in the homes of TBAs.

> *"This my picture was taken inside a TBA hut; where the TBA use to help the pregnant women to deliver their babies ... it is a woman that just gave birth to a baby boy ... so she and her baby are there and I snapped them ... you can still see what is being used to clean the woman and her baby still on the bed and she is still very weak she did not even know where her baby is she just turned the other side ... the TBA just left the room that time to get something ... it is like 10 minutes she give birth then I take the picture".*

> *"A woman is lying; her baby is behind her on the bed ... it is like she just gave birth because the baby is wet and there are blood stained white cloths and tissues on the bed and the woman is looking weak because she is not even looking at her baby ... she just lying down turned the other way ... the room looks small ... see all the rubber kegs and cloths that is packed in the room ... only small place for space that I see".*

The accompanying picture (Photograph 11) illustrates the excitement of the TBA. She consented to the participant taking her photo immediately after the delivery of the woman, eager to showcase her effectiveness and her care towards the pregnant women in the community. She said:

“Take [my] picture and show to government, if only they will see to know that I am working very hard here to help pregnant women in my community. Government do not recognise or even remember us. …Show my photo to them. We need support and trainings”.

The mere fact that the participant was allowed to take this photo (Photograph 10) inside the TBA’s room being used as the delivery theatre goes to show that TBAs are gradually opening up to being accessed and that they are open to modernisation.

When reflecting on photograph 11, the participants’ narratives clearly depict the trust the community women have for the TBAs despite the TBAs practices.

"Women believe in TBAs. They believe their pregnancy can be preserved till delivery".

"She is one of our best TBAs here in our community. She takes so many deliveries a month even more than the hospital".
"Nothing will happen to the baby. God is protecting them. The baby will grow up to be very strong”.

Linking to the context, the participants’ narratives confirmed the faith that the community women have in the TBAs.

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"Our women do not really care about how a TBA place is . They just trust them and keep going to them"

"Poverty, ignorance and wrong beliefs is killing us here. Most women see nothing good in hospital because they are already used to the TBAs".

"The woman is so proud of herself as the TBA in the community. She is very popular here".

"This TBA is well known in this community... True, she is the woman that I was born to see delivering almost all of us here. After ... after helping that woman to born, she was so happy to see me. I told her about this study we are doing. She said I must snap her and show to government, so that they will know the good work she is doing in our community for women and come and support her."

These findings were validated during the FGD I1 with the older women in the communities.

"I am an old woman. I get seven children. All my sons and daughters are married. I born all of them in the house, only three in TBA house. But no problems ... no problems at all. If blood come out plenty, TBA will give you some roots to chew and it will stop. Things have changed. This new age is wicked. Now small things, you will hear a woman has died, the baby has died ... what is the cause, we don't know. Was it not this same TBA that were taking care of us? The world is just wicked now (OWG).

Discussion: Fatusi and Ijadunola (2008) observed that the community's traditional beliefs are that the TBAs possess special skills that they use in providing preventive and curative services to pregnant women and newborn babies. Izugbara and Afangideh, (2005) study revealed that the services of traditional and local reproductive health experts are often preferred and sought by women during pregnancy and birth. The reasons were traced to the need for privacy and the community's beliefs in mystical forces and the supernatural aetiology of certain reproductive problems (Izugbara and Afangideh, 2005).

Sub-theme 6: Past experience and the belief that "first place of birth is safe'

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A further sub-theme that was identified was the role of past experiences and the belief that 'first place of birth is safe'. Reflecting on the photos and the reasons why certain practices exist, it was deduced from the participants' discussions that women who patronise the TBAs from their first pregnancy were generally unwilling to consider a change to utilisation orthodox healthcare facilities.

"Women are comfortable to deliver in TBA houses. They are used to this practice. It is safe and ok for them. They have no problems when they go there. If anything happen ... it means God wants it so. Nobody can help".

"...apart from money; ehmm! Like me its not because of money ... I am not saying we have money but to me why I am going to the TBA is because that is where I had my first delivery so I have said that is where I will have all my children because she is good to me ... she will pray".

"Our women are always happy being together. The TBA is friendly and welcomes everybody"

Comments from the FGD I1 with the older women also verified this finding.

"I am an old woman. I get seven children. All my sons and daughters are married. I born all of them in the house, only three in TBA house. But no problems ...no problems at all. If blood come out plenty, TBA will give you some roots to chew and it will stop" (OWG).

In addition, participants commented on their positive past experiences with positive attitude of a TBA. One participant stated:

"She is always very kind to women in labour. She pets them ... in fact, I suggest that government should support her to do better".

"Apart from that ... the TBAs know us, they live with us, and they take good care of us, no shouting, and no abuse. They pet the women and know the leaves to give if labour is long. Not like hospital that will rush and operate".

This was also validated by the FGD I1 with the older women:

*"What about those that even register there, but if they want to born at night, you go there, no nurse. Sometimes those small, small people that know nothing will be there. Even TBA is better than them" (*OWG).

Discussion. A Ghanaian study, similar to the statements above, reported that women reported that TBAs were more considerate and provide more passionate care than the orthodox healthcare providers (Addai, 2000).

Sub-theme 7: Poverty and low cost of TBAs

During the discussions, participants expressed that even though TBA services were not free, TBA's allowed an instalment system to accommodate both the rich and poor.

"TBA do not charge much. You can even pay as you have money even not ... immediately or at once"

"In TBA homes we pay what we have. They don't worry us. You can complete the money when you have. They take good care of

> *women in Labour. They pray for us. Nothing happens to us unless it was to happen".*

This finding was validated during the FGD I1 discussions with the older women:

> *"Women here have no money, so how will they go to clinic? Nurses will abuse them. So they like TBAs who will understand and help them even when they do not pay everything at once" (OWG).*

Discussion: Harrison, (2009) asserts that poverty is the major social cause of maternal death in Cross River State. Most people are unable to pay for healthcare services even when it is highly subsidised by government, hence they end up in the hands of unskilled birth attendants (Harrison, 2009).

6.6.3 Theme 7: Low preference for orthodox healthcare services

Overall the participants showed a low preference for orthodox health services. This theme was supported by five (5) sub-themes, namely lack of knowledge about the availability of free health care for mothers and children, past experiences of negative attitudes of healthcare providers, fear of health facility injections and operations, the absence of health care providers on duty at night, and the perceived cost of health services.

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Sub-theme 1: Lack of knowledge about availability of free health services for mothers and children

According to the participants, most of the women were not aware of the free healthcare provision by the state government for mothers and children.

> *"Women in this community do not know that hospital delivery is free. They don't know. Even now if you go to register in hospital, nurses still ask you to pay some money".*

Some of the discussions included discussions on how healthcare providers made payment demands and there was no 'free' treatment.

"Delivery should be free in hospitals. Not to say it is free but nurses are still saying pay this, pay that. Government should make sure no money is collected".

"Nurses should be telling women who attend Anti natal that care is free and they should not collect any money then these women will go back and inform other women to go".

The FGD I1 with the older women also validated these findings.

*"If we don't know that hospital is free, we won't go. No one tells us. Even when we hear and go there, we still pay money. How then is it free? If government says it should be free, let them send people to see if it is really free" (*OWG).

Sub-theme 2: Past experiences of Negative attitude of healthcare providers

A number of the participants reflected on experiencing negative attitudes from health care providers and health care facilities and this may have contributed to the low preference for orthodox health services

"All those workers they don't use to come to work sometimes ... and they will abuse you ... abuse you; so even I have money aunty I will not go there; no need .

"Nurses will abuse them. So they like TBAs who will understand and help them even when they do not pay everything at once".

"Nurses should not be shouting at people anyhow. Its makes the women fear and not go to hospital".

"The women feel free here than hospitals. Because in the hospital they don't allow relations. Even the visiting time is very short. If it is hospital nurses will be shouting at them as they are sitting on the mat on the floor" (Pic 8).

Discussions of the during FGD I1 with the older women validated these findings.

"*And we hear government say it is free. Where there is no money, nurses shout at you, abuse you, abuse your husband" (*OWG).

Discussion: The observed sub-themes of negative past experiences and the negative attitude of healthcare providers corroborates Archibong and Agan's (2010) study in Cross River State, which revealed that the attitude of some healthcare providers scare patients and discourage pregnant women from seeking appropriate care. This is thought to be a reason that patients therefore resort to non-orthodox care and often present to

hospitals with avoidable complications. Lavender (2007) observed that, having experienced culturally insensitive services and/or professional feelings of negative attitude and a sense of being blamed, discourage individuals, and if this experience is common it may have a detrimental impact on access and engagement with services by other members of a community.

Sub-theme 3: Fear of injections and operations in orthodox healthcare facilities

The psychological fear of being injected and the possibility of having a physically inflicted tears by the doctor during delivery was offered as one of the reasons for the preference by most community women to patronise TBAs, who, according to participants use natural methods such as herbal concoctions and hand palpation/massage to carry out deliveries like the "Hebrew women" in the Holy Bible.

> *"Small thing, they will rush and operate. No time given to try. We do not like that. God that puts it there has a way of making it come out".*

> *"You see many women don't like the way all this doctors do; small thing they will inject you with hot injection ... tear you; ahh! You see ....even me I don't like it; it used to scare me".*

> *"It is not good. Some women say that they are afraid of hospitals because of operation and tearing of private part. Also the way nurses treat women in labour, shouting at them causes fear. Sometimes nurses slap women even beat them up. If a woman mentions this to their husbands, they will not like them to go to the hospital".*

> *"Women are afraid of operation. They like the TBA who will always give them roots, leaves to faster labour".*

During the FGD I1, the older women validated this finding.

> *"Small thing, they will rush and operate. No time given to try. We do not like that. God that puts it there has a way of making it come out" (*OWG).

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Discussion: Okafor et al. (2004) showed that some of the women did not like going to the orthodox healthcare facilities because these facilities administer drugs and the women preferred going to the TBAs where herbal concoctions are administered. Unfortunately, the procedures they perceive as complications (episiotomy and Caesarean Section) contributed to them preferring TBAs, though these procedures were usually performed for optimal maternal and foetal outcome (Okafor et al., 2004).

Sub-theme 4: Absence of orthodox healthcare providers at night

Another sub-theme identified in support the theme of low preference for orthodox services were the perceived absence of orthodox healthcare providers at night. Narratives from the participants clearly confirmed this theme as a reason for community women's health-seeking behaviour.

> *"Sometimes it is those nurses that use to cause it they will not be coming and the place is far; so when you go there and nobody; you will not go again".*

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During the FGD I1 this findings was validated.

> *"What about those that even register there, but if they want to born at night, you go there, no nurse. Sometimes those small, small people that know nothing will be there. Even TBA is better than them"* (OWG).

> *"They should bring nurses that are good and wants to do their work, not those that run home to Calabar before night. And you go there nobody".)* (OWG).

> *"Mma, the nurses that work in our clinics should agree to live here with us, but they want township ... Calabar. How can they be coming from Calabar everyday and know our problems"* (OWG).

> *"Mma, health centres are far from us here…o! I think government should build more health centres, good roads, houses with light and water for nurses to come and stay in this community. I think if nurses stay in this our community, we women will be going to our own health centre for delivery. That is what I think Mma, I don't know if other women think the same way like me…o!"* (OWG).

Discussion: Titaley et al. (2010) and Abdulraheem et al. (2012) commented that rural populations were unable to access modern healthcare due to difficult access to healthcare personnel. This problem is often the result of the high rate of absenteeism that occurs when health workers decide to seek greener pastures in terms of increased salary, and the long distances to health facilities (Abdulraheem et al., 2012). Furthermore, pregnant women believe that there is better access to TBAs in comparison to modern healthcare providers, because TBAs are evenly spread throughout rural areas (Imogie et al., 2002; Titaley et al., 2010; Abdulraheem et al., 2012).

Sub-theme 5: Perceived costs of health services

From the reflections on most of the photos in relation to the context, negative assumptions held by community women regarding the high cost of orthodox healthcare services deter women from utilising the services. Excerpts from participants' contributions confirm most of the participants' notion that poverty is their primary reason for not accessing care from the Primary Health Centers (PHCs).

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> *"Aunty see there is no money ... if you go there [to PHCs] now they will be telling you to register with N1000 ... that one is enough for somebody to run."*
>
> *"Yes; money ... to me money is the main reason ... because without money they will not attend to you".*

Some of the discussions included healthcare providers make payment demands and there is no 'free' treatment.

> *"Delivery should be free in hospitals. Not to say it is free but nurses are still saying pay this, pay that. Government should make sure no money is collected".*
>
> *"Nurses should be telling women who attend Anti natal that care is free and they should not collect any money then these women will go back and inform other women to go".*

The FGD I1 with the older women also validated these findings.

> *"That is not even the main problem. Mma nurse as you see us here, we be farmers, traders, no money. In health centres and hospitals, nurses are talking money, money, money. Pay this, pay that . And we hear government say it is free. Where there is no money, nurses shout at you, abuse you, abuse your husband"(*OWG.*).*

> *"For me ... Mma nurse ... we will like this death....death...to stop, and if going to health centre will stop it and we are sure, good. But, but ... to me ... we have no money, so we want free treatment, free medicine, free operation. This is not too much for government to do for women and babies" (*OWG.*).*

Discussion: In support of these findings, Osubor, Fatusi & Chiwuzie, (2005), in their study of the Ologbo community, Nigeria, noted that the official cost of the orthodox service was higher than what many of the people in the community could afford, given their socio-economic level and this was reported as preventing community members from fully utilising those services. However, as Thaddeus and Maine (1994) noted, while cost might constitute a reason for the delay in seeking healthcare, people pay a higher premium for quality.

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6.6.4 Theme 8: Poor knowledge of maternal and child care in TBA homes

Overall a strong theme of poor knowledge of maternal and child care in TBA home from both the TBAs and the participants. Two (2) sub-themes were identified in support of this theme namely, TBAs lack of knowledge of proper delivery procedures and care, and lack of education on the care of their newborns.

Sub-theme 1: TBA's lack of knowledge on proper delivery procedures and care

The participants' narratives on photographs 10 and 11 revealed that they are aware of the TBAs' lack of knowledge of the proper delivery procedures and care.

> *"A woman is lying; her baby is behind her on the bed ... it is like she just gave birth because the baby is wet and there are blood stained white cloths and tissues on the bed and the woman is looking weak because she is not even looking at her baby ... she just lying down turned the other way ... the room looks small ...*

see all the rubber kegs and cloths that is packed in the room ... only small place for space that I see".

"I see on this photo a mother who just delivered lying on the ground and her baby lying naked in blood beside her inside a TBA delivery room."

"I see a woman who just delivered being left on the floor in blood and her baby lying naked beside her with cord exposed in blood".

There is a strong reliance on divine help, and the mothers and their babies are believed to be at the mercy of God in the case of emergencies. Contributions by participants confirm the non- availability of basic child delivery equipment and emergency precautions such as screened blood, the use of shock vests, and other birthing room equipment. The likelihood for infection for both mother and child is very high judging from the visible scenes in the photograph that show that bloody sanitary towels are left on the bed where a yet to be cleaned and exposed mother and baby are left unattended to.

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"This baby is exposed for long. He can be cold and sick and even die. This environment is very dirty. Even the hand gloves the TBA uses can be used also on another woman. This cannot happen in the hospital".

"Good care for mother and baby is lacking here. This cannot happen in the hospital. The environment is dirty".

"This is the practice and it is not good at all. She will use this same gloves for another delivery".

"Women in this community should be educated about the problems that this type of environment can cause. Even exposing baby in blood and without cloths like this for a long time can kill the baby. Our women do not know this. In fact, no idea about the problem that can happen".

Despite the risks that the mother and child are exposed to, comments from some participants revealed that they view the practice as normal.

"Nothing will happen to the baby. God is protecting them. The baby will grow up to be very strong"

"She is one of our best TBAs here in our community. She takes so many deliveries a month even more than the hospital".

In support of these findings, FGD I1 with the older women also confirmed this:

*"My own ... I say ... oo! Our TBAs cannot be left like that without anything. Some of them are very good in this work. Train them, give them knowledge, knowledge is power. So that they will be doing it small small and know when there is problem and can send to hospital" (*OWG.*)*

Discussion: Various studies have confirmed that what was observed and described in the photographs were prevalent in rural communities. Ofili and Okojie's (2005) study revealed that the infection control methods employed by the TBAs were found to be poor. These findings are also similar to a Guatemalan study among midwives that revealed that rural midwives worked without gloves, soap, or running water and performed poor cord management since only less than half (42.2%) used methylated spirits to treat the cord, worst still, some used sand, which could readily be a source of neonatal tetanus infection (Ogunjobi, 2015). Similarly, findings from studies in Edo state, Eastern Nigeria, revealed that TBAs were very much in short supply of modern facilities and most times are forced to use whatever is available, which are often substandard (Imogie, Agwubike, Aluko, 2002). In addition, studies by Oshonwoh, Nwakwo & Ekiyor (2014), submitted that majorit of the provided services by TBAs are unhygienic as only very few of them use any form of personal protective devices in the course of their duties.

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Sub-theme 2: Lack of education on the care of newborns

From the comments describing photo 12, it is evident that at the TBA homes pregnant women and mothers received no education regarding exclusive breastfeeding for babies or proper hygiene for newborn. From the photograph, it is apparent that the mother is still at the TBA home and is seen behaving in this manner, how then will she perform at home?

> *"I took this picture inside the home of a TBA at Ayaghanse; she is my cousin's wife and was delivered of a baby by a TBA ... a baby girl; the baby was 3 days old ... as she wants to give the baby food I snapped her....she is making pap to give the baby ... other women too are there in that room o! ... she is giving the baby breast also....I just took the shot to show feeding of baby".*
>
> *"In the picture I can see a woman making food, it is like akamu (pap) ... she is making it for her baby that is lying on the bed and she is licking the side of the plate because she does not want it to pour (spill) on the floor after putting some for the baby in the baby feeding bottle that she is carrying ... It is a normal thing now! ... what is in it?".*

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While the participants were reflecting on the photos (Photographs 10 &11), and relating them to the context those of them who had utilised and experienced care at the orthodox healthcare facility, the commented thus:

> *"The mother does not know that the baby should be given only breast. The baby can even be infected".*
>
> *"No good ANC care to have information about care of the baby".*
>
> *"If this baby was born in a hospital or clinic, there is no how the nurses would have allowed her give the baby this food. But only breast"*
>
> *"Health education for women on care of newborn baby, importance of exclusive breastfeeding".*

Community members continue to have incorrect or incomplete information regarding maternal and child care issues because more women visit TBAs who are themselves not knowledgeable and/or skilled. Hence, community members' continuous apathy

towards orthodox healthcare services is exacerbated because there is no access to skilled healthcare givers who are most often not available to breach the information gap.

In validating the above findings, the older women in the FGD I1 suggested:

> *"Nurses, Doctors, government people should be coming to us, tell us about what we should do to be good for us, our women, and our children. In churches, in markets, in our meetings, to our men, they should come and help". (*OWG).

Discussion: Imogie (2000), Ofili and Okojie (2005), and Titaley, (2010), commented that a typical TBA would be illiterate and may lack the potential to recognise birth complications and other risks. Therefore, TBA-provided maternal health services may be unsafe to the health of mothers and their babies. This theme highlights the recommendation made by Goldner (2012) that it was important for women to receive orthodox maternal healthcare since it has been proven to positively ensure the survival of mothers and their newborns.

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6.6.5 Theme 9: High recognition of importance of immunisation

Two sub-themes were observed in the theme on the high level of community awareness of the importance of immunisation and the high utilisation of immunisation services, namely the high utilisation of immunisation services by women and the high level of community involvement in creating this awareness on the benefits of immunisation.

Sub-theme 1: High utilisation of immunisation services

Participants' contributions on photo 13 affirmed that community members (women) utilised immunisation services and valued immunisation services for themselves and their children.

> *"It means that women know the importance of immunisation to them during pregnancy and for their newborn babies. They do not*

want anything to happen to their babies. So they ... they do not miss immunisations even when they don't go to clinic for any other thing".

"Women value the health of their babies".

Both mothers who utilise orthodox facilities for delivery and those who do not turn up for services access immunisation services.

"I took this picture at the Idundu health centre ... the town announcer had announced that there would be children and pregnant mother's immunisation the day before the day that I took the picture ... many pregnant women and mothers with their children came to the health centre for the immunisation so I snapped the picture ... to show how people come out to immunisation".

Comments from the participants also reveal that there are some women who only access immunisation services but never avail themselves of other services in orthodox healthcare facilities.

"For some women, it is only immunisation that takes them to clinic".

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Discussion: The reasons for high utilization of immunisation services have been reported by Snow (2007) who found that the important factors to child immunisation were: mothers' general belief of the benefits of immunisation to their children, faith in health services, sources of information on vaccination, access to services, the quality and friendliness of those services, and mothers' ability to take time away from their house chores. However, from the responses above it is evident that the community women are well vested with the importance of immunization and the service has been 'friendly' over the years with obvious benefits.

Sub-theme 2: High level of community involvement in creating awareness on the importance of immunisation

Participants' comments on photograph 13 indicated that there is high level of community involvement in creating awareness regarding the importance of immunisation. From their reflections, it is obvious that the community members were greatly involved in creating awareness on the importance and benefits of immunisation to mothers and children. The community structures, such as the village announcers, meeting groups, and churches are all engaged in creating community awareness about the importance of immunisation.

> *"Maybe [child cries] I am sure it is because everybody is involved in announcing immunisation to the women in the community. In the churches, it is announced, in village meetings they announced, the town criers announced. So, nobody will say she did not hear ... or did not know".*
>
> *"They used to go around house to house to immunise children sometimes the town announcer will go round to announce for people to come out for immunisation at the health centre so people will come out with them children ... immunisation is good o!...it will help so the baby will not get sick or die ... they use to tell us .*

The town announcer is still a very good tool in mobilising women at the grassroots level for services. Immunisation services could be mainstreamed and used to influence positive behaviour changes on health services uptake for men and women. The TBAs should not be excluded either, as they also encouraged their clients to access immunisation.

> *"In this community women take immunisation very important. Even in TBA homes, they always tell them to go to clinic and take immunisation. Even those that do not deliver in the clinic still take their babies for immunisation".*
>
> *"She used to tell us ... she will ask if you have taken immunisation if you say no she will quarrel you".*

In validating this finding, during FGD I1 the following comment was noted from the older women:

> *"Have you not seen that immunisation that is free, everybody take her child there? It is announced everywhere and we all know. They ring bell and beat drum and even close market on those days"* (OWG).

Discussion: This is in accordance with the findings of Doctor et al.'s (2012) , study on using community-based research to shape the design and delivery of maternal health services in Northern Nigeria, which showed that social influence is important in encouraging women to seek both antenatal, delivery care and immunization services. Particularly, existing informal social networks within the community can inform pregnant women and the community on the importance of immunization for mothers and children and how the health facilities have been improved and have become more "community-friendly". In addition, some of the counselling messages on the benefits of immunization and other healthcare services could be integrated into the local social networks and groups, such as village women's committees (Doctor et al., 2012).

6.7 ACTIONS FROM ATTITUDES AND ACCESS TO HEALTHCARE SERVICES BY PREGNANT AND NURSING MOTHERS

Seven (7) action recommendation emerged from the discussion on these photographs (Fig 6). The actions identified by the participants which aim to improve the impact of attitude and access to healthcare services by pregnant and nursing mothers. These included: free treatment in healthcare facilities; the involvement of husbands in Ante Natal Care for proper information; spirituality in service delivery; community support, motivation to attend health services and TBA training and collaboration.

6.7.1 Recommendation D: Free treatment in healthcare facilities

A strong recommendation which emerged was that of free health treatment. Two (2) sub-themes were identified around the theme of free health treatment, namely that free

health treatment should be "free" in the real sense and the community should be involved in raising awareness of free health services

Sub-theme 1: Free treatment should be free in the real sense.

During the discussions on suggested actions to be taken to correct the negative perception about the expensive orthodox healthcare services, the participants came up with the followings:

> *"Delivery should be free in hospitals. Not to say it is free but nurses are still saying pay this, pay that. Government should make sure no money is collected".*

Sub theme 2: Community involvement in raising awareness of free health services

Participants even envisaged the involvement of the community to achieve awareness regarding the availability of free maternal and child healthcare services, which most women in the communities are not aware of.

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> *"This is happening because of lack of money. The husband has no money that is why. As they say hospital is free, the women don't know that it is free. So announcements should be made in this community so that women will know that hospital is free".*

> *"If the hospital delivery is actually free true, true ... the women do not know about it. We are always asked to pay some money. The announcement be made in the villages that hospital is free for pregnant women and children. Also let Government make sure that nurses do not collect any money".*

These actions were validated by the older women during FGD I1:

> *"It is true that we don't know that government hospitals is free. Our children still go and come back and tell us that they are to pay this, ... pay that" (*OWG).

> *"If we don't know that hospital is free, we won't go. No one tells us. Even when we hear and go there, we still pay money. How then is it free? If government says it should be free, let them send people to see if it is really free" (*OWG).

> *"Mma, apart from seeing the nurses, let them stop collecting money from our women if government says it is free as you said.*

*Or you come and tell them not to collect money from our daughters again if they want to go and deliver" (*OWG).

Discussion: These findings corroborates the findings of the studies by Titaley et al., (2010) and Onah et al., (2006), which revealed that the cost of accessing care from TBAs was ranked to be cheaper and therefore more affordable than that of orthodox healthcare facilities, as some TBAs allow payment for services rendered over a period of time while others accept payment through a barter system which provides some relief to women. Evidence from studies according to Imogie (2000), also has it that TBA-provided maternal healthcare services is free from inhibiting factors of prohibitive hospital fees, illegal fees and bribery. Doctor et al.'s (2012), in their study on using community-based research to shape the design and delivery of maternal health services in Northern Nigeria, which showed that social influence is important in encouraging women to seek both antenatal and delivery care, therefore concluded that, existing informal social networks within the community can be used to inform pregnant women and the community about how the health facilities have been improved, existence of 'free treatment' and how it has become more "women-friendly" and comfortable for women (Doctor et al.,2012). Suggestions to avert underutilisation of healthcare services by rural women also include funding the provision of maternity care adequately through fee exemptions and waivers, loans, and healthcare insurance (Gwatkin, Wagstaff & Yazbeck, 2005).

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6.7.2 Recommendation E: Husbands' involvement in ante natal care

Sub-theme 1: Men as sole decision-makers should be involved in ANC

In their narratives on actions to be taken to ensure women's full utilisation of orthodox healthcare services, participants suggested husbands' involvement since they were best placed to be involved and they had the final say regarding where healthcare is to be sought.

> *"Husband[s] should be involved because they are the ones to insist that their wives should go to hospital and deliver. If not so, the women won't disobey their husband".*

Sub-theme 2: Challenges in addressing cultural norms and roles

However, this recommendation remained challenging as women were duty-bound to obey them. Being a patriarchal society, any disobedience from the wives is frowned upon by society.

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> *"Also ... the clan head should call meeting, ... meeting with pregnant women and their husbands... because is the men that cause this problems. Clan head should announce to them that any woman who delivers and dies in TBA will not be buried in this community. It should be a law. Then fear will catch everybody. That is the only thing that will make them obey".*

This was validated during the FGD I1 with the older women.

> *"For all these things to work for us, we should remember that we are women, we are under somebody. The husbands, the Clan heads, the big men (chiefs) of our villages must be told about what we want to do… they must agree ... I mean ... accept with us ... give us permission if you want to succeed Mma nurse"* (OWG).

Discussion: In support of the above findings, Erinosho (2005), asserts that in a patriarchal society like Nigeria, mothers cannot just take health decisions on their own without the permission from the husbands, this also connotes a cultural value of male dominant ((Igun, 1988 as cited in Erinosho, 2005).

Hence, Onayade, et al., (2010), suggested that since various studies have shown that men's approval or disapproval of pregnancy care was linked primarily to difficulties of access and the costs involved, programmes therefore needs to work with men to address these responses by involving them in all aspects of pregnancy care.

6.7.3 Recommendation F: Integration of spirituality in healthcare delivery

Spirituality in health care delivery was important to the participants and the participants suggested the consideration of such to be made an integral part of healthcare delivery. The participants' discussions of photo 9 revealed that to these community women, regular prayers and fasting strengthen their faith in God and accord them the hope for protection throughout their pregnancy and delivery should be integrated in healthcare delivery.

> *"In hospital, I used to see them praying when women go for Ante natal and when children are taken for immunisation, but this is always very short or brief. So some special prayer days should be set aside in hospital for prayer and fasting. So, that women feel assured and safe that they are protected. It will help women develop faith in God especially during pregnancy".*

> *"Hospital should see fasting and prayers as important. They should set a day aside every week for prayers and fasting for pregnant women. Not just small time for prayers on clinic days. That is not enough at all ...at all. Enemies attack during this time".*

> *"I think hospitals too should have a place for fasting and prayers. Set aside a special day, invite men and women of God to come and direct pregnant women in fasting and prayers. This will really attract women to go to hospital s. This is because there is so much attack on pregnant women to roam about looking for where there is strong prayers and fasting".*

During the FGD I1 with the older women this suggestion was validated.

> *"Nurse, we trust in God here…o! Without God it will not work for us. Prayers and fasting makes us belief God will help the woman deliver safely. So please we want fasting and prayers in our hospital. In fact, they should be calling prophets and prophetess*

*to pray for the women, so that any bad thing coming can be stop" (*OWG).

Discussion: Society of Gynaecology and Obstetrics of Nigeria, (2004), support these findings in their assertion that in Cross River State, Nigeria, churches and faith healers manage obstetric cases and have spiritual explanations for all normal and abnormal physiological and structural states, particularly in relation to pregnancy and labour and this contribute immensely to antenatal defaulting as well as negative perceptions about medical care.

6.7.4 Recommendation G: Community support

Three (3) sub-themes were identified under this theme, namely the influence of community heads through levies and sanctions to emphasise the importance of utilisation of healthcare facilities, the constitution of an influential women group to monitor the activities of pregnant women in the community and the use of community structures in emphasising facility delivery.

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Sub-theme 1: Influence of community heads through levies and sanctions to emphasise the importance of utilisation of healthcare facilities

In their narratives regarding actions to be taken, the participants stressed the need to use the influence of the community clan heads and chiefs (stakeholders) to emphasise the importance of utilisation of orthodox healthcare facilities by women.

"Also ... the clan head should call meeting, ... meeting with pregnant women and their husbands... because is the men that cause this problems. Clan head should announce to them that any woman who delivers and dies in TBA will not be buried in this community. It should be a law. Then fear will catch everybody. That is the only thing that will make them obey".

This suggestion was further validated during the FGD I1 with the older women:

"In this village, we fear and respect our chiefs…o! If after telling the women the good thing in going to put name in health centre and deliver there and they are still stubborn. If our clan head steps

*in to warn them that any woman who is pregnant and do not register in health centre or any man who does not allow the wife to register in the health centre will be punished or even send out of the community. Mma Nurse, you will see that they will sit up" (*OWG).

Discussion: This corroborates Ansari's (2007) findings, which suggested that to address the various barriers to uptake of services, people who are already engaged with and trying to change the norms and attributes which lead to low take-up of services need to be engaged. That engagement is necessary to ensure that services adequately take account of cultural sensitivities so that this does not also pose a barrier. Through the National Primary Health Care Development Agency (NPHCDA), the Federal Government of Nigeria in 2007 had set up the Ward Development Committees (WDCs) to bridge the gap between the communities and the health system at the grassroots level. They were given with the responsibility of convincing the community members, especially women, that the health facilities are there to provide safe maternity services to them for optimal maternal and foetal outcomes (Federal Government of Nigeria [FGN], 2007). Unfortunately, this study discovered that although these groups exist in the study settings, they were either not carrying out their expected roles or they didn't take their roles seriously, basing their excuses on not being motivated by the local government that formed them (FGN, 2007).

Ktpatzer's (2006) reviews on the benefits of community engagement revealed that since the health of individuals is rooted in social determinants of health, programmes that are defined by health professionals without community engagement will most likely not have sustained positive benefits. Thurston et al. (2005) noted that people can use the skills acquired through community engagement initiative to advocate for change in other sectors that impact the health of the population.

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Sub-theme 2: Constitution of influential women group to monitor the activities of pregnant women in the community

While recognising the strength and influence of leaders in the different women groups within the community, participants suggested the idea of forming a group of women and giving them with the duty of monitoring the activities of their fellow women who are pregnant to ensure facility registration and delivery, and also to report erring members to the community heads for a form of levy or caution. This became very significant in this study since it further highlights the importance of engaging the community in issues of health that concern them and encouraging action towards solution.

> *"In this our village, there is no woman who don't go to a meeting group ... in church or even in village here. Let the leaders of these women groups be told. They should announce to their women to deliver in the hospital ... they should also be checking them if they obey. If not, they should remove them from the meeting. That is my own suggestion".*

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> *"some strong women can form a group. Our woman leaders must be there. Let them be checking women who are pregnant and if they go to clinic ... I mean this is easy because in this community we know everybody. The people ... those who don't born baby in health centre, they should report. We too, ... we can also be checking and reporting to them ... this will work for us".*

This action plan was validated by the OWG during the FGDs 11 with them.

> *"He e… mm! If nurses are good, treatment is free, medicine is there, clinic open every time, and then our women may start going to the clinic. We will even take them there. Then any woman that refuses going, we will know what will do to her in this village" (* OWG).

Discussion: Manandhar's (2004) study that revealed that the participatory process has been used in communities to foster mobilisation among women's groups as a means to promote demand for maternal and child health services This process brought care closer to the home and improved linkages with the health system and local health workers also

became more accountable to their communities (Manandhar, 2004). Similarly in Nepal a participatory learning cycle in which they identify, prioritise a problem, and select and implement relevant interventions through developing women's groups resulted in a reduction of maternal mortality by 88% and neonatal mortality by 30% (Azad, 2000; Tripathy, 2010).

Sub-theme 3: Use of community structures in creating community awareness about immunisation services yields positive results.

The sub-theme identified in this theme is the use of community structures in creating community awareness regarding immunisation services yields positive results

> *"You see ... I believe, the same way our village heads send important messages to reach everybody through different churches, the town crier will go around to announce, same way...em...I mean this same way as they announce immunisation, it can be announced to every woman here who is pregnant to go to clinic and put name and also make sure not only putting name but deliver there. That it is a must".*
>
> *"I suggest that, that ... to me ... o! In the same way immunisation is preached everywhere in the community news about free hospital delivery and importance of registering and delivering in hospitals should take that form".*

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In support of this, during the FGD I1, the OWG validated this suggested action.

> *"I think Mma nurse; announcement should be made every place, as in immunisation. Churches, markets, I ... mean, mean everywhere. Let women know that health centre is free. Any nurse that collects money, they should sack her".*
>
> *"In this our village, there is no woman who don't go to a meeting group ... in church or even in village here. Let the leaders of these women groups be told. They should announce to their women to deliver in the hospital ... they should also be checking them if they obey. If not, they should remove them from the meeting. That is my own suggestion".*

Discussion: Findings from various studies are in consonance with the above findings. For instance, Rosato et al., (2008), submitted that community women health problems when channelled through women meeting and collectively discussing them, enabled

women to clearly identify their maternal health problems, gained knowledge, recognise their importance, and generate the motivation to address them.(Rosato, Laverack, Grabman, Tripathy, Nair & Mwansambo, 2008). Similarly, Lassi et al., (2010) added that the most successful community-engagement packages in addressing women health issues were those that emphasised involving family members through community support and advocacy groups, community mobilisation and education strategies, provision of care through trained Community Health Workers via home visitation, and strengthened proper referrals for sick mothers and newborns (Lassi, Haider, & Bhutta, 2010).

6.7.5 Recommendation H: Motivation to attend health services

Three sub-themes were identified in support of this theme to increase the motivation of participants to attend health services. The sub-themes were: a receptive attitude of care providers, the availability of 24-hour services, and providing occasional gifts to women.

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Sub-theme 1: Receptive attitude of care providers

During their discussions, participants suggested a change of attitude by orthodox healthcare providers to create a friendlier, more receptive, and warmer environment for uptake of services by community women.

> *"Nurses should be advised not to be harsh ... harsh to pregnant women. They should pet them and be friendly with pregnant women".*

The older women validated this suggested action during the FGD with them.

> *[The R2 bitterly expressed her feeling when she was responding] "It is not just saying … go to hospital, go to clinic … but please tell the nurses to be good to our women, to open clinic day or night, to stay with us here and not coming to work from Calabar. We want to see them always. We want to run to them anytime we have problem" (OWG).*

Discussion: In support of the findings above, Ebuehi & Akintujoye (2012), observed that TBA-assisted maternal health services are endeared into the hearts of the community women for the notion that they are ensured of social support, compassionate care, and warm reception thereby creating cultural affinity between TBAs and pregnant women (Ebuehi & Akinyujoye, 2012; Glei & Goldman, 2000). on a similar note, a study in the rural Guatemala revealed that women were less likely to deliver in medical settings because of lack of social support from orthodox healthcare providers (Glei & Goldman, 2000).

Sub-theme 2: Availability of 24-hour services

Participants mentioned this strategy to afford the community women access to maternal and child healthcare services at any time.

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> *"To me all I can say is that those nurses that are in the hospital they make sure that they are coming to work because if somebody go there and you did not see anybody she will not border to go tomorrow".*

This suggested action was validated during the FGDs held with the older women.

> *"Mma, the nurses that work in our clinics should agree to live here with us, but they want township….Calabar. How can they be coming from Calabar everyday and know our problems".* (OWGs)
>
> *"Mma, health centres are far from us here ... o! I think government should build more health centres, good roads, houses with light and water for nurses to come and stay in this community. I think if nurses stay in this our community, we women will be going to our own health centre for delivery. That is what I think Mma, I don't know if other women think the same way like me ... o!".* (OWGs)

Discussion: In corroboration with the above findings, World Health Report, (2005), asserts that the environment created for women subjects them into

poor reproductive health and unsafe motherhood, which is mostly prominent in rural areas where there is lack of adequate medical facilities coupled with no adequate number of trained medical personnel. Hence, NPC & ICF Macro, (2007), observed that rural women face difficulties in accessing health facility leading to a distrust for modern maternal healthcare and a reliance on TBA-provided healthcare services. Furthermore, as a result of difficult access to modern healthcare due to high rate of absenteeism which occur when healthcare providers decide to seek greener pasture, and not residing within the community hence not being available at night, women are dissuaded from accessing modern healthcare (Titaley et al., 2010; Abdulraheem, 2012).

Sub-theme 3: Providing occasional gifts to women

During the discussions participants suggested providing occasional gifts to women who attend clinics to encourage them and motivate others.

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> *"If government can be giving people all those gifts they use to give something like ehm; ehm baby things ... like when I gave birth at the Idundu health centre they gave me mosquito nets and I was happy.*

During the FGDs I1, the older women validated this suggested action.

> *"If some women who register in the health centres, they should try and give small, small gifts to them so that at home they can show other women [smiling]. This will make those who do not like going to deliver in health centre to go" (* OWG).

Discussion: To further emphasize the importance of ocassional gifts to women who attend health care facility for skilled care, Archibong & Agan, (2010), noted that in Cross River State, Nigeria, the women are given insecticide treated bed nets, mama delivery kits to encourage them and motivate others to utilize the services.

6.7.6 Recommendation I: TBA training and facility/TBA collaboration

Strong support for the recommendation of TBA training and TBA/facility collaboration emerged. This action was supported by two supported by two (2) sub-themes, namely improving TBA knowledge and skills of proper delivery practices and mother and child care and improving TBA and Facility collaboration.

Sub-theme 1: Knowledge and skills of proper delivery practices, and mother and child care

During their discussions, participants suggested training the TBAs to make them knowledgeable and develop skills regarding proper delivery practices and maternal and newborn care.

> *"To me I think the TBAs can be trained to do better. They are very good to women and there are those things they know which hospital people do not know. If government can train them to improve in their work and try to make them work together with hospital people, then there is no how women will die".*

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Discussion: Imogie, (2000); Ofili & Okojie, (2005); Titaley, (2010) described a typical TBA as 'an illiterate' who may lack the potential to recognise birth complications. Therefore, TBA-provided maternal healthcare services are unsafe to health of mothers and their babies and neither has it contributed to decrease in maternal mortality (Ofili & Okojie, 2005). Moreover, a prospective study in Nigeria on changes in maternal mortality rate following trainings of TBAs revealed a drop by 50% in three years of maternal death following the training (Brennan 1989 cited in Bergstrom & Goodburn, 2001). The authors therefore submitted that training TBAs may enhance their potentials in the reduction of maternal mortality (Bergstrom & Goodburn, 2001). However, reviews by Cochraine asserts that there is insufficient evidence to establish the

potentials of TBA training to reduce perinatal mortality as the reported evidence its methodology mixed with flaws and inconclusive findings (Sibley, et al., 2012).

Sub-theme 2: TBA and Facility collaboration

Additionally, the participants were concerned that if TBAs were totally eliminated from the system this would result in eliminating their livelihoods and this would pose a challenge for the TBAs and the entire community. There was also an emphasis on collaboration between the TBAs and the healthcare facilities, particularly since discouraging the community's patronage of the TBAs would not be feasible.

> *"To me ... o! I think if other women or clan head try to tell women not to TBA but hospital, there will be problem and enmity because TBAs will feel that their jobs will be taken away from them and what means will they survive if no woman goes to them for delivery? That is why I think nurses and government should be the ones to come here and educate the TBAs and women . Tell them what they should know about pregnancy and delivery".*

In validating the above suggestions, during an FGD session with the older women, the following emerged.

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> *"Mma Nurse, don't you think that if the TBAs we already know and ... we know they are very good in this work ... if government can train them, so, so they know what nurses know and also know what to do when there is bad signs. Then we will like it that way. Because now if women do not go to them again, what will they eat? No other work. What will they be doing? Hmm! There will not be happy. Even me...I cannot be happy if my work is taken from me" (*OWG).

> *"My own…I say…oo! Our TBAs cannot be left like that without anything. Some of them are very good in this work. Train them, give them knowledge, knowledge is power. So that they will be doing it small, small and know when there is problem and can send to hospital" (*OWG)..

> *"Hmmm! We should not forget the TBAs ... o! That is where they eat from. It is worrying me. When we say women should not born there, what will they eat? To me….o! I think government should step in and train our TBAs, so that they can work with the nurses in the health centre. Even God does not like lazy people. If they*

*are trained, they can still care for pregnant women, still pray and fast with them [Smiling]. They can even make the women to go and register in the health centre as they do tell them to go for immunisation. Because they are trained, they will also know when there is problem s and can quickly carry the women to hospital themselves. This means that everybody is working together to save our pregnant women from dying when they want to deliver. This is what I think will work for us" (*OWG).

*"Mma Nurse, It will not be easy…o...to stop women going to TBAs at all at all. Because these women are very good…o! Many are prophetess, they pray for women, fast for women…., in fact they have a way of locking your pregnancy so that it does not come out till it is time. Hospital people don't know all these" (*OWG).

Discussion: This is in accord with the findings from Pyone et al. (2014) who assert that previously the training of the TBAs focused largely on the ability to conduct a safe delivery at home, and to recognise women who are at risk and refer cases to healthcare to healthcare facility when complications occur. Sibley et al. (2012), therefore concluded that TBAs can contribute to an improvement in maternal and child care in poor settings if they were trained and supported to fulfil a new role of practicing as birth promoters and birth companions within an enabling environment (Pyone et al., 2014). In view of this, every pregnant woman in the community was linked to an SBA working at a health center either through referral or by being accompanied to the health center by the TBA at the earliest opportunity (Pyone et al., 2014). Evidence have proved this to be very successful and effective in many rural settings (Dietsch, 2010; Hussein & Mpembeni, 2005). Pyone et al., (2014), therefore suggest that if TBAs are trained and supported, they can contribute to improvements in maternal and newborn care especially in low-resource settings.

6.8 CONCLUSION STATEMENTS FROM PHASE 2 OF THE STUDY (PHOTOVOICE)

The following statements are derived from the Phase 2 (Photovoice) of the study:

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1. Maternal health literacy is low with poor knowledge of maternal health care and self care, child care, appropriateness of TBA home birth for specific pregnancies, lack of knowledge bout availability of free health care for women and children and there **is a need to identify a strategy to improve maternal health literacy in the community**
2. Mothers and pregnant women continue to play traditional roles such as doing household chores due to poverty and cultural roles. This necessitates **identifying ways to include the husband in the planning of maternal care**
3. Husbands play a key role in decision making and support of the women during pregnancy and there are challenges in changing these cultural norms. The community could play a role in shaping this role in a more supportive role and identify **ways to include the husband in the planning of maternal care**
4. The importance of spirituality in maternal and child health cannot be overemphasized and strategies should be identified on how to integrate spirituality in orthodox health services and through the **integration of the role of the TBA within an overall collaborative model of maternal health care**
5. Strategies for **improving access and attendance to orthodox maternal health services could include raising awareness** about free treatment, receptive attitude of care-providers and occasional gifts to women who utilise orthodox facilities to encourage them and motivate others and the availability of 24-hour services,
6. The community role in support for the pregnant women could be increased and community **sensitization would increase the community's role as a resource for maternal health literacy**
7. There is a low preference for orthodox health services and a strong preference and patronage of TBAs. Strategies should be identified by the community **to**

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improve access and attendance of orthodox health services and look to ways to integrate the role of the TBA within an overall model of maternal health care.

6.9 SUMMARY OF CHAPTER

The steps of the socio-ecological logic model (Figure 1) adopted as the second model for this study to direct the Photovoice steps was followed throughout the photovoice processes in this study.

The Photovoice FGD I in this phase identified two central stories in the photographs: 1. domestic activities and healthcare practices of pregnant women; 2. attitudes and access to healthcare services by pregnant and nursing mothers.

From the translations, transcription and analyses of Photovoice discussions and narratives, from the central story of the *Domestic activities and healthcare practices of pregnant women*, four themes emerged, namely cultural practices impacting on maternal health, lack of adequate information about maternal and child health, poverty, and the lack of help and support for pregnant women resulting in not receiving adequate healthcare. After discussion of these themes three action recommendations were made address these issues, namely to strengthen the role of men to support women during pregnancy, to strengthen the role of the community to support women during pregnancy, and to improve maternal health education in terms of domestic activities and pregnancy.

From the transcription and analyses of the narratives of the central story around *The attitude and access to healthcare services by pregnant women and nursing mothers*), five themes and six action recommendations emerged. They were: men are the sole decision-makers regarding the delivery; there is a high preference for TBAs; low

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preference for orthodox health services; poor knowledge of maternal and child care in TBA services; and there is a high recognition of the importance of immunisation by community women. Recommendations to address the above problems included: free treatment in healthcare facilities; involvement of husbands in ANC for proper information; spirituality in service delivery in orthodox healthcare facilities; community support, motivation to attend health services and TBA training and facility/TBA collaboration. These findings were supported with literature and validated with the responses from the FGD IV held with the OWGs in the two communities under study.

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CHAPTER SEVEN: MODEL DEVELOPMENT FOR COMMUNITY ENGAGEMENT (PHASE 3)

7.1 INTRODUCTION

Phase 3 describes the development of a framework to underpin a community engagement model to achieve the sixth objective of this study, which was to develop a model of community engagement for the promotion of Birth preparedness, Complication readiness and to improve access to skilled birth attendance for prevention and early detection of maternal health complications.

This chapter describes the first steps of the model development process which was done through two studies: 1) concept development which includes the identification of the concepts (Study 3 FGD II), definition and validation, classification, and verification of the main and related concepts (Study 4 FGD III) which will form the framework for the model. Study 5 is the Model Development which is discussed in this Chapter.

7.2 STUDY 5: MODEL DEVELOPMENT

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Model development is done using the process described in Chapter 4.8 of this thesis, which is based on the work of Chinn and Kramer (2004), Walker and Avant (2005), and Dickoff and Wiedenbach (1968). This included identifying the main concepts from the concluding statements of the findings of Phase 1 and Phase 2 (Table 13) in order to create meaning of the core components in a framework which will make up a community engagement model. These concepts were discussed and versified in Study 4 though an FGD (FGD III) which was held with 20 stakeholder from the study communities. The conceptual meaning provided the foundation for developing a community engagement model for the prevention of maternal health complications in Nigerian rural communities.

7.3 STEP 1: CONCEPT DEVELOPMENT

The main purpose of this step is the identification and classification of main and related concepts that will make up the core components of a community engagement model. Concepts are mental images of a phenomenon that help to organise or categorise the phenomenon (Walker & Avant, 2005). Conceptual meaning is the process whereby individuals use ideas, thoughts, or feelings to represent their experiences that are unlikely to be expressed through the definitions in discipline-specific or everyday language (Chinn & Kramer, 2004). While conceptual meaning is complex, it displays a mental picture of what the phenomenon is like, and how it is perceived in human experience–the context determines the meaning given (Chinn & Kramer, 2004). The process of concept development involves identifying (step one), and classifying and defining concepts (step two). Identifying and classifying and defining the main concepts facilitate the creation of conceptual meaning, which is the building block of a theory-building approach to create conceptual meaning of the core components of a community engagement model.

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7.3.1 Identification of concepts

Concepts in this study were identified by the 'searching out' of words and groups of words that represented the phenomena and their related actions (Chinn & Kramer, 2004) from the concluding statements in Table 13.

Based on the concluding statements in the Table 13 below, a total of eight concepts were identified and agreed upon by two researchers. These main concepts were used to develop a community engagement model for preventing maternal health complications in rural areas of Cross River State, Nigeria.

TABLE 13: Concluding statements of the themes and sub themes from phases 1 and 2 of the study

Interviews with mothers and pregnant women	Photovoice with mothers and pregnant women
1. **Maternal health literacy** is low with low birth preparedness and knowledge of complications there **is a need to identify a strategy to improve maternal health literacy in the community** 2. There is low knowledge of the dangers of home delivery and only some experiential knowledge of benefits of skilled care and skilled birth attendants and there is a need **to improve access and attendance of these services** 3. There is a strong preference and patronage of TBAs based on access, culture and cost and any strategy to be developed should look **to integrate the role of the TBA within an overall collaborative model of maternal health care** 4. Communities continue to function in a traditional cultural way with strong cultural values and patriarchal roles influencing maternal health literacy and care and **ways to include the husband in the planning of maternal care should be identified.** 5. The community does provide some support (though there is an absence of formal structures for this) for the pregnant women and community **sensitization would increase the community's role as a resource for maternal health literacy**	6. Maternal health literacy is low with poor knowledge of maternal health care and self-care, child care, appropriateness of TBA home birth for specific pregnancies, lack of knowledge bout availability of free health care for women and children and there **is a need to identify a strategy to improve maternal health literacy in the community** 7. Mothers and pregnant women continue to play traditional roles such as doing household chores due to poverty and cultural roles. This necessitates **identifying ways to include the husband in the planning of maternal care** **8.** Husbands play a key role in decision making and support of the women during pregnancy and there are challenges in changing these cultural norms. The community could play a role in shaping this role in a more supportive role and identify **ways to include the husband in the planning of maternal care** **9.** The importance of spirituality in maternal and child health cannot be overemphasized and strategies should be identified on how to integrate spirituality in orthodox health services and through the **integration of the role of the TBA within an overall collaborative model of maternal health care** 10. Strategies for **improving access and attendance to orthodox maternal health services could include raising awareness** about free treatment, receptive attitude of care-providers and occasional gifts to women who utilise orthodox facilities to encourage them and motivate others and the availability of 24-hour services, **11.** The community role in support for the pregnant women could be increased and community **sensitization would increase the community's role as a resource for maternal health literacy** 12. There is a low preference for orthodox health services and a strong preference and patronage of TBAs. Strategies should be identified by the community **to improve access and attendance of orthodox health services and look to ways to integrate the role of the TBA within an overall model of maternal health care**

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1.

The community engagements concepts are:

1. Maternal health literacy: Increasing maternal health literacy;
2. Spirituality: Including spirituality in healthcare;
3. Integrating TBAs: value, training, and TBA/hospital collaboration;
4. Trust in health services: Building trust by addressing previous experiences, attitudes, and fears;
5. Access: Improving access to healthcare;
6. Culture: Culturally acceptable care;
7. Husband role: Involving husbands in women's health issues; and
8. Community support: Enhancing community support systems.

Table 14 shows the mapping of the identified concepts to the themes from Phases 1and 2 of the study.

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7.3.2 Step 2: Definition, Validation, Classification and Verification of model concepts

The concepts were validated in two stages. Firstly, the identified concepts were defined through the literature and validated by the stakeholders (Study 4 FGD III) followed by a discussion of the concept for the purpose of the community engagement model development process supported by literature. Secondly, the concepts were classified using Dickhoff's survey questions and the verified by mapping the concepts and the survey questions (Table15).

TABLE 14: Identifying concepts

Themes	Concepts
Themes emerging from the context	
1. Limited knowledge of obstetric danger signs (I)	1.Maternal health literacy
2. Moderate experiential knowledge of benefits of skilled care in hospitals/health centres (I)	1.Maternal health literacy
3. Moderate knowledge of dangers of home delivery (I)	1.Maternal health literacy
4. High patronage of and preference for TBAs (I)	2. Spirituality 3.Integrating TBA 5.Access 6. Culturally acceptable care
5. Understanding of skilled care and prompt interventions in hospitals by previous users (I)	1.Maternal health literacy 4.Trust in health services
6. Poor understanding of Birth Preparedness and Complication Readiness (I)	1.Maternal health literacy
7. Common cultural practices and beliefs relating to pregnancy (I)	1.Maternal health literacy 6. Culturally acceptable care
8. Strong influence of husbands in decision-making about place of birth (I)	6. Culturally acceptable care 7.Husband role
9. Family support of women caring for the children and doing household chores (I)	6. Culturally acceptable care 7. Husband role 8.Community Support
10.Absence of community structures supporting women in emergencies (I)	6. Culturally acceptable care 7.Husband role 8. Community support
11.Cultural practices impacting on maternal health (P)	1.Maternal health literacy 6.Cultural acceptable care
12.Lack of adequate information about maternal and child health issues (P)	1.Maternal health literacy
13.Poverty(P)	5.Access
14.Lack of help and support for pregnant women (P)	7.Husband role 8.Community support
15.Men are sole decision-makers regarding birth place(P)	7. Husband role
16.High preference for TBA (P)	2. Spirituality 3.Integrating TBA 5.Access 6. Culturally acceptable care
17.Low preference for healthcare facilities (P)	1.Maternal health literacy 4.Trust in health services 5. Access
18.Poor knowledge of maternal and child care in TBA homes (P)	1.Maternal health literacy
19.High recognition of importance of immunization (P)	1.Maternal health literacy 4.Trust in health services
Themes emerging from action recommendations	
A. Education for women and husbands on maternal health issues (I)	1.Maternal health literacy 7.Husband role
B. Husband involvement in maternal health issues (I)	7.Husband role
C. Motivation to attend health services (I)	1.Maternal health literacy 4.Trust in health services 5.Access
D. Increase community awareness on maternal health issues (I)	8.Community support
E. Strengthen the role of men to support women during pregnancy (P)	7.Husband role

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Themes	Concepts
F. Strengthen the role of community to support women during pregnancy (P)	8.Community support
G. Improve maternal health education in terms of domestic activities and pregnancy (P)	1.Maternal health literacy
H. Free treatment in healthcare facilities (P)	4.Trust in health services 5.Access
I. Involvement of husbands in ANC (P)	1. Maternal health literacy 7.Husband role
J. Spirituality in service delivery (P)	2.Spiriturality 3.Integrating TBA 4.Trust in health services
K. Community support (P)	8.Community support
L. Motivation to attend health services (P)	4.Trust in health services 5.Access
M. TBA training and facility/TBA collaboration(P)	3.Integrating TBA 4. Trust in health services 5. Access

I=Interview P=Photovoice

7.3.2.1 Stakeholder participants for validation of concepts

The stakeholder group consisted of women leaders from the two communities, Representatives of Photovoice participants, religious leaders, TBAs, Ward Development Committee (WDC), Village Health Committee (VHC) and healthcare providers working in the PHCs in the communities, clan heads from the two communities (n=20).

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7.3.2.2 Concept definitions and validation

Concept 1: Maternal health literacy

In this study, maternal health literacy was identified as an important maternal healthcare concept for good maternal health care. The concept of maternal health literacy in this study emerged out of the findings from both the interviews and Photovoice and emerged as one of the strongest concepts.

Definition:

Formal definition: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health

decisions (Institute of Medicine, 2001). This health literacy is often aimed at behavior change to improve the health of the mother (Institute of Medicine, 2001).

Applied definition: In the context of this study, maternal health literacy will refer to the degree to which rural women and their communities (including husbands) have the capacity to obtain, process, and understand basic maternal health information and services needed to make appropriate decisions on maternal health issues. Maternal health literacy is the need for rural women and the entire community to have access to the appropriate information on maternal issues so that they can implement strategies to increase maternal health literacy and make the appropriate decisions regarding maternal health matters that concern them. In this study, maternal health literacy includes gaining knowledge of Birth Preparedness, Complication Readiness and the appropriate use of health services.

Validation:

The need for maternal health literacy to be carried out by a CEG (Community Engagement Group) was verified by responses from stakeholders.

> *"It will be very important not to leave them like that. They should be given some form of education ... from time to time ... I mean training to be given new information about health matters so that they can always have what to tell our women, "you cannot give what you don't have". It is good for them to have knowledge of everything so that they can do their work well".*

> *"I have said it before we will look for people and train them on how to go about and let the people, the men, the villagers know that now, we have a law we have people we have formed and committee that their work is for them to go around and check any woman who is pregnant to know if she has gone to the hospital".*

Maternal health literacy in the community engagement model:

Maternal health literacy would primarily be carried out by Community Engagement Group (CEG). When implemented, maternal health literacy could lead to improved knowledge on birth preparedness, complication readiness, correcting negative

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perceptions and beliefs as well as bringing about the desired behavioural change (i.e. utilisation of orthodox maternal healthcare services by rural pregnant women and mothers for the prevention of maternal health complications through Birth preparedness and Complication readiness). The Institute of Medicine (2004) submits that maternal health literacy focuses on individuals' capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Concept 2: Spirituality in healthcare

In this study, spirituality in healthcare was identified as an important concept for good maternal health care. In this study spirituality was strongly associated with the TBA concept. Spirituality in healthcare emerged in this study due rural women's need to be given the opportunity to pray (and fast) to support the healthcare they are given. Rural women highlight this aspect as very important as it was part of their culture and an integrated component of their daily lives and therefore was an important component of maternal health care.

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Definition:

Formal definition: "Religious beliefs, beliefs in the supernatural" (Oxford English Dictionary (2008).

Applied definition: In the context of this study, spirituality in healthcare is defined as the need for rural woman to support their maternal healthcare with prayers and fasting so as to ward off evil spirits and bad omens that may include maternal health complications as part of the support of maternal healthcare.

Validation:

This concept was validated by responses from stakeholders.

> *"This thing about prayer and fasting. We all know that it is very important here. All we have is God and even if a woman does not know God, when pregnant she will become closer to God. The world is bad and enemies attack more during pregnancy. So*

this should be looked into in our clinics. The nurses should keep out some days for this as they care for pregnant women, not just small, small opening prayers on clinic days, that is not enough".

"Pregnant women in this community cannot do without prayers and fasting. Like my wife who is pregnant now, she goes to church every day for fasting and prayers even when I tell her that eating is good for her and the baby in the womb. She always says that God protects and so nothing will happen to her and her baby. She even prefers delivering in the church because she believes that with God she is protected. Though she registers in the clinic. What am trying to say is that for prayers and fasting to be made part of the healthcare is very important".

Spirituality in healthcare in the community engagement model:

The need for spirituality in healthcare could be communicated to the orthodox medical care providers by the CEG, or better still, the CEG can advocate on behalf of the community for inclusion of a spirituality aspect in orthodox healthcare delivery as well as better attention to the rural women. If incorporated into orthodox maternal healthcare, service utilisation will be promoted among the rural women. According to Diallo & Frew, (2014), for effective engagement to occur, it is necessary to work with the formal and informal leadership, and seek commitment from community organisations and leaders to create processes for mobilising and advocating for the community in issues of value to them (Diallo & Frew, 2014), also linking a citizen's values and preferences to outputs is a form of allocable efficiency (Abelson & Eyles, 2002).

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Concept 3: Integrated TBA role

Integrating the role of the TBA is an important concept for good maternal health care. The strong patronage and preference for TBAs was one of the strongest themes in both the interviews and Photovoice. Training the TBAs and TBA-hospital collaboration was found to be an important maternal healthcare concept (see Table 13).

Definition:

Formal definition: The United Nations defines a TBA as a person who assists mothers during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs (WHO/UNFPA/UNICEF/World Bank, 1999). A TBA is community-based provider of care during pregnancy and childbirth, who are not trained to proficiency in the skills necessary to manage or refer obstetric complications (Imogie, 2000; Ofili & Okojie, 2005; Titaley, 2010). TBAs are not usually salaried, accredited members of the health system, although they are usually highly esteemed community members and are often the sole providers of delivery care for many women, they are not included in the definition of a skilled attendant (Canavan, 2009).

Applied definition: In the context of this study, there is a need to recognise the existing role of the TBA and also to ensure that TBAs are adequately trained and function in an integrated manner in the health system through collaboration.

- Training the TBAs refers to teaching the TBAs to ensure that the women are registered at the hospital, and to carry out the necessary check-ups prior to delivery. It also includes teaching the TBAs to recognise obstetric danger signs early, and to promptly send the affected women to the hospital.
- TBA-hospital collaboration refers to the situation where instead of conducting home births and referring women to a facility only at onset of complications, TBAs rather accompany or refer mothers to a nearby facility for prenatal care, delivery, or postnatal care.

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Validation:

This concept was validated by responses from stakeholders.

Existence of role:

> *I want to say that all what we have said here are fine and good. Even the decisions we have taken will help us all and save the lives of our women. But without pretending, let us imagine ourselves as the TBAs. We can't just condemn everything about*

them because they have been helping so much in serving the lives of our women and children within their small knowledge".

"Apart from this, these TBAs are using this work to care for themselves and their families. Who will be happy if their job is taken from them, how do we want them to survive? If they go to steal will we not jail them? Come to think of all these".

"Am a TBA … I am living at Ayanghanse here. This work of assisting at childbirth, God gives to us and also gives to me too. Since I started this work … Abiet Archieobong Ukpong. God have been helping me during labour and childbirth, this our mothers here [referring to the nurse in charge of the health centre] also used to call us from time to time and show how to … if delivering is too long, we should bring the person to the hospital. On my own part, my pregnant women, I do like them to come for immunisation. If that I ask them to come and they don't I used to stand up on my own with my money for transport, accept to pay transport for all of them and bring them to the hospital for our nurses to check them and how they are faring, She also used to teach me how I can work with them, since I started this work no one has died in my hands because God said that he will give us the reward that will be commensurate with this work that we are doing. Please that is what it is [Clap from the people]".

Training:

"So on my own opinion, I want to suggest that the group we will form should also beg the government to train our TBAs so they can gain more knowledge to take care of our women. Why because ... I know very well that there is no way we can stop all pregnant women from going to them. It is not just possible, some will still go or if it is as if we are forcing them to hospitals, they can go to register in the clinic but still go to the TBAs and deliver with them because this practices is what they are already used to, and confidence in the TBAs have been built up over time, so to wake up one day and say stop may not be achieved".

Collaboration:

"I want to suggest that we can adopt what I see them start in Ikom LGA, where to achieve this same goal, the TBAs are asked to refer all pregnant women that go to them or even escort them to the clinic/ hospitals to register and deliver. Records of this are kept and at the end of the month, depending on how many pregnant women each of them brought, the government pays them some stipends to sustain them since they no longer deliver the women. They are now treated as partners in healthcare delivery. This is really working there for them as they have started. You all know me, I fear nobody, I say the truth and do not do eye service. Let us all think about this. Thank you".

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"…if delivering is too long, we should bring the person to the hospital. On my own part, my pregnant women, I do like them to come for immunisation. If that I ask them to come and they don't I used to stand up on my own with my money for transport, accept to pay transport for all of them and bring them to the hospital for our nurses to check them and how they are faring, She also used to teach me how I can work with them, since I started this work no one has died in my hands because God said that he will give us the reward that will be commensurate with this work that we are doing. Please that is what it is".

"I am a TBA, please what I want to say now ... Please what I want to say now is concerning childbirth, Pregnant women because they do come to my house…o! The first thing when they come I use to ask them if they have gone to the hospital. That it should not be when you come to my house, you stopped going to hospital. I cannot count the benefits of going to hospital when pregnant and they say they have gone. I tell her, I will like to know I will see your card to know if you have gone to the hospital".

"I say even that immunisation that they inject you, go, that it is a good thing, they will also test you to know the type of malaria that has entered you when you are pregnant. I used to tell them and some of them say they have gone to hospital. Some ... if one is in labour and is brought to my house and if I check, it is time for you to deliver and you have not, I tell you "go to the hospital, did you have card?" they say that they have and I say "bring it". So there is one that was brought because sometimes when something happens to somebody ... is to have knowledge".

"The TBAs on their own do ask them to go and register in the clinics, but the women themselves do not like to, but…ehhhm! It is really an important thing that all TBAs here should be members of the village health committee so that we can investigate and know those of them who work hard in referring women to clinics [voices concurring in the background], also that they know those who actually turn up to register in the clinics and those who do not. TBAs are many in our communities and women are getting pregnant every second. We also have to take upon ourselves to make findings to see if every pregnant woman we see has register in the clinic. They have to proof by showing us their cards of registration".

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Integrated TBA role in the community engagement model:

Training the TBA and TBA/hospital collaboration could be advocated by CEG. Training the TBA and TBA/hospital collaboration has the potential to ensure reorientation of the TBAs to a new community-based role—that of birth companion and promoter of facility-based maternity care including delivery. This can improve access for women and result in an increased number of women receiving skilled maternity care. TBA hospital collaboration will result in an increased uptake of facility-based maternal healthcare services by the rural women. Thus, Pyone et al., (2014) submits that the TBAs require training to ensure re-orientation to a new community-based role which is that of birth companion and promoter of facility-based maternity care including delivery.

Concept 4: Trust in health services

Trust in health services is an important concept for good maternal health care. In this study, fear of health facility procedure and previous experiences was identified as an important pro-TBA factor and resulting in low trust in health services. Trust in healthcare services was low as it was influenced by previous experiences and fears of facility procedures. Previous experiences and the presence of fear may lead to increased patronage of the TBAs and non-utilisation of orthodox healthcare.

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- Trust was strongly influenced by positive behavior towards patients as experienced by the participants as provided by the TBAs. Conversely, trust in health services were also decreased through negative behaviours towards patients as experienced by the patients from the orthodox healthcare providers (nurses bullying or shouting at the women).

- Trust was also influence by fear of health facilities procedures. Fear of health facility procedure refers to the rural women being afraid of some of medical activities in the hospital, particularly injections, operations, and episiotomies. TBAs

were said to give the rural women time to labour whereas hospitals do not. Herbs and roots prepared as concoctions for pregnant women are highly preferred to the injections administered in hospitals.

Definition:

Formal definition: “firm belief in the reliability, truth, or ability of someone or something” (Oxford English Dictionary, 2008).

Applied definition: Trust refers to the rural communities’ belief that health services are reliable as experienced by positive previous experiences and positive behavior towards patients and increasing time for the birth procedure to allow enough time to allay fears about facility procedures by adequate health education.

Validation of concept of the need to establish trust in health services:

Trust was high in TBA services as opposed to hospitals as validated by responses from stakeholders.

> *“It is not just possible, some will still go or if it is as if we are forcing them to hospitals, they can go to register in the clinic but still go to the TBAs and deliver with them because this practices is what they are already used to, and confidence in the TBAs have been built up over time, so to wake up one day and say stop may not be achieved”.*

This was due to the previous negative experiences at the hospitals:

> *“So some of them would say that when you go to the hospital, they shout at you, hospital does this”.*
> *"It is only that in this place, women just like going to TBAs to deliver. Sometimes, it is because nurses shout at them too much"*
> *“So some of them would say that when you go to the hospital, they shout at you, hospital does this”.*

The opposite was shown where a participant had a positive experience.

> *“Nurses do not shout at anybody because, me my grand children were born at the hospital. Last year they born at the hospital (interrupted), they don’t shout, no one shouted at anyone, in fact they will be petting you so that you will deliver the baby freely. The more babies are born at the health centre, they are being tick right na”.*

This was further confirmed through the acknowledgement of the need to correct these baseless fears by CEG is validated by responses from stakeholders.

> *"So government has seen suffering and deaths that is going on now, so, they used their money and train our children far and wide, so that they come back and work for our health and lives".*

> *"Hospitals medically have what they use in checking people. That is how they know when it is time. There is no need being afraid of hospital. If one has no problem nothing can happen to you. Obedience is the thing. If they decide to operate, it means they have seen that if they woman is allowed to labour, she will die, they now time ... and operate to remove the baby so that both mother and child will live. So they are not doing nonsense, they have been trained. So my brothers and my sisters, we have come today to bring out the ideas that we are going to use for this and also form people whom we will give the responsibility for this".*

> *"...the best thing is to go to the hospital because these nurses are trained nurses and I like hospital's work too much that I told one of my children to follow and go and learn, so hospital have trained their people and they also write exams like they do in the secondary school, primary school, everybody "they bend down to teach". They also teach them till they come out".*

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Trust as a concept in community engagement model:

Trust as a concept is strongly linked to encouraging an absence of fear for healthcare procedures and positive attitudes. This trust can be translated to the orthodox healthcare services by the CEG. Positive behaviour towards rural pregnant women and nursing mothers by the orthodox healthcare providers can be advocated by CEG. Fear of healthcare procedure could be corrected or allayed through maternal health literacy, the awareness carried out by the CEG and these activities of CEG could bring about increased utilisation of orthodox medical healthcare. Flood & Archibald, (2003); Abelson & Guavin (2004), concludes that, representative community governance structures offer meaningful opportunities for citizens to become better informed of the complexities of healthcare and the positive changes in health care system for the benefits of the women.

Concept 5: Access to healthcare

Access is as an important concept for good maternal health care. Access to healthcare refers to the ability (physical and financial) to use healthcare facilities. Access in this study drove the health seeking behavior through proximity and cost. Financial access is only an assumed (but not real) problem by virtue of government's free maternal care.

Definition:

Formal definition: "the right or opportunity to see someone or use something" (Oxford English Dictionary, 2008).

Applied definition: In the context of this study, access to healthcare refers to physical, financial, or social access. Physical access refers to nearness to healthcare facility. Financial access refers to the ability to pay the bills. Social access refers to behavior of healthcare providers.

Validation:

Access to health care was verified as a concept by the stakeholders, including cost, transport and proximity.

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> *"They were born at Idundu hospital, three of them. Never did they collected money from me, if they do may be one hundred or one thousand, some do even come without carrying even napkin, nor pampers, nothing, nothing, they removed things from the hospital and take care of them. Our matron here tell her that in the clinic here all is free and I go, I say when you get to the house of TBA me I don't have money...o, that government will pity me".*
>
> *"Aunty, it is not that people don't pay but talking concerning means of how to transport one to the hospital. At night you may not see transport to take you to the hospital. It is why I say wherever is nearer to me, that is where I will deliver".*
>
> *"...the normal thing is that it is the man would take care of all the money for the hospital so sometimes they usually prefer places that are not expensive ... see that is why many of them prefer us to born in the TBA place".*

Access to healthcare in the community engagement model:

Access to healthcare could be translated to access to orthodox maternal healthcare by the CEG. Maternal health literacy (carried out by CEG) would sensitize the rural women about how orthodox healthcare has been improved to meet their needs, for instance existence of free healthcare services for pregnant women and children and user-friendly healthcare services. Through the CEG the infrastructures that could attract healthcare providers to live within the communities they serve could be advocated for from the policy makers or government. Affordable services, availability of providers at all times, and positive attitude of care givers towards women would in turn facilitate access, thus utilisation of orthodox maternal healthcare by the rural women. In support of these, various studies show that men's approval or disapproval of pregnancy care was linked primarily to difficulties of access and the costs involved (Onayade, Akanbi, Okunola, Oyeniyi, Togun, & Sule, 2010). Furthermore, Doctor, Findley, Ager, Cometto, Afemjado, Adami, & Green, (2012), in their study recommended that existing informal social networks within the community can help in relaying back to pregnant women and the community how the health facilities have been improved and have become more "community-friendly" and comfortable for women.

Concept 6: Culture

In this study, culture was identified as an important concept influencing current TBA use and good maternal health care. In addition, some cultural beliefs could impact negatively on women's health.

Definition:

Formal definition: The Oxford English Dictionary (2008) defines culture as: "the beliefs, values, behavior and material objects that constitute a people's way of life".

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Applied definition: In this study culture and tradition refer to firm beliefs the rural community have in TBAs that they are reliable, and this belief is passed on from generation to generation. Similarly, this includes strong beliefs in the role of women, status, and kinds of beliefs and practices regarding pregnancy and delivery.

Validation:

Cultural beliefs about the positive use of TBAS were validated by the responses from the community stakeholders:

> *"I am an old woman. I get seven children. All my sons and daughters are married. I bore all of them in the house, only three in TBA house. But no problems ... no problems at all. If blood come out plenty, TBA will give you some roots to chew and it will stop. Things have changed. This new age is wicked. Now small things, you will hear a woman has died, the baby has died ... what is the cause, we don't know. Was it not this same TBA that were taking care of us? The world is just wicked now".*

> *"... Am a TBA, my name is Eno Ime Effiong. I am living at Ayanghanse here. This work of assisting at childbirth, God gives to us and also gives to me too. Since I started this work [interrupted by a leader "where are you living?"] Abiet Archieobong Ukpong. God have been helping me during labour and childbirth, since I started this work no one has died in my hands because God said that he will give us the reward that will be measure with this work that we are doing. [Clap from the people])".*
> *"Mma Nurse, It will not be easy ... o ... to stop women going to TBAs at all at all. Because these women are very good…o! Many are prophetess, they pray for women, fast for women ... in fact they have a way of locking your pregnancy so that it does not come out till it is time. Hospital people don't know all these, prayers and fasting is very important".*

> *"As they use to say this [that] ... they carry pregnancy to TBA to care for, they lock the womb, such things I don't understand because with God "all things are possible".*

> *"…am hearing [interrupted] I say ... o that they say that the TBAs ... these our sisters who are TBAs that it is when someone goes and get treatment from them and say that she does eh ... if she does not go there to deliver, they will lock that womb. This was said before in our community meeting and I noted, it has happened to the level that they say there was someone ... a*

pregnant woman who went there, that it was until they took her there that it was until they took her to the TBA she registered that she was able to deliver. We villagers investigated and I say they should ask them ... these TBAs if they used to do so. That is what am asking".

The stakeholders also validated cultural beliefs about the incorporation of cultural practices through pregnancy by TBAs:

> *"…the TBAs we have here are like our mothers. They treat women well when they go to them. They advice them on the kind of food to eat in pregnancy so that they can deliver without problems when time reach. They give pregnant women some leaves and (ukebe) enema so that labour can be easy without much pain … Hmmmmm! The women have been so used to them already".*
>
> *"…they even have a way of protecting the mothers and the newborn baby from evil eyes and tetanus (odon)".*

A strong cultural belief that has an impact on the pregnancy was about the patriarchal role of men in the rural community society:

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> *In this village women have no right to disobey their husbands o! Whatever our husbands say is what we do. If not, we won't only have problems with our husbands alone, even the whole community will be against us. So please since women have no say here, let the husbands be called to order and be instructed about what we have all agreed here that pregnant women should register in the clinic. Because when the husband accepts, it will work".*
>
> *"For all these things to work for us, we should remember that we are women, we are under somebody. The husbands, the Clan heads, the big men (chiefs) of our villages must be told about what we want to do … they must agree … I mean … accept with us … give us permission if you want to succeed Mma nurse".*
>
> *"In this village, we fear and respect our chiefs…o! If after telling the women the good thing in going to put name in health centre and deliver there and they are still stubborn. If our clan head steps in to warn them that any woman who is pregnant and do not register in health centre or any man who does not allow the wife to register in the health centre will be punished or even send*

out of the community. Mma Nurse, you will see that they will sit up".

Culture in the community engagement model:

In the context of this study, there were issues of importance in terms of cultural beliefs that should be considered. One is the importance of integrating and respecting culture as part of maternal health care while correcting harmful cultural practices through the maternal health literacy. These activities could be carried out by the CEG who would have an important role in maternal health literacy thereby correcting negative cultural-based assumptions, creating awareness about the ills of certain cultural beliefs and practices bothering around pregnancy and delivery as well as advocating for women's support in the patriarchal society. In support of the above, Osubor, Fatusi, and Chiwuzie's (2005), posits that poor maternal health-seeking behaviour with a high preference for Traditional Birth Attendants who are unskilled were associated with local beliefs, such as those that link pregnancy-related problems to witchcraft and other supernatural causes, misguided opinions and folklore. Accordingly, Fatusi, (2004), submitted that when spiritual factors were linked to a particular problem, community and family members often believe that such conditions cannot be handled by orthodox medical practitioners, hence such people are taken to traditional healers and Traditional Birth Attendants in most Nigerian communities (Fatusi, 2004). Therefore, Portela & Santarelli (2003), suggested that, the community can be engaged to discuss solutions to context-linked obstacles to seeking the needed care by rural women, including those beliefs and practices impacting negatively on women's health.

Concept 7: Husbands' involvement in women's health issues

In this study, the role of the husband was identified as an important concept influencing access and use of health services and accessing good maternal health care. The concept emerged from the analyses of both the interview and the photovoice. In this study, it is

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found that husbands exert a great influence in decision as regards the place of delivery for their wives, as they bear the burden of the cost of healthcare services and culturally their decisions must be respected. So if husband involvement in women health issues is harnessed, it could be an important factor (concept) for utilisation of orthodox maternal healthcare.

Definition:

Formal definition: The Oxford English Dictionary (2008), defines 'husband' as a man in a marriage or a marital relationship, especially in relation to his spouse; and 'role' as the function or position of something.

Applied definition: In the context of this study, husbands' role refers to the influential status of men as regards taking decisions on issues that bothers around their family, specifically healthcare of their wives during pregnancy and delivery, and how as part of culture, their decisions must be strictly adhered to. Husbands take decisions as regards place of delivery for their wives as they bear the burden of delivery cost. Hence, husbands' involvement in maternal health issues would mean taking advantage of the influence of the husbands over the women, making the husbands knowledgeable about those health issues that affect pregnant women and making them part of women's healthcare.

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Validation:

The negative current role of the husband was identified and validated as a problem for good maternal care:

> *"Sometime it could be that husband does not encourage their wives to go to the hospital in order to stop this death. So there is work for us to do. The group (CEG) that we will form will have to go round and educate the men (husbands) too, to give them knowledge about the good things that the hospital people are doing for pregnant women. That they should allow their women go to clinis,…they can also go with them to hear and see".*

"We all have heard what that woman have said, she touch a lot of things, so women now use their pregnancy period to eat their husbands for nothing (audience answer yes) ... o, go to the hospital they don't ... o but they will lie to their husbands and collect money that it is for clinic, and their husbands do not know what is happening. All this is that we must have what to do and that we must do something that is true [noise in the background] ... women should contribute here if there is something to say so that we know what to do"

"The other one along "ASSIAH ABUFA" so it was, that they rubbished the pregnancy… that during labour we could not help, so we asked her to go to the bigger hospital but her husband carried her back to the house and she died there. Her corpse is there now".

Husbands' involvement in the community engagement model:

Husbands are found to have huge influence over their wives' health-seeking behaviour; this influence can be harnessed positively by CEG, to bring about higher utilisation of maternal healthcare. If husbands are encouraged to be part of or be sensitized on women health issues, for instance accompanying their wives to Ante Natal Clinic, they will become knowledgeable about maternal health issues which could impact positively on their decision-making role and making them more supportive. In confirmation of this Mathur, (2005), submitted that Community sensitization approaches increased men's understanding of maternal care, and improved husbands' willingness to support their wives' maternal care needs.

Concept 8: Community Support system

Community support system is the key concept for facilitating improved maternal health care in the current context being a patriarchal society with dominant male roles. This support can be facilitated and supported in two ways, namely through collaboration and increased maternal health literacy of the community.

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Definition:

Formal definition: A community support system is "a group of people with common experiences or concerns who provide each other with encouragement, comfort and advice" (Oxford English Dictionary, 2008).

Applied definition: In the context of this study, 'support system' refers to groups, associations, or institutions formed in or by the community to watch over women's health matters, including emergencies. It refers to the use of community members and the existing community structures in creating awareness of women's health issues of concern and promoting the utilisation of orthodox healthcare facilities for skilled care during pregnancy, delivery, and puerperium by community women to prevent maternal health complications.

Validation:

The need for collaboration among different community groups were identified as important for community support was validated by responses from stakeholders.

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> *"Also another one is that we have form this eh….WDC, this is WDC meaning (WARD DEVELOPMENT COMMITTEE) that the Local Government Councils formed. Our duty is to walk around and check, that is the sanitation of th…eh…place, this thing, every... the women… the TBAs names , know where they live so that we can be checking to know if they keep their environment clean. So… if we encourage these groups who go around, give then the TBAS addresses, because they will know the TBAs. Also let them know the names and addresses of the constituted group members (interrupted). So we now meet once in a month....all the groups together and invite the TBAs........whoever does not come out, we can say five, five thousand as fine, they will come out. That is what I think (interrupted-noise at the background) thank you".*

> *"For me, I want to say that it will be very necessary for members of the group we will form to ensure that they work together with the WDC and the VHC, which were already on ground. I can also sense that some members of this group can come from the already existing groups".*

> *"I have said it before we will look for people and train them on how to go about and let the people, the men, the villagers know that now, we have a law we have people we have formed and*

committee that their work is for them to go around and check any woman who is pregnant to know if she has gone to the hospital… if they investigate her and know that she does not go to the hospital they have to report her to either the chief or Clan head so they will make her to go the hospital, if she does not want to go, they report her to police, all we have to let the police know officially, it will not be a hidden thing so that we see that help and love that government has for us is worth, we accepting and owning it that is how I would like to say it".

The importance of involving TBAs in community support was also supported.

"What we now say that we have agreed on is that all TBAs in these communities, that we all know that they are TBAs must be made a member of the group that will be formed. [voices from the audience saying, "they were supposed to be members of the village health committee but they have not been coming"]. If we discover that you are a TBA and you refuse to belong to this group, you will have problems with the community, because we need help".

The need for sensitisation or training of the community was strongly supported in the stakeholder discussions:

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"... they should be given some form of education ... from time to time ... I mean training to be given new information about health matters so that they can always have what to tell our women, " you cannot give what you don't have". It is good for them to have knowledge of everything so that they can do their work well".

The stakeholders also identified strategies for the community to use to support pregnant women, including monitoring, encouraging health service use and sharing information:

"What we are going to do now is that we will have to start passing information by sending written information to different societies and groups in our communities, schools, churches, different cooperative groups and all other groups that we have here, that is any welfare group or any gathering people come together up to ten in number or even more. At the end of this meeting, the chiefs will send letter of authorisation to them. They will also keep a copy, and also send to this our visitor, so that whenever she comes back, she will see the kind of work we have been doing in the community. Because, we are going to all move by ourselves, physically and do this work well, also to help advise and encourage our women, we will also ensure that women obey and accept to go to health facilities for care, whenever they are pregnant".

"Any woman who is pregnant but refuses to go to the clinic has committed a great crime. We have to ensure that whether they like it or not, pregnant women in these our communities must register and deliver in the clinic or hospital. Also those who have babies must take their newborn babies to the hospital for care and immunisation. So we are going to pass round this information, not just passing information but we must from time to time go around our communities to visit those societies to ensure that we ask about what they have done with the information passed and also find out if they are cooperating with us"

"That is the duty our pregnant women owe us. Amongst the group, we will also have people that could go house to house to check and identify the pregnant women. Those of them who cannot show their registration cards means they do not register, because if they register, they will have the cards. It is then that we will have problems with such a woman and her husband. That is my contribution".

Community support in the community engagement model:

Formation of the Community Engagement Group (CEG) is a major component of the community support. Further community support system could be facilitated by the CEG. This would involve collaboration between different groups, engaging TBAs to be part of the community support, increasing health literacy of community members to enable monitoring, support and educational roles for the community groups.

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In support of this, evidence from reviews have highlighted successes achieved when engaging community members to support women health issues. For instance, the Malawian initiative that sought to engage with local women's groups to identify the major maternal and newborn problems in their communities, and to develop community-driven strategies to address these had significant success with 30% fewer newborn deaths and 80% fewer maternal deaths (Blomfield & Cayton, 2010; Rosato et al., 2006). This study operated on the premise that improving preventive and care-seeking behaviours, increasing knowledge, and changing negative attitudes among rural women and their communities was necessary if the utilization of skilled

attendance must be improved (Rosato et al., 2006). Likewise, Azad, et al., (2010), proposed that a significant proportion of maternal mortalities and morbidities could be potentially addressed by developing community-based intervention packages which should also be supplemented by developing and strengthening linkages with local health systems (Azad et al.,2010). Study by Lassi, Haider, & Bhutta, (2010), also found encouraging evidence in integrating maternal and new-born care in community settings such as home-based care, home visitation, health education, community sensitization packaged through community support group, women's group and Community Health groups etc. Also Community boards provided a strong link to larger local, provincial, and national bodies (Church, et al., 2005).

7.4 CONCEPT CLASSIFICATION

Once validated, the main concepts of the study identified in Table 14 were classified according to the survey list developed by Dickoff et al. (1968) to provide a context for the model development. The survey list highlights six activity aspects that include ways of looking at the concepts at a community engagement level to prevent maternal health complications in the hope of revealing how each concept could lead to the achievement of the study goals. All aspects of the activity list are important and should thus be taken into account in order to obtain a full exploration of the experience of community engagement in the prevention of maternal health complications perceived by women and stake-holders in a rural community setting.

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Six questions relating to the activity aspects are used to survey the community engagement activities, and these include:

- Context - *In what context is the activity performed?*
- Agent - *Who or what performs the activity?*
- Recipient - *Who or what is the recipient of the activity?*

- Procedure - *What is the guiding procedure, technique, or protocol of the activity*
- Dynamics - *What is the energy source for the activity?*
- Goal - *What is the end point of the activity?*

The researcher's reasoning map (Figure 7) showing the classification of concepts related to the survey list will serve the purpose of verifying how the main and related concepts were classified. In addition, using Dickhoff's framework, after the verification process a brief explanation is given of the verified concepts of the proposed community engagement model.

The identified concepts were classified and conceptualised using the six elements of practice theory as described by Dickoff, James and Wiedenbach (1968:434), namely:

- Agent : Community Engagement Group (CEG)
- Recipients: Mothers& pregnant women, Husbands, Community, TBAs
- Context: Poor rural community
- Procedure: Community Engagement
- Terminus: Improved maternal health literacy (knowledge of Birth preparedness, Complication readiness and increased utilisation of healthcare services for skilled care during pregnancy, delivery, and after delivery by rural women
- Dynamic: Partnership and dialogue, Maternal health literacy, training TBAs/ collaboration, community sensitization, access to healthcare services, facilitating culture and spirituality in healthcare services, husband role and involvement, building trust, community support, culturally appropriate care.

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7.5 CONCEPT VERIFICATION

To verify the concepts, systematic ordering of the concepts was done against the survey questions (Figure 7). This is followed by an exposition of the concepts according to the six elements of the survey list (Table 15).

7.5.1 Agent: Community engagement group (CEG)

The 'agent' refers to who will be responsible for the community engagement processes in the proposed community engagement model. The main agent in this model is the Community Engagement Group (CEG), comprising members of the Village Health Committee (VHC), Ward Development Committee (WDC), community women leaders, representatives of TBAs, leaders of women's groups, religious leaders, and clan heads. The formation of this group resulted from the FGD with the community stakeholders to validate the concepts and to participate in drafting guidelines for the development of the model of community engagement for the prevention of maternal health complications in the rural communities of Cross River State, Nigeria.

To facilitate the community engagement processes, the agent identified as the CEG can translate the factors (strengths) of TBA patronage into the orthodox healthcare through partnership and dialogue, thereby bringing about increased use of orthodox healthcare services.

The CEG would take advantage of other observed factors including maternal health literacy, TBA training and TBA/hospital collaboration, husband involvement, facilitating culturally appropriate car, access to and spirituality in healthcare services, building trust, community sensitization and a community support system, to bring about this much desired transformation (i.e. increased knowledge of obstetric danger signs, birth preparedness, complication readiness, hence patronage of orthodox healthcare for skilled attendance during pregnancy, delivery and puerperium by rural women), thereby

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reducing the occurrence of maternal health complications among rural women to the barest minimum.

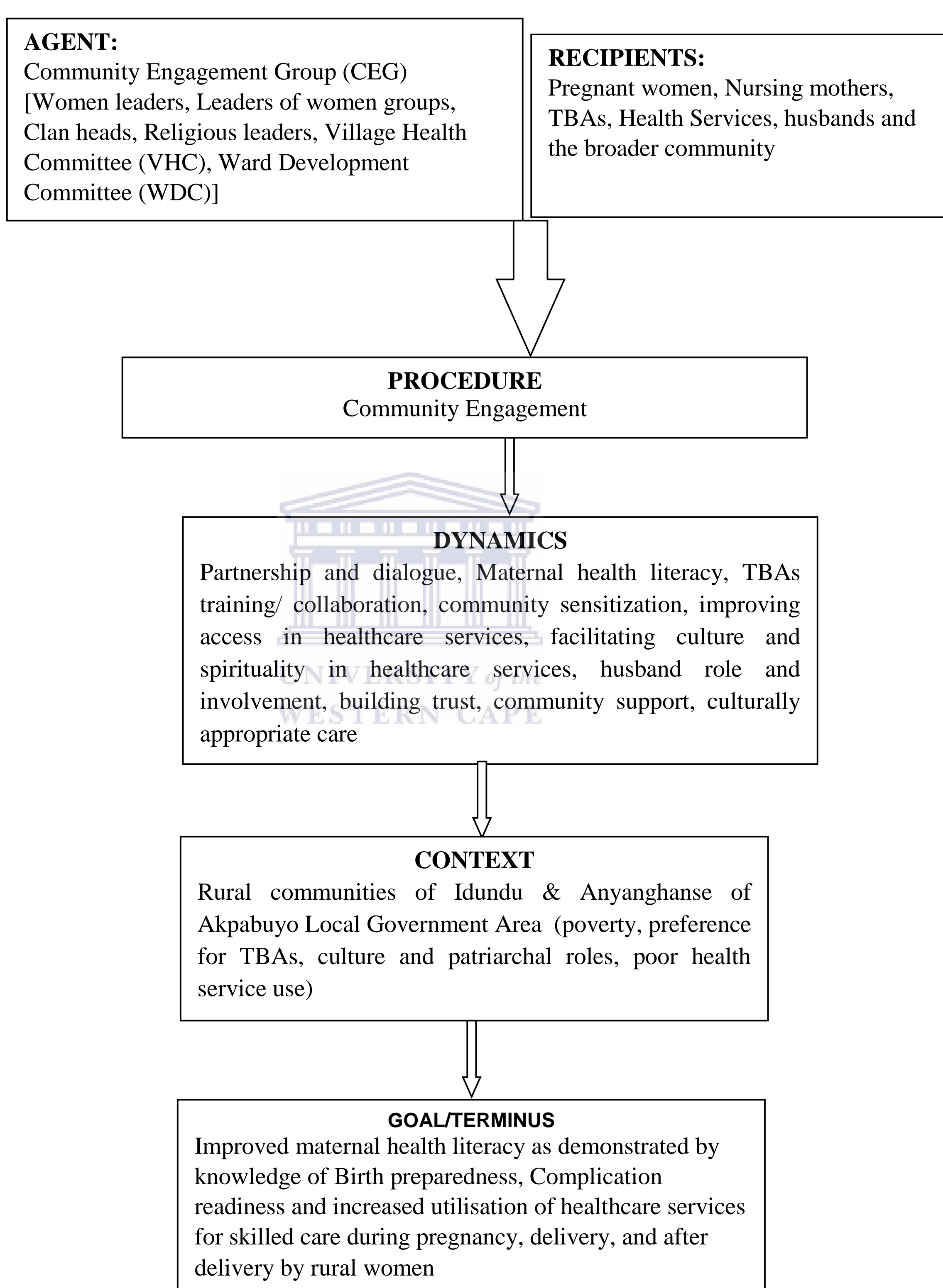

FIGURE 7: Classification of concepts using survey questions

TABLE 15 Identification and classification of concepts

Concept Identification		Concept Classification
• Increasing maternal health literacy (birth preparedness, complication readiness, role of TBA, role of Health Service, role of husband, role of community)		**Agent** Community Engagement Group (CEG)
• Including spirituality in healthcare (praying and fasting)		**Recipient** Mothers and pregnant women TBAs Health Services Community Husbands
• Integrating TBAs (recognising value, training, and TBA/hospital collaboration)		
• Trust in health services (Addressing previous experiences, attitudes, and fears)		**Context** Rural community Poverty Culture
• Improving access to healthcare (motivation to attend, gifts, attitudes, awareness of free health services)		**Procedure** Community engagement
• Culturally acceptable care (role of husband, role of community, spirituality and TBAs)		**Goal** Maternal health literacy (Birth preparedness, complication readiness and appropriate health service utilisation)
• Husband role (Involving husbands in women's health in decision making, chores, and support)		**Dynamic** Partnership and dialogue, Maternal health literacy, TBAs training/ collaboration, community sensitization, improving access in healthcare services, facilitating culture and spirituality in healthcare services, husband role and involvement, building trust, community support, culturally appropriate care
• Community support (Enhancing community support systems).		

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7.5.1.1 Discussion of community engagement groups

While the importance of skilled delivery and facility-based care for maternal care were emphasised, the review provides encouraging evidence that the benefits of community-based strategies may extend across the continuum of maternal and newborn care (Lassi, Haider, & Bhutta, 2010). The most successful packages according to the authors were those that emphasised involving family members through community support and advocacy groups, community mobilisation and education strategies, provision of care through trained Community Health Workers via home visitation, and strengthened proper referrals for sick mothers and newborns (Lassi, Haider, & Bhutta, 2010).

A community-based research to shape the design and delivery of maternal health services in Northern Nigeria revealed the importance of social influence in encouraging women to seek both antenatal and delivery care, as existing informal social networks within the community can help in relaying back to pregnant women and the community how the health facilities have been improved and have become more "community-friendly" and comfortable for women (Doctor, Findley, Ager, Cometto, Afemjado, Adami, & Green, 2012). Same authors added that some antenatal counselling messages about birth preparations and recognising and knowing how to respond to danger signs could be integrated into the local social networks and groups, such as village women's committees, as women who made at least one kind of preparation for their baby's birth were more likely to deliver with a nurse-midwife (Doctor, et al., 2012). Even if that did not include preparing to go to a facility for delivery, it is believed that greater efforts to promote birth planning and preparation will increase the proportion of women who are ready and willing to attend a facility for delivery when they go into labour (Doctor et al., 2012). As has been recommended by others in Nigeria, Onayade, Akanbi, Okunola, Oyeniyi, Togun, and Sule (2010), concluded that not only does birth preparation need

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to be a consistent element of antenatal care, but it also needs to be incorporated into community-based information networks, so that women who do not attend antenatal care also know how to prepare for labour and delivery (Onayade, Akanbi, Okunola, Oyeniyi, Togun, & Sule, 2010).

In the community, the objective has been to promote antenatal care and safe birth, provide information on danger signs in pregnancy and childbirth, the importance of planning for delivery and of standing permission from husbands to attend a facility, and to convey feedback about changes in both antenatal and delivery services that address concerns about gender, privacy, dignity, and quality of care (Onayade et al., 2010). This is being implemented primarily through community health volunteers who facilitate community discussion groups and use participatory communication tools, a community engagement discussion guide, jingles, and "body tools" (e.g. using five fingers to demonstrate the number of visits required for a child's immunisation) (Onayade et al., 2010). These activities are reinforced by an average of four health promotion jingles or spots per day on the radio for 12 weeks, and by reaching out to traditional and religious leaders to ensure an enabling environment for behaviour change. The community health volunteers had within a year worked with local (ward) development committees at 323 community engagement intervention sites across the three states (Onayade et al., 2010).

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The Cochrane collaboration review on community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes by Lassi et al. (2010) revealed that while the importance of skilled delivery and facility-based care for maternal care cannot be denied, the review provides encouraging evidence that the benefits of community-based strategies may extend across the continuum of maternal and newborn care as the most successful packages

were those that emphasised involving family members through community support and advocacy groups and community mobilisation and education strategies, provision of care through trained CHWs via home visitation, and strengthened proper referrals for sick mothers and newborns (Lassi et al. 2010).

Two case studies, one in Nepal and one in India, sought to mobilise communities for the reproductive health and maternity service needs of married adolescents according to (Blomfield & Cayton, 2010). Although the results were mixed when it came to improving knowledge of pregnancy care and delivery, they had success in other areas as noted by the authors. Hence, they concluded that "the key way in which the initiative sought to mobilise the target communities was by working largely through local organisations to produce and implement the intervention programmes, to facilitate ownership of the programmes by these groups, and to promote their long-term sustainability (Blomfield & Cayton, 2010). An early initiative developed in Ireland involved community mothers supporting disadvantaged first-time mothers as the community mothers worked under the guidance of family development nurses who provides a resource person, confidante, and monitor in a partnership for 15–20 community mothers each supporting five to 15 first-time mothers (Blomfield & Cayton, 2010). This programme influenced the development of similar schemes in the UK, for example "the Thurrock community mothers programme in southwest Essex" (Brassett-Harknett, Joshi, Butler & Bryar, 2006). It found that by the end of the study children in the intervention group were more likely to have received all of their primary immunisations, mothers and babies had more appropriate diets, and at the end of the study mothers were less likely to be tired, feel miserable, or want to stay indoors, and they had more positive feelings, and were less likely to display their negative feelings (Brassett-Harknett et al., 2006). Women in the community mobilisation sites were more

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likely to know where maternal care services were available, more likely to receive antenatal care, to seek routine care at government services, and to have deliveries in a medical facility or with a trained medical professional (Brassett-Harknett et al., 2006). In comparison to the traditional approach, the community mobilisation approach was particularly strong in tackling social and attitudinal changes among women, their households, and their community according to (Mathur, 2005). Community mobilisation approaches gave young women the confidence and skills to articulate their reproductive health concerns and demand services, increased young men's understanding of maternal care, improved husbands' willingness to support their wives' maternal care needs, and fostered better intergenerational communication and support between mothers-in-law and daughters-in-law (Mathur, 2005). Furthermore, the author conclude that in working with local health care providers, peer networks, and key adults, the community mobilisation approaches enhanced the availability of quality sources for reproductive health information, counselling, and services for young married women" (Mathur, 2005).

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Concluding statements for community engagement groups

The following concluding statements for community engagement groups are highlighted below:

- The community engagement group is the main group responsible for the development of a community engagement strategy to improve knowledge of birth preparedness and complication readiness among the rural women thereby promoting the utilization of orthodox healthcare facilities for skilled attendance during pregnancy, delivery and puerperium

- The CEG provides leadership through partnership and dialogue between the community members and healthcare delivery system on maternal healthcare issues
- The CEG collaborates with the community members to promote husbands and community support for women during pregnancy, delivery and puerperium
- The CEG facilitates TBAs training and TBAs/Healthcare facility collaboration to improve TBAs' knowledge, improve access to healthcare services and build trust
- The CEG engages with healthcare system to facilitate spirituality and culturally appropriate care in healthcare services
- The CEG engages with health services to facilitate maternal health literacy through health education, community sensitization and awareness programs on maternal health issues.

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7.5.2 Recipients: The community (mothers and pregnant women, husbands, TBAs, orthodox health services)

According to Dickoff et al (1968:423) "the recipient is the receiver of activity". The recipient of community engagement are receivers of maternal health services (mothers and pregnant women) who are in interaction with health related services (TBAs and orthodox health services), the other community members in the community and the context. The characteristics of the recipients can be seen in Table 16.

Mothers and Pregnant women: In this model, the main recipients are pregnant women and new mothers who are the recipients of maternal health services facilitated by the community engagement model to address their maternal health needs. However, when the maternal health needs of pregnant women and nursing mothers are met, the rural community and the nation at large will benefit, as maternal mortality/morbidity will be

significantly reduced. The main goal of the community based model will be to ensure that maternal health is improved through the recipient becoming more literate about maternal health issues, TBA care and hospital or facility based maternal health care collaboration; the recipient developing more trust in health services and having more access to skilled birth attendant services.

A second recipient is the entities actually providing the maternal health services, namely TBAs and the orthodox health services.

TABLE 16: Specific characteristics of recipients

Mothers and pregnant women	**TBAs**	**Orthodox health services**	**Husbands**
Passive rural community members with low levels of education	Traditional women	PHC services	Decision maker
Low knowledge	No formal training	Formally trained	Low Knowledge
Spiritual	Spiritual cultural health care	Orthodox western health care	Spiritual cultural participants
Low socio-economic level	Low socio-economic level	Well placed socio-economically	Low socio-economic status
High respect and trust for TBAs	Highly trusted by women and the community members	Loss of trust and confidence from women and community	Trust and confidence for TBAs

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Orthodox health care services: Orthodox healthcare services in the model of community engagement are defined as the provision of maternal and child healthcare services by skilled healthcare professionals within the modern healthcare facilities cited within the study communities. Providers are given the responsibility of creating individual and community awareness, and sensitising the community about health

programmes and maternal issues of concern. The Anyanganse community has a health post manned by a senior Community Health Extension Workers (CHEWs), while the Idundu Community has a Primary Health Centre (PHC), headed by a qualified senior nurse/midwife with a medical doctor visiting the centre three times a week. Doctors on National Youth Service are sometimes posted there to assist. The PHC in Idundu is well-equipped to attend to referred cases from the surrounding health posts. Only complicated obstetric cases are referred to St. Joseph Hospital, Ikot Ene, or the General Hospital in Calabar.

Traditional Birth Attendants (TBAs): In the model of community engagement TBAs are defined as those community-based traditional midwives who are not formally trained to proficiency but who provide care to women during pregnancy, childbirth, and puerperium. They are trusted by the community members who have developed a high level of confidence in them over the years, and patronize their services for pregnancy and delivery care.

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Concluding statements for recipients

The following concluding statements for recipients are highlighted below:

- The mothers and pregnant women are the main recipients and most directly in need and effected by maternal health care.
- The TBAs are those community-based traditional midwives who are not formally trained to proficiency but are trusted and have gained high level of confidence from women and the community members over the years, in the provision of care to women during pregnancy, childbirth, and puerperium.
- The Orthodox health services is the provision of maternal and child healthcare services by skilled healthcare professionals within the modern healthcare facilities cited within the study communities.

- The husbands are the family heads, within a cultural and patriarchal society. They are highly influential in decision making about place of delivery for their wives though possess low knowledge of maternal health issues. Husbands have high level of respect and confidence in TBAs regarding care of women during pregnancy, delivery and puerperium. If sensitized and involved in maternal health issues, by their position they could play a great role in promoting skilled birth at the orthodox healthcare facilities.
- The Community is the environment in which the model of community engagement for the prevention of maternal health complications in rural areas of Nigeria will be implemented. In this study, two rural communities were used namely, community A (Idundu) and community B (Anyanghase) in the Akpabuyo LGA of Cross River State, Nigeria. There is poverty, patriarchal roles with some community support but no defined community structure to assist women,, strong sense of culture and spirituality with poor use of orthodox health services and high patronage and preference for TBAs, low maternal health literacy and poor access to health care.

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7.5.3 Context: Rural community with high rate of poverty

The context refers to the environment in which the model of community engagement for the prevention of maternal health complications in rural areas of Nigeria will be implemented. In this study there were two geographical areas, namely the rural communities of Idundu and Anyanghase in the Akpabuyo LGA of Cross River State, Nigeria. Both contexts provide viable sample of maternal experiences in the rural setting. The assumption is that the participants of this study alluded to events, behaviours, and actions that occurred in both contexts to give a holistic view of the total sum of maternal experiences. These include poverty, patriarchal roles with some

community support, strong sense of culture and spirituality with poor use of orthodox health services and high patronage and preference for TBAs, low maternal health literacy and poor access to health care.

Poverty: The people of these communities are predominantly farmers and their agricultural methods are primitive. The majority of the community members experience poverty. Women often do not have money for health services and TBAs are used with payment for services rendered in installments or in kind and some debts allowed to be carried over to the next pregnancy.

Use of TBAs: There are a variety of alternative treatment sources available in these communities; they include traditional healers and herbalists, spiritual healers or diviners, and TBAs. This study exposed that most women in these communities consult the TBAs prior to seeking orthodox care during antenatal care and deliveries, even with the availability of orthodox healthcare facilities. Among these sources, there is a high preference for TBAs and spiritualists for antenatal care and deliveries. Over the years TBAs have built up the communities' confidence in them and members of the communities trust them.

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Impact of cultural beliefs: The confidence is influenced by the perceived etiology of childbirth complications that is linked to supernatural and/or witchcraft, fate, and vows. The treatment is usually in the form of atonement, which in most cases is carried out by the TBAs. In the event of childbirth complications, time is spent on prayers and the oral administration of herbs. Referrals to health facilities are only made by TBAs after failed trials of traditional remedies. Any loss of life at the TBA is accepted as fate, what was meant to be, infidelity on the part of the victim that was not confessed, or God's design.

Spirituality: Some pregnant women claim some TBAs lock the pregnancy spiritually, only to unlock when labour commences to facilitate delivery. This practice is to ensure that the pregnancy remains intact and unharmed until the expected time of delivery.

Concluding statements for context

The following concluding statements for the context are highlighted below:

- Poverty: The majority of the community members experience poverty, so women often do not have money for health services.
- Culture: The perceived etiology of childbirth complications is linked to supernatural and/or witchcraft, fate, and vows, thus the treatment is usually in the form of atonement, which in most cases is carried out by the TBAs. There are also some cultural beliefs and practices linked the kind of foods to be eaten during pregnancy.
- Interaction with context and health service utilization: Most women in these communities consult the TBAs prior to seeking orthodox care during antenatal care and deliveries, even with the availability of orthodox healthcare facilities. Orthodox healthcare services is perceived to be expensive, with poor attitude of care providers and unavailability of 24 hours services.
- TBAs: There is a high preference for TBAs for antenatal care and deliveries in these communities, with high level ao trust and confidence in the TBAs. In the event of childbirth complications, time is spent on prayers and the oral administration of herbs, and referrals to health facilities are only made by TBAs after failed trials of traditional remedies.
- Spirituality*:* Some pregnant women claim some TBAs lock the pregnancy spiritually, only to unlock when labour commences to facilitate delivery.

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Time is spent on fasting and prayers to seek God's divine protection and ward off evil hands, during pregnancy and delivery. Any loss of life is accepted as God's design.

7.5.4 Procedure: Community engagement

Procedures refer to the techniques, procedures, and protocols associated with a model of community engagement for the prevention of maternal health complications in rural areas. Dickoff et al. (1968) assert that procedure refers to the path, steps, or general patterns on the way to the accomplishment of the goal. The procedure is to realise the goal (terminus), viz. maternal health literacy to promote the utilisation of healthcare by pregnant women and nursing mothers, thereby significantly reducing maternal mortality/morbidity.

The main strategy to deliver the goal is the constitution of the CEG. The main role of the CEG would be to facilitate maternal health literacy, encourage the training of TBAs, advocate for appropriate collaboration with TBAs and health services. It is anticipated that in the role of promotion of collaborative maternal health services, the CEG would increase accurate information about health service, thereby increasing trust in these service. In addition, a major role would be the provision of community support for pregnant women and encouraging men to reorient their role into a supportive role.

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7.5.5 Discussion of community engagement

According to Tindana, Singh, Tracy, Upshur, Dear, Singer, Frohlich, and Lavery (2007), there is no standard definition of a community. The term 'community' has been used to describe interactions among people in primarily geographic terms (Tindana et al., 2007). Though it is now accepted that people who live in close proximity to one another do not necessarily constitute a community, since they may differ with respect to value systems and other cultural characteristics that are more relevant to the social

concept of community (Tindana et al., 2007). According to the same authors, a community is characterised by the following elements: membership; mutual influence; shared needs and influence; and shared emotional connection (Tindana et al., 2007). However, engagement refers to the ability of people to come together, and to gain understanding and control over personal, social, economic, and political forces in order to take action to improve their life situations (Tindana et al., 2007). Community has also been defined to include the following interrelated concepts: "the quality of holding something in common such as values, goals, needs or interests; a social bonding and an accompanying shared sense of self or identity; and the people of a certain district, neighbourhood or town" (Scott & Marshall, 2009:7).

Morgan and Lifeshay (2006), refers to community engagement as an effort that promote a mutual exchange of information, ideas and resources between community members and the health department staff (Morgan & Lifeshay,2006). In the process, it is believed that the health staff will shares health expertise, services and other resources with the community, while the community shares its own wisdom and experiences to help guide public health program efforts (Morgan & Lifeshay, 2006). In effect, there is involvement of community members and the reliance on a community's own resources and strengths as the foundation for designing, implementing, and evaluating solutions to problematic conditions that affect them (Morgan & Lifeshay,2006). As such, community engagement involves interpersonal trust, communication, and collaboration (Morgan & Lifeshay,2006). Vancouver Coastal Health's Framework for Community Engagement offers the following definition: "Community engagement is a term used to refer to a whole spectrum of activities that support the two-way interaction process between the VCH and its communities" (Vancouver Coastal Health's (VCH), 2003: 65).

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7.5.5.1 Tenets of community engagement

Community engagement enables individuals and organisations within the community to take collective actions that are aimed at improving their conditions (Bhutta, Ali, Cousens, Haider, Rizvi & Black, 2008; Bhutta & Lassi, 2010). Likewise, communities, which are empowered, are able to implement mechanisms, such as loan schemes, to assist their members in times of need, hence in order to improve maternal survival in low-income countries it is necessary to scale-up community-based interventions (Bhutta, et al., 2008; Bhutta & Lassi, 2010). Lee, Lawn, Cousens, Kumar, and Osrin (2009) propose that it is necessary to link families and birth care facilities, and that community engagement is essential in maintaining this continuum of care from communities to heath care facilities (Lee, et al.,2009).

Understanding the value of community engagement in policy, planning and decision-making within local communities and the broader health system is of critical importance since health reforms continue to change and evolve (Bhutta & Lassi, 2010). Through community engagement citizen participation and power-sharing is enhanced as communities have a voice and are given greater influence in decision-making (Bruns, 2003). The author further proposes that at this level, decision-making power is transferred from the conventional power-holders (politicians, government administrators, and health professionals) to local community members (Bruns, 2003). Community engagement as defined by this author is "a process involving citizens at various levels of participation based on interpersonal communication and trust, and a common understanding and purpose" (Bruns, 2003). Community engagement can build agreement around issues, create momentum to address these issues, help achieve outcomes and create solutions to meet community needs and encompasses a full range of activities from sharing information, to actively pursuing participant feedback, to

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jointly planning, and to community organising for health at a grassroots level (International Association for Public Participation, 2007).

According to Frankish and Kwan (2002), community engagement in planning and delivering health programs can yield greater awareness of health issues, more appropriate use of health services and prevention of diseases (Frankish & Kwan, 2002). The authors also observed that community engagement processes are more than just the use of an approach as what happens before and after is also extremely important (Frankish & Kwan, 2002). Citizens are increasingly recognised as having knowledge about local needs and resources in relation to health, to express their opinions on what kinds of services are wanted, and how these services should be delivered, the form they should take, and the settings in which they should be provided (Frankish & Kwan, 2002). Therefore, community engagement and partnership between health authorities, the general public, individuals, and communities stakeholders are necessary if action is to be taken to improve health, the environment, and the quality of life in communities (Hancock, 2002). Likewise, the Tamarack Institute notes that communities whose members collaborate experience better child development, safer neighbourhoods, increased physical and mental health, thus there must be a community will, a clear sense of community wanting to take ownership in its health issues (Hancock, 2002).

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7.5.5.2 Effects of community engagement on community members and health outcomes

People are drawn to participation because they want to have influence – to have an effect on the policies being developed and decisions being made as well as being interested in making a difference (Mackean, Thurston & Scott, 2005). As noted by the same authors, another significant factor that participants point to for their involvement in a community engagement initiative, is the opportunity to build skills and have a

positive impact on their environment and in their community. People can then use these skills to advocate for change in other sectors that impact the health of the population (Mackean, Thurston & Scott, 2005).

Based on the review published by the WHO Europe Health Evidence in 2006 on the effectiveness of empowerment strategies, the most effective empowerment strategies are those that build on and reinforce authentic community participation thus ensuring autonomy in decision-making, sense of community and local bonding, and psychological empowerment of the community members themselves (WHO, 2006). The most significant value added in terms of community governance in health appears to be related to community governance's ability to achieve better health outcomes for both individuals and communities by increasing empowerment and social capital (WHO, 2006).

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A Canadian study undertaken by Church, Wanke, Saunders, Pong, Spooner, and Dorgan (2005) provides insights into the nature, extent, and impact of citizen participation on policy and service outputs in 17 community health centres across the country (Church, Wanke, Saunders, Pong, Spooner & Dorgan, 2005) . Findings from the study show some differences between locally governed community health centres (CHCs) and those CHCs accountable to larger regional governance structures as community Health Centres with locally elected boards were more likely and able to take on advocacy roles and activities for their communities and were an important source of developing and enhancing community capacity through leadership development (Church et al., 2005). This research also found that citizen participation in Community Health Centres decision-making had led to improved programmes and services, and that the range of programmes and services and strong representative community governance structures offer meaningful opportunities for citizens to

become better informed regarding the complexities of healthcare decision-making, while enabling local community concerns to be heard and considered in programme planning that met the needs of the community. Also Community boards provided a strong link to larger local, provincial, and national bodies (Church, et al., 2005).

Findings from the review of the trends and benefits of community engagement by Ktpatzer Consulting (2006), show that because an individual's health is rooted in the social determinants of health, programmes that are defined by health professionals without community engagement will most likely not have sustained positive benefits (Ktpatzer Consulting, 2006). Hence, local community engagement where issues are defined and managed by the community in a comprehensive approach will have a sustainable positive impact on health institutions and networks (Ktpatzer Consulting, 2006).

7.5.5.3 Components of community engagement

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Consultation, involvement, and participation are terms that are interchangeably used to describe community engagement activities, however, each term intrinsically refers to different forms of engagement, which are dependent on the overall objectives (Morgan & Lifeshay, 2006). On a more encouraging note, there appears to be a growing awareness that strategic and deliberate community engagement mechanisms are valuable components in improving quality healthcare and ultimately achieving good health outcomes (Morgan & Lifeshay, 2006). Similarly, interest in community involvement in healthcare has resulted in the establishment of many different community engagement mechanisms across the country as observed by (Mackean, Thurston & Scott, 2005). Mechanisms have taken many forms, including community health councils, community advisory committees, formalised partnerships and

networks, and the use of various consultation, information-sharing, and reporting mechanisms, as well as national and provincial quality health councils (Mackean, Thurston & Scott, 2005).

Several jurisdictions in Canada have developed community engagement frameworks, clearly outlining a commitment to community engagement through a variety of methods for citizen engagement (Vancouver Coastal Health, 2003). Some researchers indicate that citizens are becoming less willing to rely on elected officials as the sole advocates of their interests and realise that the complexities on today's society requires broader input in decision-making (Abelson & Eyles, 2002). Although citizens may not necessarily want responsibility for decision-making, they do want an opportunity to express their views, to be heard, and to ensure accountability and transparency when decisions are made (Abelson & Gauvin, 2004b; Flood & Archibald, 2005). Accordingly, informed citizens are helping to redefine the care management relationships with their health providers and the movement toward client-centred care demonstrates this change in relationships (Abelson & Gauvin, 2004b; Flood & Archibald, 2005).

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It is important to develop effective community engagement strategies to accommodate differences in the increasing cultural diversity at the local level (Abelson & Gauvin, 2004). Emerging research on the influence of neighbourhoods on health is showing that local community characteristics play a role in health disparities (Association of Ontario Health Centres, 2005; PolicyLink Report, 2004). Hence, local community governance has become a necessary vehicle to ensure the inclusion of diverse populations in identifying and addressing their specific health needs and effectiveness of such community engagement structures, such as local governance of Community Health Centres provide a voice for vulnerable populations who carry the greatest burden

of health in our society (Maloff, Bilan, & Thurston, 2000). There is a significant number of discussion papers and emerging research showing the benefits of empowerment strategies, such as local community governance on health within the context of Community Health Centres (Church et al., 2001; Church, 2006), community governed primary health care organisations (Barnett & Barnett, 2004; Crampton, Davis, Lay-Yee, Raymont, Forrest & Starfield, 2005), and health co-operatives (Abelson & Gauvin, 2004).

The links between strong communities and good health are becoming more and more evident as recent evidences by Van Kemenade, (2003); Wallerstein, (2006), show that empowering initiatives can be used as effective public health strategies which can lead to better health outcomes (Van Kemenade, 2003; Wallerstein, 2006). Hence, empowering citizens, building social capital, and creating connections among people in local neighbourhoods may be key elements to creating significant positive health impacts (Van Kemenade, 2003; Wallerstein, 2006).

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The WHO Health Evidence Network review cites the World Bank's four characteristics that will ensure engagement is empowering to include "people's access to information on public health issues, their inclusion in decision-making, local organizational capacity to make demands on institutions and governing structures and accountability of institutions to the public" (Wallerstein, 2006). Likewise, a review of the evidence cites work by Robert Putnam and other researchers on social capital in the USA, Scandinavia and Japan shows that 'people who are socially disconnected are between two and five times more likely to die from all causes, compared with matched individuals who have close ties with family, friends, and the community (Rogers & Robinson, 2004). Furthermore, researchers from the University of Chicago cited a direct correlation between increased loneliness and significant increases in systolic

blood pressure, doubling the risk of heart attack and stroke and therefore concluded that one strategy for treating blood pressure might be to get people more involved in the community (Picard, 2006). A recent report published by PolicyLink in the U.S., highlights community engagement strategies aimed at reducing health disparities in low-income communities and communities segregated by race and colour (Barnett & Barnett, 2004). Their report states that, "local ownership and meaningful community participation are key to developing, implementing and sustaining community change and that community capacity is built by connecting citizens, service providers, and community leaders around a 'unifying agenda and benchmarks for change'" (PolicyLink, 2002). The report concluded that health disparities and health issues of concern to citizens appear to be much better addressed at a local neighbourhood level through the highest level of community engagement and empowerment mechanisms (PolicyLink, 2002).

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Accountability means "being held responsible" (Flood & Archibald, 2003: 4). It encompasses the concept of transparency or the ability to give explanations for the discharge of responsibilities by individuals and organisations in the health system (Flood & Archibald, 2003). Evaluation of individual or organisation actions against performance objectives and a process for correction if expectations are not met, are also elements of accountability (Flood & Archibald, 2003). From a citizen's perspective, accountability is linked to three key main concepts: transparency; trust; and citizen engagement (Abelson & Guavin, 2004). Accountability is based on a relationship between those people who make decisions and those who are affected by such decisions, therefore local community governance can be an effective way to improve direct accountability in healthcare (Flood & Archibald, 2003). These authors conclude that, representative community governance structures offer meaningful opportunities

for citizens to become better informed of the complexities of healthcare decision-making while enabling local community concerns and issues to be heard and considered (Flood & Archibald, 2003; Abelson & Guavin, 2004).

A study conducted in New Zealand compared community-governed non-profit and for-profit primary care practices and the differences found between these two types of primary health care organisations were likely associated with their ownership and governance arrangements (Crampton, Davis, Lay-Yee, Raymont, Forrest & Starfield, 2005). Community-governed non-profits were more likely to have quality management policies and to carry out local service planning and community needs assessments, and also had policies and practices in place that reduced financial and cultural barriers to access of services (Crampton et al., 2005).

Philips, (2006) commented that health programmes designed through strong community engagement mechanisms have the potential to achieve efficiency through more responsive and innovative programmes developed by and for diverse populations that are most in need (Philips, 2006). "Linking a citizen's values and preferences to outputs is a form of allocable efficiency" (Abelson & Eyles, 2002). Secondly, because an individual's health is rooted in the social determinants of health, programmes that are defined by health professionals without community engagement will most likely not have sustained positive benefits as local community engagement where issues are defined and managed by the community in a comprehensive approach will have a sustainable positive impact on health (Weinstein, Plumb & Brawer, 2006). Finally, engaging individuals in the governing of health services keeps people healthier, builds capacity and social capital, and increases skills and knowledge (Barnett & Barnett, 2004; Rogers & Robinson, 2004).

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In Canada, the success of community governance in community health centres is evidenced by the creation of innovative programmes that are grounded in the social determinants of health and responsive to the populations served (Church, Wanke, Saunders, Pong, Spooner & Dorgan, 2001). Church and his colleagues attribute much of the success of community health centres to the "unique mix of organizational culture, leadership, structures and processes" that favour a participative approach to decision making (Church et al., 2001). Barnett and Barnett (2004), posits that the development of Primary Health Organizations with greater community emphasis has the potential to increase social empowerment among disadvantaged populations and this is significant because cultural as well as economic barriers influence the use of services and it is expected that PHO development will lower rates of hospital admission (Barnett & Barnett, 2004).

In a study by Hamerton, Mercer, Riini, McPherson, and Morrison (2012) to evaluate Maori initiatives to promote healthy eating and healthy action, the changes resulting from Project REPLACE were illustrated clearly through several distinct findings (Hamerton et al., 2012). Firstly, engagement of the community health agency staff illustrated a crucial buy-in to the importance of creating and promoting healthy lifestyles, and of staff being role-models for the rest of the community, to whom they were often related. Secondly, opportunities to adapt Project REPLACE to the needs of the health agency, co-ordinators, and the community, meant that the programme co-ordinators were able to establish a model that was responsive to the changing environment and clientele (Hamerton et al., 2012). All these together led to improved acceptability of the healthy nutrition and physical activity message in the wider communities within which the health agencies are embedded, resulting in raised awareness and changes at a community level by (Hamerton et al., 2012). Whānaungatanga and the provision of activities within a Māori framework was behind

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the success of the project, which was no longer measured in terms of weight loss, but in terms of healthier community lifestyles (Hamerton et al., 2012).

In the Māori communities who participated in Project REPLACE programme, success was measured not by continuance of the programme itself, but by the sustained community-led changes that have incorporated Māori values and practices into health promotion activities which is enhanced by recognition of the importance of values such as Whānaungatanga, and enhancement of Māori cultural identity (Hamerton et al., 2012). Furthermore, the authors hoped that for these communities the seeds of change were being sown because families were prompted to look towards more traditional healthier foods and health practices and how these could be incorporated into their modern lifestyles (Hamerton, Mercer, Riini, McPherson, & Morrison, 2012). Research has also demonstrated that when children are involved in growing vegetables they may be more likely to enjoy eating them (Morris, Briggs & Zidenberg-Cherr, 2002; Morris, Chapula, Chi, Mwango, Chi & Mwanza, 2002; Alaimo, Packnett, Miles & Kruger, 2008). In one locality, the local farmers' market was used to promote healthy eating and home-grown produce (Alaimo et al., 2008).

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Diallo and Frew (2014) emphasized that before starting a community engagement effort it is important to be clear about the purposes of the engagement, the populations and/or communities you want to engage, and be knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts (Diallo & Frew, 2014). According to the authors, for effective engagement to occur, it is necessary to go into the community and establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organisations and leaders to create processes for mobilising the community (Diallo & Frew, 2014). They further noted that for

engagement to succeed it is necessary to partner with the community to create change and improve health, recognise and respect community diversity, identify and mobilise community assets, develop capacities and resources for community health decisions and action, release control of actions to the community, and be flexible enough to meet the changing needs of the community (Diallo, & Frew, 2014).

Concluding statements for community engagement

The following concluding statements for the community engagement are highlighted below:

- Community engagement enables individuals and organizations within the community to take collective actions that are aimed at improving their health conditions
- Community engagement promotes mutual exchange of information and ideas between community members and the heath staff
- Community engagement yields interpersonal trust, communication and collaboration
- Community engagement is essential in maintaining continuum of care from communities to healthcare facilities
- Community engagement accord the community members an opportunity to participate actively in the planning, designing and decision-making over issues of concern to them
- Community engagement is an opportunity for members to build skills and have a positive impact on their environment and community
- Community engagement can lead to improved services and formation of strong representative community governance structure which could enable

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members to become better informed regarding complexities of healthcare decision-making

- Community engagement provides a strong link to larger local and national bodies
- Community engagement where issues are defined and managed by the community will have a sustainable positive impact
- The purpose of community engagement in this study is to bring together the people affected by the maternal health issues as to gain understanding and control of the issue in order to take collective action to improving the situation.

7.5.6 Dynamics: Partnership and dialogue, training and collaboration, sensitization and health education

Dynamics refer to the energy source (motivation) of the activity (Dickhoff et al., 1968). The motivation for community engagement for the prevention of maternal health complications will occur through the process of a collaborative liaison between the agent, recipient, and the context. The main concepts identified during the verification process pertaining to the dynamics are through the community engagement strategies of the CEG to:

1. Increase maternal health literacy of pregnant women, mothers, husbands and community members through health edu.cation, community sensitization, husbands involvement in maternal health issues, to promote knowledge of birth preparedness and complication readiness, thereby achieving increased utilization of orthodox healthcare services for skilled care during pregnancy, delivery and puerperium by rural women.
2. To facilitate the inclusion of spirituality in healthcare in maternal health services through advocacy and TBA/health facility collaboration.

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3. Integrated TBA role (recognizing the value, ensuring training, and facilitating TBA/hospital collaboration); TBAs share the same culture and value with the people, reside within the same community and have been caring for pregnant women over the years thereby gaining the trust and confidence of the community members though having low knowledge level. If trained and reoriented to a new role of birth companion and promoters of facility delivery, rather than wait to refer women when complication sets in, increased utilization of orthodox healthcare services for skilled care for pregnant women could be achieved.
4. Building trust in health services by addressing previous experiences, attitudes, and fears; this could be achieved through dialogue with healthcare personnel and the authorities concerned, health education and awareness creation for the women, community sensitization and husbands' involvement in maternal health issues.
5. Improving access to healthcare by correction of negative assumptions about orthodox healthcare services through community sensitization, advocating for free healthcare and motivational services, facilitating attitudinal change on the part of care providers, through dialogue and partnership
6. Facilitating cultural acceptable care through dialogue and partnership with healthcare system and community sensitization to create awareness, partnership and of TBAs/healthcare facility collaboration
7. Supporting the role of the husband in women health issues by involving the husbands to make them more knowledgeable of women health issues and creating awareness through sensitization

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8. Enhancing community support system through community involvement and sensitization as well as formation of community structures to assist women in addressing maternal health concerns.

These concepts will be addressed through collaboration with other organisations, partnership and dialogue to facilitate collaboration with TBAs and hospitals. This collaboration would include the training of TBAs, health education for the community which would in turn lead to sensitation of the community and involvement of husbands in care.

In the context of the model of community engagement, it is anticipated that them would be agent collaboration with the TBAs and the Health Services. Due to the high level of trust, preference and proximity, it is anticipated that a lot of women will continue to attend TBAs. To facilitate optimal maternal health care in the community, it has been suggested that the following strategies will be taken: 1) TBAs are to be trained and supported to improve their knowledge so as to increase maternal health literacy; 2) In terms of collaboration, the TBAs will be encourage to broaden their role to a new community-based role. The purpose of this role would be a birth companion and promoter of facility-based maternal care, which is appropriate for delivery by skilled attendant, thereby contributing to improvement in maternal and newborn care in low-resource settings.

In terms of orthodox health services, a range of strategies will be employed through the work of the community organizations to increase trust in orthodox health services. This will be done through increased maternal health literacy; collaboration with TBAs may encourage the integration of spirituality and cultural based care in facility based care.

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7.5.6.1 Discussion of collaboration, partnerships and dialogue

In order to involve other decision-makers in the community and reach women who do not receive ANC, some programmes have developed Birth Preparedness package for health workers at the community level to bring about a complementary process of dialogue and building partnerships within the community, based on the principles of a reciprocal relationship, which may be useful in certain contexts in order to discuss maternal and newborn health needs and the importance of skilled care for births and obstetric complications, postnatal care of the mother and newborn, and neonatal complications (Portela & Santarelli, 2003). In the same vein, the community can also be approached to discuss solutions to obstacles to seeking this needed care, including identification of danger signs, transport schemes, and financing schemes (Portela & Santarelli, 2003).

To involve husband in maternal health care, male partners of pregnant women attending ANC facilities might increase their involvement and participation (Iliyasu, Abubakar, Galana & Aliyu, 2010; Odimegwu et al., 2005). Same authors posits that involving men in ANC has been associated with positive outcomes for the mother and baby, and includes more ANC visits, participation in high-risk behaviour reduction strategies, and more Birth Preparedness in case of pregnancy complications, though it is unfortunate that in most studies, male partner involvement in maternal and child health is still low in many sub-Saharan African countries (Iliyasu, Abubakar, Galana & Aliyu, 2010; Odimegwu et al., 2005).

In accordance with the findings from Pyone, Adaji, Madaji, Woldetsadik, & Broek (2014), who assert that previously the training of the TBAs focused largely on the ability to conduct a safe delivery at home, and to recognise women who are at risk and

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refer cases to healthcare facility when complications occur. Sibley et al. (2012), therefore concluded that TBAs can contribute to an improvement in maternal and child care in poor settings if they were trained and supported to fulfil a new role of practicing as birth promoters and birth companions thereby collaborating with orthodox healthcare providers within an enabling environment (Pyone et al., 2014). In view of this, every pregnant woman in the community was linked to an Skilled Birth Attendant working at a health center either through referral or by being accompanied to the health center by the TBA at the earliest opportunity (Pyone et al., 2014). Evidence have proved this to be very successful and effective in many rural settings (Dietsch, 2010; Hussein & Mpembeni, 2005).

7.5.6.2 Discussion of training of TBAs

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Assessments of the impacts of Traditional Birth Attendants (TBAs) trainings in Indonesia, Brazil, and Guatemala by WHO (2007), demonstrated the success of TBAs recognition of early signs of complications and the successful referral for emergency obstetric care. However, while it is recognised that TBAs can and do provide emotional and social support to the mother and can provide key health education messages, women rely on TBAs where there are no Skilled Birth Attendants, or where they cannot afford the cost of professional services (WHO, 2007). Accordingly, several studies have confirmed that, TBAs are not an acceptable substitute for skilled attendants at birth (WHO, 2007). Based on such evidence, practitioners and maternal health policymakers now conclude that TBAs (untrained) do play an important role in traditional societies, but assert that they need to work in tandem with qualified community midwives and other SBAs at facility levels (WHO, 2007).

A review of the evidence of skilled birth attendance and related maternal health outcomes, by Jokhio (2005), in Pakistan offers encouraging evidence of TBAs contribution to the reduction in maternal and newborn mortality (Jokhio, 2005). The study found that TBA training was linked to outreach and facility-based care, resulting in a statistically significant reduction of 30% of perinatal mortality (Jokhio, 2005). There are confounding factors associated with such positive evidence, as it can be attributed to other social and economic factors that evolved concurrently with the provision of skilled birth attendance and improvements in referral systems (Jokhio, 2005). While swings between advocating for community-based or facility-based care in the context of maternal and newborn health exists, it is evident from conclusions of studies that trained TBAs can contribute to reductions in both maternal and perinatal mortality (Jokhio, 2005). Pyone et al., (2014), in his study suggested that if TBAs are trained and supported, they can contribute to improvements in maternal and newborn care especially in low-resource settings.

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7.5.6.3 Discussion of impacts of health education and counselling on birth preparedness

Health education is a process of impacting knowledge on health-related issues whether by skilled or unskilled personnel, and health education is usually provided through Ante natal care (ANC) services Ensor, Quigley, Green, Badru, Kaluba, & Siziya, (2013). Same authors observed that findings from various studies have revealed an association between knowledge and use of delivery and ante natal care services (Ensor, et al., 2013). As suggested by studies in other countries such as India, increasing contacts through ANC with skilled healthcare providers appears to increase the likelihood of later use of facility for delivery (Mishra & Retherford, 2008), while ANC provided at home by unskilled personnel appears to reinforce home delivery (Ensor, et al., 2013). Therefore, health education from skilled ANC has a positive influence on knowledge

of obstetric danger signs, birth preparedness and complication readiness, that enhance the use services particularly in remote areas (Yanagisawa, Oum, & Wakai, 2006). In accord, Pembe, Urassa, Carlstedt, Lindmark & Nystrom (2009) submits that health education provides an opportunity to inform women about the signs of obstetric complications, birth preparedness, complication readiness, and cost of services and means of transport in emergencies which are important in preventing maternal mortality. In developing countries like Nigeria, routine prenatal visits is the best time for improving women's knowledge about these signs (Perreira, Bailey, deBocaletti, 2002). A study by Ridde, Queuille, Kafando & Robert, (2012), showed that a government subsidized maternity services by 80% had been in place for many years without the masses being aware, when made known to the women through health education yielded a significant increase in the number of deliveries in the health centres (Ridde et al., 2012).

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Studies conducted in sub-Saharan countries report low rates of birth-preparedness (Hiluf & Fantahun, 2007; Moran et al., 2007; Mutiso et al., 2008; Hailu et al., 2011). High levels of Birth Preparedness have been shown to be strongly associated with increased levels of use of Skilled Birth Attendants (Moran et al., 2007; Mutiso, Qureshi & Kinuthia, 2008; Hailu, Gebremariam, Alemseged & Deribe, 2011). Studies in low-income countries show that knowledge of obstetric danger signs among women, especially during pregnancy and delivery is deficient (Pembe, Urassa, Carlstedt, Lindmark & Nystrom, 2009; Hasan & Nisar, 2002).

Information, education, and counselling play vital roles in prevention of maternal death and this could be achieved by making the pregnant women (and their partners) aware of the consequences of late recognition of danger signs, delays in seeking care, and delays in receiving prompt care (Ronsmans & Filippi, 2004). These could be achieved

through appropriate health literacy programme or behavioural change communication (Ronsmans & Filippi, 2004). Optimal management of pregnancy, labour, and childbirth ensures maternal survival by ensuring that pregnant women (as well as women in labour and their newborns) have access to life-saving interventions for managing obstetric and newborn complications (Ronsmans & Filippi, 2004).

Where care is unavailable at a Primary Health Care level, mothers are referred to a secondary or tertiary facility where care may be obtained and this process can leads to delays in receiving prompt, appropriate care which may be worsened by failure to recognise the need to refer the mother in time, unavailability of transport, failure to meet transport costs, or absence of someone to accompany the referred patient (Kakaire, Kaye & Osinde, 2011). Once the birth plan is implemented, it is critical in addressing the first and second of the three delays to receive prompt care during pregnancy and childbirth complications (Kakaire, Kaye & Osinde, 2011). Their findings are in alignment with other authors such as Adisasmita, Deviany, Nandiaty, Stanton & Ronsmans, (2008) and Oladapo, Sule-Odu, Olatunji, and Daniel, (2005), who observed that many patients are referred when they already have life-threatening complications which is a reflection of the quality of antenatal care at peripheral units (where such complications may be identified early), the quality of obstetric care at the referring units, and the efficiency of the referral system (Adisasmita, Deviany, Nandiaty, Stanton & Ronsmans, 2008; Oladapo, Sule-Odu, Olatunji, & Daniel, 2005).

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Also the finding that many of the referrals were in critical condition at admission suggests possible delays in the course of decision to refer, delays in reaching the referral hospital, or poor quality of care at the referring health facility which may be as a result of diagnostic delays and misdiagnoses due to poor knowledge (Filippi, Ganaba, Baggaley, Marshall, Storeng & Sombie, 2007; Onwudiegwu & Ezechi, 2001).

In a study from Nigeria, 61% of the pregnant women studied made adequate preparations for delivery while only 4.8% were prepared for emergencies or complications (Onayade et al., 2010). The authors thus recommended that greater emphasis should be placed on education regarding emergency/complication readiness during antenatal care (Onayade et al., 2010).

A study in Kenya revealed that "87.3% of the respondents were aware of their expected date of delivery, 84.3% had set aside funds for transport to hospital during labour, while 62.9% had funds for emergencies. 67% knew at least one danger sign in pregnancy, while only 6.9% knew of three or more danger signs" (Mutiso et al. 2008). "During antenatal care, only 60 (42.9%) mothers reported having been accompanied by spouses, while for 58 (41.4%) mothers, their spouse remained at home to look after the home and children. Thirty-five (25.0%) mothers reported that their spouses helped them with household chores during the antenatal period and during labour, 96 (68.6%) mothers were accompanied by their spouses" (Mutiso et al. 2008). Apparently, the women who had birth plans were more likely to be accompanied by their spouses to health facilities during antenatal care and to the labour ward during labour and were also more likely to report more support from spouses in looking after their children or to receive assistance with household chores during pregnancy (Mutiso et al, 2008). Similarly, men who had obtained knowledge of ANC services from a health worker, and those whose spouses utilised skilled delivery during their last pregnancy were more likely to accompany their spouses at ANC facilities (Tweheyo, et al., 2010).

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Studies submit that some antenatal counselling messages about birth preparations and recognising and knowing how to respond to danger signs could be integrated into the local social networks and groups, such as village women's committees, as women who

made at least one kind of preparation for their baby's birth were more likely to deliver with a nurse-midwife (Doctor, et al., 2012).

7.5.6.4 Discussion of sensitisation of the community and involving husbands in maternal health care

Various studies show that men's approval or disapproval of pregnancy care was linked primarily to difficulties of access and the costs involved, which were sometimes to do with use of health services more broadly, and in a very few instances, with suspicion of a hidden agenda of reducing family size, hence programmes therefore needs to work with men to address these responses (Onayade, Akanbi, Okunola, Oyeniyi, Togun & Sule, 2010). Every pregnancy faces risks, but risks are more likely for women in low-income countries, hence, women, their partners, and the communities need to be educated on obstetric danger signs so that they can seek appropriate care from skilled providers timeously (Stevens, 2000).

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Iliyasu, Abubakar, Galana and Aliyu, (2010); Odimegwu et al. (2005), posits that involving men in ANC has been associated with positive outcomes for the mother and baby, and includes more ANC visits, participation in high-risk behaviour reduction strategies, and more Birth Preparedness in case of pregnancy complications, though it is unfortunate that in most studies, male partner involvement in maternal and child health is still low in many sub-Saharan African countries. Study by Tweheyo, Konde-Lule, Tumwesigye and Sekandi’s (2010) in northern Ugandan, found that several men were actively involved in Birth Preparedness and Complication Readiness when their spouses were pregnant or in labour (Tweheyo et al., 2010).

Lassi, Haider and Bhutta, (2010), observed that the most successful community-engagement packages in addressing women health issues were those that emphasised involving family members through community support and advocacy groups,

community mobilisation and sensitization strategies, provision of care through trained Community Health Workers via home visitation, and strengthened proper referrals for sick mothers and newborns (Lassi,et al. 2010). Study by Mathur, (2005) concluded that community sensitisations approaches gave young women the confidence and skills to articulate their reproductive health concerns and demand services, increased young men's understanding of maternal care, improved husbands' willingness to support their wives' maternal care needs, and fostered better intergenerational communication and support between mothers-in-law and daughters-in-law (Mathur, 2005).

Concluding statements for dynamics

The following concluding statements for the dynamics are highlighted below:

- Partnership with the community can bring about solutions to obstacles to seeking the needed maternal healthcare.
- Involving husbands in maternal healthcare increases knowledge of obstetric danger signs, birth preparedness, complication readiness and promotes utilization of healthcare services
- TBAs training can contribute to an improvement in maternal and child care in poor settings by fulfilling a new role of practicing as birth promoters and companions ,thereby collaborating with orthodox healthcare providers
- Health education increases knowledge of obstetric complications, birth preparedness, complication readiness, cost of maternal healthcare services and means of transport in emergencies, thus promoting the use of healthcare facility for delivery
- Birth preparedness and complication readiness messages contributes to increase use of skilled attendants at delivery

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- It is important to adapt the content of the birth preparedness and complication readiness messages to the needs of the users of each locality
- Community sensitization increases understanding of maternal care, improves husbands' willingness to support their wives' maternal care needs and community support.

7.5.7 Goal or aim of the model: Maternal health literacy

The overall aim of the community engagement model will be the prevention of maternal health complications in rural settings through increased maternal health literacy. The aim of the model is to facilitate the utilisation of healthcare services for skilled maternity care during pregnancy, delivery, and after delivery by rural women. It is anticipated that this can be done through improving maternal health literacy which would: 1) Improve the knowledge of women, husbands, and the community in maternal health issues that affect women; 2) Correct negative assumptions that affect women's health in terms of cultural beliefs and perception of orthodox health services; 3) Facilitate the involvement of husbands in women's healthcare; 4) Through knowledge strengthen the community support system to support maternal health; and) Train and collaborate with TBAS in an atmosphere of trust to ensure reorientation to a new community-based role—that of birth companion and promoter of facility-based maternity care, including delivery. These will improve women's access to orthodox healthcare services for skilled care.

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7.5.7.1 Discussion of maternal health literacy

According to Nutbeam (2008), the conceptualisation of health literacy as an asset focuses on the development of skills and capacities intended to enable people to exert greater control over their health and the factors that shape health. These include more

personal forms of communication and community-based educational outreach. Not surprisingly, low literacy in a population is associated both directly and indirectly with a range of poor health outcomes (Parker, 2000).

The Institute of Medicine (2004) defines health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. The institute's definition goes on to recognise the social context of health decision-making, based on the interaction of the individual's skills with health contexts and broad social and cultural factors at home, at work, and in the community. This conceptualisation of health literacy as a set of capacities also implies that health literacy is partly knowledge-based, and may be developed through educational intervention. It also emphasises that health literacy is context-specific and subject to influence by healthcare interactions and structures, such as the way in which services are organised and delivered.

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From a public health perspective, health literacy is seen as an asset to build, as an outcome to health education, and communication that supports greater empowerment in health decision-making. Actions to improve health literacy are focused on developing context-specific health knowledge and the self-efficacy necessary to put that knowledge into practice in ways that enable people to exert greater control over their health and health-related decisions (Nutbeam, 2000).

WHO has also adopted a broader definition of health literacy that reflects a health promotion orientation and views health literacy as representing the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand, and use information in ways that promote and maintain good health (Nutbeam, 2000). The WHO's definition implies the achievement of a level of

knowledge, personal skills, and confidence to take action to improve personal and community health by changing personal life styles and living conditions (Nutbeam, 2008). Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment (Nutbeam, 2008).

WHO's definition aligns health literacy more closely with an understanding that literacy is not simply a set of functional capabilities (ability to read and write), it comprises a set of skills that enable people to participate more fully in society and to exert a higher degree of control over everyday events (interactive and critical literacy) (WHO Commission on Social Determinants of Health, 2007). Progression between types of health literacy is not only dependent upon cognitive development, but also exposure to different forms of communication and message content. For example, the capacity of individuals to respond effectively to the social determinants of health will be significantly influenced by the nature of public discourse on the subject (Nutbeam, 2000).

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This understanding of health literacy identifies it as a distinct concept rather than a derivative one, thus, people who have better developed health literacy will thus have skills and capabilities that enable them to engage in a range of health enhancing actions, including personal behaviours (Nutbeam, 2008), as well as social actions for health and the capability of influencing others towards healthy decisions, such as participating in preventive screening programs or utilising healthcare facilities for skilled care (Department of Education and Skills, 2006; DeWalt, Berkman, Sheridan, Lohr & Pignone, 2004). The result is not only improved health outcomes but also a wider range of options and opportunities for health (DeWalt, Boone & Pignone, 2007). Assessing interactive and critical literacy will require additional assessment of oral literacy and

social skills, such as those involved in negotiation and advocacy (DeWalt, Boone & Pignone, 2007).

Improving health literacy in a population involves more than the transmission of health information, although that remains the fundamental task (Nutbeam, 2008). Helping people to develop confidence to act on that knowledge and the ability to work with and support others will best be achieved through more personal forms of communication, and through community-based education outreach, if the goal of promoting greater independence in health decision-making and empowerment among the individuals and communities is to be achieved (Nutbeam, 2008).

7.5.7.2 Maternal literacy and birth preparedness and complication readiness

According to John Hopkins Program for International Education in Gynaecology and Obstetrics [JHPIGO], (2001), birth preparedness (BP) and complication readiness (CR) are two interventions that address the delays in seeking skilled maternal care, by encouraging pregnant women, their families, and communities to effectively plan for births and deal with emergencies, if they occur (JHPIEGO,2001). These concepts include identifying a trained birth attendant for delivery, identifying a health facility in the case of emergency, arranging for transport for delivery and/or an obstetric emergency, and saving money for delivery (JHPIGO, 2001).

The presence of a skilled birth attendant at delivery is recognised as essential to preventing maternal mortality according to (WHO, 2001; WHO, 2004). A strategy to reduce the three phase delays should begin at the community level and be linked to improving access to basic essential obstetric care (White Ribbon Alliance for Safe Mother/India 2002; WHO, 2004; Mother Care Matters, 2000). There is no universal definition of birth preparation but many packages addressing this includes

preparedness for normal birth by selecting a skilled birth attendant (SBA) and a place of delivery, preparedness of essential items for delivery, such as clean delivery-kit, knowledge of danger signs for mother and newborn, and when to seek help, knowledge of where and to whom to go to for help, arranging access to funds and means for emergency transportation to medical care and prior identification of blood donors (JHPIEGO, 2004).

A review of available reports conducted to assess birth preparedness (BP), house-hold level behaviours that affect the health of pregnant and postpartum women and their newborns and their use of health services in rural communities of Siraha district, Nepal yielded several examples of projects that have promoted birth preparedness (McPherson et al. 2006). For instance, the Mother Care project includes birth-planning interventions and is focused on planning for emergencies, and the change project developed a maternal survival tool kit that included standard birth preparedness elements but also addressed neonatal care and the need for early postnatal care (JHPIEGO, 2004; Mother Care Matters, 2000). JHPIEGO developed tools for improving communication and collaboration among stake holders to advocate for essential maternal care (Russel, Gryboski, Miller Vostrejs & Nash-Mercado, 2004). The Home-Base Life-Saving Skills Package focuses on the family and community to increase access to life-saving care and to decrease delays in reaching referral facilities and this yielded a promising results in India and Ethiopia as there was increasing awareness and skilled service utilisation among women fully exposed to the project (Sibley & Buffington, 2003; Fullerton et al., 2003). A birth preparedness (BP) intervention in Dincypur, Bangladesh, also yielded increase in the use of emergency obstetric services, and 45% of families in the project area reported that they had access to community-support systems (Care, 2002; Islam, 2003).

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The Prevention of Maternal Mortality Programme (1987-1997) found that inadequate funds and transport were key causes of delay in deciding to seek care and in reaching facilities (JHPIEGO, 2004). The Saving Newborn Lives Initiative supported the conduct of a district-wide field study on the birth preparedness (BP) in Siraha district in Nepal from 2002 to 2004, using the Birth Preparedness/Complication Readiness matrix as the study design (JHPIEGO, 2004). The matrix outlined the roles of policy-makers, facility managers, provider communities, and families in improving maternal and newborn care, and listed out plans and action that can be implemented by each group (Russel, Gryboski, Miller, Vostrejs & Nash-Mercado, 2004).

In Nepal, a Birth Preparedness Index (BPI) originally developed by the SUMATA Project was used to measure the results of various Birth Preparedness programme related efforts (McPherson et al., 2006). The BPI is comprised of seven concepts that measure different aspects of the Birth Preparedness process and the percentage is calculated at the level of the individual responses regarding her most recent pregnancy/delivery to cover the number of antenatal care received from a skilled provider, ability to name prolonged labour as a danger sign during delivery, named excessive bleeding as a danger sign during delivery, made financial preparedness for emergencies during pregnancy, made preparedness for emergency transportation during pregnancy, delivery attended by an Skilled Birth Attendant, and received postnatal care within six weeks of delivery (Russel et al., 2004). While the study commended Birth Preparedness programmes as positively impacting on household-level behaviour, birth-planning, and promote the utilization of maternal health services, it also found that the influence of exposure to the BPP materials may differ depending on the message (Russel et al., 2004).

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In Siraha the low use of skill birth attendants (SBAs) was traced to women's faith in a traditional delivery services that views delivery as a natural event which should take place at home (Borghi, Ensor, Neupans & Tiuari, 2006; Griffiths & Stephenson, 2001). Additionally, many women view modern health services and SBAs as a "last resort", to be used only when complications develops (Borghi et al., 2006; Griffiths & Stephenson, 2001). Furthermore, studies in South Asia supports the fact that the high cost associated with emergency transport and health services is a deterant the use of services (Borghi et al., 2006; Griffiths & Stephenson, 2001).

Sibley et al., (2005) recommends that any community-based programme that seeks to address the first phase delay must go not only dwell on merely increasing household members' knowledge of danger signs, but must also focus on changing household perceptions regarding the susceptibility of mothers and newborns during delivery and the post-partum period, thus limiting the second phase delay (Sibley et al., 2005). In India, (White Ribbon Alliance for Safe Mother/India 2002; WHO, 2004; Mother Care Matters, 2000), found that a woman's relationship with and her status within the family unit, her mobility, her educational level, and the place of birth (mother's house or mother-in-laws house) were critically linked to her ability to seek health care service (White Ribbon Alliance for Safe Mother/India 2002; WHO, 2004; Mother Care Matters, 2000). In a similar study on Birth Preparedness and Complication Readiness among slim women in Indore city, India, findings highlighted that maternal literacy and the access to antenatal services were important predictors of Birth Preparedness and Complication Readiness and was positively associated with Skilled Birth Attendance (Agarwal, Sethi, Srivastava, Jha, & Baqui, 2010). These findings reinforced the widely-held notion that Birth Preparedness and Complication Readiness should be promoted during pregnancy in settings where home deliveries are common (JHPIEGO, 2001).

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The same study suggested that while improving knowledge and helping mothers to prepare for birth and emergences is important, efforts are also required to address the barriers that hinder skilled birth attendance and the use of health facilities for delivery (Agarwal, 2004). The findings of low preference for the government health facilities during obstetric emergencies in the study further highlights the need for efforts to improve the quality of care in government facilities (Ministry of Health, 2008; Family Welfare, 2012). Slum-based groups having access to loans through the community health funds may be an option, though the result of a Nigerian study showed that while the availability of loans for emergency obstetric care through community health funds increases service usage, repayment was not always realised (Agarwal, Kumar & Sindhwani, 2008). Hence, it is important to encourage slum individuals with social responsibility to form community groups, with the discussion and determining the need for such a community health fund being made an integral part (Agarwal, Kumar & Sindhwani, 2008).

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Reviews to explore the elements of Birth Preparedness and Complication Readiness and how they relate with the increased use of Skilles Birth Attendants in Burkina Faso, revealed that the relationship between the distance to health facilities, the number of antenatal care visits, the education of women and parity, and planning to save money greatly associated with giving birth with the assistance of a skilled provider (Moran, Sanghi, Dineed, Rawlins, Yame'ogo & Baya, 2006). Birth preparedness for a woman entails her identifying an Skilled Birth Attendant, making transportation plans, saving money, and identifying a blood donor in advance (JPIEGO, 2004). However the practice of individual women identifying blood donors is discouraged due to the high HIV/AIDS prevalence in certain countries, thus to centralised blood banks is preferred (WHO, 2011; Hladik, Kataaha, Mermin, Purdy & Otekat, 2006).

Concluding statements for maternal health literacy

The following concluding statements for maternal health literacy are highlighted below:

- Maternal health literacy accords individuals the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions
- Maternal health literacy enables people exert greater control over their health and the factors that shape health
- Maternal health literacy focuses on the development of context-specific health knowledge and the self-efficacy necessary to put that knowledge into practice
- Individuals, household and community members' knowledge of obstetric danger signs, birth preparedness and complication readiness must be increased, if the first phase delay to assessing skilled care must be addressed.

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7.6 CHAPTER SUMMARY

In this chapter a framework for maternal health literacy through community engagement was explored and described by means of theory building approaches of analysis, synthesis and derivation as described by Walker and Avant (2005:28). The survey list of Dickoff, et al. 1968 (11:423) was utilised as a framework for the identification and classification of concepts. In Chapter Eight a model is explored and described by means of derivation and deductive reasoning from the framework.

TABLE 17: Summary of conclusion statements for model

CEG Group	Recipients	Context	Dynamics	Community Engagement	Maternal health literacy
The community engagement group is the main group responsible for the development of a community engagement strategy to improve knowledge of birth preparedness and complication readiness among the rural women thereby promoting the utilization of orthodox healthcare facilities for skilled attendance during pregnancy, delivery and puerperium	The mothers and pregnant women are the main recipients and most directly in need and effected by maternal health care.	Poverty: The majority of the community members experience poverty, so women often do not have money for health services.	Partnership with the community can bring about solutions to obstacles to seeking the needed maternal healthcare.	Community engagement enables individuals and organizations within the community to take collective actions that are aimed at improving their health conditions	Maternal health literacy accords individuals the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions
The CEG provides leadership through partnership and dialogue between the community members and healthcare delivery system on maternal healthcare issues	The TBAs are those community-based traditional midwives who are not formally trained to proficiency but are trusted and have gained high level of confidence from women and the community members over the years, in the provision of care to women during pregnancy, childbirth, and puerperium.	Culture: The perceived etiology of childbirth complications is linked to supernatural and/or witchcraft, fate, and vows, thus the treatment is usually in the form of atonement, which in most cases is carried out by the TBAs. There are also some cultural beliefs and practices linked the kind of foods to be eaten during pregnancy.	Involving husbands in maternal healthcare increases knowledge of obstetric danger signs, birth preparedness, complication readiness and promotes utilization of healthcare services	Communiy engagement promotes mutual exchange of information and ideas between community members and the heath staff	Maternal health literacy enables people exert greater control over their health and the factors that shape health
The CEG collaborates with the community members to promote husbands and community support for women during pregnancy, delivery and puerperium	The Orthodox health services is the provision of maternal and child healthcare services by skilled healthcare professionals within the modern healthcare	Interaction with context and health service utilization: Most women in these communities consult the TBAs prior to seeking orthodox care during antenatal care and deliveries, even	TBAs training can contribute to an improvement in maternal and child care in poor settings by fulfilling a new role of practicing as birth promoters and companions ,thereby collaborating with	Community engagement yields interpersonal trust, communication and collaboration	• Maternal health literacy focuses on the development of context-specific health knowledge and the self-efficacy necessary to put that knowledge into practice

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	facilities cited within the study communities.	with the availability of orthodox healthcare facilities. Orthodox healthcare services is perceived to be expensive, with poor attitude of care providers and unavailability of 24 hours services.	orthodox healthcare providers		
The CEG facilitates TBAs training and TBAs/Healthcare facility collaboration to improve TBAs' knowledge, improve access to healthcare services and build trust	The husbands are the family heads, within a cultural and patriarchal society. They are highly influential in decision making about place of delivery for their wives though possess low knowledge of maternal health issues. Husbands have high level of respect and confidence in TBAs regarding care of women during pregnancy, delivery and puerperium. If sensitized and involved in maternal health issues, by their position they could play a great role in promoting skilled birth at the orthodox healthcare facilities.	TBAs: There is a high preference for TBAs for antenatal care and deliveries in these communities, with high level ao trust and confidence in the TBAs. In the event of childbirth complications, time is spent on prayers and the oral administration of herbs, and referrals to health facilities are only made by TBAs after failed trials of traditional remedies.	Health education increases knowledge of obstetric complications, birth preparedness, complication readiness, cost of maternal healthcare services and means of transport in emergencies, thus promoting the use of healthcare facility for delivery	Community engagement is essential in maintaining continuum of care from communities to healthcare facilities	• Individuals, household and community members' knowledge of obstetric danger signs, birth preparedness and complication readiness must be increased, if the first phase delay to assessing skilled care must be addressed
The CEG engages with healthcare system to facilitate spirituality and culturally	The Community is the environment in which the model of community engagement for	Spirituality*:* Some pregnant women claim some TBAs lock the pregnancy spiritually, only	Birth preparedness and complication readiness messages contributes to increase use of	Community engagement accord the community members an opportunity to	

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appropriate care in healthcare services	the prevention of maternal health complications in rural areas of Nigeria will be implemented. In this study, two rural communities were used namely, community A (Idundu) and community B (Anyanghase) in the Akpabuyo LGA of Cross River State, Nigeria.	to unlock when labour commences to facilitate delivery. Time is spent on fasting and prayers to seek God's divine protection and ward off evil hands, during pregnancy and delivery. Any loss of life is accepted as God's design.	skilled attendants at delivery	participate actively in the planning, designing and decision-making over issues of concern to them	
The CEG engages with health services to facilitate maternal health literacy through health education, community sensitization and awareness programs on maternal health issues.			It is important to adapt the content of the birth preparedness and complication readiness messages to the needs of the users of each locality	Community engagement is an opportunity for members to build skills and have a positive impact on their environment and community	
			Community sensitization increases understanding of maternal care, improves husbands' willingness to support their wives' maternal care needs and community support.	Community engagement can lead to improved services and formation of strong representative community governance structure which could enable members to become better informed regarding complexities of healthcare decision-making	

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CHAPTER EIGHT: MATERNAL HEALTH-COMMUNITY ENGAGEMENT MODEL (MH-CEM)

8.1 INTRODUCTION

In chapter seven the researcher dealt with the identification, classification and the definition of the main concept and related concepts that form the building blocks of the model of community engagement for prevention of maternal health complications in the rural communities of Cross River State, Nigeria. Literature to support these concepts were also reviewed.

Using the model development guidelines and the model definitions, a Maternal Health-Community Engagement Model (MH-CEM) was developed. This chapter addresses the model description. The model description is based on the following:

- The assumptions of the model.
- The purpose of the model.
- The context of the model.
- Overview of the model.
- The structure and the process of the model
- The model evaluation is discussed followed by the guidelines for operationalisation of the model.

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8.2 ASSUMPTIONS ON WHICH THE MATERNAL HEALTH-COMMUNITY ENGAGEMENT MODEL IS BASED

The Model of Community Engagement for the prevention of maternal health complications in rural settings is based on the following philosophical assumptions taken from the Citizen Healthcare Model (Doherty & Mendenhall, 2006), and Ecological Logic Model (Strack et al., 2010), as discussed in Chapter 3, and serves as a point of departure.

- Maternal health literacy and the resultant high maternal morbidity and mortality is a problem in rural communities in Nigeria
- These communities are typically poor communities with strong cultural traditions and patriarchal roles
- The health care seeking behaviours in these communities are characterized by high patronage and preference of TBAs and low utilization of orthodox health services
- Central to the model is the concept of community engagement.
- Community engagement emphasises the importance of the ultimate sphere of family and friends to a full human life;
- The community consist of human beings, co-creating their world, and therefore are builders of health in the community rather than mere consumers of health services;
- The process of community engagement stresses the development of relationships of mutual interest and collaborative energy to work on public solutions;
- Community engagement involves both planners and participants at the same conceptual page and portrays the participants as 'agents' for social change;
- A Model based on community engagement should be flexible to help the community to strategise new tactics and outcomes as they discuss and define desired community changes; and
- Provide a framework for making planned activities with expected outcomes which is useful in planning and evaluating the depth and intensity of the intervention.

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8.3 PURPOSE OF THE MATERNAL HEALTH-COMMUNITY ENGAGEMENT MODEL

The purpose of the Model is to serve as a reference framework for healthcare professionals, health policy formulators and executors, health educators, rural women, and community leaders in the rural settings in Cross River State, Nigeria, to facilitate community engagement to improve maternal health literacy and utilization of skilled attendance, for the prevention of maternal health complications in the rural settings. The Model emphasizes community engagement as its main driver to ensure that a collaborative effort of these persons/groups (which is embodied in the CEG) would bring about improved knowledge of obstetric danger signs, birth preparedness and complication readiness, higher use of orthodox healthcare services for skilled care by the rural women during pregnancy and delivery. These could be achieved through partnership and dialogue, maternal health education and community sensitization, involvement of the husbands and community, building trust, facilitating access and spirituality in healthcare services, cultural appropriate care and community support systems, thereby reducing the occurrence of maternal health complications, and the resultant high rate of maternal morbidity/mortality.

As nurses are the main providers of orthodox maternal health services, the purpose of the model within the discipline of Nursing is for it to be a practice model that adds to the professional body of nursing knowledge, in the form of formation of CEGs for the prevention of maternal health complications in rural settings.

8.4 CONTEXT OF COMMUNITY ENGAGEMENT MODEL

The context of this Model is primarily the Idundu (community A) and Anyanghanse (community B) rural communities of Akpabuyo, Cross River State, Nigeria. In these communities there is a high level of poverty, and the culture (belief system) of the

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people exert a great influence on the women's behaviour and practices during pregnancy, delivery, and after delivery. Based on the confidence and trust that the people have in their TBAs, the TBAs enjoy a high patronage from pregnant women for pregnancy and delivery care, while there is a very poor use of orthodox healthcare services. The rural communities of Idundu and Anyanghase in the Akpabuyo LGA of Cross River State, Nigeria both provide viable samples of maternal experiences in the rural setting.

8.5 OVERVIEW OF THE MATERNAL HEALTH-COMMUNITY ENGAGEMENT MODEL (MH-CEM)

The Maternity Health Community Engagement Model (MH-CEM) (Figure 8) serves as a reference framework for community engagement for the prevention of maternal health complications in rural settings. The study has shown that in the community there is high patronage of TBAs and poor use of orthodox healthcare services resulting in a high rate of occurrence of maternal health complications resulting in high maternal morbidity/mortality.

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The study identified high patronage of the TBAs and low usage of orthodox health services. This was underpinned by poor maternal health literacy in mothers, husbands and the community. The cultural role of the community emerged as a positive factor which could be utilized to move the community to positive maternal health literacy. To facilitate this, the agent has been identified as the CEG which can translate the factors (strengths) of TBA patronage into the orthodox healthcare through partnership and dialogue, thereby bringing about increased use of orthodox healthcare services. The CEG would take advantage of other observed factors including maternal health literacy, TBA training and TBA/hospital collaboration, husband involvement, facilitating culturally appropriate car, access to and spirituality in healthcare services, building

trust, community sensitization and a community support system, to bring about this much desired transformation (i.e. increased knowledge of obstetric danger signs, birth preparedness, complication readiness, hence patronage of orthodox healthcare for skilled attendance during pregnancy, delivery and puerperium by rural women), thereby reducing the occurrence of maternal health complications among rural women to the barest minimum.

The MH-CEM (Figure 6) includes different structures and processes which will be discussed below.

8.6 STRUCTURE OF THE MATERNAL HEALTH-COMMUNITY ENGAGEMENT MODEL

The structure of the model includes the definition of the model components and the relational statements. The structure includes the central elements of the model and consists components and relationships between the components. The Maternal Health-Community Engagement (MH-CEM) is visually displayed in Figure 6.

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8.6.1 Definition of model components

The model has six (6) main components which are described below:

8.6.1.1 The agent: The community engagement group

The 'agent' refers to who will be responsible for the community engagement processes in the proposed community engagement model. The main agent in this model is the Community Engagement Group (CEG), comprising members of the Village Health Committee (VHC), Ward Development Committee (WDC), community women leaders, representatives of TBAs, leaders of women's groups, religious leaders, and clan heads.

8.6.1.2 The recipients: Mothers, pregnant women, the community, TBAs and health services

According to Dickoff et al (1968:423) the recipient is the receiver of activity. The recipient of community engagement are receivers of maternal health services (mothers and pregnant women) who are in interaction with health related services (TBAs and orthodox health services), the other community members in the community and the context.

8.6.1.3 The context: Rural communities

The context includes the Idundu and Anyanghanse rural communities of Akpabuyo Local Government Areas of Cross River State, Nigeria, with their problems of poor maternal health literacy, poor access and trust in health services, strong cultural traditions, beliefs and practices, high TBA patronage, and a traditional culture of male dominance and traditional beliefs.

8.6.1.4 The procedure: Community engagement

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Procedures refer to the techniques, procedures, and protocols associated with a Model of Community Engagement for the prevention of maternal health complications in rural areas. Dickoff et al. (1968) assert that procedure refers to the path, steps, or general patterns on the way to the accomplishment of the goal. The procedure is to realise the goal (terminus), viz. maternal health literacy to promote the utilisation of healthcare by pregnant women and nursing mothers, thereby significantly reducing maternal mortality/morbidity.

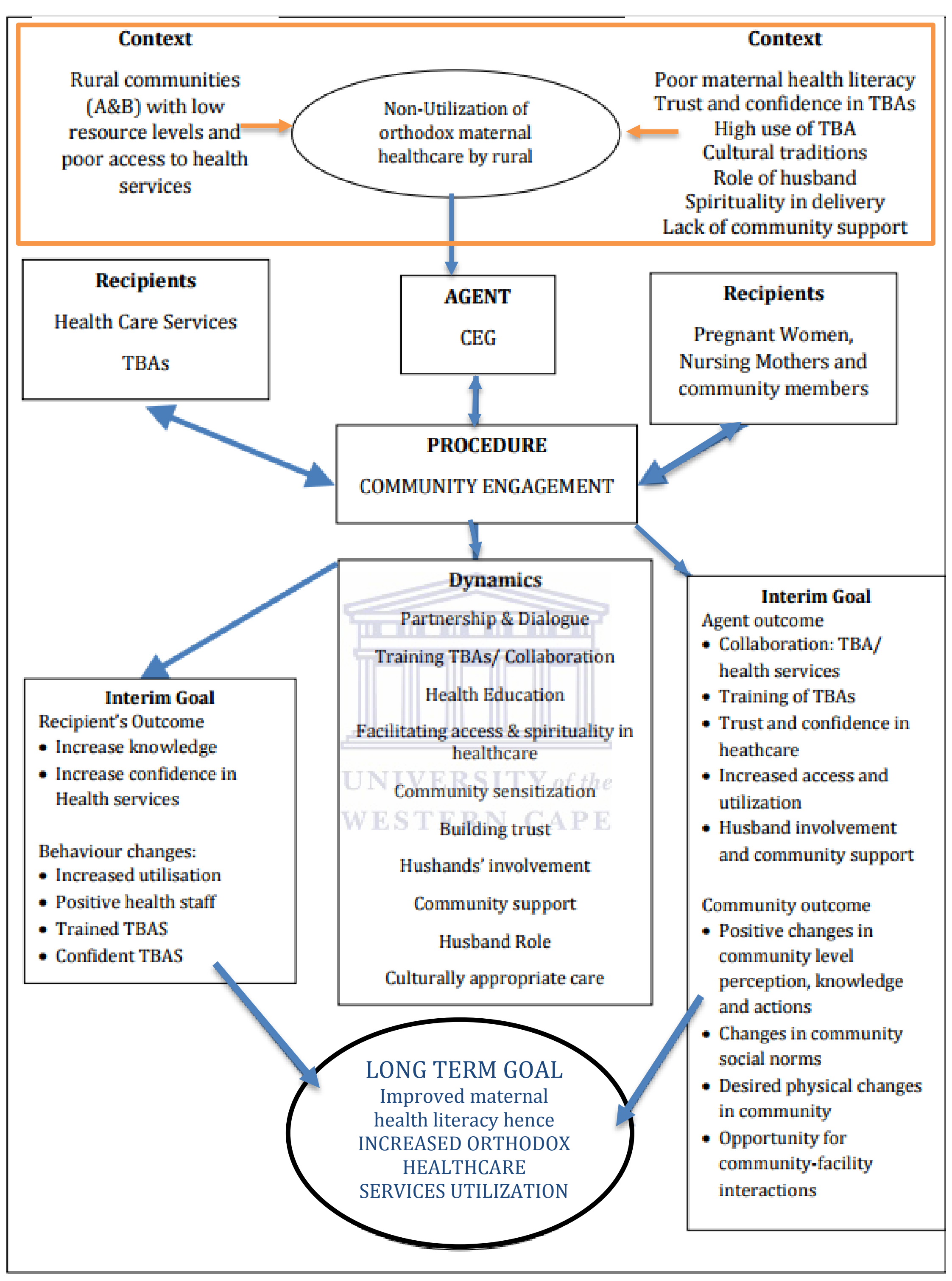

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FIGURE 8: A model of community engagement for prevention of maternal health complications in rural areas of Cross River State, Nigeria

8.6.1.5: Partnership and dialogue, training and collaboration, sensitization and health education

These **Dynamics** includes community/health facility interaction, information sharing, awareness creation and sensitisation of the community members to build confidence and trust in service delivery and providers, facilitate husbands' role to support women, spirituality in healthcare services, cultural appropriate healthcare, TBAs training/collaboration to re-orient the TBAs to the new role of linking pregnant women to the healthcare facility for skilled attendance, community support and advocacy to policy makers (government) when the need arises, and ensuring service standards.

8.6.1.6 The goal: Improved maternal health litearacy

In the Maternal Health-Community Engagement Model, the goal denotes the expected outcome from the activities of the **Agents** these include the interim and long term goals.

Interim goals: These are as follows;

Agent: Collaboration-TBA/healthcare services, TBA training, trust and confidence in healthcare services, increased access and utilisation, husband involvement and community support.

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Recepient: Increased knowledge, increased confidence in healthcare services.

Behavioural changes: Increased utilisation of healthcare services, positive health staff, trained TBAs, confident.

Community: Positive changes in community level perception, knowledge and actions, changes in community social norms, desired physical changes in community, opportunity for community/facility interactions.

Long term goal: Maternal health literacy (increased knowledge of obstetric danger signs, Birth Preparedness and Complication Readiness and the resultant Skilled Birth Attendant use) leading to appropriate utilisation of heathcare services (TBA or health

service) and increased utilisation of orthodox healthcare services, thereby reducing complication and maternal mortality and morbidity.

8.6.2 Relational statements of model

The relation statements of the model were developed by means of identifying the relationship between the eight concepts concluding statements (Table of concluding statements Chapter 7) and model components (Figure 7) with the arrows indicating the direction of the relationship. Based on the definitions of the concepts, the following relationships are proposed:

- Community engagement focusing on improving the health of pregnant women and nursing mothers takes place in the context of a rural community with problems of poor maternal health literacy, poor access, and trust and confidence in TBAs and poor utilization of orthodox healthcare services, strong cultural traditions in beliefs, practices and a traditional culture of male dominance and traditional beliefs.
- Changes in the health of pregnant women and nursing mothers takes place through the process of community engagement.
- Community engagement is based on the principles of empowering citizens through their greatest untapped resources of knowledge, wisdom, and the energy of the individuals, families, and communities who face challenging health issues in their everyday lives. Rural communities must retrieve their own historical, cultural, and religious traditions of help and healing and bring these into dialogue with the contemporary medical systems (Doherty & Mendenhall, 2006). The community is activated through maternal health literacy, training, and collaboration, whereby the community members see themselves as builders of health in the community rather than mere consumers of health services. There

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is the development of a relationship of mutual interest and a collaborative energy to action towards solving their health ccnserns in the communities.

- Pregnant women and mothers in the communities are empowered through community sensitisation, which requires that certain processes are in place, namely maternal health literacy, TBA training, and collaboration between TBAs and health services, husbands' support and involvement in maternal healthcare, as well as community support.
- Changes in the health of pregnant women and nursing mothers is anticipated when the community participates in the process.
- The main role-player in improving the health of pregnant women and nursing mothers is the CEG.
- The role of a CEG is to monitor and encourage maternal health literacy, facilitate the training of TBAs, collaboration between TBAs and orthodox healthcare services, trust confidence and spirituality in orthodox healthcare services, husbands' involvement and support, and community support, as well as culture appropriate healthcare.
- The CEG fulfills this role through collaboration, dialogue, participation and community engagement.
- The pregnant women and nursing mothers, the health services, the TBAs, and the community are involved by being active participants in the community engagement process (collaboration).
- Community engagement takes place in this context through meetings, dialogues, sensitisation and awareness creation, training, collaboration, monitoring, and advocacy, where desired.

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- The goal of community engagement is to improve maternal literacy, increase collaboration between health services and TBAs, establish trust and spirituality in orthodox health services, facilitate husbands' involvement and community support as well as ensure training of TBAs to increased access and utilisation of health services.

8.7 PROCESS DESCRIPTION OF MODEL

The model illustrates that through the proposed process of formulation and implementation of the CEG which can be facilitated and initiated by nursing professional teams working in orthodox maternal health services in similar communities. This model implementation process follows the traditional steps of identification of problem and actions, community engagement and implementation phases.

8.7.1 Identification of problems and solutions phase

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Prior to engaging with the rural women and the community, the nursing professional team will familiarise themselves with the community in order to understand the existing maternal birth practices in the context (the communities). This situational analysis can occur via colleagues or researchers who may previously have worked with the women, or who may have done some work in maternal health in the rural communities.

This situational analysis is aimed at assessing the knowledge status of rural women regarding obstetric dangers, their knowledge of benefits of utilising orthodox healthcare facilities, dangers associated with TBAs, places of past deliveries, intended place of delivery of present pregnancy (and the reasons for their preferences), explore Birth Preparedness and Complication Readiness status, understand the influence of husbands and families on decision-making, family/community support, and their opinions about

community actions to promote utilisation of orthodox healthcare services for skilled care.

Planning for the first contact with the rural women (pregnant and nursing mothers) and their community occurs during this phase. This occurs by means of familiarising the community members with the maternal health nursing professional teams' objectives and planning the activities and events that the rural women and their community will attend.

The team can meet the rural women in their rural settings. In meeting the rural women in their community settings, through descriptive interviews, focus groups or Photovoice. The team aim to ascertain the women's maternal health practices, and their fears or reservations regarding orthodox healthcare. The community together with the nursing professional team collectively review the maternal health practices with the aim of establishing how they (rural women and their communities) will be made to prevent maternal health complications through the utilisation of orthodox healthcare facility for skilled care during pregnancy, labour, and puerperium. The rural women, community members, and team establish a collaborative relationship.

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The focus during orientation is the rural women's (pregnant and nursing mothers) maternal health needs; a nursing professional may be the facilitator during this process. Through Focus Group Discussions, the nurse listens to the rural women, which discussions may offer insight into the rural women's maternal health experiences. Role expectations and responsibilities are clarified so that the rural women (pregnant and nursing mothers) know what to expect from the research team, as well as what is expected of them. In order to establish a relationship of trust, both the rural women and the research team ensure that they display a positive attitude towards each other. Collaboration between the team is formalised so that the research team and the rural

women (and their communities) work in a collaborative manner to ensure that rural women experience the interaction between them and the research team as helpful.

8.7.2 Formulation of community engagement group phase

The nursing professional team, community leaders, and rural women should explore the formal and informal supportive intervention strategies with the intention of ascertaining what interventions are applicable, given the women's maternal needs. This should lead to the formulation of a CEG. On an informal level, the use of social support in terms of family, friends, and community should be encouraged. In this study, rural women discovered that they could depend on their husbands, families, and community for maternal healthcare support. In this phase, a range of activities can be identified by the team, community leaders, and women for the CEG. The focus during the working phase is the promotion of the utilisation of orthodox healthcare facilities for skilled care by pregnant women and nursing mothers in the rural areas. Rural women and their communities should be encouraged to interact with the nursing staff in the maternal healthcare settings through activities that create a sense of belonging, as well as increases awareness of maternal health issues. Factors that could bring about higher utilisation of orthodox healthcare by pregnant women and nursing mothers in rural areas should be identified and advocated for. Rural women may indicate unpreparedness to use healthcare facilities for maternal care due to the existence of pro-TBA factors. Through a collaborative liaison approach (CEG), the relevant role players intercede by addressing these factors via adequate information dissemination.

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8.7.3 Implementation phase

During the implementation phase the rural women's experiences of using maternal healthcare services in the hospital setting could be explored and evaluated by the CEG. The women's level of awareness towards the utilisation of orthodox maternal healthcare

could be assessed to ascertain whether or not rural women are able to achieve a higher utilisation of orthodox maternal care. The CEG could examine women's behavioural changes with the intention of rural women learning healthy maternal health practices. Within this setting, rural women or their community may also be able to identify areas within their personal lives that require action, which indicates a sense of awareness towards the utilisation of orthodox maternal care. Rural women or community members who subjectively report feeling supported by the collaborative efforts of the CEG and themselves, may be considered as having a positive outcome, which indicates that rural women (pregnant women and nursing mothers) and their communities may assume responsibility for the prevention of maternal health complications through the utilisation of orthodox healthcare facility for skilled maternal care during pregnancy, delivery, and pueperium.

8.7.4 Evaluation of the model

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A guide for the critical reflection of theory has been taken from Chinn and Kramer (2004) to provide guidance on how to evaluate the Model of Community Engagement for the prevention of maternal health complications in rural settings.

8.7.4.1 Clarity

The first question is on how clear does the model appear to be? Addressing this question means that the researcher should consider semantic clarity, consistency and structural clarity. Semantic clarity refers to the clarification of the concepts which were clearly defined and verified. Consistency refers to whether the model and the concepts were consistent with the assumptions, the conceptual frameworks, the framework identified in the model development stage and consistency in use of concepts which the model aimed to fulfill. The model also has structural clarity in that the components and the

relationships are coherent. The structural description of the model is consistent with the description of the model. Clarity also asks if the model brings new knowledge which this model does.

8.7.4.2 Simplicity

The model is simple because it only has eight main concepts with identified relationships. The core components and relationships support the purpose of the model and the pathway to the outcome is clear

8.7.4.3 Generality

The eight major concepts are relevant for discipline and maternal health, and can also be applicable to general and community nursing. The phases of identification, formulation, and implementation are applicable to psychology, social work, and nursing/community health. They can be applied in other community settings.

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8.7.4.4 Accessibility

The goal of this model is to develop a community approach to prevention of maternal health complications so that the experiences of the community in the area of maternal health is deemed a joint responsibility. To evaluate the accessibility of the model it is important to assess how attainable are the goals. It is envisaged that communities will assume shared responsibility together with the health/research team for meeting their maternal healthcare needs.

8.7.4.5 Importance

The model is important because it provides nursing and other health services, community members, and rural women in the rural setting with practical guidelines on how to prevent maternal health complications (at community level) through the utilisation of available orthodox healthcare services.

8.7.5 Maternal health-community engagement model guidelines

Broad guidelines for operationalising the Community Engagement Model for the prevention of maternal health complications in rural settings will be described within the context of the rural women and their community, and orthodox maternal healthcare facilities in rural settings. The guidelines will be discussed using the three phases of the community engagement process namely: 1) identification of problems; 2) formulation of the community engagement group phase; and 3) the implementation phase. Objectives and strategies to address the objectives will be mentioned.

8.7.5.1 Identification of problems phase

Guideline: Nursing team and rural community women must create a positive work environment to ensure that the rural women develop a positive attitude.

Objective I: To establish a collaborative relationship between the nursing team and rural women in their community setting

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Strategy

- approval is obtained from community leaders to interact with the rural women;
- an adequate explanation of the objectives of the study is given to each participant (rural women);
- the rural women (pregnant women and nursing mothers) are advised that their responses are treated anonymously; and
- respondents are advised that all responses are adequately documented.

Objective II: To understand the current situation regarding maternal health practices in the rural setting; and

Objective III: To identify problems and possible solutions regarding maternal health practices in the rural setting.

Strategy

- Qualitative or quantitative research methods should be used such as personal interviews or focus groups to understand the situations;
- financial inducements are used if necessary to get the woman's attention transport money and some snacks;
- questions are comprehensive (i.e. cover all issues of maternal health importance);
- responses from participants (rural pregnant women and nursing mothers) are treated anonymously;
- participants are given the required freedom of expression; and
- all responses are adequately documented.

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8.7.5.2 Formulation of community engagement group phase

Guideline: Adequate consultation for the formulation of a community institution to promote utilisation of orthodox maternal healthcare by rural women

Objective I: To inaugurate a Community Engagement Group (CEG).

Strategy:

- problems (felt needs) regarding maternal issues of rural women are identified and possible solutions are documented during personal interviews and FGDs with pregnant women and nursing mothers;
- identified problems and possible solutions are validated by elderly women of the study communities; and

- community leaders and stakeholders (women leaders, leaders of faith organisations, e.g. churches, leaders of women groups, representatives of TBAs, health officers, nurses.) are consulted.

8.7.5.3 Implementation phase

Guideline: Assessment of the CEG through the application of the strategies implemented during the first two phases of the community engagement process.

Objective I: To discuss how CEG will carry out their functions in the long term.

Strategy

- CEG will partner and dialogue with the health care system and the community members to ensure positive collaboration;
- CEG will facilitate maternal health literacy through health education and community sensitization to increase knowledge of maternal health issues;
- CEG will ensure husbands' involvement to channel their roles into supporting women;
- CEG will advocate for TBA training and TBA/hospital collaboration to enhance trust and confidence which will promote access to healthcare services;
- CEG will facilitate culturally appropriate care and community support for women's healthcare matters.

Objective II: To make the MH-CEM sustainable in the long term.

Strategy:

- The rural women's experiences of using maternal healthcare services in the hospital setting could be explored and evaluated by the CEG;

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- the women's level of awareness towards the utilisation of orthodox maternal healthcare could be assessed to ascertain whether or not rural women are able to achieve a higher utilisation of orthodox maternal care;
- the CEG could examine women's behavioural changes with the intention of rural women learning healthy maternal health practices;
- within this setting, rural women or their community may also be able to identify areas within their personal lives that require action, which indicates a sense of awareness towards the utilisation of orthodox maternal care.

8.8 SUMMARY OF CHAPTER

In this chapter, the structure and the process of Model of Community Engagement for the prevention of maternal health complications in rural areas was developed and described by means of derivation and deductive reasoning from the framework in Chapter 7. Guidelines for implementation was also formulated.

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CHAPTER NINE: CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

9.1 INTRODUCTION

A description of the process and structure of a Model of Community Engagement, guidelines for the operationalisation of the model, and a description of the critical reflection criteria for the evaluation of the model were provided in Chapter 8. The focus of this final chapter is the review of the main findings and conclusions of the research study, key contributions to the field are highlighted, limitations and weaknesses are addressed, priority areas for future research are identified, and recommendations for this study are made.

9.2 SUMMARY OF THE STUDY

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The central aim of the reported study was to develop a Model of Community Engagement to facilitate the prevention of maternal health complications in the rural communities of Cross River State, Nigeria. Given the unacceptably high levels of maternal morbidity and mortality prevalent throughout the developing world, including Nigeria, with the acute impact being borne more by the rural communities, owing to many factors including complexities of poverty, cultural influence, lack of husband and community support, confidence and trust in TBAs with low use of orthodox healthcare services for skilled attendance and low knowledge for problem recognition and decision-making during emergencies leading to delayed actions, a Model of Community Engagement in the prevention of maternal health complications is needed if the reduction in this burden of maternal morbidity and mortality in our rural communities is to be achieved.

The literature supported the fact that engaging the rural communities in the defining, designing, planning, and taking collective action in issues that affect their health will

contribute to the empowerment of women, families, and communities and increase their influence and control of maternal health, as well as increase access and utilisation of quality skilled care by women during pregnancy, delivery, and post-partum (WHO, 2000; Australian Institute of Health, 2006; Bloomfield & Cayton, 2009).

The objectives to attain the aim of the study were:

- to explore the knowledge gap of obstetric danger signs in the rural communities of Cross River State in women of child-bearing age (pregnant and new mothers);

- to explore Birth Preparedness, Complication Readiness, and delivery practices of women of child-bearing age in the rural communities of Cross River State;

- to explore the action of family/community members in emergencies and the role of existing community-based maternal health initiatives, if any, for rural women in Cross River State; and to make recommendations for community actions to address these issues;

- to engage the community based on phase 1 findings through a participatory approach (Photovoice) to identify problems around rural women with regards to pregnancy and delivery practices and make recommendations on the community's role in the prevention of maternal health complications in the rural communities of Cross River State, Nigeria;

- to verify and validate the findings from the interview and photovoice analyses with the older women of the two communities under study;

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- to engage the community stake holders through a focus group discussion for concept validation and generation of guidelines for model development;
- to develop a model of community engagement for the prevention of maternal health complications in the rural communities of Cross River State, Nigeria, by increasing the knowledge of mothers on maternal health issues, Birth Preparedness, Complication Readiness, husbands' involvement in maternal healthcare, husband and community support, TBA training, and TBA/hospital collaboration, build trust and confidence in orthodox healthcare facilities and to increase access to utilisation of orthodox healthcare facilities for skilled attendance during pregnancy, delivery, and post-partum.

The researcher adopted a descriptive qualitative design using a participatory cyclical approach (using Photovoice) to achieve the above-mentioned aim and objectives of the study. Two models were used to direct the study, namely the Citizenship Healthcare Model and Socio-Ecological Logic Model. Both models enhanced active participants' engagement at all phases of the study, in defining health issues of common interest, planning, designing and taking collective actions to addressing them. Interpretative and participatory paradigms drawn from these models resulted in the empowerment of women, families and communities as well as increase their influence and control of maternal health in their communities.

The study is made up of three phases namely, understanding the current situation, community engagement through Photovoice, and model development, comprising five studies.

- Phase 1 (descriptive) focused on using semi-structured interviews to obtain information from the rural women (pregnant women and nursing mothers)

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regarding their knowledge of obstetric danger signs, levels of BP and CR, and the actions of family/community in emergency situations in the rural communities of Cross River State, Nigeria.

- Phase 2 focused on engaging the community women (same participants as in Phase 1) through Photovoice to photograph their daily activities regarding birth practices, based on the findings of phase 1 of the study. Through the photo narratives the research sought to identify problem bothering around pregnancy and birth practices and make recommendations on the community's role in the prevention of maternal health complications via promotion of utilisation of orthodox healthcare facilities during pregnancy, delivery, and puerperium.

Eight concepts emerged from the themes derived from data analysis (transcriptions), namely, Maternal health literacy: Increasing maternal health literacy; Spirituality: Including spirituality in healthcare; Integrating TBAs: value, training, and TBA/hospital collaboration; Trust in health services: Building trust by addressing previous experiences, attitudes, and fears; Access: Improving access to healthcare; Culture: Culturally acceptable care; Husband role: Involving husbands in women's health issues; and Community support: Enhancing community support systems. These concepts were validated during an FGD with the older women of the study communities.

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- Phase 3 was the model development comprising two steps, namely, engaging the community stakeholders through an FGD in drawing up the guidelines for the model development; and the model development process. Model development comprised four steps: 1) concept development: the identification, definition, validation, classification, and verification of the main and related concepts; 2) model development: the model guidelines and definitions; 3) model

description: the structure, definition, relation statements, and a process description of the model. The structure was described according to the following sub-headings: overview of the model, context, purpose, and assumptions on which the model is based; and 4) the development of guidelines for the operationalisation or implementation of the model in the rural communities is also developed.

9.3 SUMMARY OF KEY FINDINGS

Most of the main findings and contributions of the study have been identified and discussed in Chapters 5, 6 and 7. The following functions as a summary of the key findings of the study. It can therefore be concluded that the aim and the objectives for this research have been achieved, as the researcher succeeded in:

1. Identifying the knowledge gap of women of childbearing age (pregnant and new mothers) regarding obstetric danger signs in the rural communities of Cross River State. The study established that the rural women of Idundu and Anyanganse have limited knowledge regarding obstetric danger signs and the importance of hospital delivery. These were partly the reason for phase 1 delay (delay in decision to seek care) and women's failure to take up healthcare services. These findings led to the emergence of the concept of maternal literacy.

2. Exploring Birth Preparedness, Complication Readiness, and delivery practices of women of childbearing age in the rural communities of Cross River State. The women of the study area exhibited poor understanding of what Birth Preparedness and Complication Readiness entail, and better preparation by women who attend hospital as a result of benefits from antenatal education. Lack of preparation was observed among women who patronise TBAs and the

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women relied on their husbands for preparations towards delivery. There is high preference for TBA care during pregnancy and delivery despite their poor obstetric knowledge, as was identified by some respondents. Reasons advanced included: belief and trust in TBAs and their long-standing tradition of delivering with TBAs; assumptions that orthodox healthcare is expensive; the poor attitude of healthcare providers towards women; the unavailability of a 24-hour service in healthcare facilities; fear of hospital procedures and operations; communal living in TBA homes; spirituality in TBA services; and consideration of proximity to service points. These factors exacerbated the phase 1 and 2 delays (delay in seeking care and delay in referrals for skilled care in phases of emergency), leading to rural women's non-utilisation of orthodox healthcare services for skilled obstetric care.

3. Exploring the action of family/community members in emergency situations and the role of existing community-based maternal health initiatives for rural women in Cross River State. The study found that there is strong influence of husbands in decision-making regarding the birthplace; women are supported by immediate family members; there is an absence of community structures supporting women's health, and hence the emergence of the concepts involvement of husbands/ community in women's health issues, maternal health literacy, and community support system.

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4. Engaging the community based on Phase 1 findings through participatory approach (Photovoice) in identifying possible solutions and making recommendations on the community's role in the prevention of maternal health complications through Birth Preparedness, Complication Readiness, and utilisation of healthcare facilities for skilled attendance during pregnancy,

delivery, and post-partum. The women's photography of their real life practices and experiences surrounding pregnancy and delivery practices the narratives of the photos further highlighted the following findings: lack of help and support for pregnant women; heavy household chores on pregnant women is culturally accepted and seen as exercise to ease labour; lack of proper information regarding maternal and child health issues; men are sole decision-makers; strong beliefs and confidence in TBAs, assumption that healthcare services are expensive; ignorance of availability of free treatment in health centres; negative attitudes of healthcare providers; spirituality in service delivery in TBA homes; fear of healthcare procedures and operations; ignorance on care of the newborn, and high patronage of TBAs.

5. Based on the above findings, the women developed the suggestions towards solutions which included: increasing maternal health literacy; involvement of husbands in ANC for proper information on maternal health issues,; involvement of community structures (town announcers, women groups, churches, etc.) in emphasising facility delivery; access to healthcare through free services and availability of providers; TBA training/TBA-facility collaboration; serious sanctions on women delivering with TBAs; and the constitution of an influential group to monitor the activities of pregnant women and report the same for sanctions. The older women of the study communities were engaged in an FGD to validate the findings from phases 1 and 2 of the study, and hence concept development.

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6. The community stakeholders were engaged through an FGD to draft guidelines for the model development. Through the FGD, a Maternal Health-Community Engagement Group (MH-CEG) was formed, thus the success in developing a

Model of Community Engagement for the prevention of maternal health complications in rural settings. Within the MH-CEG, the duties of the Ward Development Committee (WDC), and the Village Health Committee (VHC), which had long existed but was dormant within the communities, were activated.

7. A Maternal Health Community Engagement Model (MH-CEM) was developed. The model is clear, simple, understandable, and important for use in the rural communities where a high rate of maternal morbidity and mortality is identified. It is believed that the MH-CEG's activities will facilitate increased knowledgeable of obstetric danger signs among rural women, better Birth Preparedness and Complication Readiness, and that negative assumptions regarding orthodox healthcare services will be corrected, that TBAs will be trained and re-oriented to the new role of promoters of facility delivery, that husbands and indeed the entire community will become more involved in maternal health issues and be more supportive, that the healthcare providers will become more user-friendly, and that the community will be advocated for in areas of need, thus combating the three phase delays to accessing skilled care. There will be a resultant increase in the utilisation of orthodox healthcare services by the rural women for the prevention of maternal health complications and reduction in maternal morbidity/ mortality.

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9.4 UNIQUE CONTRIBUTIONS TO THE FIELD OF NURSING

It is believed that the study has made four unique contributions to the field of Nursing

- Despite the impact of maternal mortality in local Nigerian rural communities, no community engagement model for the prevention of maternal health

complications in the rural communities has been documented in Cross River State, Nigeria, making this study a unique one.

- This is the first study that utilises the Photovoice participatory approach to engage community members in defining, planning, and designing an action towards promoting maternal health literacy to enhance increased knowledge of rural women and the entire community on maternal health issues in Cross River State, Nigeria.
- This study was carried out by a nurse and it will provide a strategy for nurses to work with the rural community members.
- The formation of the CEG within the model is unique in this study because it is the community structure that will carry out the activities to bring about the achievement of the aims of the study.
- In this study it was interesting to discover that Ward Development Committees (WDCs) and Village Health Committees had been in existence in the study communities, but were not really living up to their responsibilities. The WDCs were set up to bridge the gap between the community and the health system at the grassroots level. Among the several responsibilities they have is outreach to the community to enlighten them on the need for good health-seeking behaviour and the use of orthodox care (Federal Government of Nigeria, NPHCDA, 2007). Through the formation of a CEG within the MH-CEM which they were integrated, these committees were now strengthened and re-activated.
- The study confirmed the legitamcy of TBAs and the need for the healthcare system to identify ways to collaborate and include them in a planned orthodox maternal healthcare services. This model provides an innovative way in which orthodox healthcare providers can work with the CEG to advocate for TBA

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training and collaboration with orthodox healthcare facilities to ensure the TBAs relevance and livelihood. This further confirms the observation, findings, and recommendations of Pyone, Adaji, Madaj, Woldetsadik, and van den Broek's (2014) study which recommended that TBAs can contribute to improvements in maternal and newborn care in low-resource settings if they are trained and supported to fulfil a new role of birth companion and promoter of facility-based maternity care including delivery, since the TBA is a community-based provider who is trusted by the community (Pyone, et al., 2014).

9.5 WEAKNESSES AND LIMITATIONS

The study has some limitations which are discussed below:

- The researcher is of the opinion that in further research of this magnitude, there may be a need to expose the participants to more trainings on photovoice processes and methodology to achieve a richer exposure of the community.

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- The study and model were conducted and developed using participants from the Idundu and Anyanghanse communities only. The researcher would have preferred to include more communities but was unable to do so due to time and financial constraints. However, it is expected that the findings could be generalised, and that the model is applicable to most rural communities.

- This study did not accord the participants the opportunity of exhibiting the photos taken to a larger audience of policy-makers. It is hoped that this be well incorporated in future replication of this study in other rural communities.

- Evidence has shown that there is an on-going lack of financial resources to implement, support, evaluate, and sustain community-based projects in

developing countries like Nigeria. This may pose a huge challenge to this newly developed model. To address this issue, the community members were directly and fully engaged in the development of this model, so for the on-going sustainability, the activities should be owned and led by the guiding coalition. Also, an action research implementation study is highly recommended to identify factors that may affect the implementation of this model.

- Apart from the challenges in implementing and sustaining this new model, a major concern emerged regarding its scalability of this model in other rural communities beyond the pilot study phases. To achieve good life expectancy for the MH-CEM, the program must be nurtured, experience must be developed, and success must be demonstrated. Nurturing of a new project/programme is normally done through funding, ideas, education, training, motivation, and innovation. This has been partially provided by the establishment and reporting of this research study.
- Success in new programs is shown in evidence of outcomes, evaluation, and research, and the sharing of information through publications, and conferences and collaborations with internal and external groups. This research project reports the first study in Cross River State, Nigeria and the findings are due to be published in an accredited journal of maternal health care as part of the strategy to increase awareness and share information.

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9.6 RECOMMENDATIONS FOR NURSING PRACTICE, EDUCATION, AND RESEARCH

Recommendations are made for nursing practice, nursing education and research as follows:

9.6.1 Main priorities for Nursing Practice

1. There must be a collaborative approach between the rural communities and nursing/ midwifery and other health professionals, for the purpose of using the MH-CEM to achieve the prevention of maternal health complications in rural communities. The community engagement model must be presented at community health programmes, meetings, and initiatives.
2. The collaborative approach should lead to the formulation of a CEG whose duty is to give rise to factors that would bring about the utilisation of orthodox maternal healthcare services by rural community women.
3. Through this study, it was observed that there was an already existing community group (Ward Development Committee) given the responsibility of outreach to the community to enlighten them on the need for good health-seeking behaviour and use of orthodox healthcare services. This body had remained dormant for a long while. It is therefore recommended that this committee should be strengthened and supported in its duties and responsibilities, and should be made to function as part of the CEG.
4. The CEG needs to be recognised in the communities and by the government. The CEGs should be exposed to regular training and re-training to update their knowledge on maternal health issues. This would empower them in their maternal health literacy duties to the communities.
5. The government or orthodox healthcare providers should use the CEG as their contact point within the communities while carrying out healthcare initiatives.

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6. The CEG should be adequately funded to make their work effective, especially at the start.

7. Maternal health literacy should be carried out by the CEG for the purpose of correcting baseless traditions and assumptions by rural women regarding healthcare facilities, providers, and certain health procedures.

9.6.2 Main priorities for nursing education

8. Nursing and midwifery students and community health workers should be taught and be exposed to the use of the MH-CEM in the course of their training and clinical practices.
9. Providers of orthodox healthcare should be retrained to acquire knowledge and skills on the use MH-CEM in the course of their dealings with rural community members.

9.6.3 Main priorities for nursing research

10. The implementation of the MH-CEM is essential as the next step in furthering the implementation of a valuable strategy to address the high rate of maternal morbidity and mortality in the rural communities of Nigeria and other parts of the world.
11. Well-designed implementation and evaluation studies in the rural communities and context are essential to modify the model in order to improve implementation success or to reject the model. These studies should be based on the standard recommended in the practice guidelines.
12. Routine studies should be conducted to assess the Model's cost and benefits for community healthcare services.

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13. The experiences of the consumers of the healthcare services within the rural communities and that of the members constituting CEGs should be explored using qualitative methodologies.
14. In addition, cultural issues that may impact on the delivery and acceptance of the model should be the focus of further study.

9.7 SUMMARY OF CHAPTER

This final chapter has provided an overview of the research process, which reflected on the purpose of the research and the objectives being achieved. Five limitations of the study were mentioned. Recommendations were made for nursing practice, nursing education and nursing research.

9.8 CONCLUSION

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In conclusion, the study has shown that the rural women's health is of immense importance and a serious social issue. It is the researcher's belief that rural women can and should be supported in maternal healthcare issues by involving them, their families, and communities in defining the health issues of concern to them, designing and implementing strategies to address the problems. This will empower their decision-making and advocacy abilities, and promote ownership, accountability, and sustainability of the project. The aim of supporting the rural women is to ensure that they are knowledgeable about the obstetric danger signs and other maternal health issues, are birth prepared and complication ready, are well supported by family and community, that baseless traditional practices and beliefs are corrected, and trust and confidence in orthodox healthcare services built, thereby preventing the three phase delays to utilising orthodox maternal healthcare services during pregnancy, delivery, and puerperium. This will in turn reduce the risk and occurrence of maternal health complications (morbidity and mortality).

However, in order to achieve these outcome, the formulation of a CEG within a MH-CEM would be necessary. Once buy-in is obtained from the key individuals who have decision-making powers within the community and the government, implementation of the Maternal Health-Community Engagement Model becomes feasible.

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APPENDICES

APPENDIX 1a: INTERVIEW GUIDE

These questions are the themes but specific probing questions regarding specific incidents will be elicited during the interviews to obtain rich information

1. Knowledge of Obstetric danger signs:
    - Tell me about those signs/symptoms that are considered as dangerous during pregnancy, delivery and after delivery?
    - Tell me about the importance of being attended by skilled health care provider during pregnancy, labour and after delivery?
    - What are the dangers of home delivery?
2. Birth plan/complication readiness:
    - Where have you been having you babies?
    - Who attends your delivery?
    - Where do you intend to have the present baby?
    - Tell me the reasons for your choice of place of birth?
    - Tell me about how you make plan for transportation incase of emergency during pregnancy or delivery?
    - How do you make plans for saving money incase of emergency during pregnancy or delivery?
    - Have you arranged for any blood donor incase it is needed?
3. Birth Experiences:
    - Tell me about your experiences during;
        - Pregnancy
        - Delivery (Wherever you have your baby)
        - After delivery?
    - In this community, tell me about the common cultural practices as regards pregnancy, delivery and after delivery?
    - Where do women in this community prefer to have their babies?
4. Action of family/community members:
    - Who take decisions regarding birth plan and place of birth in your family?
    - Tell me about the supportive roles of your mother-in-law and other relatives to you during pregnancy, childbirth and nursing periods?
    - What roles does your husband play when you are pregnant, during delivery and nursing periods?
    - Who takes care of other children left at home when you go to be delivered of your baby?
    - In this community, is there any Community-Based maternal care initiative in place that are responsive to the concerns of pregnant women and nursing mothers especially in emergency situations?

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- What do you think can be done in this community to encourage pregnant women to attend the healthcare facilities provided for you during pregnancy and child birth for skilled care?

Appendix 1b: FGD guide for feedback from interview analysis of study phase 1 & Photovoice analyses of study phase 2.

(*After reading out the themes from the analyses of study phase 1-Interview, the facilitator asked the following questions. See appendix 1d below):*

- Do you all hear and understand what has been read out to you?
- Do they represent what we all said during the interviews?
- Is there anything we said which is not included or included which you did not say?
- Do you all agree with these findings?

Appendix 1c: Photovoice Guide (FGD) for Study Phase 2 FGD

Questions will be posted to start the FGDs using the acronym SHOeD:

- What do you see in these photos?
- What is really happening?
- How does it relate to our lives?
- Why does the situation exist?
- What can we do about it?

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Appendix 1d: Focused Group Discussion Guide for Study 3 (FGD 11):

(*Validated findings from study phase 1-interview and study phase 2-photovoice read out to the participants)*

Themes Emerging from Phase 1 interview
1. Limited knowledge of obstetric danger signs
2. Moderate knowledge of of benefits of skilled care in hospitals/health Centres
~~3.~~ 3.Moderate knowledge of dangers of home delivery
4. High patronage of and preference for TBAs
5. Understanding of skilled care and prompt interventions in hospitals
~~6.~~ Poor understanding of Birth Preparedness and complication readiness
7. Strong influence of cultural practices and beliefs relating to pregnancy
8. Strong influence of husbands in decision-making about place of birth
9. Family support for women during pregnancy and nursing periods (house chores and care of other children)

~~10.~~ 10. Absence of community structures supporting women in emergencies
Action Themes
a. Education for women and husbands on maternal health issues
b. Husbands/community involvement in maternal health issues
c. Motivational healthcare services
d. Increase community awareness on maternal health issues
Themes Emerging from Phase 2 Photovoice
1. Cultural practices impacting on maternal health
2. Lack of adequate information about maternal and child health issues
3. Poverty
4. Lack of help and support for pregnant women
ACTIONS IDENTIFIED THROUGH PHOTOVOICE
A. Recognising and Strengthening the role of men to support women during pregnancy
B. Strengthen the role of community to support women during pregnancy
C. Improve maternal health education in terms of domestic activities and pregnancy
Themes Continues
5. Men are sole decision-makers regarding place of delivery
6. High preference for TBAs
7. Low preference for orthodox healthcare facilities
8. Poor knowledge of maternal and child care in TBA homes
9. High recognition of importance of immunization
Actions Recommended continues
D. Free treatment in healthcare facilities
E. Involvement of husbands in ANC
F. Spirituality in service delivery
G. Community support
H. Motivation to attend health services
I. TBA training and facility/TBA collaboration

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A) Verification of Concepts

- What are your opinions about these findings?
- What aspect of the findings do you agree or disagree?
- What are your contributions towards these?

B) Relationships between Concepts

- How are these findings related to your lives and practices in these communities?
- What do you think can be done?

Appendix 1e: Focused Group Discussion Guide for Study 4 (FGD V): Validation and Drawing up of the guiding principles for model development.

(*Validated findings from study phase 1-interview and study phase 2-photovoice read out to the participants-see appendix 1 d above)*

A) Validation of Concepts

- What are your opinions about these findings?
- What aspect of the findings do you agree or disagree?
- What are your contributions towards these?
- What is the way forward?

B) Guiding Principles for Model Development

- Who will perform the activity?
- Who are the recipients of the activity?
- Where will the activity be performed?
- What will be the expected outcome of the activity?
- What will be the process or the technique of the activity?

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APPENDIX 2: LIST OF ACRONYMS

MMR - Maternal Mortality Ratio

MM - Maternal Mortality

BP - Birth Preparedness

CR - Complication Readiness

PHC - Primary Health Centre

ANC - Ante Natal Care

FANC - Focused Ante Natal Care

EmOC- Emergency Obstetric Care

WHO - World Health Organization

UNICEF- United Nation International Children Emergency Fund

TBA - Traditional Birth Attendants

FGDs - Focused Group Discussions

TBA- Traditional Birth Attendants

SBA - Skilled Birth Attendants

FGDs- Focus Group Discussions

UNFPA - United Nations Population Fund

NPLC- National Population Commission

CEG- Community Engagement Group

MH-CEM- Maternal Health-Community Engagement Model

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APPENDIX 3
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INFORMED CONSENT FORM (For Descriptive Interview)

Title of Research Project:A model of community engagement in the prevention of maternal health complications in rural communities of cross river state, Nigeria.

The study has been described to me in a language that I understand. I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

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Participant's name……………………………………

Participant's signature……………………………….

Witness………………………………………………..

Date……………………………………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study researcher:

Study Researcher's Name: Alberta David Nsemo
University of the Western Cape
Private Bag X17, Belville 7535
Telephone: (021)959-2274
Cell: +2347031931751

Fax: (021)959-2271

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INFORMED CONSENT FORM (For Photovoice)

Title of Research Project: A model of community engagement in the prevention of maternal health complications in rural communities of cross river state, Nigeria.

The study has been described to me in a language that I understand. I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that this study involves making **[audiotapes/videotapes/photographs]** to enable photos of events surrounding pregnancy and birth practice in the communities be taken. That my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

___ I agree to be [videotaped/audiotaped/photographed] during my participation in this study.

___ I do not agree to be [videotaped/audiotaped/photographed] during my participation in this study.

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Participant's name……………………………………

Participant's signature……………………………….

Witness………………………………………………..

Date……………………………………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study researcher:

Study Researcher's Name: Alberta David Nsemo

University of the Western Cape

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APPENDIX 5: FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: A model of community engagement in the prevention of maternal health complications in rural communities of cross river state, Nigeria.

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.

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Participant's name……………………………………

Participant's signature……………………………….

Witness………………………………………………..

Date…………………………………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study researcher:

Researcher's Name: Alberta David Nsemo
University of the Western Cape
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The Chairman,

Research Ethics Committee,

Ministry of Health - Calabar,

Cross River State,

Nigeria.

CC: The Chairman,

Akpabuyo Local Government Area,

Cross River State,

Nigeria.

REQUESTING PERMISSION TO CONDUCT A RESEARCH STUDY IN AKPABUYO LOCAL GOVERNMENT AREA

I hereby request to conduct a research study in selected communities in Akpabuyo Local Government Area of Cross River State, Nigeria.

This study is entitled: **A model of community engagement in the prevention of maternal health complications in rural communities of cross river state, Nigeria.** This study is part of the requirement for acquiring a Ph.D in Advanced Midwifery and Neonatology and will be done under the supervision and guidance of A/Professor Jennifer Chipps of the School of Nursing, University of The Western Cape.

Data will be collected in phases. First, through semi-structure interview and secondly through Focus Group Discussions (FGDs) using photovoice approach. Twenty (20) pregnant women and new mothers will be purposively selected from the two selected communities of Akpbuyo Local Government Area and used for both the first phase and as photovoice participants in the second phase. Selected older women and community stake holders will also be engaged in the study. Participants will be required to meet with the researcher on designated days. Each meeting will last between 45 minutes to 1 hour. The researcher will adhere to the rights of the participants to privacy and confidentiality. The identity of all participants will be protected. Data generated will form guidelines for the development of a model of community engagement in the prevention of maternal health complications in the rural communities of Akpabuyo.

All records will be kept for five years after publication of the results, after which they will be destroyed. Only the supervisor and researcher will have asses to the data. The participants will not be coerced into participation and should they wish to withdraw at any time during the study, they wish will be respected. The researcher will ensure adherence to the highest standards of research ethics in the planning, implementation and reporting.

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study researcher:

Study Researcher's Name: Alberta David Nsemo

University of the Western Cape

Private Bag X17, Belville 7535

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Cell: +2347031931751

Fax: (021)959-2271

Email: 3255710@uwc.ac.za

Should you have any questions wiyh regards to this study or if you wish to report any problems you have experienced related to the study, please contact:

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Head of Department

Prof Karien Jooste

Private Bag X17, Belville 7535

Telephone: (021)959-2274

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Dean of the Faculty of Community and Health Sciences

APPENDIX 7

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INFORMATION SHEET

[Instructions: This template can be used to assist you in preparing your information sheet. Please ensure that your information sheet addresses any of the ethical issues that you feel participants of your study should be aware of. Bolded, italicized text found throughout this document offers guidance and suggestions. Replace this text with the appropriate wording for your study.]

Project Title: A model of community engagement in the prevention of maternal health complications in rural communities of cross river state, Nigeria.

What is this study about?

This is a research project being conducted by ALBERTA DAVID NSEMO at the University of the Western Cape. We are inviting you to participate in this research project because you are a member of this community who has experienced pregnancy/delivery and well vested with information concerning birth practices in this community. The purpose of this research project is to develop a model of community engagement in the prevention of maternal health complications in rural communities of cross river state, Nigeria.

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What will I be asked to do if I agree to participate?

You will be asked to participate in two phases of the study. First, you will be interview in your house on: (a) your knowledge of danger signs during pregnancy, childbirth and after delivery (b) how you prepare for birth and be complication ready as well as delivery practices in your community (c) experiences of pregnant women and new mothers in your community (d) actions of family/community members in emergency situation (e) the roles of any existing Community-Based maternal healthcare initiative (if any) for the rural women.

You will also be recruited as photovoice participants in phase two of the study. You will be educated on the methodology used and ethics of photovoice. Cameras will be shared to you to take photos of birth practices within your communities and to discuss these photos within FGDs through storytelling and narratives. Audio recording will be done alongside. This is to generate data and guidelines for the model development.

Would my participation in this study be kept confidential?

We will do everything within our power to keep your personal information confidential. To help protect your confidentiality, one on one interviews, will be conducted in your homes. Your interview will be recorded in such a way so as to ensure anonymity. Every attempt will be made to prevent any other person from linking specific data to you. All information obtained will be stored under lock and key for five years after publication of the results. The publication of the results of the project, will not mention any names

of participants. If we write a report or article about this research project, your identity will be protected to the maximum extent.

What are the risks of this research? There are no known risks associated with participating in this research project.

What are the benefits of this research? This research is not designed to help you personally, but the results will generate useful data and guidelines for the development of a model of community engagement in the prevention of maternal health complications in rural communities of Cross River State, Nigeria. We hope that, in the future, other researchers will implement this model to the benefit of the entire community members.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

Is any assistance available if I am negatively affected by participating in this study?

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning potential harm to you or others.

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What if I have questions? This research is being conducted by ***Alberta David Nsemo, registered*** at the University of the Western Cape. If you have any questions about the research study itself, please contact Study Researcher's Name: Alberta David Nsemo

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Cell: +2347031931751
Fax: (021)959-2271
Email: 3255710@uwc.ac.za

Should you have any questions with regards to this study or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department

Prof Karien Jooste

Private Bag X17, Belville 7535

Telephone: (021)959-2274

Cell: 0828972228

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Email: kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department:

Dean of the Faculty of Community and Health Sciences:

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

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Appendix 8

Spreadsheet showing Data, codes, categories and themes from Phase 1 of the study (Interview)

study objective	Research Question	Source#	Codes	Categories	Themes
To identify the knowledge gap of women of child being age (pregnant and new mothers) of obstetric danger signs in the rural communities of Cross River State	Tell me about those signs/symptoms that are considered as dangerous during pregnancy, delivery and after delivery	1	"I cannot know"	Few have no knowledge	limited knowledge of obsteric danger signs
		2	"water starts entering her, she has been sickly"	majority have slight knowledge	
		3	"I don't know"		
		4	"body feels light"		
		5	no idea		
		6	"vomiting"		
		7	"blood coming out",		
		8	bleeding, water coming out		

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		9	excessive weakness, excessive bleeding		
		10	excessive bleeding, prolonged labour, labour starts without baby moving		
		11	bleeding, miscarriage, high fever		
		12	bleeding, high fever		
		13	bleeding		
		14	entering her body,		
		15	bleeding, high fever		
		16	dullness		
		17	rashes, discharge from the body		
		18	paleness		
		19	pains in lower abdomen		
		20	swollen legs, bleeding before delivery time, water flowing out		
	Tell me about the importance of being attended by skilled health care provider during pregnancy,	1	safety in delivery day	Fair knowledge of benefit of hospital care	Further enlightenment on benefits of hospital

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	labour and after delivery				
		2	benefit of immunization, prevent illness, healthy baby		
		3	attendance by doctors and nurses, drugs given		High recognization of importance of immunization
		4	expert care e.g. drip given when needed		
		5	expert care in emergency		
		6	drugs to prevent tetanus, expert knowledge, hospital is cheaper than TBA		
		7	women are taught through ANC, illnesses can be prevented, test can be performed, drugs are given to women		
		8	better care for women in hospitals than TBA, drugs are given to prevent problems		
		9	health talks at ANC, medications, immunization, expert care in emergency		

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		10	specialist care during complications, maternal safety, safety of the baby,		
		11	tetanus prevention, know the position of her child, ante natal care, maternity education, risk prevention		
		12	bleeding can be stopped in the hospital		
		13	expert care during emergencies		
		14	drugs given to mother and child		
		15	health talks, expert care, routine drugs, stop bleeding		
		16	drugs given to mother and child, healthy mother and child		
		17	drugs are given in hospital		
		18	scanning to detect any problem in pregnancy		
		19	expert knowledge, problems can be detected, drugs are given,		
		20	expert knowledge and care, drugs given, early diagnosis and treatment of problems		

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	What are the dangers of home delivery	1	no immunization, no drugs, unforeseen risks	Majority have fair knowledge of dangers of home delivery	TBA lacks knowledge and skills for emergency interventions
		2	mother and baby may develop problems, lack of proper treatment, poor sanitary environment		
		3	no idea		
		4	excessive bleeding, lack of immunization		
		5	prolonged labour, in case of complications TBA is unskilled		
		6	some TBA are more expensive than hospital, lack of medical expertise		
		7	prolonged labour with complications, retained placenta		
		8	lack of antenatal education, twitching can occur, someone can come to infect the baby (akpa), bleeding can occur		

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		9	retained placenta, lack of expert knowledge, maternal death may occur		
		10	retained placenta, complications after delivery leading to maternal death		
		11	lack of expert knowledge to prevent infection and intervene in emergency, bleeding may occur, maternal death		
		12	lack of skills to perform operation if need be		
		13	no idea		
		14	bleeding may occur		
		15	bleeding may occur, TBA lacks knowledge and skills to arrest bleeding, some lack adequate knowledge of herbs		
		16	complication may occur, TBA lacks skill to perform operation, she may have other perculiar medical problems, TBA may not be able to help		
		17	mother or baby may die		

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		18	TBA may lie about some issues that she can not do, TBA may give false hope to prevent you from going to the hospital		
		19	bleeding may occur		
		20	lack of skills to perform operation if need be, mother may die		
To explore birth preparedness, complication readiness and delivery practices of women of child bearing age in the rural communities of Cross River State	*Where have you been having your babies?*	1	TBA	Delivery at TBA	High preference for TBAs
		2	undecided, most likely TBA	Delivery at hospital	
		3	TBA		
		4	hospital		
		5	hospital		

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		6	TBA or hospital		
		7	hospital		
		8	hospital		
		9	TBA		
		10	hospital		
	Who attends your delivery	11	hospital		
		12	hospital		
		13	TBA		
		14	hospital		
		15	hospital		
		16	hospital		
		17	hospital		
		18	hospital		
		19	TBA		
		20	hospital		
	Where do you intend to have the present baby	1	TBA	Indecision	High preference for TBAs

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		2	indecision		
		3	TBA		
		4	hospital		
		5	TBA or hospital		
		6	indecision		
		7	TBA		
		8	hospital		
		9			
		10			
		11			
		12			
		13			
		14			
		15			
		16			
		17			
		18			
		19			

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		20			
	Tell me the reasons for your choice of place of birth?	1	feel safe with TBA, used to TBA	Already Used to TBA	Hospitals offer skilled care and prompt interventions
		2	TBA gives herbs, herbs are better than medicine, TBA is nearer	TBA is nearer	Assumption that health facility delivery is expensive
		3	feel safe with TBA, used to TBA	Safety in hospital	The belief that “first place of birth” is safe
		4	Sure of safety in hospital, availability of drugs in hospital	Prompt Medical Interventions in Emergencies	High consideration of proximity to service point
		5	skilled care In emergencies from doctors and nursesl, administration of drugs and drips	High cost of Health care in hospitals	
		6	medical attention from doctor and nurses for the baby, immunization for the baby, good medical care for mother and baby		
		7	women are taught how to attend to the baby, adequate tests are done,		

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			medication administered, they know how to prevent avoidable problems, nurses take good care of babies, keep hygiene, hospital teaches to prepare for the delivery		
		8	adequate care and attention in the hospital, hospital helps women make adequate preparation		
		9	TBA is closer, no person to visit me in hospital, used to TBA, many successful deliveries (5) at TBA		
		10	at TBA labour pains continued long after child birth		
		11	preserve my life, preserve my baby's life		
		12	used to the hospital, I don't usually have problems there, they administer drugs and medication when necessary, give adequate attention, they are able to solve problems		
		13	nobody to take her to hospital, TBA is nearer		

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		14	hospital can deal with complications		
		15	I have seen the benefits, first delivery at TBA was very painful, husband decided I must always use hospital after		
		16	they give drugs, medication, immunization, they listen to complains and help		
		17	I have been told hospital is better, hospital take better care of baby and mother after delivery than TBA, give medication when necessary, can do operation if necessary		
		18	elder sister died at TBA, doctors can diagnose any problem, TBA cannot, adequate attention from doctors		
		19	the ability for hospital is not there, no need for me to go to the hospital, TBA's bills are lighter, not aware of free healthcare		
		20	expert knowledge and care, drugs given, early diagnosis and treatment of problems		

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	Tell me about how you make plan for transportation in case of emergency during pregnancy or delivery?	1	no financial preparation, trust God for delivery of the baby	Better preparation by women who attend hospital	Poor understanding of what birth preparedness and complication readiness entails
	pregnancy or delivery?	2	Silent	Lack of preparation by women who patronize TBA	
		3	no preparation	Belief in Husbands for preparation towards delievery	
		4	saved some money		
		5	no preparation yet, trust husband will make provision		
		6	buying baby things, trust husband will provide some money		
		7	saving money		
		8	buying baby things, saved some money,		
		9	buy baby things		

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		10	saving money, buying baby things, buying things for myself		
	How do you make plans for saving money in case of emergency during pregnancy or delivery	11	bought baby things, arranged for transport		
		12	saving money, buying baby things, buying the list the hospital gave		
		13	no preparation		
		14	no preparation		
		15	saving money		
		16	saving money		
		17	my brother-in-law takes me to the hospital, I always save,		
		18	saved some money, I went to live nearer the hospital		
		19	no preparation		
		20	bought baby things, arranged for transport		
	Have you arranged for any	1	no	No preparation for blood donor	

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	blood donor in case it is needed?				
		2	Silent	Not aware of the need for blood preparation	
		3	Silent		
		4	no		
		5	no		
		6	Silent		
		7	Silent		
		8	no, if so, we can get blood from my husband, or buy in the hospital		
		9	TBA is less expensive		
		10	no		
		11	no		
		12	Silent		
		13	Silent		
		14	no		
		15	no		

		16	no, I have faith in God that I would not need it		
		17	no		
		18	no		
		19	no		
		20	no		
	Tell me about your experiences during pregnancy, delivery and nursing?	1	felt pains in the lower abdomen, within 3 hours, I'm delivered	Birth pains more severe and lasting with TBA attendees	Non availability of 24 hours services in health centres
		2	Silent	Maternal education enjoyed in the hospital	Negative attitude of health workers forestalls access to care
		3	in severe pains 5 days post delivery at TBA	Medical attention and care better than TBA	
		4	pains, referred from clinic to teaching hospital, Poor attitude nurses towards refered cases	Health care providers not found on duty at night	
		5	prolonged labour, got transferred to another hospital, got operated	Poor attitude of Health care providers towards women	

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		6	Very painful, delivered at TBA house, was well taken care of		
		7	Antenatal education in the hospital, benefitted from antenatal education, happy with the care by nurses		
		8	Good care for mother and child in hospital		
		9	Silent		
		10	Gained knowledge on child care, personal hygiene and immunization through Antenatal education in clinics		
		11	I have been told to endure the labour pains, to follow doctor and nurses' instruction in the labour		
		12	I use the hospital,		
		13	I have to go to the hospital during pregnancy, for immunization and medication for the baby		
		14	labour can be painful, Hospital is better than TBA’s place, hospital gives medication to mother and baby		

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		15	when I'm pregnant, I'm not very agile		
		16	I'm usually active till delivery time, I don’t fall sick, I work even in the farm till delivery, quick delivery		
		17	hospital teaches how a person will take care of himself till delivery day, the types of fruits to eat, sickness prevention		
		18	make necessary preparations for the delivery, buy baby things, I decide to go to hospital not TBA		
		19	I think hospital is better than TBA, pregnant women should go to hospital		
		20	To be pregnant is a thing of happiness, if you take medical instruction, you will enjoy pregnancy and child birth, the new baby requires much attention from the mother		
	In this community, tell me about the common cultural practices as regards pregnancy,	1	None	Tradition as regards things not to eat	Belief that early visiting after delivery could harm baby

	delivery and after delivery?				
		2	None	Tradition as regards not allowing people in immediately after delivery	Belief that certain food can make babies too big
		3	None		
		4	None		
		5	Don't eat beans, don't drink ogi		
		6	Don't eat beans, don't drink tea or things that make baby big		
		7	Don't use red colour, don't eat pork, it is the tradition, one must comply		
		8	None		
		9	None		
		10	don’t receive visitors immediately after baby delivery until all wound on the baby is healed, to avoid tetanus, its an advice, its not mandatory		
		11	don't allow people touch the baby until the cord has healed, don't expose the baby to people		

		12	don't look at masquerades, don't eat mangoes so the baby will not purge		
		13	don't eat beans, do not allow people in the delivery room because of Tetanus		
		14	None		
		15	don't eat beans, don't eat eggs, don't take blood medicine, don't drink ogi, don't eat things that will make the baby too big		
		16	don't carry heavy load, don't eat beans, don't eat beans, don't drink ogi, eat only things you are used to		
		17	None		
		18	None		
		19	Things not to eat		
		20	don't drink cold water, don't eat too much so that your child will not be big		
	Where do women in this community prefer to have their babies?	1	Silent	Majority Delivered at TBA	High preference for TBA

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		2	Silent	Few Delivered at hospital	
		3	some at TBA, some at hospital		
		4	TBA		
		5	some at TBA, some at hospital		
		6	some at TBA, some at hospital		
		7	hospital		
		8	some at TBA, some at hospital		
		9	Silent		
		10	more deliver at TBA		
		11	Silent		
		12	Most of them like going to TBA		
		13	TBA		
		14	hospital		
		15	most go to TBA		
		16	most go to TBA		
		17	Silent		
		18	TBA		

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		19	some at TBA, some at hospital		
		20	women really likes to go to TBA's place		
. The explore the action of family/community members in emergency and the role of existing community based maternal health initiatives, if any, for rural women in Cross River State	*Who take decisions regarding birth plan and place of birth in your family*	1	I and my husband, I like the decision	Decision by couple	Strong influence of Husbands in decision about place of birth
		2	Silent	Decision by husband	
		3	husband	Decision by Woman	
		4	husband's sister	Decision by husband's family	
		5	husband and me		
		6	husband		

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		7	husband and me		
		8	husband		
		9	husband		
		10	husband		
		11	husband		
		12	I and mother-in-law		
		13	husband		
		14	husband		
		15	husband		
		16	Silent		
		17	myself		
		18	myself		
		19	myself		
		20	My husband and I		
	Tell me about the supportive roles of your mother-in-law and other relatives to you during pregnancy,	1	they take care of me, nursing the baby, help with laundry, help to carry heavy loads, help fetch water, help cook	Support by husband	Communal family support

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	childbirth and nursing periods?				
		2	husband registered me in hospital, husband bought baby things	Support by in-laws and family	
		3	husband helps		
		4	help with domestic work, help with the baby		
		5	mother-in-law supports me a lot		
		6	they give gifts, they help domestically		
		7	they help a lot, domestic and psychological		
		8	my mother supports me a lot		
		9	they help with domestic duties, help watch over the children		
		10	help birth me and baby, help cook, provide food		
		11	they help a lot, domestic and psychological, helps with domestic work		
		12	cook and bring me food, wash me and massage, they look after the		

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			other kids while I'm in the hospital to deliver		
		13	bring me food, buy baby things		
		14	prepare food, fetch water for me, boil water for me to bath		
		15	husband provides food, cares for me, buys baby things, encourages me to go to hospital		
		16	she used to take care of me, assist me in some things		
		17	help me fetch water, help me cook, help with firewood, help morally		
		18	they assist me, help me cook, help me fetch water, bring me food in the hospital, he makes necessary provision, help fetch water, bring me food in the hospital		
		19	they help a lot, buy baby things, help me cook, help fetch water, makes provision		
		20	husband helps a lot, he cooks, he washes clothes, those in the place of work used to assist me		

	Who takes care of other children left at home when you go to be delivered of your baby	1	husband	Support by husband	Women are supported by immediate family members
		2	Silent	Support by in-laws and family	
		3	husband		
		4	Silent		
		5	Silent		
		6	my mother		
		7	my elder sister		
		8	my mother		
		9	husband's sibblings		
		10	Silent		
		11	Silent		
		12	mother-in-law		
		13	Silent		
		14	younger sister		
		15	grandmother and eldest child		

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		16	husband's mother		
		17	Silent		
		18	mother-in-law		
		19	in-laws		
		20	Silent		
	In this community, is there any Community-Based maternal care initiative in place that are responsive to the concerns of pregnant women and nursing mothers especially in emergency situations?	1	None	Support Group by Church	Absence of community structure supporting women's health.
		2	None	Support group by community women	Support groups are strictly for their members
		3	none here in this village		
		4	no idea		
		5	No		
		6	None		

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		7	yes, the church		
		8	None		
		9	yes, they help their members only, I'm not a member, requires financial responsibilities		
		10	Silent		
		11	Yes		
		12	None		
		13	No		
		14	None		
		15	No		
		16	yes, contributory organisations help their members only		
		17	yes, they work for members only		
		18	None		
		19	no idea		
		20	No		
	What do you think can be done in this community to encourage pregnant	1	no idea	Sensitization by government health	"Gift" in promoting uptake of maternal and

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	women to attend the healthcare facilities provided for you during pregnancy and child birth for skilled care?			team of free health care	child healthcare services
		2	free health care, highly subsidized health care	Sensitization by women who have used Healthcare	Free healthcare services for mothers and children
		3	government should give incentives/gifts to mothers who go to hospital to motivate others to go also	Sensitization through women and community leaders	Education of Women on health issues
		4	awareness creation on benefits of hospitals		Involvement of husbands and the entire community in women health matters
		5	make healthcare affordable, advise women to use the hospital		Spirituality in service delivery
		6	government should give pregnant women drugs		
		7	Women who use hospital should spread the benefits to other women		

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		8	government should create more awareness of the free healthcare for pregnant mothers		
		9	hospitals should make their bills affordable, create awareness of government's free maternity		
		10	sensitize women of the benefits of the delivering in the hospital, educate the women, get the women well informed about the hospital		
		11	women should take decision to use the hospital not TBA, women should form groups and educate fellow woment to use the hospital rather than TBA, medical personel, community women, the traditional ruler should get involved		
		12	nurses should be around always in the hospital especially at night,		
		13	Healthcare providers should sensitize the women on benefits of hospital dlivery, community groups should sensitize the community of benefits of hospital		

		14	We believe in God so days should be kept aside for fasting and prayers		
		15	no idea, give gifts to women in hospital		
		16	build more health centres, make health care close to the people		
		17	hospital should relate with the clan head to sensitize women of benefits of hospital, make it as a law for women to be going to hospital		
		18	sensitize women through women groups, involve those women who have been to the hospital		
		19	Prayers and fasting during pregnancy should be introduced in clinics/ hospitals		
		20	doctors and nurses should come and create awareness in the community, the clan head should be involved in sensitization		

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APPENDIX 9

Spreadsheet showing data (responses) obtained for Phase 2 of the study (Photovoice)

Source#	Note#	Note Label	What do you see in this photo?	What is really happening?	How does it relate to our lives?	Why does the situation exist?	What can we do about it?	Category	Theme
1	1	Mother with baby working on the farm	exercise for the mother, punishment for the baby	pregnancy is no excuse for household chores	There is no help, no support for the women	lack of help amd support at home	Support for the women is important. Family members or relations should support.	Exercise for the women	Seen as exercise to ease labour pain
2	1		mother needs help for the baby, punishment for the baby	it is the woman's duties whether pregnant or not	it is a way of assisting her husband,	relations frown at husbands helping in the farm	should have postponed farm work for that day if there was no help, or she would have kept the baby down in a safe place	Culturally accepted	Heavy household chores on mothers is culturally accepted
3	1		punishment for the baby, punishment for the mother	She is exercising. It is good for her pregnancy	it is a normal thing in this community	such exercises is believed to hasten labour	help the women	Lack of help and support for women	Lack of proper information as regards maternal and child

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			too, pains for mother						health issues
4	1		Mother with baby working on the farm			lack of help and support, without this there may be no food for the family	sensitization of men on the need to helping their wives and importance of rest during pregnancy	Sensitization of men and women	
5	1		woman carrying her child on the back bending down, the baby head is also bent down			seen as form of exercise, accepted as normal even in pregnancy, only a few days of rest after delivery	sensitization of husbands so that assisting their wives will not be seen as shameful		
6	1		woman doing exercise, punishmen			provision of food for the family upkeep, seen as the	some of the men are good, They help and pet their pregnant wives.		

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			t for the baby			woman's duty else the husband may be offended			
7	1						she needs help, if she has somebody she would have keep that baby before going to the farm		
8	1						In our culture, the man is the head and women are supposed to go to our farm to work so we can eat		
1	2	Pregnant mother sweeping	This is exercise, sleeping always not too good for her	this is an exercise just as nurses advise us to be walking around	It is good to exercise during pregnancy. It makes labour easy	it is culturally accepted as the woman's duties even during pregnancy			

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2	2		she sweeps so that her body will be light,	it is not bad; it is part of exercise like they tell us in hospital	you must do your work in the house as a good wife	Exercises is good for a pregnant woman	women need to be educated on the kind of work to do during pregnancy	Exercise for the women	Seen as exercise to ease labour pain
3	2		it had been her duties even before pregnancy	She is exercising. It is good for her pregnancy				Culturally accepted	Heavy household chores on mothers is culturally accepted
4	2		this exercise is good with her body						Proper information for men and women on kinds of work during pregnancy
1	3	Pregnan t woman carrying wood	she is pregnant and we use to go to the farm together to fetch firewood,	It is my duty as a woman to fetch firewood and go to the market whether I am pregnant or not	it is the woman's duty	It is seen as a normal duty for women in our communit y, whether	relations need to assist whenever she wants to go out	Exercise for the women	Seen as exercise to ease labour pain

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			she is 6 months pregnant			pregnant or not			
2	3		a form of exercise which could make her sweat and bath	I go to the farm, fetch water with my pregnancy and nobody use to help me	it is what our husband tell us that is final	Women still stress themselves to do something even in pregnancy		Culturally accepted	Heavy household chores on mothers is culturally accepted
3	3		This woman went to fetch firewood, the firewood is too big for her to carry. It is tiring. So it is not good	If this woman had someone to help her, am sure she will not go, She is very tired and it is showing		if she had any help, she would have rested			Lack of help and support for pregnant women
1	***4 & 5***	Pregnant woman	I see a very small pregnant girl	Meat is very good for pregnant women. It	Every woman is supposed togo to the	she also need to walk to the market	though it is a form of exercise, someone should	proper nutrition in pregnancy	

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		shopping	wearing very tight and short cloths, she is living with her parents, she is waiting to take a bike to the market. this not good	makes the baby inside healthy and the mother too	market to buy things to cook for the family	so that it will be light on her	assist the women so that they can rest		
2	***4 & 5***		this pregnant girl is holding a bag, it is like she is going to the market, standing by the road waiting for transport.	going to the market herself makes her choose what to buy that will be good for her to eat	Some husbands do not care about the kind of cloths their wives wear to go out during pregnancy	the woman is exercising, its not good to stay one place when you are pregnant	**T**he husbands should be checking the type of cloths their wives wear during pregnancy	improper dressing in pregnancy due to unawareness	

3	***4 & 5***		I snapped her as she was in the market pricing meat	Tight clothings is not good for the mother and baby	Some husbands do not give their wives money to sew maternity gowns. they keep managing their old cloths which have now become very tight because of pregnancy	Most pregnant women have no one to help them. They do their things themselve s. They see nothing bad in doing that	Attending ante natal clinic to listen to health talks will help her know the proper dressing during pregnancy.	poor knowledge of proper dressing during pregnancy
4	***4 & 5***		the pregnant woman is trying to buy meat, she is wearing a tight short gown		This cloth makes her not to be smart because it is very tight. She needs a free gown, not skirts	Most pregnant women do not attend ante natal clinic to hear about the kind of dresses they	No help or money to change cloths. Government should also help in the provision of materials to women who attend clinic to encourage others	poverty

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						should wear			
5	***4 & 5***		the cloths that she is wearing is not good for a pregnant woman, in the clinic we are always told not to wear tight cloths. It is also tight on the baby inside			Some husbands do not give their husbands money for new gowns that is free during pregnancy . Their wives keep managing old ones			Occasional gifts for women at health centres to encourage them and motivate others
1	6	Pregnan t women with young man	I see a man following the wife in labour to a TBA house, It is like she is in pain	Since the man is the provider of money during pregnancy, they sometimes prefer places	Anywhere my husband say i should go and deliver that I will go because	there is no money, if you go to clinic now, they will be telling you to register	Hospital should not be fast in operating a pregnant woman.		Men are sole decision makers

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				that are not expensive and TBA is believed to be cheaper	it is him that will give me money	with N1000,that one is enough for somebody to run	They should not shout, slap or abuse women in labour		
2	6		Her husband is escorting her to the TBA home, she was having labour pains so she is walking fast	My husband use to follow me to the clinic, even when I delivered, I also see some men do that too	Because of fear of hospital and operation and nurses, women here like going to TBA. But this is not a good practice.	money is the main reason, because without money hospital workers will not attend to you	Nurses should be advised not to be harsh to pregnant women. They should pet them and be friendly		Assumption that orthodox healthcare is expensive
3	6		a pregnant woman and a man walking towards a thatched house, it's like a TBA	Most pregnant women prefer TBA so their husbands take them there	It is every woman's happiness to have her baby in a natural way without	I go to TBA because that is where I had my first delivery	The hospital should give women time to labour, Women		Fear of health facility procedures and operation

			house, there is another pregnant women standing outside making phone call		operation, women also wants to be treated well when in labour	and I have decided to have all my children with her. She is very good to me.She prays for me always	don't like operation		
4	6		a pregnant is being escorted to a TBA home by her husband, the other pregnant woman is like making phone call	In a TBA place, they give women roots and herbs to deliver fast.In hospitals, nothing is given rather they rush to operate	I think it is due to lack of money to pay in hospitals that makes them reason that TBA is better	they are afraid of hospitals because of operation, and tearing of private part. Also the way nurses shouting at women causes fear. Sometime s nurses	The hospitals should be instructed not to rush to operate women		Negative attitude of healthcare providers towards women

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						slap women even beat them up			
5	6		this woman is in labour. She is holding her waist and walking fast, going to TBA house. The husband is taking her there.	In this place, women just like going to TBAs to deliver. Sometimes, it is because nurses shout at them too much	women like going to deliver with TBA. Husbands even like it too and encourage them	Women are afraid of operation. They like the TBA who will always give them roots, leaves to fasten labour	They should be patient and give her time for baby to come out through the natural way		Free treatment in the health centres should be " free" in the real sense.
6	6		I see on this photo a pregnant woman, looks as she is in labour. The husband is taking her	some husbands believe that hospital is expensive and because they do not have much, they prefer TBA to save money	women are comfortabl e with TBAses. They are used to this practice. It is safe and ok for them because	TBA do not charge much. You can even pay as you have money, they are more friendly	Delivery should be free in hospitals. Not to say it is free but nurses are still saying		

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			to TBA house		they have never had problems there. they trust in God	and take good care of women in labour	pay this, pay that.		
7	6			It is their tradition here, women like to deliver in TBAs houses here. They are already used to the practice		it is because of money, I paid two thousand five hundred naira to register when I booked in hospital.	The husbands are avoiding high payment in hospitals.		
8	6					Women in this community do not know that hospital delivery is free,	Husbands should be advised to encourage their wives to deliver in hospital		

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9	6					Even now if you go to register in hospital, nurses still ask you to pay some money	if it is really true that hospital is free, it should be announced in this community so that everybody will know		
10	6					In TBA homes we pay what we have and complete later.They still take good care and pray for us.	Women in the communities are not aware of free treatment in clinics as money is still collected.		
1	**7 & 8**	Traditional birth	the common	many women are afraid of	prayers and fasting	TBAs take us through	Special prayer days should be set aside in hospital for		Spirituality in service delivery in TBA homes

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		attendant house	room of a TBA home with many pregnant women and nursing mothers. Prayers are also conducted there for women and thei families	injections, operations and some stressful hospitalprocedures.	and fasting assures them of safe delivery and protection from evil	prayers and fasting every week, and this protects us and our babies. I can't stop going to them	prayer and fasting to assure women of God's protection and safety	
2	**7 & 8**		A TBA home, women seating down like they are waiting for their turn, some of the women are carrying their new	sometimes nurses are not found in their duty posts especially at night. women in labour will come from far places and not find them	Women will always prefer going to where there is fasting and prayers for their protection	Prayers and fasting is what makes us go to TBA to deliver. The world is bad and enemies attack more during	Hospital should see fasting and prayers as important. They should set a day aside every week for this, not just short prayers on clinic days	confidence in TBAs and allowance of free/ communual life in TBA homes

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			born babies			pregnancy and delivery		
3	**7 & 8**		A TBA house with a prayer alter at one corner. Pregnant women are taken through prayers and fasting in TBA homes.	yourfamily and in-laws can come to the place prepare food for you, in the hospital they will not accept that. Payment for services can even be done in kind if cash is not available or installmentally.	Some TBAs see spiritually. During fasting and prayer, they prophesy and do some assignments to ward off evil spirits	Fasting and prayer is what help us. Trust in God for protection from harm during pregnancy and delivery	Hospitals should have a place for fasting and prayers. Set aside a special day and invite men and women of God to direct it	Non-availability of 24 hours services at health centres
4	**7 & 8**		A prayer alter and women in a room. Some with their babies,	Pregnant women needs prayers and fasting	women like being together, sharing their experiences, seeing their relations	The women feel free here than hospitals. Relations are allowed. In	Relations shpuld be allowed to be around their women in labour in hospitals, they will feel more relaxed. Nurses should stop shouting at women as this causes fear	Fear of health facility procedures and operations

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			some pregnant		around them especially when in labour and after delivery	hospitals nurses will be shouting at them.			
5	**7 & 8**		A prayer corner in a TBA home for pregnant women and this place is set aside for prayers and fasting for pregnant women	This means that women like a place of prayer like this so that God will protect them to go through pregnancy and delivery without dying	Our women are always happy being together. The TBA is friendly and welcomes everybody	Poverty is the problem. Also nurses do not want to see relatives. They shout at people a lot in hospitals making women fear going there	Announcenents should be made in the villages for women to know that hospital delivery is free.		Negative attitude of health care workers towards women and relatives
6	**7 & 8**		Mothers, pregnant women, relations	Most TBAs are prophetess. They combine fasting and	They have come to TBA because of	Women believe in TBAs. They	Nurses should not say that care is		Choice of TBA is preference, not just due to cost or poverty

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			all in one room in a TBA home. Staying all of them very happily even as the room is very tight and hot. Some of them are sitting on the floor	prayers with their work to protect the women from evil	money in hospitals. Even when the place is tight, they will manage	believe their pregnancy can be preserved till delivery	free but they still collect money		
7	**7 & 8**		Nursing mothers, pregnant women and relations are all in a tight room in a TBA house. Some sitting on	Every one of them is happy to be together. This cannot be allowed in the hospital	Women do not have the informatio n that hospital care is free except they announce it to us as they do for		Even women who do not deliver in hospitals take their babies for immunization, during this time free treatment should be preached to them and nurses should be friendly		Male involvement in women health issues as they are the sole decision makers

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			the mat on the floor.		immunizati on				
8	**7 & 8**			lack of money makes all of them come here even as the place is very tight.			Husband should be involved because they are the ones to insist that their wives should deliver in hospital		Ignorance on availability of free health care for women and children in health centres/hospitals
9	**7 & 8**			Women prefer herbs and roots than tablets and injections. They are also afraid of operation			Some women still prefer TBAs because of the roots and herbs given to them to preserve thei pregnancies.		
10	**7 & 8**						Women who benefit from hospitals should preach their success stories to other women		
1	**9 & 10**	Baby delivere d at	Inside a TBA hut, a woman	Most women here prefer going to TBAs	Our women do not really	Nurses are not found on duty	Women in this community should be educated about the problems that this type of		

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		TBA's house	that just gave birth to a baby boy, lying very weak and hepless, the baby left naked in blood stained cloths	because of the hot injections doctors give and tearing of private part.	care about how a TBA place is . They just trust them and keep going to them	sometimes , and they will abuse you, so even if I have money, no need going there	environment and exposing the baby can cause		
2	**9 & 10**		A woman just giving birth is lying with her baby beside her in a very congested room. she is looking very weak.	This baby is exposed for long. He can be cold and sick and even die. This environment is very dirty. Even the hand gloves the TBA uses can cause germs.	Dirty environme nt is dangerous for this mother and child. Infection can happen	Poverty and lack of knowledge that mother and baby can die from dirty environme nt	Telling the women to avoid the TBAs totally will cause problems because that is where they are feeding from so TBAs should be trained to do better		Strong belief and confidence in TBAs
3	**9 & 10**		A mother who just delivered lying on	Good care for mother and baby is lacking here. This	Poverty, ignorance and wrong beliefs is killing us here. Most women see nothing good in		She is always very kind to women in labour. She pets them, government	Ignoran ce of hygieni c birth	High patronage of TBAs is 'choice' not 'cost'

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			the ground and her baby lying naked in blood beside her inside a TBA delivery room	cannot happen in the hospital. The environment is dirty	hospital because they are already used to the TBAs		should support her to do better	practice s	
4	**9 & 10**		A woman who just delivered being left on the floor in blood and her baby lying naked beside her with cord exposed in blood	Nothing will happen to the baby. God is protecting them. The baby will grow up to be very strong	The woman is so proud of herself as the TBA in the community . She is very popular here	Lack of knowledge		Believe that " first place of delivery is safe"	Training of TBAs
5	**9 & 10**		This TBA is well known in this	This is the practice and it is not good at all. she will		It is normal. No problems.		Negative attitude of healthcare workers deter utilization of services	

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			community, she delivers almost every woman in this place. She insisted to be snapped to show to government about her good work in this community.	use this same gloves for another woman		They are fine		
6	**9 & 10**		A TBA standing with a hand gloves on the hand. She just finished taking that delivery	She is one of our best TBAs here in our community. She takes so many deliveries a month even more than the hospital		Strong belief in TBA. Poverty and lack of knowledge		Total avoidance of TBA patronage may not be possible

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7	**9 & 10**					Women go to her very well. With her..., we are sure of safe delivery. She is also a prophetess			Negative attitude of healthcare providers
1	11	Mother feeding baby	At a TBA home in Ayaghanse, a mother is making pap to give a 3 day old baby.	The mother does not know that the baby should be given only breast. The baby can even be infected	No good Ante natal care to have information about care of the baby	This mother does not know about child care. She is supposed to give the baby breast	Health education for women on care of newborn baby, importance of exclusive breastfeeding Lack of health education at TBAs on proper care of the new born		Ignorance on care of the newborn
2	11		A woman making food, it is like pap,		If this baby was born in a hospital or		Women should be encouraged to attend antenatal clinic to benefit		Lack of proper information as regards

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			she is making it for her baby, It is a normal thing		clinic, this would not be permitted but breast only		from health talk on care of the baby		maternal and child health issues.
3	11		A new mother making custard in a plate in a TBA house. I am sure she wants to give her new born baby						Involvement of husbands in ante natal care for proper information.
1	12	Waiting at the clinic hall	Many pregnant women and mothers with their children came to Idundu health center for the immunizati on,	In this community women take immunization very important. Even the TBAs encourage us to go for immunization.	Women are aware of the importance of immunizati on for them and their babies	Women value the health of their babies	Health workers should always be at their duty posts even at night.		

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2	12		About 5 pregnant women and 8 mothers with small children, seating down on a bench waiting to be immunized .	Most TBAs get highly offended with their pregnant women if they do not receive immunization.	Most informatio n get to us women only when it is made known to our clan heads and he calls the village announcer out for announcem ent	For some women, it is only immunizat ion that takes them to clinic	Government can be giving people all those gifts like mosquito nets, etc	
3	12		women, children and pregnant women seating down at the clinic for immunizati on	The village announcer is always asked to go round announcing immunization days. Markets are closed on such days.		Every group in this communit y is involved in announcin g immunizat ion to the women	Prayers and fasting should be introduced in health centres	

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4	12						Important messages like immunization are circulated to everyone in the community through town announcer, churches, women groups etc, same method can be applied for hospital delivery.	
5	12						Clan heads should meet with pregnant women and their husbands and let them know that any man who does not ensure that his pregnant wife registers and deliver in hospital will be sanctioned, and if she dies at the TBA home will not be buried in the community.	Provision of 24hrs service delivery at the health centres in the communities'
6	12						Leaders of women groups should ensure that their pregnant members register and deliver in the clinic otherwise they should be dismembered.	Involvement of community structures such as (town criers, churches, women groups etc), in emphasizing facility delivery

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7	12						Our woman leaders should be checking on our pregnant women to see if they have registered in clinics because we know everybody here. IAnyone who does not should be reported to the clan head.	Serious sanctions on women delivering with the TBAs. Serious sanctions on women delivering with the TBAs.
8	12						In the same way immunization is preached everywhere in the community news about free hospital delivery and importance of registering and delivering in hospitals should take that form	Free treatment in the health centres should be " free" in the real sense.
								Occasional gifts for women that attend clinic to encourage them and motivvate others
								Constitution of influential women group to monitor the activities of pregnant

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								women and report for sanctions

APPENDIX 10

Spreadsheet showing data (responses) for Phase 2 (study 3: FGDII) of the study with the older women of the study communities

Group	Question	Source#	Note#	Codes	Themes
Verification and validation of concept	**Which aspects of these findings do you agree or disagree?**	1	1	What you say is true, these are the things happening here	High Maternal morbidity and mortality in the communities confirmed
		2	1	I am an old woman with seven children. All my sons and daughters are married. I born all of them in the house, no problems at all. TBA gives roots to stop bleeding, today women and babies die easily, TBA have been taking care of us, the world is wicked now	Community women are already used to TBA
		3	1	women also die fast, if going to healthcare will save the women from dying, they should go	
		4	1	TBAs are good, we know them. Government can teach them the things nurses know. TBA	Willingness to adopt healthcare

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				work is their livelihood, you should not take their work from them	practices that could safe women's lives
		5	1	Government claim healthcare is free, but the nurses take money, nurses shout at you, abuse you, abuse your husband	The assumed "Free healthcare services" is not actually free
		6	1	if a woman have to deliver at night, you go there, no nurse. Sometimes those staff that know nothing will be there. Even TBA is better than them	Hospital procedures and quick operations scare women
		7	1	they are quick to operate, No time given to try. God that puts it there has a way of making it come out	Unavailability of 24 hours services in clinics/hospitals
		8	1	we don't know that government hospitals is free. Our children still go and come back and tell us that they are to pay bills	Negative attitude of healthcare providers
		9	1	immunization is free, everybody takes her child there, It is announced everywhere and we all know.	

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	What are your contributions towards these?	1	2	if going to health centre will stop maternal death, good. But, we want free treatment, free medicine, free operation. government should do this for women and babies	Confirmes high maternal morbidity and mortality in the communities
		2	2	Nurses should stay at their duty post	Unavailability of 24 hours services in clinics/hospitals
		3	2	announcement should be made every place, Churches, markets, that healthcare is free, Any nurse that collects money should be sacked	sensitization of communities on free healthcare
		4	2	the nurses that work in our clinics should agree to live here with us,	Nurses should live in the community
		5	2	If nurses are good, treatment is free, medicine is there, clinic open every time, and then our women may start going to the clinic. We will even take them there.	Training of TBAs for better performance
		6	2	Our TBAs cannot be left like that without anything. Some of them are very good in this work. Train them, give them knowledge, knowledge is power, when there is problem and can send to hospital.	TBAs/hospital collaboration

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		7	2	Nurses can be entering the villages, go to house to house, or even churches, or even village meeting days and talk to women and men, give them knowledge on maternal health,	more Health center for better accessibility
		8	2	health centres are far from us here, government should build more health centres, good roads, houses with light and water for nurses to come and stay in this community.	Spirituality in healthcare services
		9	2	It will not be easy to stop women going to TBAs, these women are very good, Many are prophetess, they pray and fast for women, they have spiritual powers. Hospital people don’t know all these prayers and fasting is very important.	
Relationship between Concepts	**How are these findings related?**	1	3	No one tells us that healthcare is free, Even when we hear and go there, we still pay money. How then is it free?	The assumed "Free healthcare services" is not actually free
		2	3	Women here have no money, so how will they go to clinic? Nurses will abuse them. So they like TBAs who will understand and help them	Negative attitude of healthcare providers

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		3	3	it is not that TBAs is free. Women still pay money but small….small. the TBAs know us, they live with us, and they take good care of us, no shouting, and no abuse.	Proximity of TBA homes to the people
		4	3	men should be informed and made to understand why it is good for their wives to register and deliver in hospitals.	Involvement of husbands in healthcare issues
		5	3	labour sudden started at midnight the husband rushed her there, because she put her name there, but the security said there was no nurse to attain to her. The woman was stranded,	Unavailability of 24 hours services in clinics/hospitals
		6	3	Nurses, Doctors, government people should be coming to us, tell us about what we should do to be good for us, our women, and our children. In churches, in markets, in our meetings, to our men, they should come and talk	sensitization of communities on free healthcare
	What do you think can be done?	1	4	The husbands, the Clan heads, the big men (chiefs) of our villages must be told about what we want to do	Community leaders must be involved

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		2	4	tell the nurses to be good to our women, to open clinic day or night, to stay with us here and not coming to work from Calabar. We want to see them always	Nurses should live in the community
		3	4	we want fasting and prayers in our hospital	Abusive and impolite nurses
		4	4	let them stop collecting money from our women if government says it is free as you said, Let them allow women try to deliver by themselves, no operation, They also shout on women in Labour and their husbands, they should try and give small small gifts them.	Spiritual issues, prayers and fastings are important
		5	4	the Clan head should be involved	Government free healthcare is not believable
		6	4	*This is where TBAs eat from, government should train our TBAs, so that they can work with the nurses in the health centre,*	Abusive and impolite nurses
		7	4		Hospital are quick to operate
		8	4		TBAs cannot be phased out
		9	4		Train TBAs on medical skills

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					TBAs can collaborate with hospitals

Appendix 11: UWC Ethical Approval

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

18 June 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by: Dr AD Nsemo (School of Nursing)

Research Project: To develop a model of community engagement in the prevention of maternal health complications in rural communities of cross river state, Nigeria.

Registration no: 13/5/14

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Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

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www.uwc.ac.za

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a place to grow, from hope
to action through knowledge

APPENDIX 12: CROSS RIVER STATE, NIGERIA ETHICAL APPROVAL

GOVERNMENT OF CROSS RIVER STATE OF NIGERIA
MINISTRY OF HEALTH, CALABAR
RESEARCH ETHICS COMMITTEE
E-mail: crsmohresearchethics@yahoo.com
+234 08034047926

CRS/MH/CGS/E-H/018/Vol.II/055 28th November, 2013

Dr. Alberta David Nsemo

CERTIFICATE OF ETHICAL APPROVAL

The Cross River State Health Research Ethics Committee (CRS-HREC) having reviewed your application for Ethical Approval of the Research titled **"A Model of Community Engagement in the Prevention of Maternal Health Complications in Rural Communities of Cross River State, Nigeria"** has granted FULL ETHICAL APPROVAL.

This approval is valid for **ONE YEAR** from the date of its issuance.

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You may proceed with your study in accordance with the protocol. You are requested to abide by every professional and ethical code for the conduct of this research, including advising the CRS-HREC of any changes to your protocol in advance.

The CR-HREC reserves the right to request an audit of this research at any time during or post implementation.

Yours sincerely,

PROF. EDET OKON NKPOSONG
Chairman CR-HREC

APPENDIX 13: TRANSCRIPTION OF PHASE 1-3 OF THE STUDY

TRANSCRIPTIONS

TRANSCRIPTS OF STUDY PHASE 1 (INTERVIEW)

FACILITATOR'S INTRODUCTION:

Please my name is Mrs. Alberta Nsemo, I am a midwife, that is one of those who look after woman during pregnancy, childbirth and after delivery. I lecture in the Department of Nursing Science, University of Calabar and also a student in the University of the Western cape, South Africa, where am studying how to take care of women during pregnancy, delivery and after delivery together with their newborn babies.
It has been found that in our state (Cross River State), pregnant women do not go to health centres government has built for them to deliver and so they are really dying during pregnancy and childbirth. The purpose of coming to this community to do research study is to bring pregnant women and mothers together, find out what the practices in this community is when a woman is pregnant, where they go to have their babies and why. Also to see how women themselves can come together to plan different ways they..., the women in this community can help and encourage one another to attend health centres and hospitals provided for them, so that during pregnancy and childbirth it is only those who have the knowledge and skills like the midwives, nurses and doctors that will care for them during these periods. Then our women can have safe pregnancy, safe delivery and also know how to care for their babies. The mothers and babies can be alive and not die. The solution for all these problems of women dying will come from you women. This is why I am here for this study. Do you understand?

This study will take two phases. When we finish with the first round which I will ask you small small questions, I will come back for the second round, and will phone you before I come back. During that second coming, I will come and teach you how to use camera which I will bring and we will discuss the type of photos you will take in this community. I will also teach you the laws about snapping people. At the end of the study, you will own the camera. We will use these photos to tell stories and narratives of our women ways of life and practices when pregnant, during delivery and after delivery.

Also together you will discuss different ways you can help yourselves and other women to see the importance of attending clinics for skilled care during pregnancy and delivery so that our woman and babies will not die of complications of pregnancy and childbirth again, rather our mothers and the new born may remain healthy and strong always. Is that Clear?

This paper that you are going to sign is to show that you have agreed to take part in this study by answering the few questions I want to ask you. We will not use or call your name, all the information you will give will only be for this study. No other person will

know that you gave me the information. It also means that you were not forced to participate in the study. So signing this paper means that you have agreed to take part. You also have the right to stop taking part at any point of this study if you so wish without any punishment.

I will also take your contact (phone numbers) so that when I come back ……….come back, I can locate you easily for round 2 of the study, when I will be coming to train you on the camera use to take photos of our community practices as regards pregnancy and childbirth and childcare, to use those photos to tell stories, so that we know how to help our woman to use skilled attendant during pregnancy and delivery, so that they do not die from complications.
Hope you understand.

Now that you know why i have come to your house to see you,.........can you sign here for me if you will like to take part in this study? (*consent taken).*

(SAME INTRODUCTION WAS DONE WITH EVERY PARTICIPANT IN THEIR HOMES)

KEY:
- **F- Facilitator**
- **R- Respondent**

RESPONDENT 1: ANYANGANSE COMMUNITY

DATE & TIME: 8:04 AM 9/5/014

PREGNANT WOMAN

FACILITATOR'S INTRODUCTION (as above)

F: *[Flipping pages of paper] my friend good morning [paused] please can you tell me about those signs, if you know those signs that if a pregnant woman experiences, you know those signs are not good signs and can make a pregnant woman have problems during pregnancy.*

R: "I cannot know; I cannot know since I am not a traditional birth attendant".

F: *Do you know the benefits that accompanies a pregnant woman attending hospital/ health centre clinic, during pregnancy. Do you know the benefits; the benefits that accompanies a pregnant woman for attending clinic during pregnancy?*

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R: "I know, because It helps the woman on the day of delivery; the woman will not have problems, and the baby also will not have problems. You will have your baby free and peacefully, no bad sickness will enter your baby's body."

F: *Do you know those problems that can befall a mother or a pregnant woman if she does not go to the hospital, maybe go to the TBA's place who does not know those……..(looking for the rightword).....signs of problems that might occur, and she went there to deliver, when she wants to deliver or during pregnancy. What type of problems can befall such a woman?*

R: "Aunty, she will surely have problems because she was not going to inject immunizations and was not going to receive other treatments to meet up, problems can reach her anytime".

F: *Is this your first pregnancy? (checking on the recorder)*

R: "No….Not the first"

F: *Ok ! other pregnancies, where do you deliver your babies?*

R: "I deliver in a TBA's house"

F: [Pause] ok! TBA is the one that delivers you of all those children? How many children are they?

R: "They are 3……..Two boys, one girl".

F: *Are they all alive?*

R: "All of them are there".

F: *In this present pregnancy, where do you think you will deliver?*

R: "In the house of a TBA".

F: *What are the reasons why you like having you babies in a TBA's house and not hospital? There must be reasons. So please let us share in those your reasons.*

R: "The reason is since from the first pregnancy they brought me to deliver with a TBA, that is why, I am used to a TBA's house because I have seen the benefit, also she has been giving me something and I have seen the benefit".

F: *Ok! now that you are pregnant, you know that one day you will deliver a child, what are those preparations you have done and kept so that in case problems sets in unexpectedly, if you go to a TBA's house to deliver a child during this pregnancy problems comes unexpectedly or the time you want to deliver a child, is there any preparation on ground in case problem comes and they say….. maybe let us transfer to a big hospital. Do you have preparations about those kind of things?*

R: "Yes……., because the TBA use to give me something to meet up the month, when my mouth is complete, I will go there and stay until it is the day I deliver."

F: *So you don't have preparation in any way. You believe that, that TBA for those things she gives you nothing at all could happen?*

R: "Nothing used to happen".

F: *Is there any way you used to make preparation by keeping money, may be small small in preparation, in case baby……,delivery [Looking for immediate words to use] or yourself, so that when the time to deliver comes or in baby's things. How do you do such preparations concerning keeping money, what preparation is in place?*

R: "I don't use to prepare myself but I know that when the day reaches, God will do his will".

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F: *(Breadth release).....Do you use to hear about that sometimes a pregnant woman during time of delivery or time of pregnancy may need blood? Has it ever been that you have heard [PAUSED], you or your husband or your people makes preparation that ah! something could happen that she needs blood is there such preparation?*

R: "No...."

F: *[release of breadth] Ok ! Please tell me, what is eh! eh! you know! eh! eh! what is , what do you know about eh! eh! as you use to deliver your babies, how does your deliveries look like, what kind , you know, you know, what do you know about , your experiences about delivery since you have had many babies, this is not the first?*

R: "**O**h! My delivery is that of lower abdomen, when it happens I feel pain in my lower abdomen, when it pain me for a while, it can start by 3 O' clock before 6 O'clock I will deliver my baby".

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F: *Em m! when you deliver a baby free and peacefully in a TBA's Place as you have said, when you return home, concerning care, your people, your mother-in-law, your husband or those staying with you, living in the same house with you, what is your experience as they take care of you or in the way of help that they help you when nursing your baby?*

R: "They use to help me and also boil water and bath me and also help carry they baby and also take good care of the baby".

F: *[release of breadth] In your community, Are there those thin....gs that they say are things forbidden in this community that when a woman is pregnant should not do this, when she wants to deliver, should not do this or should not eat this, do this. Those things, those laws, those laws that are kept in the community concerning the time of pregnancy, delivery of baby and caring for baby, please let us discuss, let us follow and hear?*

R: "Aunty, in my place, there is no law-o! if there is anything people used to……when they have babies that say, they will not use, somebody like me when I deliver baby, I am never fast in eating garri because it gives problems in the stomach so………."

F: *Ok! In the community you live, hm! Who or in your house, who eh eh decides on the place that….,that you deliver, the hospital or TBA, who has the power to take decision about where you are to deliver in the house that you are from?*

R: "None. The people, me, my husband used to say I should go to the TBA's place and receive treatment, also I myself likes it because the TBA also gives me something and is good with me."

F: *[Breadth Release] e e h! do you have mother-in-law?*

R: It is so (Low tone)

F: *Eh! when you are pregnant, sometimes you used to be tired, sometimes you are sick, what are those, those help that your husband, your mother-in-law, your husband's people living with you, used to help you during pregnancy, or when you deliver your baby or when you want to come to deliver maybe leaving the other children at home, which and which aspect do they use to render a helping hand to you. Say it?*

R: "They used to render help to me and also sometimes carry cloths and wash for me. If I cannot do something, they assist, they carry that thing and do. They use to assist me like that and not leave everything for me to do, also assist me with baby."

F: *………… For your husband in particular, what type of help during pregnancy or during delivery and when you are nursing a baby that your husband really assist you. The major things he does for you?*

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R: "He used to help fetch water, cook for me even when I deliver newly, he does not allow me do anything until the baby is about 2 months before he allow me do something. He fetches water for me, early in the morning he wakes early to help me, I will take care of the baby, sometimes my mother takes care because his mother does not quickly come, the mother is in their village".

F: *[Breadth Release] As you have come here, or when you want to deliver, who used to look after the children you leave in the house, who is the main person that looks after those children for you?*

R: "My husband looks after them"

F: *In your community, Is there a group or organization in the community set aside that in case a woman who is pregnant develops problems, those group or organization looks after them or rushes her to the hospital or maybe when a woman want to deliver a child, has problem or anything, Is there any, any such group in the community you are from?*

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R: "None"

F: *What in your thinking, do you think in this community, that could be done to encourage women who are pregnant to have the desire and happiness to want to deliver in the hospital and not with TBA? What do you think can be done to give women the desire and happiness to say, " it is hospital that I will deliver my baby and not TBA", in your thinking?*

R: "Aunty, Aunty....., I cannot know oh! What could be done, I cannot know –o! Because we have been used to delivering with the TBA".

F: *Ok! Ok! Thank you, thank you very much. I am very happy that you participate in this study. Thanks so much.*

OBSERVER'S COMMENTS:

She opened up and was relaxed

- Lacked knowledge of risks of delivering with TBA
- Lacks knowledge of free health care services for pregnant women in the state.

RESPONDENT 2 – 012 (9/5/014) 10.20AM

ANYANGANISE COMMUNITY (NURSING MOTHER)

FACILITATOR'S INTRODUCTION (as above)

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F: *Mma Helen Please, I would like you to tell those signs that if it happens to a woman during pregnancy or child birth or during nursing a baby, you will know that it is not a good sign, and there is need for that woman to look for or go to the hospital?*

R: "……….it is……..it is……if she is not well sometimes water starts entering her, also she has to go to hospital or sometimes since she started pregnancy she has been sickly, I think she should go to hospital also".

F: *Thank you………..please can you tell me also the benefits that accompanies somebody who delivers in the hospital. I am sure you know that there are some benefits. Even if you don't deliver in the hospital, but I believe you know there are some benefit that are there or follows one who delivers in the hospital or goes to check her pregnancy in the hospital?*

R: "One good thing I know when you keep going to the hospital, they will give you immunization and will not allow you to be sick and will also, when your baby is born, it will be healthy when you attend hospital".

F: *what could be those problems that follows…., to deliver…..delivering at home, problems that can follow women if they deliver at home?*

R: "The place she sleeps to delivers is not good, sometimes the treatment given to her at home is not good with that baby, maybe that baby can have problem".

F: Is this your first pregnancy Helen?

R: [She nodded positively]

F: *Since it is your first pregnancy, that means you don't have the knowledge about how pregnancy is and delivery is. You don't have such knowledge. But you used to hear from others, your friends and those who relate with you saying something about the experience they have about being pregnant, delivering babies even at home or TBA place. What is good at the TBA's place that makes them prefer that place to hospital or what makes them prefer hospital to TBA;s place. Am sure you used to hear things like this, if not you in person, those around you or related to you?*

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R: "Oh! I used to hear from my grandmother and my friends that……, some it could be that yawning (Syncop) can start and in the hospital, they will rush and give injection, sometimes they say injection is not good, some say that leaves in the bush is better than to give injection, and so that is why I say sometimes home is better than hospital because of that reason".

F: *Good, eh! eh! my friend, Helen emm! This your pregnancy, where do you want to deliver, where do you think you want to deliver?*

R: "Me I don't know – o – oh! Because it can happen at night that I cannot reach the hospital o ! [Laughs happily ha ha ha]"

F: *(Laughs along) ok o! you don't know?*

R: "hmm Um!"

F: *But as you keep talking relating night, it is not only at night that labour start ……o!*

R: "Sometimes it can happen in the farm, it can happen at home where there is no transport to take you to hospital , that is why where it will be to deliver, that is where I will deliver".

F: *Eh eh! so as you are sitting there you have not made preparation about this delivery, saying labour can start in the night unexpectedly, so let me arrange transport that will take me to the hospital in the night or let me keep some money. Have you not made such arrangement?*

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R: "Aunty [She paused and laughs] I don't have money o! it is because of money that I say wherever it happen, there I will deliver."

F: *If you deliver with a TBA don't you pay money there?*

R: "Aunty, it is not that people don't pay but talking concerning means of how to transport one to the hospital. At night you may not see transport to take you to the hospital. It is why I say wherever is nearer to me, that is where I will deliver".

F: *So those TBA's are nearer to yo…….uu?.....ok! where you live, which is nearer? Clinic or TBA's Place?*

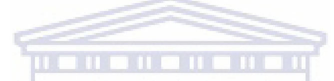
R: "[smiling] Aunty, TBA's place is nearer to me o!"

F: *The way I am seeing, it is like you want to deliver in a TBA's place. So should we take, or say that you are going to deliver at the TBA's Place because it is nearer to you?*

R: "Aunty………I have not really decided on a particular place to deliver yet, that is why I am saying wherever it happens, I will deliver there."

F: *[noisy background – Cough/phone ringing] since you become pregnant, tell me your experiences, how do you feel, do you have any problem? Anything? Te……..ll, me?*

R: "Aunty, I don't have problem o ! Maybe it is when it started that it used to be as if small small sickness used to do me. But after that I have no other problem".



F: *Ok! What are those beliefs kept in the community that forbids a pregnant woman not to do this or that or not to eat this or go here that you know about, because community by community has these kind of laws. In your own community, what are the laws that forbids pregnant women concerning food, where they sleep and where they go, that you know about?*

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R: "Aunty where am from, nobody decided for me …….o! where to deliver, where I want to deliver, that is where I will go".

F: *(Readjusting the recorder) what type of assistance does your mother-in-law, those you live with or your husband used to give to you since this pregnancy or plans to give you when you want to deliver?*

R: "Aunty, as I came and register in the hospital, it was my husband that gave me money to come and register, my baby's things too, it is my husband that wants to buy, am not the one to buy."

F: *……..[Breadth Release]. Alright. [long heef] where you come from or where you live, Are there any women group that the community forms and keep, that if anything unexpectedly happens to a woman even if she is not their wife, they assist during pregnancy or during labour, they help to take her to the hospital if the husband is not around or they run around and help that person if she has a problem, or during delivery that group comes in to assist, because it's all about pregnancy and delivery. Is there such a group in the community you come from?*

R: "[shrudding her shoulder] there is none o -!"

F: *Ok! In your thinking, what do you think could be done or what women in the community can do to assist fellow women, or they say all women whenever they are pregnant must go to the hospital to deliver. What do you think could be done to give women the joy to go to hospital to deliver whenever they are pregnant and not any other place. What do you think, in your own opinion?*

R: "Aunty, I think, it should be that as we come to the if…..if………..hospital should not collect money, sometimes if somebody……., not collect money, sometimes if somebody is sick they take her to the hospital, they should not collect money, or they collect a little money because sometimes money is the reason why they don't like coming out to the hospital".

F: *In the TBA's place, how……..,how do they do? Don't they collect money from you people?*

R: "When they bring, as they bring here, because some people, their babies can be sick and they don't have money and when they bring to the hospital, they should not wait for money before attending to the babies."

F: *But, I know that in this state, government offers free treatment to pregnant women and new born.*

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R: "Some people who don't register in the hospital, maybe they used to pay money but since I have not had a baby before, I wouldn't know".

F: *Mma Helen, thank you – o !*

OBSERVER'S COMMENTS

- *The smile of the researcher boost the confident of the respondent*
- *No awareness of free healthcare service for pregnant women & Newborn in the state.*
- *Family members caused a little distraction during interview.*

RESPONDENT 3- 008 (NURSING MOTHER-5 days)

Date: 9/5/14 (11.30AM)

Anyanganse community

INTRODUCTION BY THE FACILITATOR (as above)

F: *Sister please let me ask you a question I won't really take your time. Since you put to bed since Friday, today is Tuesday, this is about 5 days now. What is the sex of your baby?*

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R: "Female".

F: *Please do you know those……..those signs that if a woman is pregnant or has a new born baby it would make that woman know that it is a bad sign, it is not good. Do you know………., do you have any knowledge about such sign?*

R: "I don't know…..0!"

F: *You don't know? Ok! If you don't know, do you know the benefits that maybe if a woman is pregnant and attends a hospital for nurse to look after her or delivers in the hospital or after delivery she takes the baby to the hospital, do you know the benefits of such actions?*

R: "I know"

F: *What are the benefits?*

R: "Those benefits that goes with attending hospital are that when you go to the hospital, nurses, doctor will know and test the body to know what the problem is and also gives you drugs that responds to that problem".

F: *Ok! It is good. Do you know the problems that goes with any woman who does not deliver in the hospital. Those problems that can follow such a woman? Do you know if problems could follow any woman who does not deliver in the hospital of if there will be no problem?*

R: "I have no idea"

F: *No idea? Ok! As you have delivered, there are some preparation a woman does when she is pregnant, saying "so that when I deliver, let me prepare", maybe in term of money or in preparation towards the baby or in the feeding things and the way she arranges the house or with regards to children left at home or in preparation saying "in case something unexpectedly happens that is not a good sign and there is need to go to hospital", whether I have money or even there is a way people used to say, the TBA used to say," go to the hospital, you have no blood in you, so that doctors will put small blood". Do you make such preparations in any way at all?*

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R: "I did not do"

F: *Good……Emm! You said this is not your first baby. What are the experiences you have had in other babies? Do you have any experience you can tell other women that ok! Other children I had them here or these were my experiences or I delivered them in the hospitals and those were my experiences or hear the experience that my friends who are around, who are my neighbours do have at*

the hospital or TBA's place when they want to deliver. This place is like this and that place is like that?

R: "All my children, I deliver with a TBA not home. I don't have experience about delivery in the hospital".

F: *Ok! with your experiences in the TBA's place, what interests you about this place? There must be a reason why you like going there to delivery. There must be a reason. What are your reasons?*

R: "The reason I like TBA's Place is because the TBA's place that I attended in my first pregnancy and delivery I received treatment from TBA and it was good with me, that is why I like delivering with the TBA".

F: *In different communities, there is usually some beliefs (laws) that they say "don't do this", if a woman delivers should not do this or if she is nursing a baby, should not do this or should not go to some kind of place. Does such laws exist where you live or come from?*

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R: "There are such laws..."

F: *Like which?*

R: "When I went to the hospital, I was told different things I should eat and those I should not eat , such things I did not eat".

F: *What are those things they said you should not eat?*

R: "They used to tell me that i should not drink tea……..much of tea, should eat fruit, small fruit like that and things that are light……"

F: *What did they say tea does?*

R: "I don't know because like in my first son, they said I should not eat that the baby was too big inside my belle".

F: *Ok! In the community you come from or live, women generally, where do most women like going to deliver? In the hospital or TBA's place?*

R: "I have no idea but my sisters like delivery in the hospital".

F: *Emm! [Paused] In the house you come from, who decides where the wife will deliver. Is it the husband or mother-in-law or herself or husband's siblings? Who takes decision saying "this one you will deliver in the hospital or at the TBA's place"?*

R: "My husband used to carry me because I used to register in the hospital, my husband used to take me to the hospital and also bring me to the TBA's place."

F: *Ok! (Breathe release…….) Ok! What type of help does your mother in law used to give to you or those living with you or your husband used to give to you, like now that you have delivered, what type of help in different aspect do they used to help you?*

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R: "My husband helps me as God gives him the ability especially as my mother in law had died".

F: *Now that you are away, who looks after your children at home?*

R: "My Husband"

F: *Ok! Then eh……….m, where you come from, is there any association or a group, maybe women or mixed women and men group, who if unexpectedly labour starts any pregnant woman in this community, they may take her to where she will deliver or anything maybe sickness and her husband and people are not around, they assist such a woman in the community, you come from. Does such a group exist?*

R: "We have such in where I come from in Mfamosing 1 but not here where i live"

F: *What is it called?*

R: "Great vine ladies."

F: *Is it women women group?*

R: "Women women they are...."

F: *They do help all women or only members of the group?*

R: "If it happens they help generally."

F: *What did you say they are called?*

R: "Great Vine Ladies"

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F/R: *Good. G-R-E-A-T……V-I-N-E LADIES.*

F: *Ok! In your idea and opinion what do you think that could be done by the people of this community so that women in this community would like to go out to hospital to deliver, not only to go to check their pregnancy, get immunized, collect drugs for blood but when it is time for delivery they….go….to….TBA's place and desert clinics that Government has built for them. What is your opinion, what do you think can be done so that women can be encouraged and have the joy of going to the hospital to deliver their babies, because we have discovered that women can attend hospital during pregnancy but during time for delivery they go to TBA and deliver. So what could be done to encourage women to be happy to go to the hospital to deliver?*

R: "Mma Nurse,…….h m m! In my own opinion in that aspect, is that because of how the world is like this now (Changes mood, becomes sobber) some people

decides to go to TBA to deliver their babies, but I usually encourage people to go to hospital – o! so that they can check their body and I also encourage those who wish to deliver in hospital to go. I used to encourage some people."

F: *Em! But my main question is not anwsered and I don't want to keep you long. The question is what do you think could be done as your suggestion, your idea as a woman from this community, you can say if this is done, women can or if this is like this, women would like to go to hospital, so in your suggestion what do you think can really be put in place to make women happy to say, "I want to go to the hospital and deliver". I don't mean you encouraging another person to go and deliver, I mean what do you suggest could be done because for you to born, want to born in a TBA's house, whether you like it or not, there must be something that interest you there. What do you think if done in the hospital women will feel very happy to go to hospital to deliver babies?*

R: "In my own side, government should do something about it and also look after women, like in the general hospital I went to, they gave mother gifts, I am sure that if sometimes mothers are given gifts mothers will be happy and would attract them to go and deliver in the hospital that is my own idea."

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F: *Thank you*

OBSERVER'S COMMENTS:

- In severe pain post delivered
- Delivered in a TBA house
- Was given drugs by the TBA
- Baby 5 days old.

RESPONDENT 4: 014 (IDUNDU COMMUNITY)
Nursing mother
9/5/014; 12:53PM

INTRODUCTION BY THE FACILITATOR (as above)

F: *Mma Nkoyo, please you will tell me those signs that if a pregnant woman sees, or a woman who want to deliver sees or a nursing mother like you sees, she will know that those signs are not good, that there is need to run to the hospital to see a doctor, or that can bring problems to the mother or child, those are the kind of signs I want you to tell us if you know about?*

R: "Aunty like this my baby that am carrying, the first sign I see is that since he was born he is never sick but he has problem in the ear that is why I run with him for doctor to see him………….."

F: *Generally, I mean every other sign not only the one that affects your child. What other things do you know about that if it happens to a pregnant women or a woman who delivers newly or a nursing mother, they know that these are bad signs. Not only those ones that have happened to you or your child?*

R: "Like a pregnant woman, who is pregnant, when she is going about and sees how her body is, [paused] she sees how her body is, maybe your body is light, you cannot……………………………..[Baby crying causing distractions] you have to come to the hospital to do test to see what the problem is".

F: *Ok! [Breadth release] what are the benefit that accompanies somebody who goes to the hospital to deliver. Is there any benefit?, what are the benefits that accompanies one who goes to the hospital to deliver and not go to TBA?*

R: "The benefits are that you can go to that hospital to deliver, when you go……….For example like this my own when I went to the clinic, I was brought to the clinic, when labour became too difficult, they transferred me that I should go to general hospital………………., Labour still was very difficult, they then sent me to teaching hospital. So there, they put me drip so that it can give me power so that I can push out the baby when it's time for me to born my baby".

F: *What is the problem that goes with those women that deliver at home and does not go to the hospital. I mean the problem that can befall them. ?*

R: "Mma Problem…………………"

F: *Not all o! but problems can happen which you know. What are those problems that can happen to them because they did not go to the hospital but went to TBA?*

R: "The problem that can happen to them is that as they are delivering that baby at their home…...Ah! A-h!....[She lacks words] delivering at home without giving that baby immunization that first day, that the baby is born, also the mother too they don't give that mother treatment too. Bleeding used to happen to a woman too who delivers at home, without help from there she may die."

F: *[Taking a deep breathe]………Is this your first baby.*

R: "No [very low] feeling shy"

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F: *o….k….! but where did you deliver this your baby?*

R: "Teaching hospital"

F: *[Deep Heave]…….why did you decide to go to deliver in the hospital? Tell me the main…. exact reason that you said if not in hospital I won't deliver?*

R: "Why I decided to deliver in the hospital is because I used to receive immunization in the hospital until the day I was to deliver, saying that when that day reaches I will deliver freely without anything happening".

F: *Ok! [Deep breathe]. And do you always prepare for your baby, prepare saying when I want to deliver, in terms of money, baby's things, in emergency that*

could call for you being referred, as it had happened to you? Did you make preparations for it before it happened like that?

R: "I prepared"

F: *What kind of preparation did you make?*

R: *" [Paused….took a deep breath] The preparations I made was….it used to be that when the father of this baby gives money, I will buy baby's things and keep them. I will also follow and buy small small things, buy like food thing [distracted by the baby] when the time to deliver drew near, I bought food stuffs, so that when I deliver, so I will have what to eat".*

F: Did you make preparations about blood, in case blood is needed?

R: "I did not do"

F: *Ok! [hiss] so this your delivery what kind of experience did you have, during pregnancy or during when you were delivering your baby. Tell us about those your experiences?*

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R: "Aunty, pains (baby cries)…………"

F: *Are there other things that happened to you, all those things……..?*

R: " They used to put, they put hands inside my body and checked if the baby stands……….was lying well".

F: Did you feel good in your body as they kept checking you to know how your baby was, also referred you when there was problem the way it happened? [baby cried & distracted mother]

Is there any experience you had that made you not to be happy among the doctors or nurses?

R: "[Baby kept crying and distracting] Remain for a while, shaking her head."

F: *Speak – speak!*

R: "After the clinic people wrote a referral note that I should go to general hospital, so when I went, they said I did not register. First they asked me to lie on the bed….., they removed …….removed urine from my body………………………..Then secondly, [noisy background] they said the baby does not reach to be born yet, they also said I should do exercise and I did exercise and I finished I went back and they again put hand and checked saying that the time does not reach at all for the body to be born. So……..,, that they will not look after me that I should go to teaching hospital. Even bed was there, but they did not allow me to stay saying there is no space but there is bed. Then, secondly, they said that they were instructed not to attend to anybody brought here that did not register. All through that night I suffered, received pain with baby in the belle, I was not happy. Even with the baby's thing that I took there including my things that I carried there, so that they use in delivering me, they said it should be taken outside, so those things were removed. I was not happy. I went back, when I went back, I told the big woman in our clinic [idundu clinic], what happened and she was not happy."

F: *Did the clinic matron not give you a referral letter?*

R: "Eh eh…..! the letter I was given, it was not the matron that gave, but the nurse who were there gave me, saying that….. that is how they use to give any one they refer."

F: *They were supposed to have attended to you because of that letter, so did they see that letter?*

R: "They saw [but refused to use]".

F/R-but this is the same letter I took to teaching hospital and they attended to me.

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F: *Ok! No problems.*

In your community, are there those laws that forbids that if you are pregnant or nursing a baby, should not do this or that,……..are there those kind of laws in the community where you live…. That says don't eat this, don't eat that, during pregnancy, delivery or when nursing a baby?

R: "I don't know of such in my community. But on my own, what I know about they said I should not drink tea, should not drink ogi (pap). Eh….."

F: *Because of what?*

R: "Because baby was big….they said I should not eat what is sweet".

F: *So women in your community, where do they like to deliver their babies? Hospital or TBA's place?*

R: "They go to TBA"

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F: *[Echoes] TBA? As they go there, do they say why they go there?*

R: "I don't know – o!"

F: *So [Paused] who decides where you should deliver, your husband or you? As you… you went to the hospital, are you the one decided your husband or your mother-in-law?*

R: "My husband's sister said I should deliver in the hospital, I also accepted delivering in the hospital".

F: *Ok! What kind of assistance do they render to you, your husband mother-in-;aw or your husband's people during pregnancy, delivery or period of nursing a baby. When you delivered, what kind of assistance did you receive from term?*

R: "Like when I was pregnant they used to ….because I am living alone, fetch water for me, sweep for me and also help in other small small things like when I delivered they will help and bath the baby and also wash my cloths saying it is not good for me to start working yet, till am strong".

F: *In the community you live or in the community you come from, are there any group or organizations that the community forms and keep, so that if anything happens to a pregnant woman or nursing mother or a woman who is pregnant, they come in and help even if the husband or husband's sibling or her people are not around, they come in and help. Is there such a group?*

R: "I have no idea o - !"

F: *In your own opinion, what do you think can be done in the hospitals so that women would be happy and like going to health centres to deliver. That what and what should be done by the women in the community so that it makes all the women to see the benefits of going to hospital to deliver?*

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R: "[Take a deep breathe] thinking of what to suggest [she readjusts] Aunty this one, I don't know o! because they sa…..y eh eh! [uses proverbs] *"Ama Item ama ifiok asua nduat ebiet unam" meaning "He who like advice likes wisdom, he who hates scolding is like an animal*" anybody who likes herself will to go to the hospital and anyone who doesn't like herself goes to the TBA, anything she sees at the TBA's place does not concern anybody, does not concern the doctor".

F: *No! it concern, it concerns be……cause this study is about women and their babies and [noisy background] it is not good for anybody to die again. E….very body is important to us. We went all women be it our wives, mothers, sisters to be alive. That is why we are doing this study for women to see the benefits of delivering in the hospital, so they don't die again.*

What kind of advice can you give so that it can help women see the need to deliver in the hospital?

R: [paused giving a hiss]…if I see any woman who is pregnant, i will tell them that she should go to the hospital. That it was hospital that helped me. If what happened to me I went to TBA, maybe I would have lost my life or ……..i live and baby dies. So she should go to hospital, then she will see the benefits.

F: Thank you v….ery much Nkoyo.
Thank you oo!

OBSERVERS COMMENT:

- Baby was distracting during interview
- Facilitator was tired.
- Respondent is knowledgeable about benefits of attending hospital.

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RESPONDENT 5: 016 (Pregnant woman)
Idundu community
DATE/TIME: 9-5-014 (2:21PM)
Interview done in English/pigin

INTRODUCTION BY THE FACILITATOR (as above)

F: *So Cecelia, to your knowledge, what do you know...., what are those dangerous signs that a pregnant woman sees or sees when she wants to give birth to a baby?*

R: "This one is not my first pregnancy. It is no second pregnancy. When I was with baby the first one. It was infact I suffer and before I put to birth the do operation [Respondent uncomfortable with pure english]"

F: *You can use pigin.*

R: "Ok! I can use pigin. when I want to put to bed, they do operation. So I suffered then when I was in labour, it took me one week,……. I suffer, I cr…..y then later on, they took me to hospital. They said I should, they should do operation. So since……., that was 2006, so I was afraid that maybe this will happen again. So my husband said I should not worry maybe God will make it to change this time around. Since then that is why I say let me ju….st go in then i…….God, God will make it for me."

F: *Hm m! Hmm! Alright*

R: "So ……..there is something I want to talk. That place am staying, where am staying, this my pregnancy, there is this place they used to tell me I should go, go to,…..native do….c….tor. There is one thing that this people used to do in this place, they say they will pump my …….my stomach, tummy. Then, I will ask them... will person pump somebody's tummy when there is a baby inside? They will pump your stomach and you will…..you will purge. I say no….! in my place we don't use to do that kind of a thing, is only when you have problem you go to the hospital, they will take care of you, they will check you, they will tell you what is your problem. They say No…..o ! I should go….o! So….so…so…something like witch.... winch [witch], I say no….o! winch cannot come out from me and in particular am not from here. That is what they used to tell me in my place am staying, I should go to eh…….this so…..so…person they will check me, I will register two thousand five, I say two thousand five for native? They say yes, the woman will be checking me till I deliver, I say no I will not go to that place.

F: *Ok! Cecelia [Taking a deep breathe] what do you think is the importance of somebody going to the hospital to deliver?*

R: "Importance! Importance is that in the hospital here they will, they have some things that they will, there is many things that nurse, they can do for you, that

the other person cannot do because when you go to native doctor, the only thing I used to see, they will cook something inside the pot, maybe when you want to put to birth the blee…..the blood will come out before the baby, you can die but in hospital maybe when you , they know that you are weak, they can use drip, that drip will give you the strength that the baby will come outside".

F: [Taking a deep breathe] so what….ok! these takes care of dangers, people, eh….. having their babies at home, they are exposed to dangers. Is that what you said?

R: "Hmmm…..!"

F: *So anything can happen to them because those people don't have enough knowledge. [Take a deep beathe] Alrigh…..t. [Clear throat] you said where did you have your first baby?*

R: "2006"

F: *In the hospital?*

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R: [noded positively]

F: *Ok! This one where do you intend to have this one?*

R: "In the hospital"

F: In the hospital? Ok! At least you've seen the importance of the hospital.

R: " Yes"

F: *Ok! [Clear nose] Em…..m! what are ……..tell me one good reason why you prefer to give birth, to dey born your pikin for hospital?*

R: "Because one, when you……when you have pregnancy, when you come to register, they will register you, they will take care of you till that time will come, that you will put to birth, that is why I like to go there, then anytime you have maybe you have headache, anytime you come to them, they will take care of you that is why I so much like hospital [noisy background]"

F: *Thank you. [Taking a deep breathe] ha….ve you made plans for this delivery, arrangement on ground, money transport in case it happens in the night since you've taken decision to born in the hospital?*

R: "No, when the time comes my husband will have the money, God will provide the money for us. When that time come, because my husband is working."

F: *Noisy Background [Breathe Release] do you know that sometimes pregnant women might need blood during delivery or something?*

R: "Yes I know"

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F: *Eh…..hee! Is there any plan on ground should in case, am not….., we are not praying for it, it may not happen?*

R: "NO..."

F: *No? Ok! [Drawing Nostrils]*
What can you tell us, your experience was like in the first delivery during pregnancy, during delivery, what was your experience like? You said you had your baby in the hospital, how did you find the hospital, the care by nurse and all that?

R: "Th…………e, my labour start, that was on the……, on the nine May, two thous…….an..an…d six, then aro….und 9 nine O'clock in the evening, in the night, so my mother took me to the hospital, I was there….., because I was having power, strength. They say he……ey! It will not…….., k…a…I ! it will waste, take time. I will not soon put to bed. I was the……re….o! people that

were inside in labour room, all of them they put to bed, I was then the only one that did not put to bed. Then, I slept there in that place two days…….Th…..e n..e…xt da…..y, the nurse now refer us to big clinic in ogoja there in my place. Then we went to the place around, around…., ok! that was on Saturday in the night. Then the next day Sunday in the morning, then the doctor told me that the baby is too b….i…k [big] I cannot put to bed so they will do me operation then I told the man there no trou…blem, if God say then that be the way, then I…..am……am ready. Then they took me to the place they say they should dress me, dress me, take me to de……..e….mm….., eeee! How do they call this place…..?"

F: *Theatre?*

R: "Theatre, because when I went, I…………enter the place…..eee! infact I experience many things inside there but I have the mind. They say I should sleep, I sleep. They ……Dr asked me…..Cecelia, can you pray? I say why…? I Can pray, [breathing] imme…diately I open my mouth to pray, imm..e..dia..tel..y I say 'IN Jesus Name', I pray", they remove the baby. I shout "Je…sus" that is what I shout. Infact I was….Nurse…i….i d…i..e, there in that dream that I was dream, I….. dream about my grandfather, then I told him "Papa", this place is very nice for me to stay", the man say "No, my s…s.., my daughter, this place is not for you, go back", that is when I come back for life. So that is my experience in my first child."

F: *Ok! [Breathe in] Thank you very much [Draws in nostrils]. Where you come from Hm…m…, Is there any belief or practice that they say if you carry belle do not do this, no chop this, no go this place. If you born pikin make this person no come and all those practices and beliefs?*

R: "[Jump in] y..e..s..now!"

F: *Wait there.....Make we hear them.*

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R: "Like in my place, Hmm! When, when you have pregnancy, they will say….., when somebody have put to birth. Maybe your….yo…ur mother is not there where you born, they say don't go there…..o! when you go to that place you will miscarriage, she d…., then in my place we have, they say d..o..n't e..at b..e..a..ns…….o! they say if you eat e..e..e..h, drink custard or Akamu, it will make the baby to be large inside your tummy."

F: *In your….., where you come from, where do people generally like going to deliver? Is it in the home, in the church, is TBA or in the hospital?*

R: "Some they went to hospital, some they used to deliver in their home, some churches".

F: *Ok! who takes decision where you will born for you house! Is it your husband or yourself or your mother-in-law? Who dey decide the place where you want born pikins?*

R: "Is myself o! even my husband"

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F: *What kind of help and support your people dey give you when you carry belle like this or where you dey carry pikin? Your husband, your relations, your mother-in-law, your husband's sisters and brothers. Is there any kind of support they like giving you during this time?*

R: "Like my mother-in-law, she's very very caring. So when I went to her place because we are not from the same place with my husband, she takes care of me, she give me all my needs, she will……, sometimes when I sit down, she will ask me…."Cecelia what is the problem, are you annoyed?" I will say "no mummy I am not annoyed, it's because of my condition". She will say "please don't do face like this". No! The woman is very very good to me. She takes care of me very well."

F: *Ok! thank you [nose in drawing] In the community where you stay here, is there any group put in place where be say if labour start or you get any problem, your family people no dey, they come in and help and support but it is the community form them. Is there any group like that?*

R: "No"

F: *Ok! what do you think as a woman [paused and draws nose] women can come together and do or government can do in the hospital, so that every woman would want to go to hospital go born not to go church or house again. What is your advi....ce.?*

R: "Eh…h…h! Government should help them maybe they will change, they will they will change their lives so that they will……maybe anytime they want to put to bed, they will come to the hospital. Maybe some time, they don't have money that is why that... they are afraid to come to the hospital."

F: *But in this state, treatment is free, delivery is free, they don't collect money (noisy background), so do you think is the money that is the problem?*

R: "I don't know for them…..o..o! like myself I don't like to……."

F: *[Music distraction] But what do you advice, what do you think like advice?*

R: "Mma…..my own is that anyone that wants to put to birth should come to hospital and deliver that…….to help yourself and your baby inside."

F: Thank you v…e…ry much cecelia.

OBSERVER'S COMMENTS:

- The respondent was nervous while responding
- Respondent's phone rang and caused distraction

- The Respondent had Communication problem. The Respondent find it difficult to response well in the local language and the common pigin English which were used during the interview. This was because she was married from another state and brought down to the research community by the husband.

RESPONDENT 6: 015 (PREGNANT WOMAN)
IDUNDU COMMUNITY
DATE/TIME: 9/5/14 (4PM)

INTRODUCTION BY THE FACILITATOR (as above)

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F: *Sister Alice……Em….m…m!.....please I want you to share with me, those signs you know about, that can bring problem to a pregnant woman during pregnancy or when she want to deliver or when she is nursing a baby. That if these signs are present, they are not good for that woman and will not be good also for the baby in the womb?*

R: "[Paused] ok! Aunty it is only that…..because I want to talk about like my own, when this pregnancy started me, it really disturbed me……so it worried me too much that I told my husband to carry me to hospital. So he said I should go to a TBA but I said he should bring me to the hospital. So it worried me so much that I came to hospital and saw the nurses. They gave me medicine and also gave me a day to come back to the hospital."

F: *What was this problem,……what was this problem?*

R: "The problem was that since when that pregnancy started I was really sick, I was sick real sick, whatever I put in my mouth, I will vomit, It did me somehow, somehow in my body, was really sick."

F: *Apart from the your own problem, do you have an idea about those signs that you know that could be bad for woman that if she is pregnant and she sees those signs or when she wants to deliver those signs presents? Other signs?*

R: "[paused] those signs?.....those signs are that, a woman who is pregnant……that….if pregnancy starts her……..she will feel as it is in her body, so she should know……h…e…m…, as you would miss your period, she should look for her way of how you should get up and find your solution."

F: *[paused] ple….a..se…, do you know the benefits that follows a woman who delivers in the hospital….., those benefits…..benefits that are there for a woman who goes to the hospital to deliver?.*

R: "The benefit that is in the hospital is that when you deliver your baby, that first day you deliver, they will come and give injection because there are some of our women that deliver, and they don't remove Odon [Tetanus] from their body so when they see that your have your baby, they bring themselves in, they carry their hands and touch that baby so that things will harm the baby..... bringing death to that baby [noisy background]"

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F: *[Drawing nose] pause…Eh….m..m! what are those problems that can follow a woman that goes to deliver at home and not go to hospital?*

R: "[paused for a while] The problems that could follow such a woman…….because there are many many...... things are there that a TBA can……, there are leaves, if labour is difficult that they can take and give you……give you……you chew….so that you deliver fast because some…….some of these our women are afraid that when they go to the hospital and labour is too difficult they will take them to theatre and operate them, there are problems, and problems that women fear about operation, fear small knife."

F: *Hmmm! But if they go to the home (TBA) what kind of problems could occur? What are those problems that can happen to them in TBA's place?*

R: "Because Hospital is good, if you have your baby, there are some TBA's places that collect from you more than ten thousand but if hospital, if you register in the hospital, they will not collect from you as much as a TBA would, they make it easier for you because it is under government."

F: *What are those problem….problem…problem [Emphasy for clarity] that can happen, bad things that can happen to somebody who delivers at home, that is what I am asking concerning TBA's place?*

R: "Problems….[.looking for words to use]. It is that, some things the TBA does not know, if they bring you to the hospital, the hospital will help."

F: *[paused – deep breathe] Is this your first pregnancy?*

R: "No"

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F: *Ok! In your first pregnancy, where did your deliver?*

R: "I delivered in a TBA's Place"

F: *Ok! Emm…m! [deep breathe] this one, where do you intend to deliver?*

R: "Mummy, even if it happens in the hospital, I will deliver there because I have registered and all my things are intact in the hospital. If incase it happens in a TBA's place, I will also deliver there with TBA".

F: *O….ok! what is the reason why you [Draws nose] think that if it happens in the hospital, you deliver in hospital, if in TBA, you deliver in TBA? Why don't you have the main place that want to say ok! this is where I want to deliver, and prepare towards that?*

R: "[Paused] Mummy is not that on my own….because like my husband, it ….can happen like that and he……may decide to take me to a TBA, but I keep telling him I want to deliver in the hospital and keeps saying TBA's place".

F: *Ok! what are your reasons for wanting to deliver this one in the hospital?*

R: "There are benefit and benefits that if you deliver in the hospital, the baby will be given help, will be given injection, the baby will not be sickly, some sickness like measles will not do him and other kind of terrible sicknesses will not affect the baby. There are benefits."

F: *What are your preparations towards this hospital deliver by keeping money, preparing by buying baby's things, in preparing in case labour starts at night since you want to deliver in hospital, this person will carry me to hospital or this motor will carry me or this machine is available for me. What kind of preparation do you keep on ground?*

R: "Preparation is that as I am pregnant, I have started buying my things and kept, my husband has not yet given me money to buy things and keep but when it is time he will buy what he wants to buy, he will give me money to start buying baby's things and keep small small."

F: *[Deep breathe] what kind of experience did you have in your first pregnancy that you carried, during pregnancy, during when you went to deliver. How the TBA took care of you, how……what kind of experience can you tell another person about pregnancy, a woman carrying pregnancy and to deliver?*

R: "Experience that I have when it started it pained me but not much. It pained me and tortured me….., I went to the TBA's place and stayed and stayed there and delivered my baby, there was no problem."

F: *Were you taken care of very well there? How did you see the care there?*

R: With low tone…."They took good care of me" (noisy background)

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F: *What kind of thing in the community that you are from or where you live, that is kept as laws that pregnant women should do this or that or if a woman is nursing a new born baby. She should not do this or that eh….eh! should not eat this or go there or do this or that those kind of laws are they there where you come from or lives? What are those laws?*

R: "There is none like that"

F: *Are the no laws like that, that says don't eat this, don't do this, don't go here during pregnancy, nursing period?*

R: "Laws that are there when a woman is pregnant…. They say she should not eat beans, not drink tea [Phone distractions] should not eat somethings that can make a baby big in the belle, so that on the day of delivery, it may not be difficult."

F: *Ok……e y !! That beans make labour difficult?*

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R: "[Smiles] things and things that makes baby big...."

F: *Eh…he..ey !! [Draw nose] O..ok! In the community you come from or where you live, where does most women like going to deliver?*

R: "Most women…eh…eh! Some women likes going to deliver with a TBA , some likes going to deliver in the hospital".

F: *[Draw nose] Ok! who decides where you go to deliver, like you are saying that husband say I should deliver here, but I want to deliver here. Where you are from, who is the main person that decides, that what ever, that is what everybody stands by? Who decides, saying, "my wife will deliver here". Is it husband, you or mother-in-law?*

R: "Hmm! Mummy because I am under somebody I had decided delivering in hospital but wherever he says, I will stand by that since...., because I will cross my hand over his head since he is the head of the house."

F: *[Paused.....Draws nose……Takes deep breathe] what are those help that people in your house……give to you……., during pregnancy or when nursing and are in the hospital?*

R: "My Husband's sister gives me cloths and also render some help since my mother-in-law is not there, my father-in-law is not there. They are my mother-in-law, they are my father-in-law."

F: *[breathe release – draw nose] As you are here, when you will deliver this your baby, who will look after the other child you have at home? [readjusts, draw nose.....pause] who will look after the child you will leave at home when you go deliver……..when you deliver?*

R: "My mother is there"

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F: *In the community you come from or where you live, Is there any community group that is formed by the community, that if a pregnant woman has problems even if she is not from your family the members of that group will go and assist her in money or in taking her to hospital or in rendering support to her especially if her people are not around, during pregnancy or when labour starts unexpectedly?*

R: "There is none……o…o! unless it is……the community members cannot render help unless it is the group you belong that will have love to assist whenever they hear you have problems before they carry you there."

F: *Like what type of group can be that in your community?*

R: "These groups that acts as contribution group, if they have love, they will carry you saying that you are their member, full member of theirs before they do it. As you used to see them do to people."

F: *In your opinion, what do you think could be done, for that women……what can government do……., what can women in the community do to make every woman like to deliver in the hospital so that deaths could leave our communities. What do you think can be done in your thinking?*

R: "[Paused] The government…..,the govt should render help for pregnant women, the government should give pregnant women drugs so that they can be healthy, the baby in the womb can be healthy too."

F: *So now, don't they give drugs in the hospital?*

R: "They give"

F: *Then many women don't come. What else do you think can be done in addition, that whoever hears will rush to tell her friend, to tell about, that everybody….., every road leads to the hospital, saying "if not in hospital, I will not deliver". What do you think in your own opinion that if done, can make such things happens that every woman likes going to the hospital to deliver?*

R: "Because there are some woman who likes hospital and some who don't like hospital to deliver. They will say "Since they were born, their mother never gave birth to them in hospital and they too will have their babies at home".

F: *So no matter what is done, they will not come. Is that what you are saying?*

R: "…….Is not every….body,….because I am not in their minds to know, I only know myself.

F: *O…O..Ok…O! Mma Alice thank you. I will come to you again thank you.*

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OBSERVER COMMENTS:

- Noise at the background distracted the facilitator and the Respondent.
- Respondent was not certain (confused) while responding about where she will deliver her baby.

RESPONDENT 7 – 017 (NURSING MOTHER)
DATE/TIME: 9/5/14 (5.20PM)
COMMUNITY – IDUNDU COMMUNITY

INTRODUCTION BY THE FACILITATOR (as above)

F: *Please can you let me know those signs that if a woman who is pregnant or who wants to deliver sees it will be known that it's a bad sign which can kill the woman. Do you know such signs?*

R: "Y..e..s……..I know, because as all those children I born, it is whenever……when….when I, it is time for me to born the baby, water used to come out first before but in this particular child, it was blood that came out first, blood came out plenty that I said "God what could cause…….be like this"? I went and told somebody who advised me to come to the hospital, I was told that it was labour. So that particular sign made me to know that…..that is not the normal kind of labour."

F: *Blood to come out?*

R: "Blood to come out because I have never seen before."

F: *Do you know about those benefits that follows women if they go and deliver in the Hospital?*

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R: "I know because…..those things……those things…..those things, you will have knowledge about those things you never knew about. Like me…..like me, the children I used to born, after delivery, people….they will teach me how I am to stay, while in the TBA house……, those friends that deliver their babies with the TBA, they don't used to tell them any knowledge they gain from there, but if it is in hospital, like health center, Anyanganse I used to attend, the used to teach us knowledge, upon knowledge on how a woman should stay or how to take care of her baby."

F: *What are the problems that can befall women who go to deliver with the TBA. Problems they could see, that could befall them because they go to the TBA and not hospital [noisy environment]?*

R: "Problem…..problems that can befall them when……..wh…e..n they go to TBA is No1… they can deliver without the placenta coming out . No2 they can be………they can labour with suffering for long without delivering. Then when you go to the hospital, all….when you see…the nurses and the doctors will test you and know all the problems….,all those small problems since when you were pregnant from one month to seven months onwards, they will give you drugs…..some drugs…., because TBA only knows enema without knowing what the problem is inside one's body"

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F: *Where do you deliver your children?*

R: "I used to deliver in the hospital. All my children I deliver in Ediba health centre"

F: *Ok! this baby you deliverd in Ediba too (noisy background) long paused?*

F: *Tell me why you also decide to deliver in the hospital?*

R: "Why I like hospital is because I have benefitted from the nurses, I have also benefitted from doing….and taking care of babies, because when you have trust

in hospital when pregnant, they will tell you know to take care of your baby, then hospital, hospital will make all my baby's things to be very clean".

F: *(Paused)…whenever…..you are pregnant and wants to go and deliver, do you always prepare yourself in money, baby's things, or who will take you to the hospital in case labour starts unexpectedly in the night or in case the need blood in the hospital, have you ever made such preparations? Have you ever done those kind of things?*

R: "E..e..yes…I used to do because when you go to TBA's house, TBA will not tell you to buy baby's things and keep, TBA will not tell you that, but when you ....you go to the hospital, they will always tell you to be prepared in case labour starts unexpectedly in the mid-night."

F: *What, what type of…….[looking for words] experience do you used to have in your deliveries. You said you have been delivering in the Hospital……, what are the experiences you can tell other women, that would have them go to deliver in the hospital too? Experience during the pregnancy delivery, the way nurses look after you ....o, take care of you…..o! what are your experiences?*

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R: "I used to bring back…..bring back blessings home, and used to tell other women, tell my friends that if they are pregnant and go to hospital, they will feel happy in themselves and will also see benefits because the education and teachings that the nurses will give you, TBA will not give you that way, TBA will not give you. One of my friends had said she will join me there."

F: *Are there any laws in your community that forbids a pregnant woman not to do this, not to do that, in food …..o! or in what to do or in where to go….o! Does that kind of law exist in your community?*

R: "It is not there….o! where I come from. It is only there where my baby's father come from only. There is no law in my place only in my baby's father place".

F: *What law is in your baby's father place, tell me.?*

R: "E……e..eh! What is in my baby's father place is that you don't use…..you don't use red thing, anything that is red, also you don't eat things like pork, you don't eat ….em…em different different kind of meat that he counted for.. for…. So there are many many laws in his place, you can't even count."

F: *What is the reason why they say one should not eat those meat?*

R: "Because…..beacsue, his place, it is forbidden to eat those things, so one has to act according to the how their laws is."

F: *Where you come from and where your husband is from, where do women like going to deliver most. Is it in the hospital or TBA's place?.*

R: "In the hospital. Where I come from, we believe in hospital, their place too, they believe in hospital, then because why….TBA only does things at home, she doesn't have what government has."

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F: *In your house, who says this is where you have to deliver, in a hospital, in a TBA, is it the husband that takes that decision, is it the woman herself that says she will deliver in hospital or is it her mother-in-law or husband's siblings?*

R: "All of them….All of them wants hospital, husband…., all the children I deliver in the hospital, even my husband goes to hospital, me too I go to hospital, any small fever that comes, we talk about hospital".

F: *What type of help does your husband, mother-in-law gives to you when you are delivering your babies or when you are pregnant?*

R: "Since I used to be pregnant, he used to give……all of them gives me a great help, that is why I used to get pregnant every now and then (She laughs)…..They used to give me happiness in the house, whatever you are

doing, they will help you, they don't allow things to overpower you, then when you have the baby too, they will be doing great things for me and also help me always."

F: *When you have delivered who takes care of those children you leave at home?*

R: "My senior Sister. All those children are lagos now".

F: *So where you come from or live, Are there any group or organization kept in place in the community that takes care of women who develops problems even when the husband is not around or other relatives, that group enters and assist by taking her to the hospital, or assist in monetary aspect? Do you have such a group in your community?*

R: "In my place, there is no group than church, no organization than church. We all rely on church, then nothing happens to anyone of us unexpectedly."

F: *(Paused) In your opinion, what do you think can be done in our hospitals, what can be done for our women, so that all our woman around like to deliver in the hospital than going to the TBA?*

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R: "I….I…..to me, in my neighborhood, as I am going back…….or going to hospital I used to call home that I am in the hospital, I also used to tell them what happens in the hospital whenever am discharged home, then there was once I was given mosquito net in Ediba, I took it and showed around to my people and they were all happy that anytime they are pregnant, they will join me to know where I used to attend clinic and receive treatment. They use to think that I attend idundu clinic. It is only now that I don't have transport to go to Ediba health center, that I now attend clinic in idundu health centre."

F: *So does Idundu clinic not also give net and these treatment?*

R: "They do. But where I used to work, Ediba health centre was closer."

F: Ok! thank you mma Blessing. I will visit you again so that we continue on the 2nd phase of this study together.

OBSERVER'S COMMENT

- The Respondent is knowledgeable about the importance of going to hospital during delivery.
- The Respondent was confident on sharing her experience.
- The correspondent was not feeling too well.

RESPONDENT 8 – 019

Pregnant Woman, Idundu community

TIME/DATE: 10/5/14 (9.20 AM)

FACILITATOR'S INTRODUCTION (as above)

F: *Salome [rain disturbing at the background] Please, you will let us know what you know about those signs that if a pregnant woman has, or somebody who wants to deliver….if it happens to a woman who wants to deliver or nursing mother, she knows that those signs are bad signs, that if she does not rush to the hospital to see doctor, that she might loose her life, do you know those signs, do you know signs like that?*

R: "Madam…..i think those kind of signs that some one can see that can be bad signs during pregnancy… sometimes, one can notice bleeding…, I think that is a bad sign or water coming out of a pregnant woman's body, she has to rush to see a doctor."

F: *Please do you know those benefits that follows those women who deliver in the hospital? Are there benefits at all? What are the benefits?*

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R: Benefits that accompany women who deliver in the hospital is that hospitals looks after them in terms of injecting them and giving drugs and in loo……king….after the women and the babies they deliver. They look after them in the hospital than in the house.

F: *What are those signs …….bad…si….gns, that can….or bad things that can happen to women who goes to deliver with a TBA or in the church or house?*

R: Those bad signs that can happen to women who deliver at home are that you can deliver that baby at home, …..because you did not attend anti-natal in the hospital, they don't give you injection. Some twitching problems used to affect them, also Nwanga (Yawning) can happen to them. Secondly, also that can….bad person can come in….., somebody who had delivered a baby and suffers from [akpa] comes in and touch the baby, and the baby dies, that is not good.

F: *[Drawing in breathe] Is this your first pregnant?*

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R: The second

F: *Ok! Where did you deliver your first baby?*

R: I delivered…..at the teaching hospital

F: *[Drawing in nose] Where do you want to deliver this one*

R: I will deliver in the hospital, in the Idundu health centre, why because the other hospital is far.

F: *[paused] draw in breathe, why do you prepare and decide to deliver in Idundu health centre. What is your main reason for wanting to deliver in the hospital?*

R: The main reason that I want to deliver in the hospital is that I like hospital due to how in the hospital they look after somebody. Secondly, in the hospital, I have been given a list for me to use at home to prepare for hospital delivery.

F: *[Noisy Background]. Eh….mm! when one is pregnant, she knows she will deliver one day, what kind of preparation have you made in terms of money or buying of things or in case labour starts unexpectedly at night. What preparations have you made on ground before the day of delivery?*

R: "I have to keep money knowing that labour can start anytime unexpectedly, buy things and keep those things to be used in taking care of the baby, I have to prepare, buy them and keep in place so that when that day comes, I can bring them to hospital".

F: *It should be that you have been hearing that some people needs blood during delivery, not everybody, sometimes during pregnancy, they see that she lacks blood, even in the hospital, you can be told that you will need blood. Have you ever had such thoughts, saying" what if I need blood". God forbid we are not saying that kind of thing should happen. That this is the person I would want to donate for me, if need be. Have you made such arrangement?*

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R: "He…e…e..m! I think they can take blood from my husband."

F: *[Drawing in breathe] H..n…mm!*

R: "It can be bought from the hospital"

F: *You said you had delivered one child before and that this pregnancy is the second. What kind of message can you give to other people concerning your experiences in the previous pregnancy, during delivery. What were your experiences in the hospital, how you were taken care of, how you felt, how it was with you, during that first pregnancy?*

R: "I…….Used to tell them that home delivery is not good. " Delivery in the hospital, it is good because after delivery, they take good care of your baby". They can take the baby from the mother and go and put…….e..m..m..m!.....madam, I don't know how they call that place.

Then they will give that baby injection, immunization, and also give the mother injection. Giving birth at home, sometimes you can give birth at home and you start bleeding so much, the TBA may not be able to endure. Hospital is good because they will give you injection, give you tablets, look after both the baby and mother too".

F: *Where you come from or in your husband's community, or your real community, Are there those laws that says when you are pregnant, don't do this, if you are nursing a baby, don't do this, don't eat this, don't go there. Are there such laws? If there are……what and what are they let us know?*

R: "No….o! I have not heard such laws".

F: *Ok! In the community you come from or where you live, where do women like going mostly to deliver? At a TBA, in the church or in the Hospital?*

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R: "Some people go to hospital, some go to church and some to TBA."

F: *Which do you people like going most?*

R: "TBA's place is where people like going most".

F: *Why do you think people like going to TBA's most?*

R: "I think it is due to lack of knowledge that makes them go to TBA"

F: *Ok! During pregnancy or your previous pregnancy, what……who are those that decide in your house and say "this is where you are going to deliver" your husband, you or your mother-in-law or your husband's sibling or your siblings?*

Who are those that take decisions saying" this time, you are going to deliver here"?

R: "Like in my own during my first pregnancy. My husband really warned that he does not like home delivery. That anytime it happens and he not around when I get there I should call him that he will come".

F: *Ok! what kind of help does your husband give to you during pregnancy, when nursing a baby or those who are living with you or mother-in-law or your husband's relations or your relations. What kind of help do the render to you?*

R: "My husband used to assist me since it is not a man's duty whatever he can, he used to assist me. My mother is person who really assist me".

F: *As you leave home or as you will be going to deliver who do you think...., who will you leave the other baby to look after you at home?*

R: "My mother will look them after for me".

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F: *In the community you live or where you come from, Is there any group formed by community, like an association, that are there to look after pregnant women or look after those who deliver newly in case people are not around and labour starts unexpectedly at night, then they rush and pick a car to assist. Such group like that.....owned by the community. Is there such?*

R: "Madam, I have not seen. In my community, there is none".

F: *[Paused] Em....em ! In your opinion as a woman that you are, you know that it is not good or women to keep dying during pregnancy or delivery. What do you think the women in this community can do, the doctors, the nurses or government can do, to really ginger women to long for , to go to hospital to deliver, without going to TBA homes again. What do you think can be done?*

R: "I think they should be sending letters out to different churches to tell women to be going out to hospital. Some of them think hospital money is always too much. I think they should be sending letters to churches to tell them if any woman is pregnant, she should go to hospital that they don't collect money, because it is due to lack of knowledge. They think that hospital used to collect money. That is what I think in my idea."

F: *Salomi, please you have done so well. I am pleased. Thank you for giving us your time.*

OBSERVER'S COMMENT

- The Respondent was fetching water from the rain; hence both the Facilitator and the Respondent were distracted.
- The Respondent was open in her conversation.
- Poor knowledge of hygiene (fed a child with unclean utensils)

RESPONDENT 9 – 023, Pregnant woman
Anyanganse community
TIME/DATE – 10/5/14(11.22pm)
FACILITATOR'S INTRODUCTION (same as above)

F: *How are you?*
R: *Fine*

F: *Ok! please you will tell me those signs that if they manifest in a pregnant woman or woman or a woman after delivery, they will know that it's a bad sign and can take the life of the woman. They will really know that it is a bad sign, ...if it happens to a pregnant or a woman after delivery. That it is not good if it happens to a woman during time of delivery or after delivery?*

R: "If something happens to a woman…..a pregnant women when she is pregnant or she wants to deliver, she feels weak or excessive bleeding comes up or it is that……em….m…m! delivery that is there to help or that somebody can

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see….that no one can help from there, they can take her to the hospital for them to help her, so that she will live and child will live."

F: *What are those good things that goes with one who, a woman that goes to deliver in the hospital, those things that are good…., why it is good for a woman to deliver in a hospital?*

R: "[paused]why it is good for a woman to deliver in the hospital……., the reason is so that immunization she used to go and take or the teaching she gained from the hospital, so that she may go and deliver there……so that if labour becomes difficult, she can be given injection or drugs, so that she can deliver easy, that woman deliver fast in a way that she will live".

F: *What are those bad things that can happen if a woman goes to……those bad things that can happen to a woman who goes to TBA to deliver not hospital to deliver?*

R: "Those bad things that can happen to a woman who goes to the TBA to receive treatment……and not go to the hospital, she then goes to TBA to deliver her baby, then the placenta refuse to come out or it remains and this TBA does not know the type of leaves…or type of leaves to give to this woman for the placenta to come out. It is there that the mother used to die and the baby lives [Baby distracting] or mother dies".

F: *Ok! Do you have other children? Is this your first pregnancy?*

R: "No. this is not my first pregnancy"

F: *Ok! the other pregnancy, where did you deliver?*

R: "The other pregnancy, I delivered in a TBA's house".

F: *Is this the second?*

R: "This is not the second but the third".

F: *All of them, you delivered with a TBA?*

R: "I delivered in a TBA's house and not in the hospital".

F: *This one, where do you intend to deliver?.*

R: "This one [Paused] be…ca…use I …..since I have never delivered in a TBA's …….[mixed up words] in a hospital before, I will deliver in a TBA's place".

F: *Ok! what is the main benefit you have seen from this TBA's place, that you deliver all your children there, you like to go to deliver at a TBA's place?*

R: "The benefit I have seen is that…if I go to the hospital, or the hospital is not close to me…., if I go to the hospital to deliver the baby, and there is no body to assist me, to bring things to me…..then reason I go to deliver in a TBA's place [Baby disturbing]".

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F: *Are you aware that when one is pregnant she used to make preparations about that baby, she prepares in terms of keeping money, buying baby's things or preparing by arranging motor vehicle so in case labour starts unexpected at night or machine that will take you to place of delivery, sometimes you keep somebody who if blood is needed, he donates………God has forbidden? What kind of preparations do you always make when you are pregnant towards the baby you will deliver?*

R: "Preparations that I used to make when am pregnant concerning my baby…saying my time has gone far…from there I stand and consider that my time has gone far…., it is for me to enter and start buying baby's things like clothes or powder, I buy baby's things and keep, so that if baby is delivered now, they can bath and use those things on it, use soap on the baby and powder

the baby, so that if somebody comes to visit or carry the baby, the person can do that".

F: *In other children that you used to deliver at the TBA's place what are those experiences you have had at the TBA's place. What are your experiences there that you can tell other people saying "if you go to TBA's place, it is good" what can you…….eh…eh! your experiences during pregnancy, when you went to deliver, in care upon care and how was it with you. What are those experiences you can share with us?*

R: "[Breaking]…..what I would like to share with others,….that is…or..if labour …., or pain in the lower abdomen…. Or ….maybe that where she intended going to…, hospital like that…….she walks there…..or that money is going to be too much, then they can now tell her…."Let's go to TBA's place because they don't collect much money as others collect."

F: *What type of laws are there in your community or where in your community or where you live that says if you are pregnant don't eat this, don't go there, when you deliver….don't go there, don't do this. Laws like that……Are there such laws in your community. What are there?*

R: "Such laws are not there in my community ….o!"

F: *Who used to say "Go and deliver in the hospital or go to TBA and deliver". Is it your husband that says, Is it you or your mother-in-law or your husband's siblings or who?*

R: "Is not my husband that says, my mother-in-law is dead, my father-in-law is dead. So am the one that likes going. Infact, my father's sister is a TBA".

F: *What type of assistance does your husband and your…….mother-in-law use to give to you when you are pregnant or when you deliver, or your husband's*

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siblings or those living with you? What kind of help do you get from them during pregnancy and delivery?

R: "During pregnancy and delivery, they used to……if I go out and leave the children behind, they look after them knowing that they are their brother's children. They take care, giving them things, bathing them [Baby crying distracting] when am not around".

F: *If you ………e…e….e…eh labour start now who will look after your children amongst those that are in the house with you?*

R: "If labour start now, it is their father's sibling that look after them for me".

F: *where you live or in your community, Is there any group or association that is a group of only women or women and men that exist, that the community formed in case labour starts any woman who is pregnant and her people are not around, they can help and take care to the hospital or help in taking her for check up or bring out money to assist her . Is there such group in your community?*

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R: "Such group exist but am not a member"

F: *What is the name?*

R: "They call "NKA IBAN" (WOMEN'S GROUP)"

F: *Why don't you belong to such a group since they used to give assistance?*

R: "As I don't belong, is because my ability is not up to that....!"

F: *Do they contribute money or what do you they do?*

R: "They sometimes contribute money if it is the turn of a particular member, they contribute and give her gifts, household items".

F: *That's g..o..o..d. Ok! In your own opinion and in your thinking, what do you think is the advice you would give to be done in our hospital so that woman would like to go to the hospital to deliver?*

R: "In my…….own thinking, am…am….i would suggest that they should give advice, the line of advice I mean…….In some hospitals, there is how somebody goes to deliver and the hospital bill will be too big. So I want to say they should bring down hospital costs".

F: *Now that hospital is free. They do not charge money. Why don't women go?*

R: "Like now that it is free, but women don't go, it is because some of them do not know about that".

F: *Thank you my friend*

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OBSERVER COMMENT

- The Respondent's baby was crying and distracting both the Facilitator and the Respondent during the interview.
- Unaware of the free MCH care services provided by the government
- Refreshment would have help to make the Respondent give more attention during the interview, since she complained of hunger and she needed to cook.
- Exhibited more confidence on TBA than hospital because she has delivered in TBA about five times without any problem.
- The Respondent is also living with a TBA Step father.

RESPONDENT 10 – 024, Nursing Mother
Anyanganse community
TIME/DATE – 10/5/14 (1pm)

INTRODUCTION BY THE FACILITATOR s(as above)

F: *Please tell me those sign that if they occur when one is pregnant or goes to deliver or delivers, they occur and its know that those signs can take a woman's life away?*

R: *" Those signs that can occur that can take a woman's life are excessive profuse bleeding can occur, labour could start without the baby moving in the belle, Labour can last up to one week. Those kinds of things can take one's life".*

F: *I believe you are aware of those benefits that can follow a woman going to deliver in the hospital under the care of qualified nurses. What are the benefits that follow a woman going to deliver in the hospital?*

R: *"The benefits that follow a woman going to deliver in the hospital are that, in the hospital, when you go, when labour pains you too much to the extent they see that it can take your life, they have a way of saving your baby's life and your own life too".*

F: ***[Pause]*** *what are those things that can threaten people's lives when go to deliver in a TBA's house not hospital. What bad things can happen to them in TBA's house?*

R: *"Those bad things that can happen to them are that they can deliver....., after delivering the baby comes out while the placenta does not. Those kind of things can cause a woman to die".*

F: *[Drawing in Nose] Is this your first baby?*

R: *"No.....o!"*

F: *Where do you deliver your babies?*

R: *"I delivered one of my children in TBA's house and two in the hospital".*

F: *The first one, you delivered in a TBA's place, then later you decided going to the hospital to deliver the rest.*

What was your reason....., why did you decide to change to be going to the hospital?

R: "That………that it's be…..ca….use labour can pain you t….i…..ll…. after when you have the baby, after having the baby….., you can become breathless and die. That is the reason. So I see that the hospital is better than a TBA's place, that is why I started going to the hospital".

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F: *When one is pregnancy, (hold baby's hand, she is distracting) she used to make preparations so that when baby comes or labour starts, by keeping money, buying baby's things, arranging for transport in case labour starts at night or things like that. What kind of preparations have you been making whenever you are pregnant towards the coming of the baby, some people used to make preparations apart from arranging for transport, concerning blood in case it is needed, arranging for a person who will donate. Here you ever done such preparations? If you do, what type of preparations do you used to do for all these children you have had?*

R: "I have never made preparation concerning blood but I have made preparation ……….. firstly, I used to buy pampas and keep, buy pad that I will use and baby's things and keep for the day baby will come".

F: *In all these children you have delivered, what kind of experience do you derive from being pregnant, delivered…………in all the children you have hard. What experiences have you gained concerning pregnancy delivery and nursing a baby?*

R: "I have derived a lot of experience about delivery and nursing a baby, one is that, like………I can be………… because the first time I had a baby, I had no experience. The second one I delivered, I had experience concerning caring for baby, personal hygiene, washing baby's thing very clean and taking good care of the baby. Immunizing my baby whenever due".

F: *Ok! Who decides where you are to give birth? Your husband, yourself or your husband's people, or your mother in-law ?*

R: "Like my husband decided that I should deliver in the hospital and no more at home".

F: *What kind of assistance do they used to give you. Mother in-law, husband, your relations, those who live with you. What kind of assistance do they used to give you whenever you go to deliver or pregnant?*

R: "My mother in-law used to help me when I have a baby, she will cook food and bring to me that same day, bath my baby and bath me".

F: *Ok! In your community or where you live, where do women like going to deliver most?*

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R: "This community prefer TBA's house more".

F: *What laws are on ground in this community that when one is pregnant, she should not do this, eat this, go here. When one delivers or is nursing a new born baby. What kind of laws or beliefs are there where you come from or live?*

R: "When one delivers newly, she must not be quick to eat…………(looking for what to say)………there are no laws……..o! "

F: *Not only in food alone, also in action or one coming to visit or……….. or maybe where you go to. Things like that?*

R: "Like when a baby is born newly, they don't always allow people to visit, like a person with "Odon" (tetanus) should not visit the baby until everything is healed in a baby's body. That is the kind of belief we have in this place".

F: *Whenever you go to deliver, who used to take care of other children in the house for you……… I mean whenever you go to deliver?*

R: "I don't have anybody that takes care of my…………….. that looks after my children for me…………….. I look after them alone".

F: *You used to take them to the hospital you go to deliver?*

R: "Ye…………….s"

F: *I mean those children you leave at home?*

R: "Ok! Those I leave at home, their father looks after them".

F: *In your own thought and opinion, what do you think can be done, hospital people, doctors, government, what should be done so that women would like to go and deliver in the hospital and leave home delivery. What do you think can done to encourage women to go to hospital to deliver?*

R: "Am saying that the doctors, all big people should come together……….when they come together, they should call all the women in the community together and tell them that the hospital is better than TBA's place, they should also educate them and when they are well informed, they will decide to start going to the hospital ".

F: *Comfort, thank you.*

OBSERVER'S COMMENT:

- The Respondent knows the important of going to hospital

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- The Respondent was in hurry to go and pick her son from school.
- The Respondent needed money before signing the consent form.

Respondent 11 – 034

Pregnant Woman – Idundu Community

Date/Time – 10/5/14(3.20pm)

FACILITATOR'S INTRODUCTION (as above)

F: *How are you. Please we will take a little of your time with these questions. I will not take your time. Please can you discuss with me those signs you know about which of it happens to a pregnant woman or a woman who delivers a new baby or who is nursing a baby, that it could pose danger, that it can take the mother's life even that of the baby?.*

R: "One of the dangerous signs during pregnancy that can cause danger is bleeding from the body and if the bleeding should continue without doctor or whatever……..it's miscarriage, then the second one is fever, as in when the person is having fever…………..fever comes up very strongly or she has lower abdominal pain or waist pain like that so there are bad signs. Then swelling of the face and legs also contribute".

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F: *Thank you. Please what…………to your own thinking, what are the important things or the importance of a pregnant woman attending hospital or clinic when pregnant or when she wants to have her baby, rather than go to church or eh – eh….! traditional women?*

R: "e…… eh! One of the important thing…….the important thing for pregnant women to attend ante-natal in the hospital to meet with the doctor is one, so as to take her T……….that is Tetanus and also know the position of her child and the doctor will also, will also………and (lack words)…………as in those things that can be harmful and how to take care of her body. So the important thing is that the pregnant women should always attend ante-natural in order to know the position of her baby".

F: *What are the dangers of having a baby at home and not going to the hospital or in the church?.*

R: "O oh! The dangers are: one, the Traditional Birth Attendant might not really know the infection or ………what to inject the baby. They don't inject, the only thing is after delivery they only do what they are supported to do………but they won't inject the baby neither the mother and in case something……… in case bleeding occurs after delivery, they………they………they won't have…………, there are some of them that do not have the knowledge of stopping that bleeding and this can lead to death. So these are the dangers".

F: *(deep breadth) is this your first pregnancy?*

R: "Yes mma "

F: *O – Ok! You've never had any other one. e……e……..emm-m! whe…..re……do you intend to have this baby when the time comes?*

R: "Well………, is at the hospital. Already, I have registered".

F: *What is your reason for choosing to have your baby in the hospital and not in the church and not at home, and not with the TBA?*

R: "So as to protect my baby's life and mine too".

F: *(Pause) take a deep breadth. E.. em…m! Tell me…, ha…ve you made plans about, since you want to deliver in the hospital, pregnancy and arranging for transport in case it happens in the night and maybe your husband is not around or somebody how will follow you to the hospital. Those kind of preparations……..or even going as far as preparing for blood in case it is needed…… God forbid, it may not be needed but sometimes it is good to arrange and prepare in case, so that it wont be eh….eh….eh! as….. you kno…..w….., taking you unawares. Is there any form of arrangement in keeping of money, buying baby's things, preparing, arranging for somebody who will follow you to the hospital, someone who will carry you to the hospital or to the clinic if it happens in the night, in case your husband is not around such preparations please share with us?*

R: "Yes...s mm…a……ah. I have prepared…. I have prepared. First and foremost, I have gather the baby's items, all the items (emphasizing) ready and I have also had those things that is needed during delivery like cottons, some materials for pieces and the rest of the things. Then about someone that will follow me to the hospital, I have also arranged. My Mum is there, my younger one is there,

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then……… and my husband is also there in case it happens but the one I have not arranged is that of blood, the whatever………….whatever……….because I know it will not occur".

F: *Th-ank you. I know this is your first pregnancy so you don't have any past experience about how pregnancy is, how where you had your baby was………, how they treated you. But at least, I believe you must have been hearing from people, that this is how pregnancy is – o! this is how delivery is oh! If you go to TBA……… this is how they care for you – oh! If you go to hospital this is how………… Some people try to compare notes. Please can you share such……….some of those experiences you've heard with us?*

R: "Oh! Like during birth, delivery, I have been told that there….. is the labour room, that…….. I have been told that is always, labour is always painful. But no matter how painful it is, you must learn to endure, then you must also keep to the nurses or doctors' instructions in the labour room in order to protect your baby".

F: *Then, apart from that…………, what are those em…m…..em! in your………….where you…………..., the community you live here and where you came from, what are those practices that are forbidden, they say customs, beliefs, don't eat this, don't go there when you are pregnant, when you have a new baby, don't allow this, don't do that. Some of those things exist. What…………what are…………can you tell us about the ones that you have encountered or exist where you come from or where you live?*

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R: "Well, I have always heard of the one they say if you have a baby………., you shouldn't expose the baby to people, you shouldn't allow people to visit the baby until the cord is healed. Or after circumcision, you shouldn't allow the people to visit the baby in order not to harm the baby, and like once I visited one of my friends, my aunty, she …………she………. Was tying black thread across the baby's legs, so when I asked her, she said that it is for prevention, that it will help to prevent the baby from being hurt since the naval and the cord…………as is not healed. Then about the type of food, any persons, like as I am, people have been encouraging saying I shouldn't take starch, I shouldn't take beans, those things that help to build up the body and that I

shouldn't………….., there are things if am to follow…………. I won't take anything, I don't listen to them, I eat everything".

F: *Ok! Pause. E……….em…..mn! in your community or where you live here, generally where do many people like to go to have their babies?*

R: "Well, most persons like giving birth to their children in traditional health care".

F: *In your family, who takes decision on where you have to deliver. Is it you, or your husband or your mother in-law or whoever?*

R: "Well………., is my husband "

F: *Em---m—m! Tell me a little bit about the supporting roles your people,…………..your husband, how he supports you during this time, during………… your mother in-law, even your mother, your brothers, sisters, those living with you?*

R: "My, my husband, though does not have parents, he is an orphan but he has been playing his major role……….like helping me in the house……., sometimes in the morning, he will tidy up the house before going to work, fetch water for me. He's………..he's stressing everything. Then my….my….parents are, my mum always render that motherly help to me and my father also and my younger ones, they….. they've been so good to me".

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F: *Em---mm! Now, in where you live or even in your community where you come from, is there any group formed by the community, that could be of an assistance to pregnant women if they are sick and their people are not readily around or help those who are having babies newly in case they need help. Like a community group, they come together rendering such help, and they are formed by the community or maybe labour starts in the night, they bring transport or they bring money if your people are not readily around. Is there any group like that in the community?*

R: "O – oh! I…….. I………. don't really know because as I am, to my own, its only my neighbours at where am living, my neighbours, they render help to me, then beside them is my husband and my parents".

F: *Precious, on your own what is the contribution, what is your own idea, what do you think, the woman of this community can do, how can they come together, what initiative can be formed so that the women encourage one another that it is most important to go to the clinic to deliver, so that we can prevent problems*

that can arise, causing the death of our mothers and the young babies. What is your own advice, your contribution, what do you think from your own side, can be done amongst the women in the communities coming together, initiative, what can be done, so that women are encouraged to be coming to the hospital?

R: "Well, the women in the community should always…………should…………should have a particular group. Then always………….be……..as in……………be discussed based on delivery and along the line, they………. They………… shouldn't……………they should stop listening because I know some of them, it is not really their fault, giving birth to a child in traditional houses, is not really their faults, rather it's the fault of their mother in-laws, their parents, so, they should make sure they avoid such advice, they shouldn't listen, so they should form theimselves and everything in this life is all about determination, and determine not to visit such places for delivery in order to protect their babies' lives, so they should form, they should determine also that whenever anything like this happen, am going into the hospital in order to have my full treatment."

F: *Thank you so much. So who do you think should be members of this group that should be formed. What if this group is formed and the majority of them are those who like going to TBA and they rather encourage others to go. What…………what do you think should be constitution of this group? Who and who should be in this group to be encouraging other women and telling the women about the goodness of going to the hospital and clinic. Who on your own do you think should be members of this group?*

R: *"Well………., of the group……………the head or leaders should be a person from the hospital, from health centre, from clinic, a medical doctor who understands much about delivery in the hospital and health. So he should be the one to encourage this women of delivery……… about delivery in the hospital. Ok! For now, I know that the……. Health care personnel that is here in this community, has been trying her best, sometimes go around, giving health talk, giving health education to the people that they should come to the clinic, but at the end they won't come".*

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F: *So do you think that……., and they are visitors, they are posted here from the ministry of health. Do you think since they have been talking and nothing is done, do you think if membership is formed from the members of the community, it will not do a great deal of good? Because if members are those coming from this community and community members know that this is our people and these are the same people telling us that "it must be hospital", don't you think that they may listen better? If that is the case, who from the communities should be chosen to form this group? Who do you think the women will listen to in the communities?*

R: "Well, the community prime minister the traditional ruler can gather a meeting in either the health care centre and then during the meeting, he will then ask the health…….. as in the health personnel to address the women on what to do. Then it should be done under their agreement. So the community traditional ruler should gather all the pregnant women, all the health personnel will address them. "

F: *Thank you very much precious.*

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OBSERVER'S COMMENT

- The Respondent is knowledgeable on the important of hospital delivery.
- The Respondent pointed out that most women patronize TBAs due to family and in-laws pressure
- The Respondent does not have someone to support with domestic work at home.
- The Respondent was complaining of Headache during the interview

Nursing Mother – Anyangase community

Respondent 12 – 027

Time/Date: 10/5/14 (5pm)

FACILITATOR'S INTRODUCTION (as above)

F: *Tell me those signs………..signs that if it happens during pregnancy, during delivery or during after delivery in a women, it will be something that may take the life of the woman. They have to urgently take her to the doctor. Hmm! ?*

R: "Like bleeding…………ble…….eding. bleeding can make someone to urgently look for doctor. When one is delivery, after delivery, blood rushes out, that would make them to rush the women to the hospital to see doctor".

F: Pause*. What are the benefits that follows a woman who goes to deliver in the hospital?.*

R: "The benefit that follows a woman who goes to deliver ink the hospital, because like that bleeding if she bleeds after delivery, she will be given injection (baby distracting) for that bleeding to stop."

F: *What are those problems that can happen to those women that goes to deliver in a TBA's house and not hospital to deliver...Those problems?*

R: "What makes women to………."

F: *Those problems that can happen to a woman at the TBA's place (emphasizing) that she went to deliver?.*

R: "Ok! Like……..as it could be that the baby could be such that the woman should be operated, if she goes to a TBA's place, they will not operate, if she is not rushed to the hospital……………..so, they have to rush her to the hospital so that if that baby is to be operated, they can operate and remove the baby alive".

F: *Are you nursing a baby or pregnant?*

R: "Am nursing a baby"

F: *Is this your first child?*

R: "The third one"

F: *The third one. Where do you deliver your children?*

R: "I used to deliver them in Idundu health centre"

F: *Ok! (Pause – takes a deep breadth) why do you like delivery in the hospital? The main reason.?*

R: "I like………. I like to deliver in the hospital because I used to deliver there without having any problems. Like if you have any problem and inform them, they will give you drugs. No problems at all, you will deliver your baby safely and take home without having problems because if there is any problem, they will solve.. "

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F: *When one is pregnant, she used to make some preparations and arrangements for what child that she, will deliver, buy things, keep money, plans for emergency in case labour starts at night, some will even make plans for blood in case it is needed, the person that will donate for her. Things like that. Have you ever make such plans whenever you are pregnant?*

R: "I don't use to plan – o!(child disturbs)"

F: *You have never planned, keep money, buy baby's cloths, planning for transport?*

R: "I…………….. I used to…………….. I have planned. Whenever am pregnant, I used to plan for money for delivery, everything, also buy the things the hospital gives me list to buy. I will buy and keep so that when labour starts, I take them to the hospital".

F: *What can you say about the experiences you have during delivery because you have children, pregnancy, what kind of experiences do you have from pregnancy, delivery and nursing a baby?*

R: "(Pause) Aunty please I don't understand"

F: *What I call experiences. Do you have any experience………… or what are the experiences you can share with others concerning pregnancy, experience of delivery. Like this are my experience because I have had children before. These are my experience....?*

R: "The experiences I have during pregnancy,……………… I used to go to hospital and deliver. I have delivery experience, …………..when am in labour pains, I go to hospital. Experience………… I have delivery experience".

F: *What are the laws or beliefs kept where you come from or where you live…. that says don't do this, don't eat that. If you deliver a baby, don't do this, don't look that. Those kind of laws are many from community to community. What types are in your community or where you live?*

R: "(Pause) those laws – when masquerade comes out if one is pregnant one should not look, like food when one is pregnant like these mangos, they used to say when you deliver, do not eat so that the baby will not purge. That is what they used to say".

F: *Women, where you live and where you come from, where do they mostly like to go and deliver their babies.?*

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R: "Most of them like going to TBA's house in this community to deliver".

F: *Ok; (Pause and take in breadth) who decides in your house, where you go to deliver? Your husband that decides or is it you that decide or your mother in-law or your relations?*

R: "I used to decide. My mother in-law too used to decide".

F: *Ok! What assistance do they give to you……… Your husband, mother in-law, your husband's people, your people whenever you are pregnant and when you deliver. What kind of assistance do they give to you?*

R: "When I deliver, they used to boil water and bring to me. Cook food and bring to me and also render other help."

F: *Ok! Who used to look after other children when you go to the hospital to deliver?*

R: "My mother in-law used to look after them for me".

F: *In your community or where you live, (baby cry distracting) is there any community group that is made of men or women that if your mother in-law is not around or your husband is not around and labour starts may be in the night or there is nobody to rush and assist you, they come and help you in terms of money or transport. Is there such a thing in your community?*

R: " There is none……………there is none".

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F: *In your opinion, what do you think can be done to improve hospital, making it better for women to like going there to deliver?*

R: "I think like in the hospital, they have to make the nurses to be around always. Nurses that are there should be around. Because when I went to deliver my second daughter's pregnancy, I registered there and did everything and collected number. When it was time for labour, I went there, I saw no nurses, not even one. When I called, this one will one will tell me "I had come and gone" and the other one said "I am gone. I then had to go back home. So, the nurses must try and be in the hospital so that any time one is in labour and is taken there, they can see nurses".

F: *Thank you so much, my friend.*

Thank you ver…..ry much.

OBSERVER’S COMMENTS

- Respondent was distracted by her baby
- The Respondent is knowledgeable on the importance of hospital delivery.
- The assurance of confidentiality make the Respondent to be open to the Facilitator during the interview.

Nursing mother

Respondent 13 – 028 . Anyanganse Community

Date/Time – 11/5/14 (10 am)

FACILITATOR'S INTRODUCTION(as above)

F: *What are those signs that if it happens in a pregnant woman or one who delivers newly or a nursing mother, they know that it is not good, those signs are not good. They have to look for a way to see the doctor, if not so she may die or the baby dies?*

R: "Mummy……..it can be that because she went to deliver with a TBA, blood comes out, or after……… she or when it is time, that pregnancy…….. or that baby needs to be operated, they have to find out………..and see the doctor".

F: *What are the benefits that follows one who goes to deliver in the hospital. What are the benefits that are there for one who does that, go to the hospital to deliver?*

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R: "The benefits are that the person may go,………… because she can go to the TBA’s place, on getting there something happens that you would have told the nurse, you can tell the TBA may not know. Any problem that you have and tell the nurses, they must know".

F: *What type of problems can unexpectedly happen to a woman for going to a TBA’s place to deliver and not go to the hospital to deliver?*

R: "Mummy, it can be because it may be that she does not have somebody who will be taking food to her. TBA’s place is nearer, she has to enter there and deliver".

F: *Are you nursing a baby?*

R: "Yes"

F: *Is this your first baby?*

R: "Nodded positively"

F: *Ok! Where did you deliver?*

R: "I delivered in a TBA's place"

F: *(Long pause) why did you decide to go and deliver there?*

R: "Why I went there to deliver……….. because I didn't have someone to bring food to me in the hospital and the TBA's place was closer (baby cries distracting)"

F: *(Pause) re-adjusted) draws in breadth) when one is………pregnant, she used to make preparations, also buy things and keep money, and say this person is to bring me food, this person is to take care of me, this person is to be visiting me. Such preparations did not take place?*

R: "Yes mummy (implying no) "

F: *As you were pregnant and delivered your baby, what experiences do you have about delivery and pregnancy?*

R: "Mummy I have experience that during pregnancy, when it is time to pregnancy, I have to go and meet……….. eh! eh!, I have to go to the hospital. When it is time for delivery, I also have to go there. When it is time to inject the baby, I take it there for injection".

F: *Ok! Where you are from and where you live, what type of laws and beliefs are there, that says when one is pregnant, should not do this, or should not eat that, should not go there, when nursing a baby should not do this. All communities have such laws, what are those laws in where you live or come from?*

R: "Mummy, there are o! There are. They say, they used to say when one is pregnant, should not eat beans, things like………… There is also as you go to deliver, they don't allow people to enter anyhow because of things that people carry, like Odon (Tetanus)".

F: *(Pause) where you come from and where you live, where do woman like going to deliver most?*

R: "Mummy, they like going to TBA's place"

F: *In your house, who used to say this is where you have to deliver when you are pregnant. You or your husband or your mother in-law or your husband's siblings?*

R: "Mummy, my husband "

F: *Ok! What kind of assistance does he give to you, they give to you when you are pregnant or when you deliver at home?*

R: "Mummy, they used to assist me…………, buy baby's things, also know that they have to bring me food".

F: *Ok! Where you live, is there any association that is formed by the community that if one is pregnant like you, or any woman at all who is pregnant, may be the husband is not readily around, her people not around, labour starts unexpectedly or anything happens they bring out money or look for a way to bring motor to assist her to the hospital. Is there such a group?*

R: "In my place, such group is not there ...o!"

F: *In your own opinion as a woman, that don't also want women to die while pregnant again, what do you think can be done in the hospital – doctors, government, community people, hospital people could do so that women could like to go and deliver in the hospital and stop patronizing TBA'S places?*

R: "Mummy, government has to inform everybody to come out……… because is not everybody that know that hospital is good. Government has to inform them that hospital is better than TBA, many people don't know".

F: *In the community, apart from government and the nurses, what can we do at the community level to help co-woman to prefer going to hospital?*

R: "Mummy, we have to go and inform them that hospital is good, that is what and what they do in the hospital. Go to the hospital stop patronizing TBA's".

F: *Thank you very much.*

OBSERVER'S COMMENTS

- The Respondent lack home support.
- She was cooking food and also was washing her baby's clothes before the interview started.
- The Respondent complained of distance to Hospital, no one to take her down there during delivery, but can easily work down to TBA which is closer
- The facilitator needed to finish fast so that she can release the Respondent to continue on her domestic chores.
- The Facilitator also helps to bath the Respondent's baby to show her support to her.

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Pregnant woman – Idundu Community

Respondent 14 – 029

Time and Date = 11/5/14 (12noon)

FACILITATOR'S INTRODUCTION

F: *Please tell me those signs that if you know about, that if it happens to a woman when pregnant or during delivery, or after delivery, that they are very bad signs, that if that woman does not see a doctor urgently, she might die?*

R: "Those signs………..water used to enter somebody like that………,, and they will take it to doctor, doctor will know what to do".

F: *Water only?*

R: "Hmmm! Water and bleeding".

F: *What are those benefits that are there in a woman delivery in the hospital?*

R: "The benefits are that, in hospital is good when one delivers, they will know the injection to give the baby and also to give the baby and also to give the mother. That is why people go to the hospital".

F: *What bad thing can happen to a woman who goes to TBA's place to deliver and leave the hospital?*

R: "Hmmm! Because like that serve bleeding, is not everybody that knows………..like those who go to TBA's places, or some are afraid that they don't have money for hospital, so they like going there".

F: *Are you a nursing mother or pregnant?*

R: "Pregnant "

F: *Is this your first pregnancy? Which no of pregnancy is this?*

R: "The third one"

F: *Ok! The third one, where do you deliver your babies?*

R: "Those other two I delivered at home "

F: *TBA's house ?*

R: "Yes"

F: *This particular pregnancy, where do you want to deliver?*

R: "I want to deliver in the hospital "

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F: *Ok! Why do you decide that you will deliver this one in the hospital while you delivered the others at home?*

R: "Becau…..use……..like the first thing that happened to me…………..I delivered that my first baby, my baby did not cry nor moved. They said it was water that choked it. But I used to see in the hospital as they do if one delivers a baby and she does not cry. They used to put something into their mouths and suck the water out. It was by the grace of God that my baby cried".

F: *Ok! (Pause) e – e- e – mmm! When one is pregnant, she used to prepare, keep money, arrange for motor that will take her to hospital. Now that you have decided to deliver in the hospital, in case labour starts at night unexpectedly. Some people can say "if blood is required, this person will donate for me". They make all that arrangement, keep money, arrange transport, machine and keep. Such preparations have you done for yourself?*

R: "Aunty, I have not done – o! but I will consider doing that".

F: *Please, since you have children before, what experiences do you gain for yourself in pregnancy, or having had babies before. What kind of experiences have you gained?*

R: "I know that the experiences I have is that labour can be painful and I also have delivery experience. Those are the experiences I have".

F: *Please tell me the experiences comparing TBA and hospital that you now intend going to* deliver?

R: "Hmmm! Hospital is better than TBA's place, because when you deliver they will give you injection and know what to give the baby (baby crying in the surrounding)".

F: *Where you come from, laws are there and beliefs that says if a woman is pregnant, she should not do this, when she deliver, should not do this, should not eat this, should not go there. Do you have such laws in your community?*

R: "They are not there".

F: *Where you live and where you come from, where do women like going to deliver most?*

R: "In the hospital"

F: *Who in your house decides where you are to deliver, your husband, you or your husband's people or mother in-law?*

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R: "My husband"

F: *What kind of assistance do they give to you when you are nursing or pregnant or thing like that or when nursing a baby, when pregnant, what kind of assistance do they give you?*

R: "They used to prepare food, fetch water for me, boil water for me to bath".

F: Ok! Like this pregnancy, when you go to deliver, who will look after the other children at home for you?

R: "My junior sister"

F: *Ok! In the community you live, are there any association, that if your husband, mother in-law, your people are not around and labour starts unexpectedly, they maybe come to assist you, with money, with motor or machine or rush and assist you before your people arrives. Is there such a group of women or men?*

R: "Aunty, is not there – o!"

F: Ok! In your opinion, what advice can you give to the community women, churches, hospitals or government, or what can be done to encourage women to deliver in the hospital and not TBA's places, so that there will be no more deaths?

R: "The advice is that…………..since it is that hospital is good. Many people used to die in a TBA's houses. As I have now heard, I will tell my other partners, my friends like that, who are pregnant to go to hospital".

F: Thank you my dear.

OBSERVER'S COMMENT

- The Respondent is unaware of free Maternal and child healthcare services available in the community.
- The Respondent find it difficult to communicate well during the interview
- (Behavioural Change) The Respondent took her decision to deliver at the hospital and knowing the importance of hospital delivery.

Respondent 15 – 035

Nursing mother (Idundu community)

11/5/14 (2pm)

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INTRODUCTION BY THE FACILITATOR(as above)

F: *Good morning. Tell me those things that if a woman who is pregnant sees or who is about to deliver, if she sees these signs, will know that these signs are not good ones but bad signs that goes with a pregnant woman?*

R: "Those signs ……………as I know…………..are that …………..(she sighs) it is not good for a pregnant woman to see blood………………..to see another blood, that comes to bleed her again. Also, if she experience high fever, very high fever, or small small sickness like that, I think they are not good signs when a woman is pregnant".

F: *Please you will t…e…..ll, and tell me why it is good for a pregnant woman to go to hospital like health centre. Why you think that it is good for a pregnant woman to go to hospital either when she is pregnant or when she is nursing a baby or during delivery?*

R: "It would have been good for a woman to go to the hospital when she is pregnant, because they will look after her, take good care of her, check her, she goes for check up, they will advice her, give her dates to be coming for check ups. They check her well well, whenever she has problems they give her some drugs, so they take care of her well, so it is good for one to go to hospital when pregnant."

F: *Thank you very much. Tell me those signs those bad things that can happen to a woman who goes to deliver at home like this TBA's, that are here in our communities?*

R: "Those bad signs that follows pregnant women, that delivers at home especially bleeding, there is a way a woman delivers at home bleeding starts, she bleeds and bleeds more than she should bleed normally, whereas in the hospital they would have rushed and stop the bleeding then the TBAs have no knowledge and no drugs to………., except………..some of them even leaves in the bush, they don't really know well. So I think that…………..eh…………..eh (she sighs) women should be going to the hospital to deliver than home".

F: *Please, is this your first baby?*

R: "No, not the first"

F: *So, tell me where you used to deliver your babies?*

R: "The first one – e, that first one I delivered at home, the second, I delivered in the hospital".

F: *Now that you are preg…..…nant, this pregnancy you are carrying where do you want to deliver?*

R: "I also want to deliver in the hospital because I saw the benefits".

F: *Who………… where and where and do you………….. like your first child, you said you delivered at home, the second one where did you deliver?*

R: "Hospital "

F: *So this one you are carrying where do you want to deliver?*

R: "Hospital"

F: *Just tell me why y…ou agree that you want to deliver this one in the hospital?*

R: "Because I saw the good that he hospital did on that day. My first labour was very difficult that even I saw suffering and secondly my husband did not agree again with my another, he said I should live her because she is also in that line of TBA………..infact my grandmother. So……..my husband said I should go and deliver in the hospital. This one too, he says I should also deliver in the hospital".

F: *We know that a pregnant woman used to be in preparedness, one of these preparations is means of transportation, should labour starts unexpectedly. So tell me the preparations that you have put in place as its concerns means of transportation?.*

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R: "Means of transport ?"

F: Transport, like machine or motor or taxi ?

R: "Have done no preparation for a thing like that ".

F: *Apart from means of transportation we know a pregnant woman, sometimes used to………., if the husband siblings come to the house leaves a little thing in your hands, something like money we know also that sometime mango can fall and she says let them sell that mango so that she can use that money and care for her baby. So concerning money, still preparation, preparing you are………..how are you, how have you prepared yourself about money.*

R: "Well there is a small care that I contribute and keep saying that when it is time since I have no assistance except my husband. I sa….y when it is time, when I carry, I used and be in the house and use to help myself and myself."

F: *We know that, sometimes it used to happen that a woman went to deliver and there is no much blood enough in her. Hospital will say let them buy blood, some say do you have somebody who can donate blood to for you….. be it your husband, your sibling or her husband people. We are not saying that such a thing like that will happen, you as a pregnant women. Have you made, have you done such preparations?*

R: "Hmm! I don't have such preparations because I don't even say it should happen to me".

F: *Since you have delivered children before, you said you have two. Tell me, us those signs, those lessons, those……….that is called in English language "experience" that you had when you were pregnant, when you delivered the first and the second and when you were nursing?*

R: "When I was pregnant tho….se, well is not like when I was, was not pregnant because when I was not pregnant I used to be strong, stronger than when I was pregnant. When I am pregnant, even a baby is better than me (she laughs) eh….eh….eh! Experience that I have about when am pregnant is that I won't be able to work again as when I was not pregnant".

F: *In this community, you are living we know that different communities have different laws – saying a woman who is pregnant, when it is up to five months, you must not go and weed farm, you should not do this and that. So where you live, tell us about such laws if there exist?*

R: "There are laws b…..u…..t…., yet there are laws kept, especially as regards to foods, when pregnancy progress far, they say don't eat such and so foods, don't eat beans, don't eat eggs, don't take blood medicine again so that the baby may not be too big, that………., they say things like that, those things that can cause the baby to be big, like pap, they tell you not to drink so that the baby may not be too big. That is the experience we have here".

F: *Mma Sarah, you have said that you have many children, so it means you have been here in this community for long. Where do you see the women of this community like group to deliver their babies most. It is in hospital or TBA?*

R: "They are more in a TBA's house than hospital – o! in this our communities."

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F: *Thank you. In your house, who is the person at the head who decides that this is where you have to deliver. Who takes the decision, is it you, your husband or your mother in-law?*

R: "My husband takes the decision".

F: *In your house, now that you are pregnant, what type of assistance does your husband, his siblings, your mother in-law gives you in times like this?*

R: "My husband has no sister, no father, no mother. It is only me and him so my grandmother is there, that's all."

F: *So now since there is no other person tell me the assistance your husband gives to you?*

R: "He tries in his power to support by helping me in food, baby's things, care. He tries as he can to support me, encourage me to go to hospital, he tries persuading me and assisting me to go for check up."

F: *As you had your first baby, when going to have the second, who looked after that first one at home?*

R: "My first child, my grandmother was there and she used to help. This second one, I had waited for the first one to grow before and was able to care for herself".

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F: *Mma Sarah, in this community, is there any group formed by the community that in case labour starts a pregnant woman unexpectedly and the husband is not around that group is obliged to assist those pregnant women even nursing mothers?*

R: "I have never seen such groups – o! is not there"

F: *Now that you are a mother, you had mentioned that during your first delivery, it was somehow, the reason you supported hospital delivery for the second and even this third pregnancy. You have experienced labour in TBA's place and in hospital. What do you think women in this village can do to assist co-women to see the need to come out to the hospital when pregnant, delivery or nursing a baby, to stop our women and babies dying, because studies have shown that many women have died at TBA's homes than hospitals?*

R: "People are different. Eh! Since people have different minds and reasoning, sometimes due to what they keep hearing, they develop fears about going to the hospital not knowing that hospital is better. So………..i don't know what to do

for them to turn up….o! because they already have enjoyed TBA's place to deliver than hospital".

F: *What if you are asked to go and tell chief to do this or that for women to go to hospital to deliver. What would you have asked chief to do to encourage women go to hospital when they are pregnant and when they want to deliver.*

R: "Well, our women like gifts too much. Maybe small gifts could be given to the chief to give women who turn up in hospital so that they follow the gifts and come out."

F: *Mma Sarah, thanks so much.*

OBSERVER'S COMMENTS

- The Respondent lacks birth preparedness (Pregnant woman)
- knowledgeable about the importance of hospital delivery.
- The Respondent noted that fear of hospital procedures is one of the factors that make pregnant women not to go to hospital during delivery.
- She suggested Incentives and gifts to motivate women to attend clinics.

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Respondent 16 – 04 (Folder B)
Anyanganse Community (Nursing mother)
13/5/2014 (9.34AM)

FACILITATOR'S INTRODUCTION (same as above)

F: *Mma Blessing please tell me signs that if a pregnant woman is seen with these signs, it will mean that they are not good signs, that it can bring bad things to the pregnant woman. Please tell me?*

R: "Like……..is these signs if a woman is pregnant, maybe she is not sma…., smart or she is so dull. But some people since……….is not all people that is like that, they are some people that are like that. Not all people that are like that, those signs that they used to known that maybe she is feeling fine or she can go to the hospital or she can do………and so on and so on."

F: *If a woman is pregnant and she goes to the hospital what benefit can one say, she will receive from the hospital?*

R: "When she is pregnant and goes to the hospital, it will be good because they will eject her immunization and give her small drugs that she will use and take. From they when she use the……., the drugs will be good to her and she will the benefit, she will see some improvement in her body. Mmm…"

F: *What do you think if a pregnant woman, goes to the TBA's place. What bad thing do you think can happen to such or pregnant woman ?*

R: "Li….ke……, that woman, if a woman who is pregnant goes to the TBA's place, some can deliver some maybe....... may have a problem that they need\ to rush to the hospital".

F: *Like what problem ?*

R: "Some it can be that it may be that she needs operation or she has another problem in her body and that TBA cannot do it."

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F*:* *Please is this your first child ?*

R: "No "

F: *Number what...?*

R: "Number three"

F*:* *Where do you deliver your children?*

R: "I deliver them in the hospital "

F*:* *[Take a deep breath] this hospital that you used to go I believe is nurse that used to take care of you ?*

R: "Mmm [implying Yes]"

F: *Why do you like going to this hospital?*

R: "I go so that…….because………..of that immunization that they used to inject. Because that immunization used to be good they also give those small drugs and takes care of you whatever……..however it is with you, you tell them".

F: *We know that as a woman everything in this world lies on preparation. A pregnant woman used to be in preparation so what preparation did you make especially about some thing....., something like means of transportation. Saying my husband's friend will carry me or this my husband's sibling will carry me or my sibling, concerning transport, what preparations did you make?*

R: "Ah……..before that day is complete you have to know. Before it enters that month that is your month, before your month is complete you have to prepare yourself. You have to have transport, sometimes your husband is not around or your husband's friend is not close by you need to have small money for transportation that you will use and pay the transport to where you want o deliver, then later on you can call, they can make call. Or if it is some that they say your husband has a car you……let know early so that he will come and carry you and drop you at the hospital."

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F: *Which means that there is need also for preparation concerning money?*

R: "(answered immediately)that one is so. Eh---eh. The husband, before that day your husband has to keep small money so that the day that that thing starts they will carry and use."

F: *Even though I believe that it did not happen to you. We know that some women when the time to deliver draws near, they used to bleed too much to the extend that they say they should look for blood and put her. Did you make such*

preparations. Saying if it is needed so..so.. person will give me. Did you make such preparation?

R: "No I did not do and it did not happen too"

F: *Thanks be God. What the whites calls "experience" like knowledge that people used to say "kai the knowledge that I had". Like what experience did you have, when you were pregnant.?*

R: "(Smiles happily). Hmm…. Me right from my pregnancy, when am pregnant I don't used to feel anything say like we…. ak or they say……, I used to do things from a month, one month till it reaches the complete month I used to do something. I don't felt sick, I don't feel anything even when I go to the hospital I used to work both in the farm in the hospital. I used to work without feeling anything. I don't feel like say….. even it does not seem to me that am pregnant. I used to feel more normal."

F: *(Asked immediately) What about time for delivery?*

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R: "My time for deliver I used to born at once "sharp" one two three. I don't waste time once I enter I have to delivery."

F: *In this community that you are. Tell me things like……things like laws that they say when a woman is pregnant she should not do this not do that, not do this, not go there, not eat this?*

R: "Mmm……when a woman is pregnant, they used to say like….she should not do, should not carry things that are too heavy, eh…eh what is too heavy. She should not put on her head something that really press her too much so that it does not press the baby in the stomach. She should not…..drink, eat…….beans, ogi, like……that or even one takes eat she should be used to that eat".

F: *Since this is your third child I believe you been here for long (Takes in deep breath) where can you say that these women really used to go to deliver whether in the hospital or TBA's place?*

R: "TBA's place for….this ....o... because we were not living here, we were living first at town we just came and lived here in the year two thousand and eleven. As I came and saw.... used to see that this side people really like the TBA's place".

F: *Alright where they deliver who is the one that takes decision when you are pregnant whether your husband or your mother in-law?*

R: "My husband used to….to look after them when I deliver his mother comes eh…comes she also used to carry me and go but while…..as she carries me so is my husband that takes care".

F: *So is your husband to decides where you are to deliver? So please tell me the assistance that your husband's siblings, your mother in-law, your siblings and your husband, the different assistance that they used to give to you even when you are nursing a baby now?*

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R: "[Takes in a deep breath] you know all families are not like all families o because some there are some in-laws that does as if she/he has seen you and there are some that does as if she/he has not seen you. So I like this my own when I deliver, they used to welcome very fine eh…..when my mother in-law takes me to her place, she used to take care of me and assist me in some things but later on because I will come and go to my place when I stay there a little so when I go to my place I now become the one that does all the things alone eh….eh…. [Baby disturbing]but they used to come and visit "

F: *Since you said that this is your number three child. Your children, your other children, your other children, those two, who took care of them when you went to delivery this one baby?*

R: " Oke…..y, they were with my husband's mother"

F: *Ok, in this community that you are do they have anything like an association that they say this association takes care of pregnant women should in case it happens unexpectedly, this association can go and help?*

R: "Have you seen such thing, have not seen, what I used to hear is that they do is like……say an association that is like contribution they used to come like that, that is the only thing that I have seen but if say that women help others I have not seen. So this aunty come….last week and told me that day was Tuesday so I wanted to come but rain stop me from coming that day so I could not come again".

F: *We know that pregnant women have died a lot especially on the day of delivery ?*

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R: "It is so ..."

F: *And that many of them that have died, die at the TBA's place, like you said, bleeding starts and the TBA does not know what to do, the baby does not lie well she does not know what to do. So I believe in truth that you would want this kind of thing to stop. So what do you think that if they do this, it will help women so that once they take in they will look straight to the health centre even if while she is going she sees a TBA standing on the road, she will close her eyes and say it is the health centre that she will go. What do you think that if they do it will help women.[Baby disturbing]?*

R: "Ok…..ey, it is….to…..that is so…if there is ability, the nurses and the doctors come here and look for a place and open the place. But even as they will open so is not……some people is not very body that will be used to……some people here will not…….even their men tells them to go, they will not go, some will have fear because I have heard some women say that they will not go to the hospital, all those things that they say…. I will like very much if God makes

them to open that place that is closer so that it will be once you leave your house, you enter it would have……. it will be very good."

F: *Mma Blessing thank you very much like we said when we look for you we will call you.*

Please thank you.

OBSERVER'S COMMENTS

- Baby was distracting the Respondent during the interview
- The Respondent was tensed during the interview
- The Respondent complained that far distance to the hospital and clinics make most women to choose to delivering at home.

Respondent 17 – 03 (Folder B)

Anyanganse Community

Date 13/5/14 (11.15am)

Nursing mother

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INTRODUCTION BY THE FACILITATOR (as above)

F: *Mma Helen good morning , please can you tell me those signs that if a woman is pregnant, they stand and look, is like to look and see that paw-paw that was green turns to yellow or ripens and they say "that pawpaw is ripe O" those signs that if a woman is pregnant and those signs show forth, they say that those signs are not good signs that they are signs of bad things and that they can bring death to the woman or baby or even miscariage?*

R: "Those signs......(looking for words to use)...., because if one is pregnant and one stands and see they can come and tell her "or you are pregnant she can say either yes or no because some people used to say they are not pregnant she can say she is pregnant or if one is pregnant they can come and say let her go to the hospital especially maybe if she is pregnant and some things comes out of her body like rashes like that or those, they are things some that used to come out of one's body. So they come and tell her to go to the hospital and when she goes

to the hospital, they will inject her immunization that they used to give to pregnant woman and also give her drugs because it can be that one is pregnant and is sick and they take her to the hospital and give her drugs in the hospital".

F: *Tell me those bad things that can happen to a woman especially during delivery who goes to the TBA's place to deliver ?*

R: "Bad things that can happen to a woman who is pregnant. A woman can go to the TBA's place and when she got there she meets a TBA who is not a good TBA who is not strong if God does not assist her she can go and after going cannot still deliver, she can deliver either you die or your child dies which is not good. So that is why people used to go…..like this me I did not go I went to the hospital right from when I took in, right from one month I started attending hospital and I also went and delivered in the hospital."

F: *Please tell me is this your first child?*

R: "Yes, this is my first child"

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F: *So that means you delivered this child in the hospital?*

R: Mm….. (Meaning yes) I delivered in the hospital""

F: *Meaning you were attended to be a nurse?*

R: "Mm….. I was attended to by a nurse "

F: *Please tell me the reason why you went to the hospital to deliver ?*

R: "Why I went to the hospital to deliver because I used to hear since when I was not pregnant…they say that hospital used to be good. When you go to deliver they will take care of you well and also treat your baby if there was a problem, they will give you……do your body well and your baby when they finish….pay money and you go. Because hospital is very good suppose it could be that you

went to the hospital to deliver and if you could not deliver, they can operate you or put you any force drip..., hospital is very good I like it".

F: *We know that everything in this world depends on preparation. One has to prepare, so when you were pregnant please tell me those different preparations that you made especially concerning transport saying when labour starts this my husband's sibling will come and carry me or this my husband's friend will come and carry me. Then concerning money, whether you used to follow and do card contribution like some women do and some follow and sell small things so tell me, the type of preparations that you have made?*

R: "Well i did not have….since…..am……I don't have what am doing, the only preparation was the day I want to go the hospital, my husband's sibling has machine and I will tell him come and carry me to the hospital and he will carry me and drop. There is also some days that if I want to go, I have money….o, I will pay transport and go because I cannot be that we will go to the hospital, they will write the day that you will come back, when they day reaches either you are sure that you must go, you must look for money and keep preparing before that day, so that when the day reaches you will go to the hospital."

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F: *Since you said that this is your first child, did you make preparations even though it did not happen saying.... if it happen and I need blood this person will donate?*

R: "Mmm…..since it is that I did not think of such plans that it will happen. I had faith in God that He will do His thing as He used to do for all others. So I did not believe that blood will be needed and it did not happen".

F: *Eh…..eh….what the whites says "experience", "lessons", "knowledge", tell me the different experiences that you had when you were pregnant even now that you are nursing this baby, the different experiences that you had?*

R: "When you go to the hospital right from when you are pregnant. When you go to the hospital, they will teach you those things, how you are to take care of yourself till it is time for you to deliver, how…..show you the types of fruits

that you have to eat and also show you how you should take care of yourself, it can also enter the baby, they have to show you…., teach you…….even the cloths you wear the baby, even the food you make and give to the baby are been taught in the hospital, they say before you make food for the baby you have to wash your hands and make all your environment clean to avoid sickness disturbing the baby".

F: *In this community that you are, sometime we know some people used to say when a woman is pregnant she should not wear red cloths, should not do this or that. So what are the different laws that this community has about a woman who is pregnant?*

R: "Mmm…. I have not seen any law that they have about the woman who is pregnant, all of us are like that. Even me, since when I become pregnant till I delivered have not seen any law, there is no law of any one thing".

F: *In your hou…se who is the one that takes decision and say this pregnancy you will deliver here or deliver there, whether you or your husband or your mother in-law?*

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R: "There is no body, is only me and my husband that can take decision. Because my husband can say whether where do you want to be delivered and I will tell him that hospital is good for me o! that is where I walk and go, that is where I will deliver because you attend hospital, clinic then when you are to deliver you are to go there and he will say “ok”.

F: *Okey. During this child’s pregnancy tell me the assistance that people gave to you like your husband’s siblings, your mother in-law, your siblings even with your husband?*

R: " They used to assist me in small things, maybe there is some times how it used to…….because when you go to the hospital they will teach you not to carry things that are too heavy, so……..they used to help me. They used to fetch

water, firewood, some help me and cook my mother in-law can also sometimes there is a way tell them to feel and I will tell them and they will say or go to the hospital".

F: *In this community that you live eh… do they have anything like an association that they say should labour starts anyone and her people are not around then even if am a member, I can raise my voice and ask another person and say come let's go and help this lady for labour has started in this community has any such thing?.*

R: "Yes they have, they have"

F: *We know, which I believe you know even though you have not seen, that a lot of women have died during delivery especially at the TBA's place, like what…….if you are made the women leader, what advise can you give….what do you think that if it is done it will encourage women, help them so that when they are pregnant, they will look the road straight to the hospital. What do you think if done will help so that these deaths will stop?.*

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R: "They have to come and tell……tell the clan head when they tell the clan head, they give bell to ring and they give the information, when they inform them about this death in the community the clan head will call the women and discuss with them (Baby disturbing and distracting the mother) ,so when all women hear they will also say what they will do so that women can be going to the hospital".

F: *Now among those things that you say they should do tell me one or two that you think that when you go you will tell the clan head that if he does this that your neighbour that does not like going to the hospital will follow and go to the hospital?*

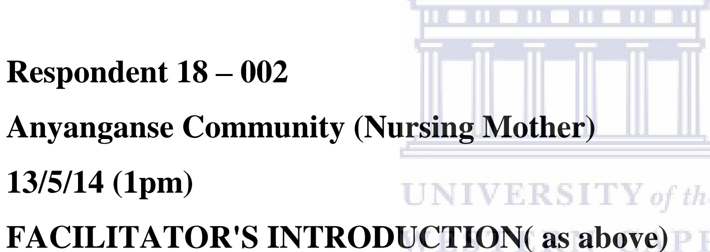
R: " When…… when they go I will tell the clan head that there are nurses that have come that they want everybody, all women (Baby disturbing) to be going to the

hospital and that I would like him to give bell let them ring and call all women, even those that are not pregnant yet but later they will be pregnant so….you should ring bell…..give bell to go so that they will say..., so that all will know. The one who did not know, to have the knowledge of hospital".

F: *Thank you very much like we said that this is the first face we will call you again for the second thank you.*

OBSERVER'S COMMENTS

- The Respondent baby was distracting during the interview
- The Respondent's first delivery...she was unable to response to the interview questions well because this was her first experience.
- She pointed out that if the make it as a law for to be going to hospital it will reduce the rate of pregnant women going to TBAs to deliver.



Respondent 18 – 002

Anyanganse Community (Nursing Mother)

13/5/14 (1pm)

FACILITATOR'S INTRODUCTION(as above)

F: *Please I want you to tell me the signs, bad signs that if a woman is pregnant and these signs show forth. If one sees can say that these signs are not good signs that they are signs that if not looked after it can make something bad to happen?.*

R: "Oke…..y that ....., what I know myself is that if a woman is pregnant and she looks pale and her lips looks pale it shows that there is no blood and is something that she should go to the hospital. So she does not like to go, sometimes even this TBA's place she does not go, she just stays at home".

F: *Tell me the reason why you think if a woman is pregnant and she goes to the hospital it will help her.....good with her very much?.*

R: Why I say so…..is that hospital is good, like me because I take example from myself. when I was pregnant, I went to the health centre at Idundu, my stomach was very big, people used to say that I will deliver twins. So, I went to the hospital and did scan and I saw that hospital is good. They also looked and told me what is my problem and I also took it the paper to them. I then know that if something disturbs you and you go to the hospital that the whites can make you know even doctors can make you know".

***F**: Tell me the bad thing that may happen to a woman who is pregnant and labour comes she goes to the TBA's place. Tell me the bad things that can happen?*

R: "The bad things that can happen……reach such a woman is that it can be that hospital can help you but sometime……they have seen how that baby lies they tell you or take you to scan and ask you to do. Then if you don't go to the hospital that thing coming, the TBA may lie to you because she does not know where you would plan to go like the hospital she will tell you to leave that, she will give you treatment to reach that place, then you will sit down not knowing what will happen to you. when the day of delivery reaches they don't know any way. It will now be that hospital you did not go ….and they have to take you to that hospital then they will not be able because they had already deceive you and kept for a long while".

***F**: Please where…….is this your first child?*

R: "No it is not, this is my fifth child"

***F**: Mma Edu, please where do you deliver your children ?*

R: "I deliver at Mary Slessor "

***F**: (Asked immediately) in the hospital or TBA's place?*

R: "Hospital "

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F: *That means as you used to go to the hospital, it is nurse that used to attend to yes?*

R: "Yes"

F: *Please tell me about the reason why you agreed….. choose and say….”my children, I will deliver in the hospital?*

R: "Why we agreed that my children I deliver in the hospital is because my elder sister used to deliver at the TBA’s place, but on that faithful day that she was to deliver…….she could not deliver, she died and left that pregnancy so….. I said that such a thing will not happen to any of us again, because we were just three females and I being third put to birth, my immediate senior sister has not put to birth yet, so I said let me be going to the hospital to avoids things of such, because there could be a problem disturbing and doctors say that they have to do your work this day or that day. So that if that date pass before you go it becomes too late".

F: *Please as…….we know that you used to be pregnant then, when you were pregnant, as we know that a pregnant woman….., everything depends on preparation. What preparations did you make concerning transportation, what the white call “transport” saying should it happen this machine will carry me or this my husband’s sibling or this my husband’s friend……..will carry me what preparations did you make?*

R: "My preparation was that we lived near to the hospital, I used to go and live with my father since it is nearer to the hospital".

F: *Concerning………..apart from that li…..ke money, we know they used to do card contribution saying apart from my husband I too can follow and help myself what preparation did you make concerning money too?*

R: "I used to save like that, when I was there I used to sell wrappers, when I was there I left those my wrappers here, I used to go and live there follow them and do their business, my step mother used to go and buy plantain and bring and I

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used to sell there so that I too can…., because I can deliver and my husband is not there, I can use and help myself".

F: *Please thank you very much please we know that it is not anybody's prayers but it could be that sometimes one can go to deliver and blood come out too much that they say let them put blood. In all these children that you have, did you make such preparations?*

R: "No, I did not do"

F: *And it did not happen ?*

R: "It did not happen too"

F: *Ok, tel….l me please tell me since you have many children, what…. What the white call "experience" that you had when you were pregnant, when you went to deliver, even when you are nursing your babies?.*

R: "Okey, the knowledge that I had when I was pregnant is that, that when am pregnant I know that as am pregnant I have to deliver and when it reaches the time I have to deliver, so I used to do my preparations, and should it be that I go to the market I will buy those things one by one and some and keep till it reaches the day that I deliver".

F: *like what experience? like you have said.... that your first experience is that your elder sister used to ..... that she lost her life during delivery at the TBA's place so like what experience have you said ah do you know I wanted to claim that step and I realized that till I was pregnant and delivered that I did not claim that step. Like what experience you have?*

R: "[Take in a deep breath] Eh…eh like knowledge of things like that is that....for me as I had the knowledge and said I have to go to the hospital...., that I had was that.. one I …. I agreed that when I said let me go to the hospital that nobody will tell me don't go apart from that church. Church I can say after what am

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doing I will go to church so that whatever work God wants to do in the body He can help".

***F*:** *When you live especially where you where when you delivered your children, we know that some community they used to say when you are pregnant, don't wear red clothes, don't do this, don't do that. Again they give different laws like that so in this your community, are there laws like that?*

R: "No, we go to church such thing cannot happen" (Noisy background)

***F*:** *In your community where you live ..., like you in this area where do you know that women really like going to deliver....whether at the TBA's place or in the hospital?*

R: "Women at this side really likes going to the TBA's place very much"

***F*:** *In your.... Even though you don't, what do you think is the reason?.*

R: "Mmm.........why they go is because they like to collect that enema,.....i used to see them take that enema,.... used to take it..... like me since am not there with them, I don't do it,.. is only that once I deliver am back".

F: *So when they go to hospital, hospital does not give drugs to take ?*

R: "[Answered immediately] they give drugs now they used to give,… like me sure sure they gave me drugs".

***F*:** *So when you were pregnant, especially the other children who is the person that used to take decision and say this pregnancy you will deliver here, is it you or your husband especially mother in-laws, they used to worry very much?*

R: "If I will do what?"

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F: *Who used to say that this pregnancy you are carrying you will deliver here or in this church or in the hospital who is the person that takes such decisions?*

R: "Please nobody know that only that when labour starts, you can go and deliver, only that it will not be at the TBA's place because when you attend hospital, they will tell you the day that you will deliver or they will tell you the time when you go, you will deliver, when the road is open they will tell you that the road is open prepare or……..go and bring your things and come and live".

F: *Where you live, we know that "people are wealth" what assistance do people give to you when you are pregnant, when you are nursing especially like this one you are carrying, like your mother-in-law, your husband's siblings, even your siblings,…………fetching water, washing clothes?*

R: "(Smiles) mmm….. they used to assist me like that when I deliver, they used to fetch water for me when I deliver, sweep, cook food and bring to me in the hospital. Sometimes before they come nurse have assisted me in things like that, eh……eh…..they used to help me".

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F: *What special assistance does your husband used to give to you?*

R: "He will come, when my husband comes, since my husband works far away, he will give his brother and he brings so anything that he wants to give to me his boss will bring it and give to my husband brother so then my husband's brother will bring it to me in the hospital and so what I want to give to him, he will help me and give".

F: *So for other children, since this is the fifth when you went for this one's delivery, the other four who took care of them?*

R: "My mother in-law that looked after"

F: Your mother in-law?

R: "Eh….."

***F**:* *In this community that you are is there any association that they say association that assist pregnant women so that if labour starts one unexpectedly and am in that associate I can raise my voice and call somebody and say "come o! lets help for labour has started this woman because this is my duty in the association?*

R: "We don't have"

***F**:* *Ok [takes deep breath] we know that women have died a lot especially at the TBA's place. Is not a hidden thing and one needs no prophecy to tell one in the church. As you are here like you lost that your elder sister you are still feeling the loss. What do you think that if they do this thing, it will help women to be going to the hospital when they are pregnant. Hospital is free till you deliver, so what do you think that if they do it, it will help me so that once a woman take in she will go to the hospital straight?*

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R: "Eh…..is for them to…..like in the place of women, women as they have said, like say meeting like that because such knowledge like that take me to that if a woman is pregnant she can come from the hospital to join the meeting that…………she can come from the hospital to join the meeting so when you do that you can tell her to be going to the hospital that hospital is good. So she has to go because she has seen that she is not the only one that is there, they are many that are going to the hospital".

F: Mma Edu, thank you very much. like we had said this is the first round, we will call you again. Thank you.

OBSERVERS COMMENTS

- The facilitator was very exhausted

- The Respondent does have any support at home except the husband whom most times do not always been available.
- The Respondent decided to go and stay with the father since the father's house is closer to the hospital.
- Children were making noise at the background.

Respondent 19 – 01 (folder B)
Idundu community (Nursing Mother)
14/5/14 (9.30am)
FACILITATOR'S INTRODUCTION (as above)

F: *Please tell me those signs that if a woman is pregnant and you see these signs they say kai!.... these signs are bad signs, there are not good not signs, please tell me?*

R: "Those bad signs are these, then if a woman is pregnant she has to go to…., she has to go to the TBA's place because this hospital was not there yet. Before if a woman is pregnant she has to go to the TBA's place".

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F*:* *(Laying emphasy) I said if a woman is pregnant, those signs that if they see, they say that these signs are not good, there are bad signs that sometimes it can make the baby die or miscarriage happens, those signs are what..., I want you to tell me please?*

R: "These are bad signs..... then if a woman is pregnant so the TBA see bad things in that pregnant woman body and does not do that bad sign out..., so it could be that if that pregnant woman deliver, the mother could die or the baby dies because she did not do away with the bad sign."

F*:* *Those bad signs are what I want you to mention to us even if it is one whether it is headache, waist pains, pains at the lower abdomen or bleeding, like which one?.*

R: "Pains at the lower abdomen that it used to be".

F: *Please you will tell me why you see that if a woman is pregnant it will be good for her to go to the hospital please tell me the reason.?*

R: "[Pause] that place is this... because the nurse ca….n know something in the stomach or says that something like this could be done like this or that. She tells her the good… that the mention nurse can know that good thing in drugs like that (looking for words), to inject that woman so that on the day of delivery she can deliver".

F: *Thank you O! you will tell me those bad things that accompanies, that can happen to a woman who goes to deliver in a TBA's place. Some things like threatening things that can happen to her?.*

R: "(Pause) So…. Those bad things that can happen to a woman who is pregnant and goes to the TBA's place to deliver, in this, if that woman's side or the husband's side, if they had "Ekpo Nka Owo"……….then that woman, that pregnant woman if she is pregnant and goes to sleep with another man....., then when the day of delivery reaches and she does not mention, and goes to the TBA's place and does not like to mention either that "Ekpo Nka Owo"……………..will kill that pregnant woman".

F: *I said O!............but if she goes to the hospital it will still come and kill her. Am talking about something lik.....e, something that can happen and the TBA has no knowledge of, which the hospital could have been able to take care of?*

R: "Either it be bleeding..."

F: *Ok...ey, please is this your first child?*

R: "It is not, this is the third"

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F: *Please tell me where you used to go and deliver your children?.*

R: 'The first one I delivered at the TBA's place, the second I delivered in the hospital, then this third I delivered at the TBA's place".

F: *[Taking deep breath] okey [take in deep breath] where you want to deliver your children mmm like that last child that you went and delivered, why did you go to the place that you went to for this last one?*

R: "Why I went to this last place because………because the ability for hospital is not there. There is no need for me to go to the hospital that is why I went to TBA's place. Because I know that the TBA's place………will be…………lighter and then if I go to that hospital it may be too long for me". *(Referring to price difference)*

F: *Okey!... please do you have any knowledge that if a woman is pregnant from the month she takes in to the day she delivers, that everything in the hospital concerning her is free? Do you know that. Tell me yes or no?.*

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R: "Is it free?"

F: *Now that you are saying that if she….e go…es to the TBA's place that it will be lighter for you?.*

R: "As you can see they did not tell me fast enough and eh…..eh after you have delivered that they will come and say "hear this, hear this".

F: *So you did not know early enough?*

R: "Yes"

F*:* *Alright! As it was that as you have delivered, tell me about the preparations you made concerning transportation,... like say telling the machine man, the taxi man. Did you arrange with them, should labour start in unexpectedly?.*

R: "(Feeling shy) I don't use to tell, it is just that when the day reaches, I come out and stand on the road, climbed machined and go to where I want to go, I go to the TBA's place".

F*:* *Em!………mma please don't be offended. Still in preparation for delivery, we know that sometimes some people used to do card contribution. Some women used to do small handwork, some used to sell small market, so that "they can use and help themselves during delivery". Did you make such preparation in terms of money?*

R: "I did not make. I did not make any one"

F*:* *Okey. Please we know that when a woman delivers sometimes she bleeds to much that they look for somebody to donate blood for her. (Noisy background) in all these your children, did you make such preparation?*

R: "I did not do. Is just tha…t eh!.... when….., it did not happen. But……but…….you can go to the TBA's place and the women can give you everything that she will give, she may not know. But when you to go another place, that place will know fast and they will give you something for that bleeding and you will take".

F*:* *Please since you have three children now, tell me about the lessons that you had; what the whites calls "experience" when you were pregnant, when you deliver, at that TBA's place which you said I have delivered at the TBA's place and in the hospital. So tell me about: first when you were pregnant, how it was, the experience that you said "Kai! When am pregnant again I will not do this o! I will not make such mistake again?*

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R: *[Take in deep breath, at the same time readjust] mmm!..... I don't understand that one o!*

F: *I said when you were pregnant you should tell me those lessons that you learnt, the experience, that you had at the time you were pregnant?*

R: "Okay when it is time that a woman wants to........" *(Looking for words to use)*

F: *(enter immediately) .... Pregnant ?*

R: (follows suit) "........ is pregnant. Then when it is time for her to deliver, when labour is too painful you will say whatever you like, say "when I deliver this one, I will not deliver again O! when I deliver this one I will not deliver gain". You will say different things like that depending on how painful that labour is"

F: *Since you have delivered at the TBA's place, you have also delivered at the hospital (baby cries). Tell me which place is better, i mean the care that was given to you at the TBA's place and the hospital, how was it?*

R: "At the......., at the..........hospital that I delivered at Akwa Ibom (Baby cries causing distraction) that woman nurse used to be very good when it is..........., when it is her things, she will allow you to use, water is for free, everything is for free. Then if you go to TBA's place, some places of the TBA, sometimes things can be for free, then if you go to a bad TBA place it will then be that this place was good; then the other place is not good, it is bad".

F: *Are you saying that the hospital that you attended was very easy with you when you delivered?*

R: "Yes"

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F: *Where you are living, like some communities used to say, when a woman is pregnant should not do this, or that, does not do this or that or eat this so those laws like that are they there where you live or where you come from?*

R: (clears throat)" they are there but……but when a woman is pregnant, things upon things will hungry her to eat. So they can say something like we should not eat, you should not eat. But is not you that likes to eat that thing O! is just because of the pregnancy that you are carrying that makes you to be tasty for things like that, like that".

F: *Tell me, where you live or where you come from, where do people really likes going to deliver whether at the TBA's place or in the hospital?*

R: "Some women really likes, where I come from, some women likes the TBA's place very much like in those days, these hospital was not really very available, so it in this TBA's place that used to be available. They will always say they are delivering at so so place, at so so place before these hospitals came in. now hospital is available. If a woman takes in, and she goes to the TBA's place, she is the one that likes to go. The other ones as they takes in, she knows that hospital is available, she goes".

F: *Okay i….n your home that you are, you mentions where you will go to deliver? Is it you or your husband or your mother-in-law or your husband's siblings or who?*

R: "Am….. am the one that will say.... Am the one that will say the place that will be suit for me, because they are some TBA's place that you can go and deliver, before you know, you can deliver, before you know you are dead , or before you know you can deliver and the baby lives, so when it is like that I will decide and say I want to go to TBA's place to deliver. My husband can say, hospital o! I will say no let me go to the TBA's place".

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F: *In the house that you live, tell me about the assistance that your husband's siblings, your mother in-law, even your siblings used to render to you when you where pregnant, even now that you are nursing your baby?*

R: " In the first place that I was that place was good, that place was good. My mother-in-law loved me and used to assists me, even my sister-in-law used to help but this one that I am there is no assistance in anything whether my husband's siblings or mother-in-law or father-in-law, they don't know me (changes mood) they don't count me as anything….. count me as anything at all".

F: *Okay, tell me the assistance that yours husband gives to you when you where pregnant even now that you have delivered?*

R: "The assistance that he used to render, he can go to work like that and while coming back with baby's things like food or he buys…………buys…………things like food or he fetches water or he cooks for me when I deliver".

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F: *Please you will tell me since this is your third child, then the other children when you were pregnant who looked after them for you?*

R: "You mean that first one?"

F: *First and second ?*

R: "The first and second, one place that am staying.... that they used to take care of me well. This my mother-in-law, my father-in-law used to love me, everybody loves me".

F: *Okey that is the first place?*

R: "This new place is not good, is a bad place that they don't, they don't take me as anything."

F: *Now in this community that you are, is there any association that render help to pregnant women should labour starts, in that association members could raises voice and call another and say come for labour has started this person. Let's go and help. Is there any association like in this community?*

R: "But..... maybe there is"

F: *As we know that women have died plenty during delivery especially at the TBA's place like you said that bleeding can set in and the TBA does not know what do and if they don't rush to the hospital that woman can die. What is the advice that you can give and say "I am saying if they do this and do that, that it would help women so that when they are pregnant, they will go to the hospital (Baby cries), so that they can stop dying because it is very, true that in the hospital they know how to take care of women who are pregnant especially during delivery than the TBA. What is your advice …… .....it is for free, they don't pay money until you deliver?.*

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R: "The message that I will give is that when a woman is pregnant she should go to the hospital because some TBA's place, somebody can die like some places the TBA does not really know what to give to that pregnant woman, she should go to the hospital when they carry you and go to the hospital, they will know everything, both to look after them – the pregnant woman, both to do what they should do".

F: *Eh!.....even with that not everybody likes going to the hospital so, what do you think if it is done by the women of this community, you will help women to be going to the hospital once they take in? because this research of aimed at women helping fellow women, especially during delivery. What do you think that if they do, it will help women to like going to the hospital when they are pregnant?*

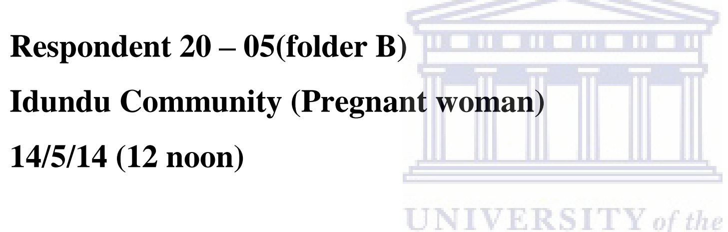
R: "(Pause) I don't know O! "

F: Thank you very much. Like we have said; this is the first stage. The second stage i will also call you. Thank you.

OBSERVERS COMMENTS

- The facilitator was very exhausted
- The Respondent responded bitterly that she don't have any support anywhere.
- Respondent was sober when she was responding on care and preparedness during delivery.
- Respondent's baby was crying and disturbing the interview.
- To the Respondent Delivering with the TBA is normal and is their culture, what she was born to see.

Respondent 20 – 05(folder B)
Idundu Community (Pregnant woman)
14/5/14 (12 noon)



FACILITATOR'S INTRODUCTION (as above)

F: *Aunty please I want you to tell me those signs that if a woman is pregnant and these signs manifest they know that they are bad signs. That either it can make that woman to die or loses her pregnancy?.*

R: "Those signs are many, first of them is the legs swelling, when your legs swells and becomes big, it means that water has entered you, that is bad signs. The second signs is bleeding, that is, it is not yet time to deliver and blood starts coming out from your body that means that you are going to lose that baby the third is you were just standing down and water comes out from your body too much that means that that baby can die and remand there in your stomach".

F: *Please..... please you will tell me the benefits that follows a woman who goes to the hospital to deliver whenever she is pregnant?.*

R: "Benefits are very much. We like this on our own cannot know how the baby lies, cannot know if our time has reached, as we going to the hospital the doctor there will show us and also check our body and anywhere that there is problem they will say... hear what you will do, hear the drugs that you will take. If we attend hospital till it reaches when we are to deliver we cannot have any problem".

***F**: Since you have said that they are benefits like that also tell me the bad things that can happen if a woman who is pregnant goes to a TBA's place to deliver?.*

R: "She may die……O, she may die, second it could be as she went, she could not deliver as she was to... they have to operate her. In TBA she may be so weak in such a way that the time that they say they should rush to the hospital, she may die or that baby dies and remain in her stomach".

***F:** Please is this your pregnancy?.*

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R: "It is my first pregnancy".

***F:** So please where do you intend to deliver this baby?.*

R: "I want to deliver in the hospital oh because right from the third month that I started attending clinic".

***F:** We know that everything in the world has to do with preparations. So as you are a woman who is pregnant, what preparations have made concerning this child that you want to deliver?.*

F: "Have done preparations O!, especially concerning transport. Be……cause this delivery thing, doctor can say today is the day you will delivery, but it happen because that day or tomorrow it happens like that, so i have made arrangement by telling one who has a vehicle that when it happens I will call him to come

and carry me, so there is somebody then, other things that hospital said they should buy I have bought and kept in place".

F: *[Takes in a deep breath]you will tell me even though is not, we don't pray for it to happen, but sometimes it used to happened that they say they need blood, have you made such preparations. Saying if they need blood, this person will give me or this one will give me?.*

R: "............why I say it will not happen to me is that I have been attending hospital, and they have been checking how my baby is and tell me things too, that I have to eat and drug that I have to take so that I don't have problems so I don't think I will have such problem".

F: *And you have not done.....?*

R: "I have not made preparation concerning that one..o!"

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F: *What the white call and say "experience", "knowledge", even though you have not delivered yet, but now that you are pregnant, tell me the experiences that you have and also heard from other people who have delivered about pregnancy and delivery?*

R: "Others that have delivered said...........even though I have not delivered yet. To be pregnant is a thing of happiness but it used to come with many problems but people who listen to what they said, it will be good with them. Some of them, what used to be the main problem is in our homes , if a woman delivers she will really take care of that baby and now leave other members of the house and it will now be as if she hates them, so that is the only problem that really used to be, but apart from that I think it used to be a good thing when one delivers".

F: *[Takes in deep breath] please tell me in this community, are there any laws that they say when a woman is pregnant she should not do this or that, should not eat this or that please tell me?.*

R: " That one is true O!…., there are laws, O!, when one is pregnant they say, "don't drink too cold water", that when you drink the baby will hit, hit you, then secondly they say, "don't eat too much so that your child will not be big, that you will not be able to deliver O!.. the way you should, that they have to operate you and other laws like that they are many".

F: *In the house that you are like in this community that you are where do women really likes going to deliver?*

R: "Eh……eh in this our village, women really likes to go to TBA's place very much to deliver".

F: *Even though you don't follow them,………what do you think is the reason they like going there?.*

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R: "Eh!………because, this our side is a bit distanced away from township, I think that is why and again some of them were born into it and saw it, that is they were born there and their mothers and grandmother used to deliver there at the TBA's place. I think that is why they used to follow and go to such places".

F: *In……… your house who is the person that takes decision saying this child……… this pregnancy that you are carrying you are to deliver here, you are to deliver there". You, your husband, your mother in-law or who?*

R: "My husband and I used to put heads together and……and come to agreement about where I have to deliver".

F: *In your house or neighbourhood what...., what assistance do people give to you like your mother-in-law, your husband's sibling or even your own siblings when*

you are pregnant or when you have delivered even though you have not delivered yet, but like now that you are pregnant?.

R: "Now that am pregnant my husband is the highest assistance to me because it is just both of us that are there. The day that I cannot cook he cooks, the day that I cannot wash plates he washes clothes he washes, everything is done by him and …………..is just the two of us that used to do it we don't have anybody. And again those in the place of work used to assist me".

***F**: Eh….please em!…………… I heard you say something about place of work, where do you work?*

R: "Am teaching in a small private school………O! in this our village".

***F**: I….in this community that you are, is there any association that is set up by the community ......that association is to take care of pregnant women, in case labour starts a pregnant woman unexpectedly and her people are not around that association can go and help her?*

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R: "I have not seen such association here……o it is not here."

***F:** Please mma teacher thank you a lot. Please sin….ce you are a woman, we know that many women have died during delivery especially at the TBA's place. What do you think, in your opinion, what do you think that women can do because this is the reason of this research, it is for women to help fellow women.....women should do, saying that when this is done, that it will help women who are pregnant, not go to the TBA's place, it is for her to go straight to the hospital till it reaches her time of delivery?.*

R: "In the first place, the first thing that they have to do is since this village has gone inside too much, there is need f…or doctors to give nurses to come and they doctors also follow and come and let those in this our village to have knowledge about the benefits that a women who goes to the hospital to deliver

when she is pregnant will get. Again another thing is the clan heads to rise and say that any woman who goes to the TBA's place that if she dies the community will reject such corpse for their people. She will not be burried in this village."

F: *Please mma Teacher thank you ve…ry much. like I said that this is the first stage for this research, when it is time for second stage i will call you. Thank you.*

OBSERVER'S COMMENTS

- The Respondent is knowledgeable on importance of delivering in hospital.
- The Respondent complained that hospital is far away from where she lives which is also a major factor that encourage women to deliver at TBA's house.

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STUDY PHASE 2: COMMUNITY ENGAGEMENT USING PHOTOVOICE & FOCUS GROUP DISCUSSION (FGD)

Introduction:

Three (3) weeks after giving the participants cameras to take photos in their communities, a Focused Group Discussion (FGD), drawing participants from the two study communities (8 & 7 respectively= N 15)was organized, to check qualities of and discuss photographs through storytelling and narratives. The 5 persons who could not attend for family reasons had all sent in their cameras earlier. This method enable people to reflect on their lives and communities as regards the study focus through the dual voice of visual and spoken narratives to serve as agent for authentic change (Carlson, Engebretson, and Chamberlan, 2006). There was a simultaneous recording of the discussions by the researcher. The researcher also took notes and triangulation of analysis was built into the data collection process, therefore allowing for the highest possible reliability of data (Polit & Beck, 2012, p 543). Using Wang and Redwood-Jones (2001) photovoice guidelines, Questions were posted to start the Focus Groups using the acronym SHOeD;

- What do you **S**ee in these photos?,
- what is really **H**appening?,

- How does it relate to **O**ur lives?,
- why does the situation **E**xist?,
- what can we **D**o about it?

Participants codified themes from issues that arise from the photos.

TRANSCRIPTION OF STUDY PHASE 2: PHOTOVOICE (FGD II)

Written consent was obtained from all the 15 participants before the commencement of the session.

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Key

F-Facilitator

R-Respondents

Facilitator's Introduction

F- Good morning my participants

Rs- *Good morning mma*

F- How are you all? Hope you are all doing well and your babies. I want to thank you all for coming out today that we had fixed that we will all come out, and also want to thank you (baby cry distracting) and also thank you for participating in the first phase of this study, agreeing to answer all the questions when I was coming to your houses, and also accept....ing to go and snapping the pictures in your communities. Now, I am back again. After printing all those pictures and selecting the ones that are good for us to use and discuss, as we had earlier agreed. That is the reason we are all here and

....e....e....h!.... and we all know, we are not forcing anybody to participate in this phase of the study. You have all agreed, that is why you have signed the concern forms for me. Is it not so.....?

Rs- *Yes*

F- So now we are going to talk about these pictures one after the other , as it relate to us in the lives......in our lives, in our, in this community, the lives of the pregnant women the lives of the new mothers and how we behave and act, a....nd do, when we are having babies in this community. That is why we are here. So..... I thank you for your coming out and your co-operation. So I hope everybody will be prepared..... this time, so that we talk about these pictures and know how we will use our discussions to help ourselves and women (child cried). Do we understand?

Rs- *Yes*

F- Pictures.....(dragging) flipping through to get selected pictures.

PHOTOVOICE PROPER

(*10 selected pictures were shared among the participants to pass round- same were collected back and grouped based on 2 categories of " domestic activities and health care services by pregnant and nursing mother". As the photography was being passed from one participant to the other, each of participant told short stories and narratives around the photos base on the questions SHOeD).*

Group 1: DOMESTIC ACTIVITIES

Picture 1: **Mother with baby working on the farm**

F- What do you see in this photo?

RESPONSES

R1 : *"Its my friend carrying her baby on the back and doing her work in the farm beside their house ...she is weeding the farm..... this is exercise o! But also punishment for the baby.....as she is carrying the baby on her back like this is a punishment to the baby because the baby's head is facing the ground and the sun is also hitting on the baby"*

R2: *"I see a woman carrying her small baby on the back working inside a farm.... ...this baby she is carrying on her back...she is punishing that baby if there was nobody*

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to help her she would have looked for a place....like a very cool place and release this baby and keep before would come and start working in the farm if there is nobody in the house to help her..."

R3: *"...a woman in her farm with her baby weeding the grass with her hoe..... ....this baby; she has punish this baby by putting this baby on her back and weeding the farm....and she is also punishing herself because she would also receive pains and take it back home...."*

R4: *"A young woman carrying her baby and working in their small farm maybe close to the house...."*

R5: *"....a woman carrying her child on the back bending down....the baby head is also bent down because of the mother is bending down and working...."*

R6: *"For me am seeing a woman doing exercise.......She is doing exercise. As she is weeding farm she is do....ing exercise. But the exercise that the woman is doing, like her baby......the woman is... is...for the baby it is pu nishment...for...the baby"*

F- What is really happening (Reflection)?

RESPONSES

R1: *".......ah! whether you are pregnant or not you must prepare food for your husband.......you must go to TBA....as exercise......."*

R2: *".....even if they help you they feel its help o! After; you will come and take over........my husband use to help me like to carry the children but when I come back I will take over......."*

R3: *"She is exercising. It is good for her pregnancy. It will lighten her body"*

F- **How does it relate to our lives (Linking to context)?**

R1: *"There is no help, no support for the women"*

R2: *"........hah hah hah; is it when you are always going to the farm that you will know what is happening? ....my husband goes to the farm too but go to work in Calabar .....he tells me things ....what to do and I support him......."*

F- **Why does the situation exist (Understanding)?**

RESPONSES

R1: *"It is because of lack of help and support at home. If there was somebody to help, she would have left the baby at home"*

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R2: *"ahh! ....aunty even if your husband want to help you he will not want to do it because of his friends or family people so they will not say he is soft.....woman wrapper......"*

R3: *".....the woman (TBA) that use to deliver me say when you go to the farm walk about do your work you are exercising your baby will be active and come out fast without wasting time when you are giving birth......"*

R4: *"....its lack of help that is supposed to be rendered ....so till she goes and come back from the farm she and her children will not eat.......so you see"*

R5: *"........i don't think its bad ...for me o!.....it is like exercise for the body....every day we must eat so we must go to the farm and do work at home....nobody will do it for you except when you have born you will rest small......."*

R6*: ".......we work; we do work; very hard work like farm ooo! Some people born for farm self and we rush them home......but if they don't go there will be no food in the house and hunger will come for us.........your husband go vex with you....."*

F- What can we do about it (Action)?

RESPONSES

R1: *"Support for the women is important. People at home should be helping women. Family members or relations should support. Mothers, husbands, in-laws should be helping and supportive"*

R2: *Either she should have stayed back from farm for the day since there was no help or she would have kept the baby down in a safe place, maybe under the tree before she starts working"*

R3: *"(Baby crying and distracting) It is to help the women...., to help"*

R4: *".....they (government) should help us to let our husband to understand.......that too much work is not good.....our husband is suppose to help us and be petting us....but no help....... "*

R5: *".......ehen; yes now! they use to tell us at the hospital we should come with our husband so he will understand what we are going through.........because they (referring to husbands) are the ones that are supposed to understand; ......is it not them that put it (referring to pregnancy) inside?......if they can teach them so they will not be ashamed to be assisting us when we are pregnant it will help......."*

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R6: *".......except they will tell our husband to be helping us ....but some of the men are good o! They help their pregnant wives they stop them from going to the farm like my husband he use to pet me......does not allow me to do hard work when I a pregnant"*

R7: *".....its lack of help ....if she has somebody she would have keep that baby before going to the farm.....she needs help....if there was someone to help to go and get the firewood it would have been good they would have been helping her with somethings in the house...".*

R8: *"......nothing o! It is part of our culture ....the man is the head we (referring to women) here we are supposed to support and go to our farm to work so we can eat....."*

PICTURE 2: ***Pregnant mother sweeping***

F- What do you see in this photo?

RESPONSES

R1: *"This is exercise as am seeing. This is exercise. So when she does the exercise.....as a pregnant woman, she is.....is not good for her to be sleeping or lying down always. As she is sweeping, she will sweat, after she will bath and go to sleep (baby crying)*

R2: *(Baby distracting)"This pregnant woman........why she is sweeping........she sweeps so that her body will be light. She does not sit...eh mm! She does not want to sit and watch things being done. She wants to work so that her body will be light.*

R3: *"....yes its me that snap the picture......its my sister...she is pregnant and sweeping the compound....she is in her husband's house; its she that sweeps it every morning.....even before she became pregnant .....its a big compound"*

R4: *"I can see a woman, she is pregnant and sweeping the house......she is bending down and sweeping..... ....this woman is doing exercise and this exercise she is doing is good with her body....it makes it less on her....its not good for a pregnant woman to be lying or sitting down always....this exercise that she is doing is good for her; it will make it light on her...."*

F- What is really happening (Reflection)?

RESPONSES

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R1: *"I will not like it if my husband is sweeping the house .....people will say I m a bad wife allowing my husband to sweep and fetch water........I like it .....it is part of exercise like the nurse tell us to be walking around so that delivery would be easy"*

R2: *"........whether you are pregnant or not you have to eat ......you still do all those work you normally do ......you must sweep your house in the morning.......your husband will go out and you are at home ....it is only you and the children....it is not bad; it is part of exercise like they tell us in hospital....."*

R3: *"She is exercising. It is good for her pregnancy. It will lighten her body"s*

F- **How does it relate to our lives (Linking to context)?**

R1: *"It is good to exercise during pregnancy. It makes labour easy"*

R2: *".......you must do your work in the house as a good wife o!........nobody will support you if you say its because you are pregnant.....ehen! are you the first woman?.....so we must sweep the house.....we stay and take care of the house.......you are suppose to do what your husband say because he is the one that will pay the money.........yes you can tell him your own but if he says this is where you will go that is it......"*

F- **Why does the situation exist (Understanding)?**

RESPONSES

R1: *"....how can you expect your husband to be the one to sweep your house if people see it they will take you to be a bad wife......"*

R2: *"Exercises is good for a pregnant woman. It makes her active not lazy".*

F- What can we do about it (Action)?

RESPONSES

R1 *"see to me I think it is we the woman that should be educated on the kind of work we should not be doing when we are pregnant.......like me now they told me it is not good for me to be bending down to sweep the floor as I am pregnant and I don't use to do it ...my husband cannot force me......it is my younger sister that is staying with us that use to sweep........".*

PICTURE 3: ***Pregnant woman carrying wood***

F- What do you see in this photo?

RESPONSES

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R1: *"The woman in this picture is our neighbour and she is my friend......she is pregnant and we use to go to the farm together to fetch firewood which we use to cook for the house.......she is 6 months pregnant and I snapped this picture as we were coming back from the farm....."*

R2: *"I see a pregnant woman carrying a big firewood on her head......she is laughing.....this is exercise as am seeing ....if she finish doing exercise she would now go and bath after sweeping.......because sweat will be coming out of her body and make her feel light and it's a good thing"*

R3: "*This pregnant woman went to fetch firewood, Though it is good for a pregnant woman to be active, but what ....what am seeing here....the firewood is too big for her to carry. It is tiring. So it is not good"*

F- What is really happening (Reflection)?

RESPONSES

R1: *It is my duty as a woman to fetch firewood and go to the market whether I am pregnant or not .....a man cannot be going to the market for you all the time because you are pregnant......"*

R2: *"....me I use to do everything in the house ......go to the farm ......fetch water with my pregnancy and nobody use to help me......."*

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R3: "*If this woman had someone to help her, am sure she will not go.....that is what i think. She is very tired and it is showing"*

F- **How does it relate to our lives (Linking to context)?**

R1: *"..........it is my duty ......it is the woman's duty to cook, fetch firewood and take care of the house......without she going to get the firewood she would not be able to cook and eat ...sometimes there is food in the house but there is no firewood to cook.....so it is the woman job ...."*

R2: *"........it make us not to know what is happening outside....like news..... it is what our husband tell us that is final.....like now it was my friend that told me about the government free health programme for pregnant women and under five children that is why I went to the hospital o! If not my husband will not agree....."*

F: Why Does The Situation Exist?

Responses

R1: " *It is seen as a normal duty for women in our community, whether pregnant or not"*

R2: *"Women still stress themselves to do something even in pregnancy".*

R3: *"Am sure if she had someone to help her, she will not go".*

F- What can we do about it (Action)?

RESPONSES

"....there is need to provide any kind of help to her.....from her husband, brother in-laws, mother in-laws and the woman's siblings....... by taking care of the baby when she wants to go out"

PICTURES 4 & 5: Pregnant woman shopping

F- What do you see in this photo?

RESPONSES

R1: *"......I snapped this picture because I see this girl as a very small girl and she is pregnant........she is living in our place with her parents and she is pregnant like 4 months now.....she is waiting to take a bike when I snapped the picture.....she wants to go to the market......the cloth she is wearing is too short and tight and its not good......"*

R2: *"....for me what I can see in this picture is a girl who is pregnant holding a bag; its like she is going to the market...standing by the road waiting for transport...."*

R3: *"....this other picture is my brother's wife whom I accompanied to the market to buy meat ...she wants to cook so I snapped her as she was in the market pricing meat......"*

R4: *"......I can see a pregnant woman with some other people ....its a market ....where they are selling meat....the pregnant woman is trying to buy meat....she is wearing a gown ...."*

R5: *"....secondly, the cloths that she is wearing is not good for a pregnant woman to wear....the clinic that we use to go; they use to tell us that we should not wear tight cloths because as it is tight on you its also tight on the baby inside the belly...you should wear cloths that would be free on your body"*

F- What is really happening (Reflection)?

RESPONSES

R1: *"Everyone knows that a pregnant woman has to eat good food. Meat like this is very good for pregnant women to make the baby inside healthy and the mother too."*

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R2: ***"M****yself i like a pregnant woman going to the market herself so that she knows what to buy that will be good for her to eat".*

F- **How does it relate to our lives (Linking to context)?**

R1: *"........ahh! as a woman am suppose to go to the market to buy things to cook for the family........what is there? It is my own to give birth and its the man's own to provide the money.....to take care of the children ......he is the head of the house so if he says he does not want immunization what can I do?......although I have heard it is good but people will blame me for disobeying my husband......"*

R2: *"Some husbands do not care or check the kind of cloths their wives wear to go out during pregnancy"*

R3: *"Some husbands do not give their wives money to sew maternity gowns. So they keep managing their old cloths which have now become very tight because of pregnancy".*

R3: *"This cloth makes her not to be smart because it is very tight. She needs a free gown ..., not skirts"*

F- **Why does the situation exist (Understanding)?**

RESPONSES

R1: *"...the reason why this pregnant woman is going to the market is she need help but she also need to walk to the market so that it will be light on her...."*

R2: *"........and its a form of exercise .....the woman is exercising ....its not good to stay one place when you are pregnant; that's what they tell us at clinic.....so; its exercise"*

R3: *"Most pregnant women have no one to help them. They do their things themselves. They see nothing bad in doing that".*

R4: *"Most pregnant women do not attend ante natal clinic to hear about the kind of dresses they should wear".*

R5: *"Some husbands do not give their husbands money for new gowns that is free during pregnancy. Their wives keep managing old ones".*

F- What can we do about it (Action)?

RESPONSES

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R1: *"Sometimes, though it is a form of exercise, someone should assist the women so that...that they can rest".*

R2: *"The husbands should be checking the type of cloths their wives wear during pregnancy".*

R3: *"The women should be encouraged to attend ante natal clinic to listen to health talks as to know the type of dressing good for them during pregnancy"*

R4: *"Women like this, sometimes they have no help or money to change cloths. Government should also help by providing materials to pregnant women especially those who attend ante natal, to encourage them and motivate others."*

Group 2: **Attitude and access to health care services by pregnant and nursing mothers**

(pictures sorted out)

PICTURE 6: ***Pregnant women with young man***

F- What do you See in these photos (observation)

RESPONSES

R1: *(baby crying) "I see a man following the wife in labour to a TBA house to deliver...., to go and show a TBA. It is like she has pain".*

R2: *"......the picture is my friend and her husband; she and her husband was coming to the TBA home......she was having labour pains so she is walking fast and her husband is following her at the back......."*

R3: *"I see a pregnant woman and a man walking towards a ....a thatched house it's like a TBA house because there is another pregnant women standing outside making phone call ......I see a bag and cooler on the floor beside the pregnant woman making phone call......there is a small boy standing and looking at the first pregnant woman and her husband..."*

R4: *"To me what I can see here is that a woman who is pregnant is being escorted to a TBA home by her husband......the other pregnant woman is like making phone call to her family or husband to give them message......"*

R5: *"What i am seeing here (child crying and distracting}, it is like this woman is in labour. She is holding her waist and walking fast, going to TBA house. The husband is taking her there. Whereas the husband is supposed to take her to the hospital".*

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***R6:** "I see on this photo a pregnant woman...looks as she is in labour. The husband is taking her to TBA house"*

F- What is really happening (Reflection)?

RESPONSES

***R1:** ".....the normal thing is that it is the man would take care of all the money for the hospital so sometimes they usually prefer places that are not expensive ....see that is why many of them prefer us to born in the TBA place....."*

***R2:** "Ahh! My husband use to follow me o!....he goes with me sometimes to the clinic .....when I born this baby....he use to go with me.....and when I was there I use to see some men come with their wives also; some of them like and to make sure their wives goes to exactly where she was asked to go because some will not go....."*

***R3:** "Most pregnant women do not like to deliver in the hospital. Their husbands wnts them to deliver with a TBA, so take them there.*

***R4:** "It is not as if he would not have taken her to hospital o! but... but because in.. in a TBA place, thry say that if labour is difficult, they have some roots......roots, herbs that they give women, when they chew...chew, they will deliver fast. (child crying and distracting). While in hospitals, nothing is given and when labour stays long, they will say.....they will rush and operate ."*

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***R5:** "It is only that in this place, women just like going to TBAs to deliver. Sometimes, it is because nurses shout at them too much".*

***R6;** "I think....think some husbands too, they want their wives that if they go to hospitals....it will be too expensive. So it is better to deliver with a TBA to save money."*

***R7:** "It is their tradition here...o! women like to deliver in TBAs houses here. They are already used to the practice".*

F- How does it relate to our lives (Linking to context)?

RESPONSES

***R1:** ".......we are women; it is any where my husband say i should go and deliver that I will go because it is him that will give me money........even if I want to go to general hospital at Ikot Nakanda; if he say no .....I cannot ....no money; we are suffering......"*

R2: *"because of fear of hospital and operation and nurses, women here like going to TBA. But this is not a good practice. I think husbands should rather encourage their wives to go and deliver in the hospitals."*

R3: *"it is every woman's happiness to have her baby in a natural way without operation, women also wants to be treated well when in labour".*

R4: *"I think it is due to lack of money to pay in hospitals....that....that makes them reason this way and think that TBA is better for their wives to deliver".*

R5: *"women like going to deliver with TBA. Husbands even like it too and encourage them. That is what is going on here".*

R6: *"women are comfortable to deliver in TBA houses. They are used to this practice. It is safe and ok for them. They have no problems when they go there. If anything happen....it means God wants it so. Nobody can help".*

F- ***Why does the situation exist (Understanding)?***

RESPONSES

R1: *"Aunty see there is no money ....if you go there (PHCs) now they will be telling you to register with N1000 ...that one is enough for somebody to run..."*

R2: *"...yes; money....to me money is the main reason.......because without money they will not attend to you......"*

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R3: *"...apart from money; ehmm! Like me its not because of money.....I am not saying we have money but to me why I am going to the TBA is because that is where I had my first delivery so I have said that is where I will have all my children because she is good to me......she will pray.... "*

R4: *"It is not good. Some women say that they are afraid of hospitals because of operation and tearing of private part. Also the way nurses treat women in labour, shouting at them causes fear. Sometimes nurses slap women even beat them up. If a woman mentions this to their husbands, they will not like them to go to the hospital".*

R5: *"Women are afraid of operation. They like the TBA who will always give them roots, leaves to faster labour".*

R6: *"TBA do not charge much. You can even pay as you have money even not....immediately or at once. They are more friendly than nurses and....and they take good care of women in labour".*

R7: *"I am sure it is because of money. Like me here I paid two thousand five hundred naira to register when I booked in hospital, after that I only paid for tests. At the end*

of delivery you can only appreciate the nurses if you like....that is if your delivery is normal not c/s. Some people do not have this to pay and register. Some are just afraid of hospital".

***R8:** "Women in this community do not know that hospital delivery is free. They don't know. Even now if you go to register in hospital, nurses still ask you to pay some money".*

***R9:** "In TBA homes we pay what we have. They don't worry us. You can complete the money when you have. They take good care of women in Labour. They pray for us. Nothing happens to us unless it was to happen".*

F- What can we do about it (Action)?

Responses

***R1:** "Hospital should not be fast in operating a pregnant woman because they don't like it. They want to have their babies the natural way, so they should be given times to labour.....but....but not to rush and operate them. Also I mean the nurses should be patience with them. They should not shout at women and slap and abuse them".*

***R2:** "Nurses should be advised not to be harsh....harsh to pregnant women. They should pet them and be friendly with pregnant women".*

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***R3:** "They should not always rush to operate the women when in labour....they hospital should give them time......small time to try. Women don't like operation".*

***R4:** "The hospitals should be instructed.....not....to be rushing to operate. Maybe the time did not reach that the woman should deliver her baby. They ....they should be patience and gi....ve her time for baby to come out".*

***R5:** "Delivery should be free in hospitals. Not to say it is free but nurses are still saying pay this, pay that. Government should make sure no money is collected".*

***R6:** "Why this is happening....hm m! Sometimes it is money. They husband is thinking that money will be too much in the hospital. That is why he decided to take her to TBA. Though people say hospital is free for pregnant women and children. Money is still collected".*

***R7:** "Husbands should be advised to encourage their wives to deliver in hospital".*

***R8:** "What should be done is that......if.....if (child crying and distracting)if it is really true that hospital is free, it should be announced in this community so that everybody will know.*

R9: *"This is happening because of lack of money. The husband has no money that is why. As they say hospital is free, the women don't know that it is free. So announcements should be made in this community so that women will know that hospital is free".*

PICTURES 7 & 8 : ***Traditional birth attendant house***

F- What do you See in these photos (observation)

RESPONSES

R1; *"....ma; this is the picture I snapped inside the common room of a TBA home at Idundu....the number of pregnant women and women that give birth there is usually very plenty.......on this picture we have some of the women that have already delivered with their babies and the pregnant women in that room.....the women in labour pain are either standing or moving around in the room as mma (the TBA) have instructed........by the corner of the room is a table alter where we (the pregnant women) use to pray for ourselves and family......" (see photo 8).*

R2: *"In the picture are women seating down like they are waiting for their turn........like about 7 women some are pregnant and some are not pregnant; some of the women are carrying their new born babies......it is a TBA home; yes it is a TBA home they are inside a TBA home........"*

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R3: *"This is a TBA house. Where women go to deliver. At the corner is where they set up a table forr prayers. Pregnant women are taken through prayers and fasting in TBA homes. Can see many women here....some have delievered and some pregnant and waiting to deliver".*

R4: *"(Babies crying) I see a prayer alter and women in a room. Some with their babies....some pregnant".*

R5: *"I see a prayer corner in a TBA home for pregnant women and this place is set aside for prayers and fasting for pregnant women".*

R6: *"I see mothers, pregnant women, relations all in one room in a TBA home. Staying all of them very happily even as the room is very tight and hot. Some of them are sitting on the floor".*

R7: *"On the photo, women with their newborn, pregnant women and relations are all in a tight room in a TBA house. Some sitting on the mat on the floor. They don't even mind".*

F- ***What is really happening (Reflection)?***

RESPONSES

R1: *".......you see many women don't like the way all this doctors do; small thing they will inject you with hot injection.......tear you; ahh! You see ....even me I don't like it; it use to scare me ...."*

R2: *"sometimes it is those nurses that use to cause it they will not be coming and the place is far; so when you go there and nobody; you will not go again.....for me aunty if you ask me; you see the TBA will pray with and you give you fasting to do....when you come all the women come together to pray at the altar .....yes now! She has an alter in the house everybody comes together we pray....."*

R3: *"....your people like your sister or your sister in-law can come to the place prepare food for you......even in the hospital they will not agree; you cannot even try it......I like it......she will massage you; tell you when you will born and you will born......we use to pay o! ....give her food stuff like yams, cassava.....she also tell us to do test; immunization.... "*

R4: *"Pregnant women needs prayers....o! They really need prayers and fasting because this is a trying period, that is why they ask people to be praying for them too when they will be fasting and praying for God to see them through".*

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R5: *"This means that women like a place of prayer like this so that God will protect them to go through pregnancy and delivery without dying".*

R6: *"Most TBAs are prophetess. They combine fasting and prayers with their work that is why God is helping them to help women in this community".*

R7: *"Every one of them is happy to be together. This cannot be allowed in the hospital".*

R8: *"I am sure it is due to lack of money that makes all of them come here even as there is no space. It is very tight".*

R9: *"Women prefer herbs and roots than tablets and injections. They are also afraid of operation".*

F- How does it relate to our lives (Linking to context)?

RESPONSES

R1: *"This prayers and fasting and fasting assures them of safe delivery and protection from evil eyes".*

R2: *"Women will always prefer going to where there is fasting and prayers for their protection. The world is very bad Mma and .....and you don't know your enemies".*

R3: *"Some of the TBAs see spiritually. During fasting and prayer, they prophesy and do some assignments to ward off evil manipulation on the pregnant women that would have caused them to die or their babies to die".*

R4: *"In our community, women like being together, sharing their experiences, seeing their relations around them especially when in labour and after delivery".*

R5: *"Our women are always happy being together. The TBA is friendly and welcomes everybody".*

R6: *"They have come to TBA because of money in hospitals. Even when the place is tight, they will manage.*

R7: *"Women in our community are already used to TBAs and feel safer in their hands".*

R8: *".........the truth is that we don't use to hear some of these information except they come and tell our chief and he announce it; like they way they use to tell us about the immunization.....I did not n\know about; that it is free for a pregnant woman to born in the hospital it is just here I am hearing it o!..... "*

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F- ***Why does the situation exist (Understanding)?***

RESPONSES

R1: *"Mma, see....I don't play with my God...o! Anything done without putting God will never work out. Here.... em.. em, in the villages here, there are many evil eyes after you, ...especially when pregnant. If you don't cover yourself with prayer and fasting, hm, hm! they will kill you and your baby. TBAs take us through prayers and fasting every week, some even see spiritual things and prophesy...and tell you what to do. I can't stop going to them...o!*

R2: *"Prayers and fasting is one of the things that move them come to TBA to deliver. God is everything. And during pregnancy you have to surrender yourself to God. The world is bad and enemies attach more during pregnancy and delivery".*

R3: *"Fasting and prayer is what help us. We all rely on God who can do everything and protect us from harm during pregnancy and delivery".*

R4: *"The women feel free here than hospitals. Because in the hospital they don't allow relations. Even the visiting time is very short. If it is hospital nurses will be shouting at them as they are sitting on the mat on the floor".*

***R5:** "Poverty is the problem. Also nurses do not want to see relatives. They shout at people a lot in hospitals making women fear going there".*

***R6:** "Women believe in TBAs. They believe their pregnancy can be preserved till delivery".*

F- What can we do about it (Action)?

Responses

***R1:** "In hospital, I used to see them praying when women go for Anti natal and when children are taken for immunization, but this is always very short or brief. So some special prayer days should be set aside in hospital for prayer and fasting. So, that women feel assured and safe that they are protected. It will help women develop faith in God especially during pregnancy".*

***R2:** " Hospital should see fasting and prayers as important. They should set a day aside every week for prayers and fasting for pregnant women. Not just small time for prayers on clinic days. That is not enough at all ...at all. Enemies attack during this time".*

***R3:** "I think hospitals too should have a place for fasting and prayers. Set aside a special day, invite men and women of God to come and direct pregnant women in fasting and prayers. This will really attract women to go to hospital s. This is because there is so much attack on pregnant women to roam about looking for where there is strong prayers and fasting".*

***R4:** "Nurses should sometimes allow.......allow relations around their people so they can feel happy at home. Nurses should not be shouting at people anyhow. Its makes the women fear and not go to hospital".*

***R5:** "If the hospital delivery is actually free true true......, the women do not know about it. We are always asked to pay some money. The announcement be made in the villages that hospital is free for pregnant women and children. Also let Government make sure that nurses do not collect any money".*

***R6:** "Nurses should be telling women who attend Anti natal that care is free and they should not collect any money then these women will go back and inform other women to go".*

***R7:** "Even if many women do not deliver in the clinic, they like taking their babies for immunization. So, during this immunization, the nurses should pet women, show them love and encourage them to come to deliver in the hospital, that it is free. Because*

women may know that hospital is free but may not go because nurses shout at them and are not friendly. They do not pet".

R8: *"Husband should be involved because they are the ones to insist that their wives should go to hospital and deliver. If not so, the women won't disobey their husband".*

R9: *"Some women still prefer TBAs because of the roots and herbs given to them as enema to preserve their babies in the womb until delivery. This is not done in hospital".*

R10: *"Other women who benefit from hospital delivery should tell others in the communities to go and deliver in the hospital".*

PICTURES 9 & 10: Baby delivered at TBA's house

F- What do you see in this photo?

RESPONSES

R1: *"This my picture was taken inside a TBA hut; where the TBA use to help the pregnant women to deliver their babies......it is a woman that just gave birth to a baby girl .....so she and her baby are there and I snapped them.....you can still see what is being used to clean the woman and her baby still on the bed and she is still very weak she did not even know where her baby is she just turned the other side....the TBA just left the room that time to get something....it is like 10 minutes she give birth then I take the picture...."*

R2: *"A woman is lying; her baby is behind her on the bed.....it is like she just gave birth because the baby is wet and there are blood stained white cloths and tissues on the bed and the woman is looking weak because she is not even looking at her baby.....she just lying down turned the other way.....the room looks small......see all the rubber kegs and cloths that is packed in the room ....only small place for space that I see..."*

R3: *"I see on this photo a mother who just delivered lying on the ground and her baby lying naked in blood beside her inside a TBA delivery room.*

R4: *"I see a woman who just delivered being left on the floor in blood and her baby lying naked beside her with cord exposed in blood".*

(picture 10 showing TBA with hand gloves after taking delivery)

R5: *"A un---ty-----, hm! this TBA is well known in this community---oh! True, she is the woman that i was born to see delivering almost all of us here. After, ... after helping that woman to born, she was so happy to see me. I told her about this study we are*

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doing. She said i must snap her and show to government, so that they will know the good work she is doing in our community for women and come and support her."

R6: *"I see a TBA standing with a hand gloves on the hand. She just finished taking that delivery".*

F- ***What is really happening (Reflection)?***

RESPONSES

R1: ".......you see many women don't like the way all this doctors do; small thing they will inject you with hot injection.......tear you; ahh! You see ....even me I don't like it; it use to scare me ...."

R2: *"This baby is exposed for long. He can be cold and sick and even die. This environment is very dirty. Even the hand gloves the TBA uses can be used also on another woman. This cannot happen in the hospital".*

R3: *"Good care for mother and baby is lacking here. This cannot happen in the hospital. The environment is dirty".*

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R4: *"Nothing will happen to the baby. God is protecting them. The baby will grow up to be very strong*

R5: *"This is the practice and it is not good at all. she will use this same gloves for another delivery".*

R6: *"She is one of our best TBAs here in our community. She takes so many deliveries a month even more than the hospital".*

F- How does it relate to our lives (Linking to context)?

RESPONSES

R1: *"Our women do not really care about how a TBA place is . They just trust them and keep going to them".*

***R2:** "Dirty environment is dangerous for this mother and child. Infection can happen.".*

***R3:** "Poverty, ignorance and wrong beliefs is killing us here. Most women see nothing good in hospital because they are already used to the TBAs".*

***R4:** "The woman is so proud of herself as the TBA in the community. She is very popular here".*

F- ***Why does the situation exist (Understanding)****?*

RESPONSES

***R1:** "....all those workers they don't use to come to work sometimes ......and they will abuse you.... abuse you; so even I have money aunty I will not go there; no need ...."*

R2: "Poverty and lack of knowledge that mother and baby can die from dirty environment".

R3: "Lack of knowledge".

R4: "It is normal. No problems. They are fine.

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R5: "Strong belief in TBA. Poverty and lack of knowledge".

R6: "Women go to her very well. With her..., we are sure of safe delivery. She is also a prophetess"

F- What can we do about it (Action)?

Responses

***R1:** "Women in this community should be educated about the problems that this type of environment can cause. Even exposing baby in blood and without cloths like this for a long time can kill the baby. Our women do not know this. Infact, no idea about the problem that can happen".*

***R2:** "To me......o! I think if other women or clan head try to tell women not to to TBA but hospital, there will be problem and enemity because TBAs will feel that their jobs will be taken away from them and what means will they survive if no woman goes to*

them for delivery? That is why I think nurses and government should be the ones to come here and educate the TBAs and women . Tell them what they should know about pregnancy and delivery".

***R3**: "She is always very kind to women in labour. She pets them....infact, i suggest that government should support her to do better"*

PICTURE 11: Mother feeding baby

F- What do you see in this photo?

RESPONSES

***R1:** "....I took this picture inside the home of a TBA at Ayaghanse; she is my cousin's wife and was delivered of a baby by a TBA .....a baby girl; the baby was 3 days old.....as she wants to give the baby food I snapped her....she is making pap to give the baby......other women too are there in that room o!......she is giving the baby breast also....I just took the shot to show feeding of baby....."*

***R2:** "In the picture I can see a woman making food, it is like akamu (pap).....she is making it for her baby that is lying on the bed and she is licking the side of the plate because she does not want it to pour (spill) on the floor after putting some for the baby in the baby feeding bottle that she is carrying.......It is a normal thing now! .....what is in it?......"*

***R3:** "I see a new mother making custard in a plate in a TBA house. I am sure she wants to give her new born baby -one day old".*

F- ***What is really happening (Reflection)?***

Response

***R1:** "The mother does not know that the baby should be given only breast. The baby can even be infected".*

F- How does it relate to our lives (Linking to context)?

RESPONSES

***R1:** "No good Anti natal care to have information about care of the baby".*

R2: *"If this baby was born in a hospital or clinic, there is no how the nurses would have allowed her give the baby this food. But only breast".*

F- WHY DOES THIS SITUATION EXIST?

Response

R1: *"This mother does not know about child care. She is supposed to give the baby breast"*

F- What can we do about it (Action)?

Responses

R1: *" Health education for women on care of newborn baby, importance of exclusive breastfeeding".*

R2: *" Women should be encouraged to attend Anti natal to listen to health talk when pregnant so that they can care for their newborn babies".*

R3; "To me I think the TBAs can be trained to do better. They are very good to women and there are those things they know which hospital people do not know. If government can train them to improve in their work and try to make them work together with hospital people, then there is no how women will die"

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PICTURE 12: Waiting at the clinic hall

F- What Do You See In This Photo?

RESPONSES

R1: *"........I took this picture at the Idundu health center........the town announcer had announced that there would be children and pregnant mother's immunization the day before the day that I took the picture......many pregnant women and mothers with their children came to the health center for the immunization so I snapped the picture.....to show how people come out to immunization....."*

R2: *"Ï can see about 5 pregnant women and 8 mothers with small children.....they are seating down on a bench; like waiting for their turn as they use to wait in hospitals to see doctor......."*

R3: *"....some women, children and pregnant women seating down ....it is a hospital because there are posters on the walls like in hospitals with information on healthy tips...."*

F- ***What is really happening (Reflection)?***

RESPONSES

R1: *"In this community women take immunization very important. Even in TBA homes, they always tell them to go to clinic and take immunization. Even those that do not deliver in the clinic still take their babies for immunization".*

R2: *"....she used to tell us ....she will ask if you have taken immunization if you say no she will quarrel you......."*

R3: *"they use to go around house to house to immunize children sometimes the town announcer will go round to announce for people to come out for immunization at the health centre so people will come out with them children......immunization is good o!...it will help so the baby will not get sick or die.....they use to tell us ...."*

F- How does it relate to our lives (Linking to context)?

RESPONSES

R1: "It means that women know the importance of immunization to them during pregnancy and for their newborn babies. They do not want anything to happen to their babies. So they ....they do not miss immunizations even when they don't go to clinic for any other thing".

R2: *".........the truth is that we don't use to hear some of these information except they come and tell our chief and he announce it; like they way they use to tell us about the immunization.....I did not n\know about; that it is free for a pregnant woman to born in the hospital it is just here I am hearing it o!....."*

F- Why does this situation Exist?

RESPONSE

R1: *"Women value the health of their babies".*

R2: *"For some women, it is only immunization that takes them to clinic".*

R3: *"Maybe (child cries)I am sure it is because everybody is involved in announcing immunization to the women in the community. In the churches, it is announced, in*

village meetings they announced, the town criers announced. So, nobody will say she did not hear.......or did not know".

F- What can we do about it (Action)?

Responses

R1: *“,,,,,to me all I can say is that those nurses that are in the hospital they make sure that they are coming to work because if somebody go there and you did not see anybody she will not border to go tomorrow...”*

R2: *“......if government can be giving people all those gifts they use to give somethings like ehm; ehm baby things ....like when I gave birth at the Idundu health centre they gave me mosquito nets and I was happy........”*

R3: *“.......see Aunty; another thing is that people use to appreciate prayers.....at the TBA place they use to pray and do fasting....if they can be doing prayers it will be good; you know that for a woman to be pregnant it is not easy ......during labour it is usually between life and death so prayers is important; and fasting........”*

R4: *"You see.....i believe, the same way our village heads send important messages to reach everybody through different churches, the town crier will go around to announce, same way...em...i mean this same way as they announce immunization, it can be announced to every woman here who is pregnant to go to clinic and put name and also make sure not only putting name but deliver there. That it is a must."*

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R5: *"Also...the clan head should call meeting,....meeting with pregnant women and their husbands... because is the men that cause this problems. Clan head should announce to them that any woman who delivers and dies in TBA will not be buried in this community. It should be a law. Then fear will catch everybody. That is the only thing that will make them obey..,"*

R6: *"In this our village, there is no woman who don't go to a meeting group..., in church or even in village here. Let the leaders of these women groups be told. They should announce to their women to deliver in the hospital....., they should also be checking them if they obey. If not , they should remove them from the meeting. That is my own suggestion."*

R7: *"some strong women can form a group. our woman leaders must be there. Let them be checking women who are pregnant and if they go to clinic.....i mean this is easy because in this community we know everybody. The people....those who don't born baby*

in health centre, they should report. We too,.....we can also be checking and reporting to them....this will work for us."

R8: *"I suggest that, that ....to me....o! In the same way immunization is preached everywhere in the community news about free hospital delivery and importance of registering and delivering in hospitals should take that form".*

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PHASE 2: FGD IV (Validation and Classification of Concepts)

Participants: Fourteen(14) participants from the 2 communities under study comprising older women (mother-in-laws and grandmothers N=8), representatives of photo voice participants (N=4) and women leaders (N=2).

Facilitator's Introduction:

My mothers, I welcome you all here and I thank you all for accepting to come out today when your woman leader invited you to this meeting. We will not keep you here for too long , so within the next one 1hour we will all finish and go back home.

My name is Mrs Alberta Nsemo, I am a nurse from this our state and I teach nurses and midwives in our big school in Calabar(University of Calabar). I am also going to a big school in university of Western Cape, South Africa , to study about how to care for our

women when they are pregnant, when they want to deliver and after delivery, including their new born babies. Because we all know that many of our women especially...... in our villages do die a lot when pregnant, during delivery, after delivery and the new born babies too. Plenty studies and work show that the reason is because our women do not like going to the health centres and hospitals that our government have built for them when pregnant to deliver even when services are free. They like going to TBAs,.... churches to deliver, some even deliver at home. It is in the government clinics and hospitals that we have nurses, midwives and doctors who are trained to take care of pregnant women till delivery. So, they know what to do to save their lives, if there is any problem. Still our women do not like going there.

Findings also let u know that our women in the villages are complaining that they do not know what is going on, that they are not involved , nobody carry them along to know what government is doing for them. They are not even asked what they want or what will be good for them. So that is why they leave Government things for government people and do what they know. This means that our women in the communities are not happy that they are not called together to know from them what their problems are and what will be good for them, to stop our women from dying when pregnant or during childbirth.

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For this reason, my school gave me permission to come down to your communities (Idundu and Anyanghanse) and gather women(Pregnant and new mothers) because they are the ones affected, and use them to do findings here to know what is really happening, how women care for themselves and prepare for birth when pregnant, how their families and communities care for them, where they go for care during pregnancy and delivery, what happens if there is any problem that can cause death. Because your Local Government Register show that here many women don't go to health centre when pregnant to register or even go to deliver their babies and there is a very high record of women and babies dying here.

These women that were selected and used for these findings were also given cameras and were trained on how to use them and take photos of what is happening with pregnant women in their villages. Am sure you saw when they were doing this work around, because some of them are your daughters and daughters in-law. After printing the photos , these women came back together to use the photos to tell stories about all what is happening in your communities with pregnant women and new mothers, why

they do not go to health centres, what can be done to make them go there for trained nurses , midwives and doctors to care for them, who will know what to do immediately there is a problem. This is the only way we can stop or prevent our women, daughters, daughters in-law from dying during pregnancy or delivery.

We all know that to deliver a baby is a happy moment, and we all want the mothers to live and take care of their babies. Is it not so?

RS: It is true.....true mma.

F: Ok! I am happy we all know this. So you are here to listen to the findings from the work the women did. So that you will say if all these are happening in your communities. So you will accept or not accept. You will also add what you know to what they did and suggest what can be done using the work they have done. So that being the women's problems , the women can bring solutions to them. All we want to achieve is to ensure that all pregnant women register at the health centres and deliver there, so that they can be in safe hands and these dying here and there will stop.

Please I beg everyone to listen, and say something when I ask questions, so we can finish fast and go home. Thank you.

F: Do we have any questions?

RS: No mma.

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R1: Hmm! mma Nurse. We don't know how to thank. you.....o! but God will bless you for choosing our communities to do this work, it m...e...a..ns you love us. You want our women to live. We the women are very happy with you. The woman leader told us when you came to start this work. God will make this program work for us. Thank You .

F: The study was in two phases and from the discussions with the women, we arrived at many findings which we will base our discussions today on.

FINDINGS (Themes from Phases 1 and 2) READ OUT TO THEM

A) Verification and Validation of Concepts

F= Which aspects of these findings do you agree or disagree?

***R1: ''Mma** Nu...rse, Hmm! all you are telling us now, na sooo! Nothing wrong, ...they are all what is happening here. It is true'.*

R2: **"***I am an old woman. I get seven children. All my sons and daughters are married. I born all of them in the house, only three in TBA house. But no problems ...no problems at all. If blood come out plenty, TBA will give you some roots to chew and it will stop. Things have changed. This new age is wicked. Now small things, you will hear a woman has died, the baby has died.....what is the cause, we don't know. Was it not this same TBA that were taking care of us ? The world is just wicked now.*

R3: *I think they call it computer age. Everything is sharp sharp. Women are also dying sharp sharp. If to go to health centre will save our women, then let everybody go there and born. Make....make dying stop please."*

R4: *"Mma Nurse, don't you think that if the TBAs we already know and....we know they are very good in this work.....if government can train them, so, so they know what nurses know and also know what to do when there is bad signs. Then we will like it that way. Because now if women do not go to them again, what will they eat? No other work. What will they be doing? Hmm! There will not be happy . Even me...I cannot be happy if my work is taken from me".*

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R5: *"Mma mary....that is not even the main problem. Mma nurse as you see us here, we be farmers, traders , no money. In health centres and hospitals, nurses are talking money, money, money. Pay this, pay that . And we hear government say it is free. Where ther is no money, nurses shout at you, abuse you, abuse your husband".*

R6: **"***What about those that even register there, but if they want to born at night, you go there, no nurse. Sometimes those small, small people that know nothing will be there. Even TBA is better than them".*

R7: **"***Small thing, they will rush and operate . No time given to try. We do not like that. God that puts it there has a way of making it come out".*

R8: ***"It*** *is true that we don't know that government hospitals is free. Our children still go and come back and tell us that they are to pay this,....pay that".*

R9; *"Have you not seen that immunization that is free, everybody take her child there? It is announced everywhere and we all know. They ring bell and beat drum and even close market on those days".*

F= What are your contributions towards these?

R1: *"For me...o! Mma nurse.....we will like this death....death...to stop, and if going to health centre will stop it and we are sure, good. But, but.....to me.....o!, we have no money, so we want free treatment, free medicine, free operation. This is not too much for government to do for women and babies".*

R2: ***(R2 cut in and interrupted the R1)*** ***"….****They should bring nurses that are good and wants to do their work, not those that run home to Calabar before night. And you go there nobody".*

R3: ***"****I think Mma nurse; announcement should be made every place, as in immunization. Churches, markets, I….mean, mean everywhere. Let women know that health centre is free. Any nurse that collects money, they should sack her".*

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R4: *"Mma, the nurses that work in our clinics should agree to live here with us, but they want township….Calabar. How can they be coming from Calabar everyday and know our problems".*

R5: *"Hee….mm! If nurses are good, treatment is free, medicine is there, clinic open every time, and then our women may start going to the clinic. We will even take them there. Then any woman that refuses going, we will know what will do to her in this village".*

R6: *"My own…I say…oo! Our TBAs cannot be left like that without anything. Some of them are very good in this work. Train them, give them knowledge, knowledge is power. So that they will be doing it small small and know when there is problem and can send to hospital".*

R7: *"Many women do not know when they have problem. And nurses some days don't have any work to do in the health centre, they just sit and story. Some days they can be entering the villages, go to house to house, or even churches, or even village meeting*

days and talk to women and men, give them idea….I mean knowledge, so that they know what to do for themselves, know signs of trouble in pregnancy, husbands will also know the good things about hospital and take their women there".

R8: *"Mma, health centres are far from us here…o! I think government should build more health centres, good roads, houses with light and water for nurses to come and stay in this community. I think if nurses stay in this our community, we women will be going to our own health centre for delivery. That is what I think Mma, I don't know if other women think the same way like me…o!"*

R9: *"Mma Nurse, It will not be easy…o...to stop women going to TBAs at all at all. Because these women are very good…o! Many are prophetess, they pray for women, fast for women…., in fact they have a way of locking your pregnancy so that it does not come out till it is time. Hospital people don't know all these, prayers and fasting is very important. We believe in God and it is God that helps us. Nurses do not have much time for fasting and prayer with women unless….they will start doing something about this. If not so, I know that our women will still go to TBAs and churches even after registering in health centres".*

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B) Relationship between Concepts

F= How are these findings related?

R1: *"If we don't know that hospital is free, we won't go. No one tells us. Even when we hear and go there, we still pay money. How then is it free? If government says it should be free, let them send people to see if it is really free".*

R2: *"Women here have no money, so how will they go to clinic? Nurses will abuse them. So they like TBAs who will understand and help them even when they do not pay everything at once".*

R3: *"Mma Nurse, it is not that TBAs is free. Women still pay money but small….small. Apart from that….the TBAs know us, they live with us, and they take good care of us, no shouting, and no abuse. The pet the women and know the leaves to give if labour is long. Not like hospital that will rush and operate, and will not even want to see them come around".*

R4: *"It is the husbands that struggle to pay this money, so they want their wives to go to where they can pay. It is them that decide. So….I….I think that the men should be informed about all these things we are trying to do….and ….and….I mean let them understand why it is good for their wives to register and deliver in hospitals. If not so, even when the women know the use and wants to go, if the oga say no….they won't go".*

R5: *"One time like this….Mma okon who put name in health centre, labour sudden started at midnight the husband rushed her there, because she put her name there, but the security said there was no nurse to attain to her that she went to Calabar, where family are is. The woman was stranded, so the husband took her to a nearby TBA who also refused to attend to her because everybody knows Mma Okon as hospital person. Every woman in the village heard about what happened. Mma nurse, if it is you, will you like going to the clinic to put name again? No! I am sure you will go to who you can see anytime labour starts….day…o or night…o!"*

R6: *"Mma nurse, we want to knows what is happening, what the government is doing for us, so that we can also thank the government. If we have no information they don't tell us, how will we know? For me...o! I want to say that they should do as they immunization. Nurses, Doctors, government people should be coming to us, tell us about what we should do to be good for us, our women, and our children. In churches, in markets, in our meetings, to our men, they should come and talk".*

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F **= What do you think can be done?**

R1: *"For all these things to work for us, we should remember that we are women, we are under somebody. The husbands, the Clan heads, the big men (chiefs) of our villages must be told about what we want to do…..they must agree….I mean….accept with us….give us permission if you want to succeed Mma nurse".*

R2: ***(The R2 bitterly express her feeling when she was responding)*** *"It is not just saying...go to hospital, go to clinic….but please tell the nurses to be good to our women, to open clinic day or night, to stay with us here and not coming to work from Calabar. We want to see them always. We want to run to them anytime we have problem".*

R3: *"Nurse, we trust in God here…o! Without God it will not work for us. Prayers and fasting makes us belief God will help the woman deliver safely. So please we want*

fasting and prayers in our hospital. In fact, they should be calling prophets and prophetess to pray for the women, so that any bad thing coming can be stop".

R4: *"Mma, apart from seeing the nurses, let them stop collecting money from our women if government says it is free as you said. Or you come and tell them not to collect money from our daughters again if they want to go and deliver. Let them allow women try to deliver by themselves, no every small thing operation. They also shout on women in Labour and their husbands too especially when they don't have plenty money. (She was looking sad)They should stop that rubbish. Please tell them to change if they want to see women coming to the health centre. If some women who register in the health centres, they should try and give small small gifts to them so that at home they can show other women (smiling). This will make those who do not like going to deliver in health centre to go".*

R5: *"In this village, we fear and respect our chiefs…o! if after telling the women the good thing in going to put name in health centre and deliver there and they are still stubborn. If our clan head steps in to warn them that any woman who is pregnant and do not register in health centre or any man who does not allow the wife to register in the health centre will be punished or even send out of the community. Mma Nurse, you will see that they will sit up".*

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R6: *"Hmmm! We should not forget the TBAs….o! That is where they eat from. It is worrying me. When we say women should not born there, what will they eat? To me….o! I think government should step in and train our TBAs, so that they can work with the nurses in the health centre. Even God does not like lazy people. If they are trained, they can still care for pregnant women, still pray and fast with them (Smiling). They can even make the women to go and register in the health centre as they do tell them to go for immunization. Because they are trained, they will also know when there is problem s and can quickly carry the women to hospital themselves. This means that everybody is working together to save our pregnant women from dying when they want to deliver. This is what I think will work for us".*

STUDY PHASE 3 (FGD V): Concept validation and Generating Guiding Principles for Model Development (using survey list according to the 6 vantage point by Dickoff et el, 1968)

- Who will perform the activity?
- Who are the recipients of the activity?
- Where will the activity be performed?
- What will be the expected outcome of the activity?
- What will be the process or the technique of the activity?
- How will the activity be sustained in these communities?

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Participants: (Community Stake Holders)

Women leaders from the 2 communities, Representatives of photovoice participants, Representatives of religious leaders, Representatives of TBAs, Healthcare providers in charge of the community Primary Healthcare facility, Representatives of Ward Development Commitee (WDC), Clan heads from the 2 communities. N=20

Venue: Clan Head's Palace

Time: 4pm

Opening prayer: By one of the religious leaders

Opening remark by the Clan Head of Idundu Community: We are here today concerning our pregnant women and problems during pregnancy and delivery a--a--a-nd problems of new born, also why most women do not like coming out eh...h...m! to receive treatment, also to go to hospital. Then, ...so that ways can be sought, also to

form some committees as regards the ways we can monitor and also make findings concerning how all these problems could end.

For......these reasons, i gave the town crier bell to ring in the community right from here to our border near Asabangka. Because this program,.......this hospital......is not only caring for Idundu alone nor Anyananse alone, but for the entire ward this is the centre for medical treatment. For that ......for that reason, bell was rang that everybody should come out including TBAs be---ca----use, they should come and get advice, and also do findings........ Today we will also form groups that will be investigating and ensuring that women are made to obey (long pause, somebody coughed) and also get advice, also receive treatment and help that government give.

That is what we have at hand to do here today, so........when we finish with this, we will still sit back to have our committee meeting. Now, we will give our visitor chance to brief us on what she has to tell us. That was why the bell was rang inviting all of us here........men and women, so that we can hear for ourselves and agree on how we are going to help our women and children not to die again during pregnancy and delivery and also know the ways government has mapped out to help us. The sister that is handling this study is here with us. We are going to listen to her so that she can guide us on how everything should go. We have to co operate with her to ensure we succeed with this program in our communities, so that we can benefit from government through this. (clapping from the audience).

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Facilitator's Introduction: I greet everybody here present and I thank all of you for comimg out despite your tight schedules. I am Alberta David Nsemo, a nurse midwife and a lecturer in our big University in Calabar (University of Calabar). Currently a student in University of the Western Cape, South Africa, where I am studying how to care for women during pregnancy, childbirth and after, as well as the newborn.

Studies have shown that many young women are dying in our country Nigeria including our state, Cross River State especially in our rural communities, in the course of pregnancy and childbirth. Studies have also shown that this high death rate is because our women do not like using the health centres and hospitals government has provided for them, for expert care by trained midwives and doctors who will readily know when

trouble sets in and what to do immediately. Am not condemning the TBAs in anyway because they are actually helping in the care of our pregnant women but the problem is how many of them are that knowledgeable to recognize danger signs and refer promptly for expert medical care. Other studies also confirm that many women in our rural communities do complain that they are not being carried along to know what the government is doing for them, they have little or no idea of what they should do with themselves when pregnant, so they keep going to TBAs that they know best. Many studies have shown that in other parts of the world, using community members in planning out strategies to support and encourage women to go health centres or hospitals provided for them for expert care during pregnancy, during childbirth and after have been very effective in reducing pregnancy-related ill health and death among women. Based on these, as a requirement for my studies in South Africa, i came to carry out studies in the rural communities of my state, Cross River State.

On this background, your communities were selected for this study. So last year, after obtaining permission from the state government, Akpabuyo Loocal Government Chairman and your Clan Heads, some pregnant women and nursing mothers were selected from Idundu and Anyanganse communities and used for the study. They were made to answer questions on; what they know danger signs of pregnancy and childbirth to be, where they like receiving care during pregnancy and childbirth and their reasons, preparations towards delivery, the support they have from family and community.

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The same women were also given cameras and trained on camera use to take photos in their communities, of pregnant women and nursing mothers showing; how they care for themselves, if supported by family and community, where they receive care and treatment, how they care for their newborn etc. These women also gathered to discuss the photos they took and what problems are there, and also came up with suggestions of what could be done.

This study cannot be concluded if the findings from the study and the suggestions from the women is not shared with you who are the strongholds of these communities, for your inputs, suggestions and final confirmation. You are also to contribute to what these communities should do to ensure that every pregnant woman registers in the health centre or hospital and delivers there, so that the death of our mothers and newborn can be reduced or stopped . This study will bring up a model of community engagement

that will be used to ensure that women use health care facilities so that maternal ill-health and death during pregnancy and childbirth can be reduced or even stopped. Other nurses will also be testing this model occasionally to see how effective it is and if it can be replicated in other places.

These were the findings from the interview with the women:

- Most of them do not know what danger signs during pregnancy and delivery are.
- They lack clear knowledge of the importance of hospital delivery.
- Health centres are far for the women compared to Traditional Birth Attendants (TBA) homes and churches.
- No birth preparedness especially in planning for transport and blood donors.
- Most women just prefer TBA.
- The assumption that hospital services is expensive.
- The women have been used to TBAs from the beginning.
- Nurses are not found on duty post if labour starts at night.
- Health workers are not friendly. They shout at them especially when delivery items are not complete.
- Hospital cumbersome procedures and hurried operation (CS).
- TBAs are more friendly and communality is allowed (relations).
- Prayers and fasting is a common practice at TBA homes to draw women closer to God and ward off evil forces.
- Husbands are heads and decides on place of delivery.
- Lack of community structure to monitor pregnant women and support in emergency situations.

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The women came up with the following suggestions:

1. The need to be knowledgeable about reproductive health issues.
2. 24 hrs services in health care facilities.
3. Husbands should be involved in Ante Natal Care (ANC).
4. Free treatment in health centres for pregnant women and children.
5. Occasional gifts to women who attend clinics to encourage others.

6. Health care workers should be more friendly towards women to encourage them.
7. In health centres, days should be set aside for fasting and prayers. Prophets and prophetess should be invited.
8. Town criers, women groups, churches should be involved in emphasizing health facility delivery.
9. Influential women group should be formed to monitor activities of pregnant women to ensure they register at the clinics and deliver there.
10. Women who deliver with TBA should be sanctioned from the communities, and anyone who dies there should not be allowed to be buried in the community.
11. The same way immunization is preached everywhere in the communities, news about free healthcare and importance of hospital delivery should take the same form.

As stake holders in these communities, your contributions will be able to guide the study by addressing the following questions:

What do you think should be done?

Who will perform the activities?:

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Who are the recipients?

Where will the activity be performed?

What will be the expected outcome?

What will be the process or technique of the activities?

How will the activities be sustained in the communities?

R1: If you are not a woman, your sister, your wife, your relations is a woman. If you are not pregnant, your sister or daughter is pregnant. If you do not have ehm! ehm! a child, your relation has a child. So…, all that is being said here now means government is thinking well of us. This take us back to the era that the missionaries brought hospitals to us alongside with churches. In those days, they were doing things for the good of our people and looked for a better life for us first not money, money comes last. So government has seen suffering and death that is going on now, so, they used their money

and train our children far and wide, so that they come back and work for our health and lives. So, what has been said concerns all of us, also we have heard all she has said. People don't lack excuse, so excuses of our pregnant women are numerous too. Now, we are looking for ways of making our pregnant women live, so why we are sitting here today is to start something that we can use to help our women live during pregnancy or delivery. For this reason, everyone should bring out ideas and suggestions. This woman has been working on this in our communities for a long time now, so it is time now for her to get from us what we agree on and stand by, so that she can go back with something to present as the outcome of her work in our communities. She is coming to us with confidence that whatever we will decide on, we will manage it, holds it and use it to ensure that our women remain healthy and alive, so that when she returns to visit us, she may meet all of them healthy and alive as she left them.

Those are the ideas we want to build together now. That is what we have to do now. So let us move on. Women should bring their ideas, TBAs should bring theirs, so that our women can stay alive. This does not mean that our TBAs will not be doing their work, they have been helping and will continue with the knowledge they have. Hospital workers will do their work with the science knowledge they have. Because in all, there are hidden things, I mean hidden things are there in everything of which everyone cannot know but only the few eyes that know. One knows what she learns.

Hospitals medically have what they use in checking people. That is how they know when it is time. There is no need being afraid of hospital. If one has no problem nothing can happen to you. Obedience is the thing. If they decide to operate, it means they have seen that if they woman is allowed to labour, she will die, they now time .... and operate to remove the baby so that both mother and child will live. So they are not doing nonsense, they have been trained. So my brothers and my sisters, we have come today to bring out the ideas that we are going to use for this and also form people whom we will give the responsibility for this. For instance, in police force today there are so many types, all to tackle our country's problems because on daily basis, crime rate is increasing. So, every police department has a duty to perform depending on the nature of crime committed.

So, likewise, we should not feel committees are too many. We should be ready to form groups within our communities that will be going around monitoring the activities of

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our women. I hope a man will not harass us that we are trying to chase their wives, may God help us. In any case, we are going to form a group that when they see a woman with pregnancy, you ask her if she has gone to register in the hospital or health centre? That is what the community wants to do. When we do our work well within this group, government will support us. So everyone should bring his or her idea. Thank you so much.

R2: I am the nurse in charge of our big health centre serving this communities and you all know me**.** We know that we have brought TBAs to join us here, eh….. All there is ....is....for the TBAs, it could be that what is said here is sweet or not sweet, but what have to be done we must do. If a pregnant woman attends clinic in health centre , when it is time for her to…..or seven to eight months, she is made to go and do scan, the reason is to know where the baby is because on two occasions we have had problems here that during labour one is taken to the TBA. After they have rubbished everything they bring her to the clinic. Because if she has been coming to clinic we would have asked her to go for scan, so we know that the baby would not be able to come out through the right way and we ask her to prepare for operation to bring out the baby , the baby lives and she lives. The other one along "ASSIAH ABUFA" so it was, that they rubbished the pregnancy that during labour we could not, so we asked her to go to the bigger hospital but her husband carried her back to the house and she died there. Her corpse is there now. So please it is not a struggle everybody should contribute, no one is taking anybody's job, what we want is for our women to live, everybody lives. So….please nobody should be offended, one's job is not taken away from anyone. That is what I want to disabuse from your minds. Thank (Clap from the people).

R3: Welcome! I am a TBA, please what I want to say now (interrupted and asked what her name was. She Responded) My name is Promise Kparika. Please what I want to say now is concerning childbirth, Pregnant women because they do come to my house…o! The first thing when they come I use to ask them if they have gone to the hospital. That it should not be when you come to my house, you stopped going to hospital. I cannot count the benefits of going to hospital when pregnant and they say they have gone. I tell her , I will like to know....... I will see your card to know if you have gone to the hospital. So some of them would say that when you go to the hospital, they shout at you, hospital dose this, but I say even that immunization that inject you, go that it is

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good thing, they will also test you to know the type of malaria that has entered you when you are pregnant. I used to tell them and some of them say they have gone to hospital. Some.... if one is in labour and is brought to my house and if I check, it is time for you to deliver and you have not, I tell you “go to the hospital, did you have card?” they say that they have and I say "bring it". So there is one that was brought because sometimes when something happens to somebody.... is to have knowledge.

There is one that came and the child was squatting in her womb. When you go, there is no way, the baby first put excreter in my hand, so I told her that there is no way…o, even me, I did not have the knowledge to ask her to bring her book, her book (SCAN) since she said that she had done (scan) took picture. With that fear I asked her to call her father to come so that we can take her to the hospital fast that there is no way…o! so I took her to “Teaching Hospital”, they checked her and said there is no way. They returned me to the hospital at moore road, Calabar. They said that I should go, it was night. So when we got there , they interview her ...... said everything. When it was around 2:am at night, she said to me “mommy is like I will put to bed” I said “Good what did I want, that I wanted her to put to bed, so they took her to the labour ward, later the husband came out and said that they want to operate. I said "so was I lying by saying that they have to operate her", even the first place we went said so. So, I used to tell them...... because instead of one to come and enroll yet you have seen that you will not be able to assist in the child birth you are just wasting time till one dies. so I do tell women to please go to the hospital that used to be my word. It is not as if they have not being coming, they have been coming and I also do tell them to go the hospital.

R4: O!…..I would have asked that question so that they would know…..am hearing (interrupted) I say….o that they say that the TBAs …these our sisters who are TBAs that it is when someone goes and get treatment from them and say that she does eh….if she does not go there to deliver, they will lock that womb. This was said before in our community meeting and I noted, it has happened to the level that they say there was someone….a pregnant woman who went there, that it was until they took her there that it was until they took her to the TBA she registered that she was able to deliver. We villagers investigated and I say they should ask them ...... these TBAs if they used to do so. That is what am asking. If they are complete in number here. Please my brothers and sisters that is what I wanted to ask today.

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R5: They have mentioned names na…h. They have that other one they say that until they take her to her place (the TBA place) before she puts to birth. So I wanted to a….sked. I thought that they wanted to call them....... all of them the TBAs to come here, because if someone comes to your house to deliver, you have given her treatment and she does not deliver until they bring her there before she deliver Ehmmm! ….(interrupted and asked what his name was) I am Ekpeyong Akabom (noise at the background). (Another interruption by the Clan head… "eh….m, what am saying is that, if…those things were not good thing. What we heard , were not good thing , if there are good thing to the one who did them, we saw it that it should not have been so. So for today that we are here, we are here to warn against such things that anyone who used to lock a pregnant woman saying "if it is not in my place the woman will not deliver", (she should not lock again). (Interruption by another community leader…) " Why we are saying so, is that eh…..no one is stoping TBA from taking care of any pregnant woman, but what we frown at is that she should not take care to the extent that the woman should not go the hospital to benefits from there and the hospital also knowing her problem that are there, will stop them before it is time for labour…childbirth. We don't want any woman saying that she is a TBA a…nd she takes care of a pregnant woman in a way that she dies, the baby dies too. God is writing, is better for one to own the debt that she will be able to redeem, rather than one owing God the debt that she will not be able to redeem to God, who believes in God and knows that God is truth will receive her reward.

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They should not be locking of the womb; they should take care of them and not lock their wombs. Give your treatment and care for the pregnant woman , if she likes to deliver at your house, when It is time, hospital have done their work, she will come and deliver. You also have to let hospital know that a child was born. This is the number of children that have been given birth at my place. The child lives and the mother lives that is what they want. So if you locked her , it means…if it becomes something that doctor has to operate and bring out the baby or that hospital has to assist, so the job that the doctor will do, you will make the doctor to have a bad name because it will be hard for baby to be born through doctor's assistance or in the hospital. So, such things we say that are not good. No one should lock a pregnant woman's womb, but care for her if she has to….If God wants her to deliver at your place she will. If it be that she has to put to bed wherever labour sets in. It does not stop you to caring for her. That is what

we are discussing about. A TBA should not fail to make sure that the pregnant woman that she is caring for goes to the hospital. Like one of us here a TBA have said that she does not fail to investigate them and know (Noise at the background…The people Claps their hands).

R6: …. Am a TBA, my name is Eno Ime Effiong. I am living at Ayanghanse here. This work of assisting at childbirth, God gives to us and also gives to me too. Since I started this work (interrupted by a leader "where are you living?") Abiet Archieobong Ukpong. God have been helping me during labour and childbirth, this our mothers here (refering to the nurse in charge of the health centre) also used to call us from time time and show how to…if delivering is too long, we should bring the person to the hospital. On my own part, my pregnant women, I do like them to come for immunization. If that I ask them to come and they don't I used to stand up on my own with my money for transport, accept to pay transport for all of them and bring them to the hospital for our nurses to check them and how they are faring, She also used to teach me how I can work with them, since I started this work no one has died in my hands because God said that he will give us the reward that will be commensurate with this work that we are doing. Please that is what it is (Clap from the people).

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R7 : …Progress, Progress CHC, Please my name is Deaconess Grace Samuel Okon AKAS Mma Police. (Baby cries at the background) So, please, concerning what is on ground, am not a TBA…O (Baby cries and distract) but I have children that I have put to birth and stopped. As they use to say this tha…t, eh… they carry pregnancy to TBA to care for, they lock the womb, such things I don't understand because with God "all things are possible" Am a mother of seven, the first pregnancy that I …I had, I had miscarriage at three months old, when I took in again that first one I was even rushed to the hospital, but there was no help, so the second time, when I took in for my first daughter, so I started attending clinic, they asked me… like they used to say that they gave something to pump ah…. I have not seen what this white men drugs cannot do…o. So they did that test and checked I was in the hospital for two weeks. They did test, did this and that, did you have problem? I said "yes", I list problems how was it and I told them, so they treated my case till I born and stopped I never had such problem again. So… sometimes they say they gave somebody something to pump, I don't…, I don't understand it oh. To say I went to TBAs place for TBA to give me something to pump,

sometimes they say I did this and that, the best thing is to go to the hospital because these nurses are trained nurses and I like hospital's work too much that I told one of my children to follow and go and learn, so hospital have trained their people and they also write exams like they do in the secondary school, primary school, everybody "they bend down to teach". They also teach them till they come out. Like as they use to say, they locked the womb, I don't understand because till I have put to birth and stopped I have not locked or unlocked. My own is when am with pregnancy, nurse will…have not even asked me to open, I have opened and I will tell her to check how the pregnancy is …o, if the baby lies well or not. She is the one to know because is what she went to learn.

If that baby does not lie well, she will tell you. For this one that they say (she makes mouth), labour had not even started they have operated me, ah…ah, ok a statement saying they did not even wait before they operate you, they are sure that you will not be able to deliver even they will have front and back. So the best thing is, please we should, those that have children, they that have daughters in-laws, those that have friends should make their children to… or weather their daughter in-laws to go to the hospital. It is not a law for one to say tha…t even if it is that hospital bills used to be too much for them to be running away. They said they don't charge anything that you have have when they finish the work whatever you give out of love, they collect and thank you. Is not as if there is a levy but as they do run away from the hospital is something that I don't understand. Sometimes when they go there…. But there is need for a TBA to be around shall in case it happens at home. This me, I have never stepped my foot at the TBA's place and the baby comes out. It was that I delivered before they went to look for the TBA, because she was not around, before they could look for and find her, I was already resting.

When she came, she then removed the placenta and did what she was supposed to do. Is not as if am condemning the TBAs but they should be begging our women also to be going to the hospital, because I have seen two young men who complained that their wives who are pregnant, they don't go anyway but they don't go to hospital or clinic days, they stayed at home sleeping. When clinic hours are over they look for food and eat, her husband get home and asked her if she had gone to the hospital, she says no . Sometimes, they lie, the husband would say last month she collected two thousand naira from me saying is hospital that wants it, the other time she collected three thousand

saying that is hospital that wants it. I told him that hospital does not want …o, because sometimes, our women used that opportunity to be getting money from their husbands. It is not good. They use that opportunity that they are pregnant and eat their husband money. Nurses do not want they say they wanted, they did not do this, they said they did. When you are pregnant whatever you see you collect because this child is not only the man who own him, the child is for both of you (Phone ring). Long throat will not allow. So they demand too much from their husbands and is like they want to give them problems. So please our TBAs… they do give advice in clinics (baby cries) nurses and midwives know more on how to care for pregnant women and they should tell them to come out, because some do come, but can't go to anybody's house and force her to come to the hospital (baby cries) you will not go and beat them. Thank you (the people clap).

R8: We all have heard what that woman have said, she touch a lot of things, so women now use their pregnancy period to eat their husbands for nothing (audience answer yes)…o, go to the hospital they don't …o but they will lie to their husbands and collect money that it is for clinic, and their husbands do not know what is happening. All this is that we must have what to do and that we must do something that is true (noise at the background) ehm….m women should contribute here if there is something to say so that we can move to some other thing.

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R9 : Glory be to God…..eh….m am talking about this pregnant women issue. I am the woman leader in any any anyanganse. I have been used to women a little, this pregnant women issue, like in Anyanghanse that we live, Thank God that our health centre is opened because since when that health centre was closed, I have always been having problems with this chief Otu, because our chief is just like the Clan head. This pregnant women issues use to disturb me because, Tuesday last week, nurses who were at the health centre saw that many pregnant women came out, I used to move from one house to the other telling them that if they don't go to the hospital when pregnant , if they die that they will not be bury in this Anyanghanse community, that I do follow and weed the street that you will be taken home. Even there is one that all of us use to say that the baby dhe was carrying was "Fibroid " even I wanted to come and meet the matron nurse, I brought her but she was not around, so after waiting I left (baby cries). But that one that lady went for clinic at that our health centre, nurse checked her and let her

know that there is a child in her womb, nurse even called doctor at the health centre but doctor said that there were many persons for him to attend to, that he will not be able to come immediately and the lady does not have a husband. So this lady was with this pregnancy…even her Aunty which is exactly what we are saying gave her treatment, without knowing that there is a baby in her womb, it was at the dying minute that she knew (woman's voice heard at background)…ok. So this thing had being there before they now confirmed and told her. I told her that I will take her to the hospital for scan, she said Aunty she does not have money, she does not like scan, she does not like roaming In the hospital. I told her that "do you see all this that you are walking around and doing that I will tell clan head, so that if anything happens to you they will not …you will not be buried here." They will take you to your village. I have bee talking to you to go out to the hospital that I have my three ground children in the hospital. They were born at Idundu hospital, three of them. Never did they collected money from me, if they do may be one hundred or one thousand, some do even come without carrying even napkin, nor pampers , nothing, nothing, they removed things from the hospital and take care of them. Our matron here tell her that in the clinic here all is free and I go, I say when you get to the house of TBA me I don't have money..o, that government will pity me.

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So I say that these our chief should look for what they will do, because there is one that puts to birth very small and she has not been given injection…o. I stood at that Jehovah's witness and told her that "see you said since you were born you have not been given injection", then how did it get this one injection that you get pregnant (laugh by the audience), that you will not be given injection, how did you? (Laugh and noise by the audience) well, you will go to the hospital, all of them, I shouted at them that they have to go to the health centre and they went, they were many there at that health centre…so they should look for how they will…do this thing, because this thing is disturbing us, because young woman that are taking in new now are collecting money from their husbands and sometimes their granf fathers give them money, they say is five thousand to go to the hospital, but they use that money for contribution and to eat pork meat, she does not go to that hospital, she keeps saying she will not be able to take injection….o. So…eh…na she does not want to go.

Nurses do not shout at anybody because, me my grand children were born at the hospital. Last year they born at the hospital (interrupted), they don't shout, no one shouted at anyone, in fact they will be petting you so that you will deliver the baby freely. The more babies are born at the health centre, they are being tick right na. As we can see now, government is developing that our hospital, so we spread at childbirth the hospital will be big. So there is need for our big people to let us know how we will do cause me to disturb them..o..o in that our street, I had up to eight there like as it is going to be Tuesday now, I will tell all of them to carry their children and give them immunization even if you gave birth that time, you go and receive your immunization on this Tuesday. Like today all of them have gone . so this task is in the hands of the chiefs, we the women will stand by them. But as for the TBA, nobody will stay back, because they have been going, but for some the TBA will check and for those who said, nurses only check they don't turn the baby, they will go and the TBA will check and turn the baby. But for the one that they say that they use to lock the womb, I have seen how one was in labour and was taken to TBA place, but she could not deliver until they took her to the former TBA who first took care of her that she delivered. I have heard with these my ears, until they returned her to the TBA who gave treatment that the lady delivered there (noise at the background. People with surprise and show frown at it) yes, so they should warn them not to do again. Glory be to God (the people responded AMEN, Clap from the audience…Noise at the background with participant murmuring).

R10: I want to stand by what they just concluded, speak and talked on saying tha…t, that a pregnant woman goes to deliver and did not they took her to another place, she did not till they took her back to the first place, please I say if they know such a person for such a person is a murderer (interrupted-she should be removed from among the TBAs, Noise at the background). They should call her and caution her or hand her over to the highest authority, please sir….please (Reaction from people-Arousing noise. The people clap).

R11 : Listen please, please listen, eh…eh! What I want to say now is like these things we are hearing here are sorts of eh…eh…Security report. Eh…eh, we will look for individual, one after the other that we have to look for, to again investigate and know how we do our work. Eh…eh… that last statement made by the vice chairman is true,

it is not to stand here in the public and say (interrupted-ok). We have heard those reports that we have received here. Even for ourselves, we will have some part to use people and do not stand here to say everything because we know human beings as they are, they will say hear what this person said about you, you heard what that one said about you? So we know how we will go about it. To do all that, we have to do. Do we understand the statement? (The people gave a chorused answer-yes…yes, we do). Such things must not be allowed by us to continue. We have to call that person and warn very well and tell her that anyone that any problem reaches because of that will know you. So lets hold it there. Thank you very much for the entire thing that has been said here (the people clap).

R12: Eh …m! (noise at please the background) what I want to say now is, we….have gotten some information about pregnant women, they are very many, I think that it will be good (noise at the background) for us by ourselves to ask God to give us the directives for us to form (noise at the background) those people that will monitor the way and manner that they will monitor pregnant women in our communities. It is good for us to form groups of male and female and give them power, but before we do that, we will assemble our communities, give churches letter, walk from place to place to let them know the advice that they have to give to women as regards to pregnancy, because government have tried, so we commit ourselves toward assisting government, so that the benefits that government want to reach us can reach us.

Eh…we have from today say that TBA, any woman that you are caring for the pregnancy you should make sure that such women would have showed her certificate from the hospital and her card that she is using to receive treatment from hospital. Anyone that you do not see with hospital card, and you have card that she is carrying is not the hospital own, you let the chief in your community to know or if it is the Clan head so that they can call such a person and caution that while with pregnancy, she must go to the hospital. We will also look for ways...... I have said it before we will look for people and train them on how to go about and let the people, the men, the villagers know that now, we have a law we have people we have formed and committee that their work is for them to go around and check any woman who is pregnant to know if she has gone to the hospital (noise at the background and phone ringing), if they investigate her and know that she does not go to the hospital they have to report her to

either the chief or Clan head so they will make her to go the hospital, if she does not want to go, they report her to police, all we have to let the police know officially, it will not be a hidden thing so that we see that help and love that government has for us is worth, we accepting and owning it that is how I would like to say it (the people Clap).

R13 : Mine what am trying to say....... thinking is that eh…. My name is Idem. Idem Effiom. So I have se….en according to madam saying those people who use to go out day by day (village Health workers), we see people doing that work, I believe that those people who walk about, they can give us, because they have been........, they know all the…women, the pregnant women, they move from house to house seeing and knowing pregnant women as they go round. Because I think i have seen them, such are the people that bring real data to come and give to the hospital. So when they give to the hospital, we the chiefs now get the list from them. The TBAs.... we use to invite them to our Ward Development Committee(WDC) meeting, but they don't like coming. In order for us to know…know how many TBAs that is there within this ward and communities . So when we know, we give, let us say every, eh…end of the month or once a month that all of them must come out for meeting. In this meeting...., WDC members, Village Health Committee members and the group that will be formed will all be there. If they don't come out, we impose some...Eh…some…eh fine. When we impose plenty fine on them you will see, they will be coming out then from there, we start to educate them. I said without that they will not come out because we have sat here and every time to say it. Also another one is that we have form this eh….WDC, this is WDC meaning (WARD DEVELOPMENT COMMITTEE) that the Local Government Councils formed. Our duty is to walk around and check, that is the sanitation of th…eh…place, this thing, ev…ery..... the women… the TBAs names , know where they live so that we can be checking to know if they keep their environment clean. So… if we encourage these groups who go around, give then the TBAS addresses, because they will know the TBAs. Also let them know the names and addresses of the constituted group members (interrupted). So we now meet once in a month....all the groups together and invite the TBAs........whoever does not come out, we can say five, five thousand as fine, they will come out. That is what I think (interrupted-noise at the background) thank you.

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R14 : Oh! Sir thanks you very much. What I have to say here is that to investigate the TBAs from time to time, when we will form groups and after forming the group, we will then know, what is going on. So from time to time we will be rotating this meeting, madam (referring to the matron)…and those that we will form madam when we want to start our operation well, she will give us one of her nurses. When they go, they investigate TBAs and know how many pregnant women that she is caring for. Am sure you have heard, and they will also ask, if they are going to the hospital or not she will let us know and after that place they will go to another place, after that we will go round and check for this will help.

We are saying the truth,.... whoever refuses to comply, like the other one that a woman locks the door and jumps through the window out (noise), that woman came and reported to me and after knowing that it is true, I sent people to follow her and go, when they went they said they knocked the door, removed her and told her that " if you do not want to go to the hospital, you and your husband have to…" we see…so this makes the problems in women too much, so we have to stand up and help them, so that at the end all that we will do, God will gives us the grace to do it so. This is what we have to do. Whatever that fights it will stop, I say it has stopped (people answer Amen!). So that anyone that wants to be stubborn will be held and they know what punishment to be given.

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Sometime it could be that husband does not encourage their wives to go to the hospital in order to stop this death. So there is work for us to do, so it is for us to tell the health officer that….eh what she is doing, she should also go and give report about all that we have agreed here, and that we all will find ways of helping to do this work to see that all the women who are in our communities, when pregnant have…all of them are to benefit from what government has given to us. The one that does not want to…we will also know the type of punishment to give to such a person. What we can do we will do (the people clap).

R15: (Noise before he begins) what I want to say concerning ….still on this health issue. In the first place, I want to rejoice with our visiting health officer and also to talk about those things that we had already know and I also thank all the women that have come out here, especially these TBAs, because we have been looking for a way for them to come for meetings, they refused. So for them to be refusing to come out for

meetings, I see it as stubbornness, because we have to let them know that these children they assist at childbirth are people's children, our children and they belong to our communities, so that anything that happen to these children will not only affect the parents....... the biological parents but it will affect us and the communities. So it is a bad manner for them to refuse to be coming out for this meeting, like now they would have been asked why they have not been coming out for meeting, or are they afraid that like the officer said that, their refusal to come out is like hospital is struggling work with them, they should be coming out so that they can also discuss and know the ways and how we can care for these children and do this child delivery well, they are our children, they are the community children. So for them not to have been coming out before, am not happy about it. Wha…t chairman and chief Edem have said I support very much.

We have to…, they say…eh…eh in a community nothing, if they don't really check…"if an abomination is not checked in a community, it becomes the culture of the people there". If nothing is done to them, for them to know that, that their actions are not good, they will continue to do it. So with that I think tha…t, that the benefits of our coming out here, when we have not put anything into action is not there. So we have to be sure that we move from one place to another to… since they don't come out to hear for themselves, that we have come to see, and if there is need to close down their places, they close down, if they don't meet up the standard, because of their stubbornness so…that is what I have to say. Let us beg them to be coming out to learn from......to gain information, because "knowledge is health and health is life".

When we discuss things that concerns life, we should take it serious. Is not as people think that weather they use to give money , so when they come, they go back until the day that they have occasion, then a day like this, to turn around and see these women as a surprise and these TBAs. A…nd I am very happy when people are many in a gathering, it gives humor and people feel happy. You see..., these our chiefs that have come out today keep on coming out, so that we put heads together to ma…ke, make the village better. Thank you (the people clap).

R16: I greet everybody that have come out here today. My name is mma mary, i lead women group in Apostolic Church here in Idundu community. I want to say that all what we have said here are fine and good. Even the decisions we have taken will help

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us all and save the lives of our women. But without pretending, let us imagine ourselves as the TBAs. We cant just condemn everything about them because they have been helping so much in serving the lives of our women and children within their small knowledge. So on my own opinion, i want to suggest that the group we will form should also beg the government to train our TBAs so they can gain more knowledge to take care of our women. Why because...i know very well that there is no way we can stop all pregnant women from going to them. It is not just possible, some will still go or if it is as if we are forcing them to hospitals, they can go to register in the clinic but still go to the TBAs and deliver with them because this practices is what they are already used to, and confidence in the TBAs have been built up over time, so to wake up one day and say stop may not be achieved. Apart from this, these TBAs are using this work to care for themselves and their families. Who will be happy if their job is taken from them, how do we want them to survive? If they go to steal will we not jail them? Come to think of all these. I want to suggest that we can adopt what i see them start in Ikom LGA, where to achieve this same goal, the TBAs are asked to refer all pregnant women that go to them or even escort them to the clinic/ hospitals to register and deliver. Records of this are kept and at the end of the month , depending on how many pregnant women each of them brought, the government pays them some stipends to sustain them since they no longer deliver the women. they are now treated as partners in healthcare delivery. this is really working there for them as they have started. You all know me, i fear nobody, i say the truth and do not do eye service. Let us all think about this. thank you. (the house screams and clap loudly).

R17: Glory be to God (Amen from audience). First of all, I want to thank God for keeping all of us healthy and alive. All what we have to discuss here is of great importance and dignity to us and our communities. This work, we have now accepted to do is our community work and it involves government. It will be wise to let the police know about what we are about to do. This group will ever serve as the community police. When the police are involved any problem we encounter out of this work can be reported. Also this work and all the good things we will be doing to better the lives of our people should not only remain with us here in the communities, the government should be made to know about what we have agreed to do and our good works here. May God bless all of us. (Amen and Clap from the audience).

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R18: Glory to Jesus (Amen) Glory to God! I thank God for this good turn out today to answer this call. I am really wondering if the reason why our pregnant women do not like going to hospital is due to fear. It will be wise to also find out the reasons from them as we move around. Because in this community, many pregnant women do not like hospital, they keep going to TBAs who keep them there and commit havocs. This is not good. So I pray that all what we have agreed here should be carried out in Jesus name (Amen and Clap from the Audience).

R19: On my own part, I can see the fears on the faces of our TBAs present here. Though I cannot read their minds, but as a human being, I believe they have fears that their jobs are going to be taken from them and this is the source of survival. Also here we are all saying they should be members of this group that will be formed to make sure every woman goes to hospital. If it is you, will you be happy? Let us speak the truth. They may not be happy, but cannot say it out here. So I am supporting what the last speaker said and may want to suggest something, because I have heard that other local government councils in this state are trying to practice this in their communities and it is working well. I am suggesting that the TBAs can be made to work hand in hand with the health workers by bringing pregnant women that go them to the clinic and follow them up to make sure they register and deliver in the clinics. At the end of the month, government can be appreciating them with little money through the local government to encourage them. This is my contribution and I believe I am speaking the minds of the TBAs here (The TBAs smiles and huge Clap from the Audience).

R20: Hmmm! Today, what we are going to do now is that we will have to start passing information by sending written information to different societies and groups in our communities, schools, churches, different cooperative groups and all other groups that we have here, that is any welfare group or any gathering people come together up to ten in number or even more. At the end of this meeting, the chiefs will send letter of authorization to them. They will also keep a copy, and also send to this our visitor, so that whenever she comes back, she will see the kind of work we have been doing in the community. Because, we are going to all move by ourselves, physically and do this work well, also to help advise and encourage our women, we will also ensure that women obey and accept to go to health facilities for care , whenever they are pregnant.

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Also to benefit from all treatment and immunization that government sends down, even the children themselves will also benefit. Because, all these treatment and immunization that is been given during pregnancy does a great deal of good for the baby in the womb. Any woman who is pregnant but refuses to go to the clinic has committed a great crime. We have to ensure that whether they like it or not, pregnant women in these our communities must register and deliver in the clinic or hospital. Also those who have babies must take their new born babies to the hospital for care and immunization. So we are going to pass round this information, not just passing information but we must from time to time go around our communities to visit those societies to ensure that we ask about what they have done with the information passed and also find out if they are cooperating with us. So, that government herself can be happy with us, knowing that all the money they have spent to better our health is not wasted.

That is what we have decided to do and we must do it. We must also be committed and commit ourselves to assisting the government achieve this aim, so that we can remain healthy, our children can be well and not suffer from preventable diseases like measles. Through all these immunizations and treatments, children illness and deaths have been reduced. So here we have taken a decision and agreed.

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R21: Ehhm! Before we disperse today….because some people may leave and not come back. So here and now, we should decide on a date to meet and constitute the group (murmurs from the audience). Just for that purpose. (A voice from the audience stressing "the group should be constituted today")

R22: Hmmm! I am very happy today about all what has been said. What we now say that we have agreed on is that a…ll TBAs in these communities, that we all know that they are TBAs must be made a member of the group that will be formed. (voices from the audience saying " they were supposed to be members of the village health committee but they have not been coming). If we discover that you are a TBA and you refuse to belong to this group, you will have problems with the community, because we need help. My own mother was a TBA, in fact the first in this community that received delivery kits from the government in those days. TBAs should not be afraid to belong here, no one is putting in jail, come and be part of it to learn and know what to do, "she who obeys does better. It is God who gives TBAs the talent, no one is against you and

what you do, but you must join sus, so that you can be better advised to do well. That is what I have to say. (Clap from the audience)

R23: The TBAs on their own do ask them to go and register in the clinics, but the women themselves do not like to, but…ehhhm! It is really an important thing that all TBAs here should be members of the village health committee so that we can investigate and know those of them who work hard in referring women to clinics (voices concurring from the background), also that they know those who actually turn up to register in the clinics and those who do not. TBAs are many in our communities and women are getting pregnant every second. We also have to take upon ourselves to make findings to see if every pregnant woman we see has register in the clinic. They have to proof by showing us their cards of registration.

That is the duty our pregnant women owe us. Amongst the group, we will also have people that could go house to house to check and identify the pregnant women. Those of them who cannot show their registration cards means they do not register, because if they register, they will have the cards. It is then that we will have problems with such a woman and her husband. That is my contribution (The audience Claps).

R24: My name is Chief Okon Ekpenyong, i welcome everybody and i really thank God for this meeting. For me, i want to say that it will be very necessary for members of the group we will form to ensure that they work together with the Ward Development Committee and the Village Health Committee which were already on ground. I can also sense that some members of this group can come from the already existing groups. It will be very important not to leave them like that. ee...mmmm! they should be given some form of education....from time to time....., I mean training to be given new information about health matters so that they can always have what to tell our women......" you cannot give what you dont have". It is good for them to have knowledge of everything so that they can do their work well.

R25: Good afternoon everybody. This thing about prayer and fasting . We all know that it is very important here. All we have is God and even if a woman does not know God, when pregnant she will become closer to God. The world is bad and enemies attack more during pregnancy. So this should be looked into in our clinics. The nurses

should keep out some days for this as they care for pregnant women, not just small small opening prayers on clinic days, that is not enough.

R26: Chief Okon Ebong is my name**.** Pregnant women in this community cannot do without prayers and fasting. Like my wife who is pregnant now, she goes to church everyday for fasting and prayers even when i tell her that eating is good for her and the baby in the womb. She always says that God protects and so nothing will happen to her and her baby. She even prefers delivering in the church because she believes that with God she is protected. Though she registers in the clinic. What am trying to say is that for prayers and fasting to be made part of the health care is very important.

R27: I want to say that we know that prayers is important, but we should also know that nurses have a lot of work to do in a day so if they give so much time to prayers and fasting , how will they attend to other things. Why can't the women go for prayers and fasting either in their churches or wherever and know that when they go to clinic it is for care.

(GROUP MEMBERS APPOINTED= CONSTITUTING 5 MEMBERS IN ADDITION TO WARD DEVELOPMENT COMMITTEE & VILLAGE HEALTH COMMITTEE MEMBERS)

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F= (FACILITATOR'S CLOSING REMARKS)

I want to thank everybody here for the cooperation you have shown in this meeting, because we have really gained your cooperation and all what you have said is true. Then I want to make one thing clear to us, this duty is a voluntary job, we will be doing it for the love and good of our women, children and our communities, all because we do not want them to die again. We all know their worth, the value of mothers and wives. I know when something like this comes up, people will say it is our government that sent them, so, now that i am a member of this group…will I be paid salary? You may not say this out here but I know that after now people may go back bothering the Clan heads about such questions.

The way am hearing, the nature of this voluntary assignment and work will attract no salary, but occasionally, the groups might be appreciated by the community members.

But note that there is no salary. Whatever we agreed here to be done is for the benefits of all of us and our families and communities, there will be no money, no salary, especially at the start. It will be done out of goodwill and love for one another by ensuring that mothers and children will no longer die, through ensuring that every pregnant woman registers and delivers in the health centre and hospital. The group that has been formed maybe serving as advocacy group between the community people and health care providers as well as the government.

Through this intervention, the benefit that will come up might prompt the group in future to advocate on behalf of the community to the government. Through the group the community challenges can be made known to the government and suggestions on ways of improving them put forth, so as to achieve improved utilizations of healthcare services by our women. If this group becomes active, move with one voice, any request or suggestions to the government through them will be attended to promptly, than one person going to the government. This is because; this group will now be representing the community voice. I bet all of us here that through this group a lot of benefits will be attracted to your communities. Congratulations to all the new appointees. I wish you well in your new assignments.

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Now, if I may recall what we have said and agreed here:

- The Clan head have agreed to have a meeting with all the new appointees within the next two weeks.
- That the selected members will be working with the already existing groups (Ward Development Committee (WDC) members and the Village Health Committee (VHC) members .
- That this group will meet and choose for themselves a chairman and the secretary.
- That their duties will be to monitor the activities of the our pregnant women and report same to the Clan head.
- That the erring and stubborn women who will refuse to use the services of our health centres and hospitals will face sanctions when reported.
- That the group may attract a name in due course.

I hope these were all what we agreed on concerning this new formed group (Yes..oooh! By the audience)

F= Thank you for listening and God bless all of us for being interested in the good and welfare of one another. May God continue to show us and our families mercy in Jesus Name (Audience responded Amen…ooo!).

F= I have nothing to give you, but just appreciate this water (Soft Drinks and biscuits) to quench your thirst and this token for your transports, for the love you have in answering to this call (Audience-thank you…ooo! May God bless you).

OBSERVATION:

- Cheerful clap after the Facilitator's Speech.
- Clan head reemphasized on what Facilitator had said trying to motivate the people to come up with suggestions concerning Facilitator's Model interview.
- The people listen with keen interest
- TBAs' initial facial expressions denoted anger, but towards the end of the meeting they put up some smiles.
- Women and some men were frowning when the issue of locking of womb was mentioned.
- Some participant used funny words to make some points clear, also to avoid offending others, especially the TBAs .
- Everybody admitted and respected each others' opinion.
- Generally, everybody participated actively.

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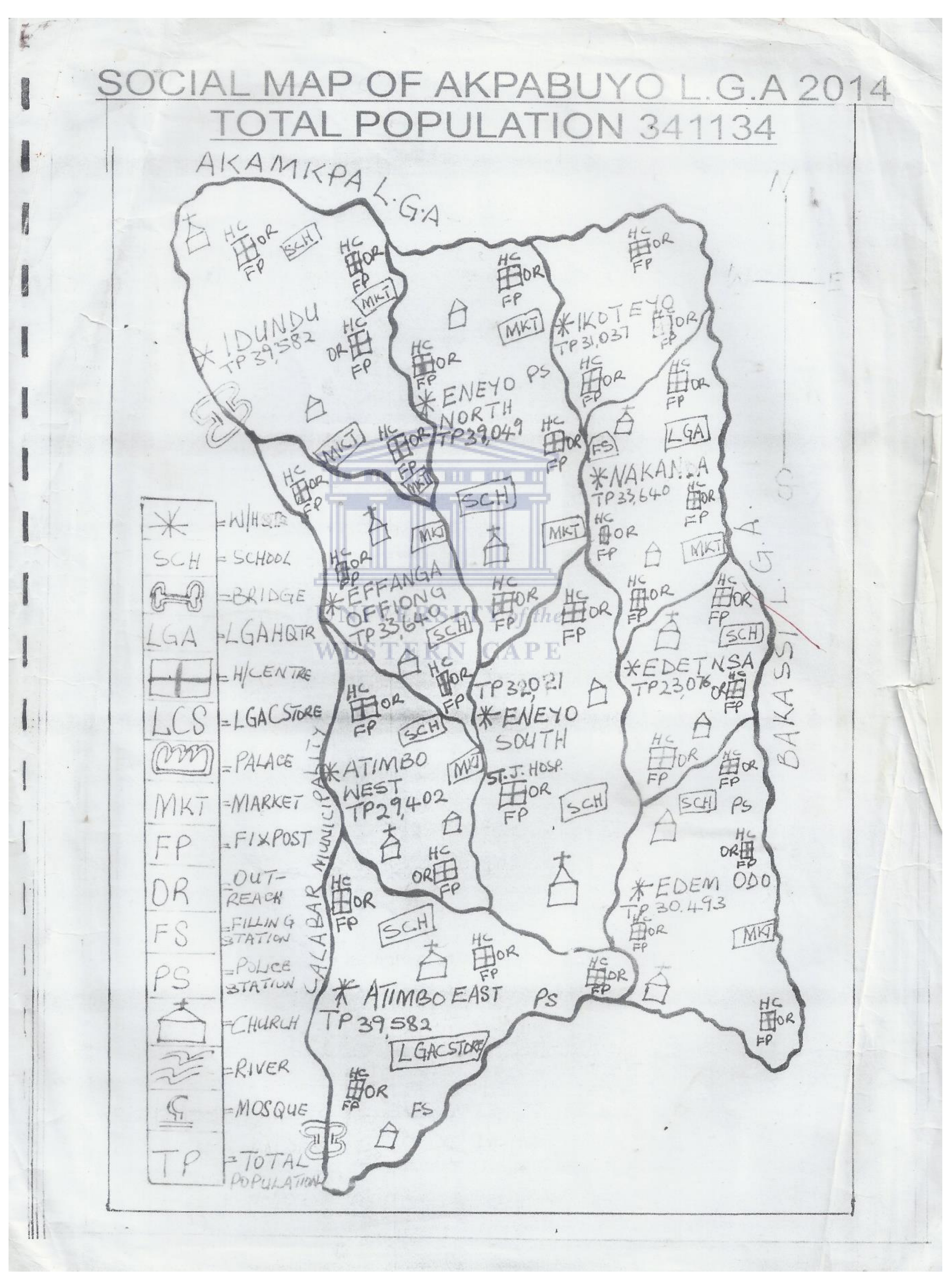
APPENDIX 14

MAP OF AKPABUYO LOCAL GOVERNMENT AREA SHOWING STUDY SETTING



APPENDIX 15: CERTIFICATE OF EDITING

ISABELLA MORRIS

Editor

M.A. Writing – University of the Witwatersrand

1E Westlake Drive, Lakeside, 1609

081-0468501

18 November 2015

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

CERTIFICATE OF EDITING – ALBERTA NSEMO

I hereby confirm that Alberta David Nsemo's dissertation entitled "**A MODEL OF COMMUNITY ENGAGEMENT IN THE PREVENTION OF MATERNAL HEALTH COMPLICATIONS IN RURAL COMMUNITIES OF CROSS RIVER STATE, NIGERIA**" for the University of the Western Cape was edited by me in October 2015.

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Sincerely

Isabella Morris

Associate Editor

Professional Editors' Guild

APPENDIX 16: TURNITIN REPORT

Turnitin Originality Report

A MODEL OF COMMUNITY ENGAGEMENT IN THE PREVENTION OF MATERNAL HEALTH COMPLICATIONS IN RURAL COMMUNITIES OF CROSS RIVER STATE, NIGERIA from Alberta Nsemo by Harrison Glory

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