

Prevention of Maternal Health Complications: Voices of the Rural Women through the Lens

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Abstract: Photo voice is a technique based on participation, educational empowerment, consciousness-raising and self-documentation among ordinary people, compelling them to be agents of change. Local people are given cameras to capture images of their everyday life experiences and practices within their community, then describing the images in the context of their life, thus the critical reflection and dialogue this photography promotes can serve to reveal significant social, cultural and political issues.

The aim of this paper was to engage community members through photo voice to highlight problems regarding pregnancy and birth practices, identify possible solutions and make recommendations on communities' roles in the prevention of maternal health complications.

Method: The study adopted a qualitative design that combined photo voice participatory approach and focus group discussion in collecting the data. Purposive sampling was used to select 20 participants from Idundu and Anyanghane communities of Akpabuyo Local Government Area of Cross River State, Nigeria. Guba's model of credibility, transferability and authenticity was applied to ensure trustworthiness of the data. Ethical principles was adhered to. Data was analysed using Tesch's method of content analyses.

Results: The themes that emerged from the data analyses revealed the following among others; men are sole-decision makers regarding place of delivery, high preference for Traditional Birth Attendants' (TBA) care and lack of community structure to support women's health. Suggestions towards improving rural women's utilization of skilled care included; improving maternal literacy, involving husbands in ante natal care, use of community structures to emphasize facility delivery, TBA training/TBA-facility collaboration, and constitution of Community Engagement Group (CEG), to monitor and encourage utilization of skilled attendants.

Conclusion: It is believed that the activities of the Community Engagement Group may bring about increased utilization of healthcare facilities for skilled care by community women during pregnancy, delivery and after delivery, hence prevention of maternal health complications.

Keywords: Community Engagement Group, maternal mortality, maternal health complications, Photovoice, prevention, rural communities, , skilled attendants.,

I. Introduction

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 [1]. 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 [2]. 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 [3]. Health gains and healthy lives require more than just the provision of services but such services has to be well utilized. However, the use of skilled provider in developing countries remains low according to the Demography and Health Survey [4]. Based on the health promotion approach as outlined in the Ottawa Charter [5], "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" [5]. 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 [6]. 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 [6]. A study in Calabar, Nigeria, revealed less progress in the rural areas in comparison to progress in the urban areas [6]. 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 [7].

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 [8],

engagement of community through action and advocacy to improve maternal and child health services [9],[10] 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 [11]. This method according to [9], also enables people to identify community strengths and assets and their shared concerns as a basis for issue selection and action.

II. Problem Statement

Pregnancy-related poor maternal health and maternal death are still a major problems in most Nigerian states including Cross River State, and it is assumed that most of these cases can be prevented when births are assisted by Skilled Birth Attendants (SBAs). 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 [7], 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 [7]. 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 [6]. 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 [12], 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. [13], 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 [13]. 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 to prompt such mechanism in the rural communities of Cross River State.

III. Aim of The Study

The aim of this study was 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.

IV. Research Questions

How knowledgeable are women in issues pertaining to pregnancy and delivery in this community
How prepared are women in terms of birth preparedness and complication readiness?
What are the delivery practices of women of child bearing age?

V. Literature Review And Framework

In Nigeria, maternal mortality indices vary across regions, cultures, and settings, with the worst statistics recorded in remote rural communities. Study by [14], revealed that in many parts of rural Nigeria, most pregnant women do not deliver in a facility with a Skilled Birth Attendant (SBA). 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 [14]. According to these authors, the findings indicated that social influence is important in encouraging women to seek both antenatal and delivery care. 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 [15]. The fact remains that most of the deaths are preventable by simple, affordable and available interventions as well as attitudinal change [7].

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 [16, 17]. 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 [16,18],[19, 20] 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, could have significant impact on the services they provide [17].Low levels of knowledge and awareness of risk factors, causes, and treatment for given conditions was observed among those failing to take up services [16]. 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 [20].

[17]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. Negative experiences may affect access and engagement of service by the community [17]. 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 [21]. 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 [22]. According to [23], 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 [23]. 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 [24]. [1] 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. 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 [25]. Perception and knowledge of the community members in Nigeria regarding maternal health problems play a role in their care-seeking behaviour [26]. For instance study by [1] 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. Such misguided opinions and folklore are likely to result in a delay in seeking medical attention on time [26]. 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. [26].

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 [1]. [1] 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 [1]. 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 [27-28, 29]. 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 [30]. 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 [30]. 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 [31]. 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 [32]. 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 [33]. 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 [34]. [35] 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.

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 new born problems in their communities, and to develop community-driven strategies to address these had significant success with 30% fewer new born deaths and 80% fewer maternal deaths [21, 35]. 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 [36].

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 [37]. 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 [37]. As a data collection method, the idea of providing research subjects with cameras is relatively new [37]. 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 [38]. 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 [38]. 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" [39]. For instance, [40], in their study on picturing the health of Aboriginal women in a remote northern Australian community, used Photovoice with Tlcho 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 [10]. The Socio-Ecological Logic Model was used to direct this study. 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” [41]. [10] 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 [39, 42, 10]. 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 [43,44].

VI. Methods

6.1 Design

The study adopted a qualitative design that combined 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 [45]. The researcher using the qualitative approach method was able to explain the relationships between the social, cultural, political, physical environments, and the individual by analysing the stories they tell [46]. The research delves in-depth into the complexities and the process of the participants’ real life experiences [47], and is designed to provide a complete and accurate description of a particular situation, social setting, or relationship [48]. Consequently, participants are not subjects of research, but rather, are active contributors to research who participate in all phases of the research process [49, 50].

Fig. 1 Participatory approach throughout the study

6.2 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 (Community A) and Anyanghanshe (Community B). 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.

6.3 Sampling

Non-probability sampling known as purposive sampling was used. This type of sampling is based on the judgment of the researcher [51]. 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 Anyanghanshe) was made. 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.

6.4 Photovoice Process

The Photovoice FGD I was preceded by the group recruitment and training in Photovoice and photography and was followed by FGD2- member checking and verification by the group of the key themes that emerged from the photovoice process.

6.4.1 Photovoice community engagement group establishment

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

6.4.1.1 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.

6.4.1.2 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 field notes of the meeting were done.

6.4.2 Photovoice Focus Groups

Two Focus Group Discussions (FGD I and FGD II) were held. 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.

6.5 Instrumentation and data collection

Three weeks later, an FGD I was conducted, drawing participants from communities A and B. out of the 20 participants recruited, only 15 turned up for the photovoice narratives (n=15, 8 & 7 respectively). 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. 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 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?

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 [39]. 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 [45]. Participants codified themes from issues that arose from the photos.

6.6 Data analysis

Photos were grouped and categorised while in the FGDs. Participants told stories and narratives about each photograph, which was recorded alongside note-taking. After the initial translation and transcription of the recorded narratives, data was analysed following Tesch's eight-step method of coding [52]. The analysis involved data reduction, organisation and subsequent interpretation using themes [53]. The Tesch's proposed eight steps in data analysis followed thus:

1. The researcher carefully read through all the transcriptions, making notes of ideas that came to mind.
2. The researcher selected one FGD and read it to try to get meaning in the information, writing down thoughts coming to mind.
3. After going through the transcripts, the researcher arranged the similar topics in groups by forming columns, labelled major topics; unique topics; and leftovers.
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.
5. The researcher found the most descriptive wording for the topics and converted them into categories. 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.
6. A final decision was then made on the abbreviation of each category and the codes were arranged logically.
7. The data material belonging to each category was put together in one place and preliminary analysis performed.
8. Recoding of the data was done [52, 54].

6.7 Member checking and verification

A week after the completion of the photovoice, participants were gathered in the town hall and given verbal feedback on the analysis of the findings and the themes that emerged from the photovoice FGD. The verification group discussion lasted about 50 minutes and field notes of agreement were taken.

VII. Validity and Reliability of Qualitative Research

The model for trustworthiness in qualitative data, which must be maintained, is that identified by [55].

Credibility: [55] viewed credibility as the overriding goal of qualitative research. Credibility refers to confidence in the truth of the data [45]. The following strategies were used to ensure the credibility of the study: Observational notes were taken during the FGDs to strengthen data; techniques used during the 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.

Dependability: [51] 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 ensures that the data reflects the participants' voice and not the biases of the researcher [51]. Confirmability, was ensured by audiotape recordings of the Photovoice as well as researcher's own notes. This enabled the researcher and an external coder to confirm the FGDs and the themes elicited from them.

Transferability: 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 [55]. 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.

Authenticity: Authenticity was ensured by using quotes from the participants' responses to describe their experiences in the final report. This enabled the reader understand the real experience of the phenomenon as it lived.

VIII. Ethical Considerations

The following clearances, permissions, consents, and approvals were obtained before the commencement of the study: ethical approval from the, Ministry of Health, Cross River State, Nigeria; approval from the Chairman, AkpabuyoLGA 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.

8.1 Ethical principles

All the participants 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. The researched planned for any potential harm by trying to anticipate potential problems associated with photovoice process.

8.2 Photovoiceethics

In addition to the above general principles, [56] 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 before photo-taking; (3) the safety of participants must be considered as photographs produced can cause embarrassment; (4) participants should own the prints and negatives they produce to prevent commercial exploitation and appropriation; (5) photos taken should be developed by the researcher and should not be shared with anyone but the researcher; (6) 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; and 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.

IX. Results And Discussions

9.1 Participants' description

There were 10 participants from each of the two communities under study (Communities A& B), 20 in total as shown in Table 2.

Table 2: Participants' demographics (N=20)

9.2 Photovoiceprocess

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.

Photo 1: Pregnant women and new mothers during PhotovoiceFGD.

The cameras were earlier turned in for the printing of the photographs. AnFGD 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 under two headings, namely (A). "Domestic activities and healthcare practices of pregnant women" (Figure 1), and (B). "Attitude and access to healthcare services by pregnant women and nursing mothers" (Figure 2). The themes and sub-themes are presented according to these headings.

As the photographs were being passed between participants, each participant gave a short description of what they could see in the photographs. Using [56]Photovoice guidelines, the discussion was facilitated by posing the following questions:

- What do you **See** 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.

9.3 Themes emerging fromphotovoice

9.3.1 Domestic activities and pregnant women's healthcare practices (Group A)

Photographs 2, 3, 4, 5, and 6 (**Fig. 2**) 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 2 photos, four (4) themes with sub-themes and three (3) actions emerged as shown in Table 3.

Fig. 2: Photos showing Domestic activities and healthcare practices of pregnant women and new mothers

Table 3: Themes, sub-themes and actions emerging from storytelling and narratives of photos on domestic activities and healthcare practices of pregnant women and mothers.

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 were;

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 ...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 ... 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". (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 ... it's a market ... the pregnant woman is trying to buy meat ... she is wearing a gown". (Photo 6)

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. 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 fear of being labelled a weakling.

"Ahh! ... Auntie 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 ...".

"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?".

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.

“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.

“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 ...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 ..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 and low skilled delivery at available health units among rural women in Tanzania and the heavy house hold chores of women [57]. 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 [57].

Theme 2: Lack of adequate information about maternal and child health issues

Three (3) sub-themes supported this theme;

Sub-theme 1: Strenuous work on pregnant women is seen as exercise to reduce prolonged labour

According to the participants, 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 ... this woman is doing exercise and this exercise she is doing is good with her body ... it makes it less on her”. (Pic 3).

“I see a pregnant woman carrying a big firewood on her head ... this is exercise... 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.

“The reason why this pregnant woman is going to the market is she 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”.

“The woman (TBA) that used to deliver me say when you go to the farm and 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 ...”.

“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.

"..... 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 it's also tight on the baby inside the belly ... "(Pic 5)

"I snapped this picture because I see this girl as a very small girl and she is pregnant ...like four months now ... the clothes she is wearing is too short and tight and it's not good". (Pic 5)

Discussion

In support of the above findings, [1] 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 [58] Kenyan study, which revealed that the families who were knowledgeable about maternal health issues were more likely to report more support from spouses.

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;

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 do while pregnant as it was culturally acceptable for pregnant and non-pregnant women to perform domestic 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 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 ... but if they don't go there will be no food in the house and hunger will come ... 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".

Discussion

Poverty plays a major role in access and quality of maternal health services.[59] Stated that poverty prevents Nigerian women from accessing Ante Natal Care, having the time to rest, and eating balanced diets, all of which are essential to safe pregnancy.

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;

Sub-theme 1: Lack of help and support from husbands

According to most participants, the lack of support and help from the husband result in women, whether pregnant or not, performing all basic tasks at home, and most women being prevented from accessing correct and first-hand information on their pregnancy and any health concerns they may have. The participants stated that women may not be aware of the benefits of child immunisation and free Antenatal Care (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.

"..... is it when we are always going to the farm that we will know what is happening? ...My husband goes to work in Calabar ... he is the one that tells me things ... what to do and I support him."

Even when men (husbands) want to either take total responsibility or assist their pregnant wives in certain tasks, they can't because of fears and concerns of being seen as a "woman wrapper" by other community members, including women.

"Ahh! ... Auntie 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. [60] 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.

9.3.1.1 Actions from domestic activities and healthcare practices of pregnant women

Three (3) action recommendations to improve the impact of intense domestic chores pregnant women were identified by the participants as thus:

Recommendation 1: Recognising and strengthening the role of men in support of pregnant women

On 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;

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 husbands 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 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.

"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".

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".

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 [61]. Similarly those men whose spouses utilised skilled delivery during their last pregnancies were more likely to accompany their spouses at ANC [61]. According to [62,63], 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.

Recommendation 2: Strengthen the role of the community to support women during pregnancy

Two (2) sub-themes supported this recommendation;

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 kept that baby before going to the farm ... "

"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. Hence, the caregivers and health 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 [64]. 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.

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 [65]. 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 [66].

9.3.2 Pregnant and nursing mothers' attitude and access to healthcare services (Group B)

Photographs 7, 8, 9, 10, 11, 12, and 13 (**Fig. 3**) were grouped together as they 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 from the narratives of these photos, ten (10) themes, sub-themes and seven (7) action recommendations emerged as shown in Table 4.

Fig. 3: Photos showing attitude and access to healthcare services (Group 2 photos)

Table 4: Themes, sub-themes and actions emerging from storytelling and narratives of photos on pregnant and nursing mothers' attitude and access to healthcare services (SHOeD) in figure 3.

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;

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 woman standing outside making phone call ...". (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 ..."(Photograph 7)

This 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; which 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.

"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 wants 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 and 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 who take care of all the money in the hospital so sometimes they usually prefer places that are not costly ... see that is why many of them want 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 IkotNakanda, 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.

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 [67] 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.

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;

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." (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 an area to prepare food and a corner for 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".

"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. 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 you and give you fasting to do ... 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. The participants' discussion of photograph 9 above revealed the strong religious inclination of the community 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".

"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".

" 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"

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 [60]. The spiritual belief of people of Cross River State has a serious impact on their health-seeking behaviour [68]. 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 [68]. On the aspect of pregnant women and their relatives feeling more at home at the TBA homes, [69] 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"

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.[70] 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 [71] 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. [72].

Sub-theme 5: Confidence in the TBAs

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 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".

"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 ... 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". (Photograph 10)

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.

"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 support her."

Discussion

[25] 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. [73] 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 [73].

Sub-theme 6: Past experience 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"

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".

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 [74].

Sub-theme 7: Poverty and low cost of TBAs

During the discussions, participants expressed that even though TBA services were not free, TBAs 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".

Discussion

[68] 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.

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;

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".

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 if 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).

Discussion

The observed sub-themes of negative past experiences and the negative attitude of healthcare providers corroborates [7] 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. [17] 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; ah! 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".

Discussion

Study by [75] 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.

Sub-theme 4: Absence of orthodox healthcare providers at night

Another sub-theme identified in support of 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".

"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 Calabareveryday and know our problems"

"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.

Discussion

[70, 76]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 [76]. 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 [70, 76, 77].

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).

"Aunty see there is no money ... if you go there the health centre 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."

"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. Mean while we hear government say it is free."

Discussion

In support of these findings, [1], 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 [98] noted, while cost might constitute a reason for the delay in seeking healthcare, people pay a higher premium for quality.

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;

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 with the baby yet to be cleaned and exposed mother and baby are left unattended to.

"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".

Discussion

Various studies have confirmed that what was observed and described in the photographs were prevalent in rural communities. [79] 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 [80]. 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 [77]. In addition, studies by [81] submitted that majority 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.

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 Ayaghansé; 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 ... 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!

While the participants were reflecting on the photos (Photograph 12), 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.

Discussion

[70, 79, 82], 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 [83], 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.

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;

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".

Discussion

The reasons for high utilization of immunisation services have been reported by [84], 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".

"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"

Discussion

This is in accordance with the findings of [14], 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.

9.3.2.1 Actions themes from attitudes and access to healthcare services by pregnant and nursing mothers

Seven (7) action recommendation emerged from the discussion on these photographs (Fig 3). The actions identified by the participants with the aim to improve the impact of attitude and access to healthcare services by pregnant and nursing mothers. These included;

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 this theme;

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.

"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".

"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"

Discussion

These findings corroborates the findings of the studies by [70, 85], 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 [82], also has it that TBA-provided maternal healthcare services is free from inhibiting factors of prohibitive hospital fees, illegal fees and bribery. [14], 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 [14]. 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 [86].

Recommendation E: Husbands' involvement in ante natal care

The following sub-theme emerged under this theme;

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.

"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".

"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".

Discussion

In support of the above findings, [60], 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 [60]. Hence, [67], 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.

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".

"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".

Discussion

[87] 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.

Recommendation G: Community support

Three (3) sub-themes were identified under this theme;

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".

"In this village, we fear and respect our chiefs...o! 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"

Discussion

This corroborates [22] 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 [88]. 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 [88]. [89] 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. [90] 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.

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 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 belong to a meeting group ... in church or even in village here. Tell the leaders of these women groups to 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".

"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".

"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".

Discussion

[94] Study 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 [94]. 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% [92, 93].

Sub-theme 3: Use of community structures in creating community awareness about immunisation services yields positive results.

The participants strongly related to the use of community structures in creating community awareness regarding immunisation services yielding 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 make sure she deliver there".

"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".

"I think 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".

Discussion

Findings from various studies are in consonance with the above findings. For instance, [36] 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. [36]. Similarly, [94] 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 new-borns [94].

Recommendation H: Motivation to attend health services
Three sub-themes were identified in support of this theme;

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".

[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 the town.. We want to see them always. We want to run to them anytime we have problem".*

Discussion

In support of the findings above, [95] 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. 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 [96].

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.

"To me all I can say is that those nurses that are in the hospital should make sure they come to work, because if somebody go there and do not see anybody she will not border to go again tomorrow".

"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 the town everyday and know our problems"

"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....."

Discussion

In corroboration with the above findings, [97] 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, [4], 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 and not being available at night, women are dissuaded from accessing modern healthcare [70, 76].

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.

"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."

"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".

Discussion

To further emphasize the importance of occasional gifts to women who attend health care facility for skilled care, [7] 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.

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;

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".

Discussion

[70, 79, 82] 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 [79]. 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 of TBAs [98]. The authors therefore submitted that training TBAs may enhance their potentials in the reduction of maternal mortality [98]. However, reviews by Cochrane 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 [99].

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 go toTBA but hospital, there will be problem and enmity because TBAs will feel that their jobs will be taken away from them and bywhat 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".

"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 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".

"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"..

"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"

" 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"..

Discussion

This is in accord with the findings from [100] 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 facility when complications occur. [99] 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. In view of this, every pregnant woman in the community was linked to an Skill 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 [100]. Evidence have proved this to be very successful and effective in many rural settings [101, 102]. [100], therefore suggest that if TBAs are trained and supported, they can contribute to improvements in maternal and newborn care especially in low-resource settings.

X. Conclusion Statements

The following statements are derived from the study:

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 about 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 improve access and attendance of orthodox health services and look for ways to integrate the role of the TBA within an overall model of maternal health care.**
8. However, in order to achieve these outcome, the participants suggested engaging the community members through formulation of a group, Community Engagement Group (CEG), with the aim of supporting the rural women to ensure that they are knowledgeable maternal health issues, are well supported by family and community, husbands are involved in the planning of maternal care, that baseless traditional practices and beliefs are corrected, trust and confidence in orthodox healthcare services built, and integration of the role of the TBAs within an overall collaborative model of maternal care. This will in turn reduce the risk and occurrence of maternal health complications (morbidity and mortality).

XI. Recommendations

Recommendations are made for nursing practice, nursing education and research as follows:

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 constituting a Community Engagement Group (CEG), to achieve the prevention of maternal health complications in rural communities.
2. The constituted CEG's duty is to give rise to factors that would bring about the utilisation of orthodox maternal healthcare services by rural community women.
3. The CEG should be strengthened and supported in its duties and responsibilities. This group needs to be recognised in the communities and by the government, and 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.

4. The government or orthodox healthcare providers should use the CEG as their contact point within the communities while carrying out healthcare initiatives.
5. 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.

Main priorities for Nursing Education

6. Providers of orthodox healthcare should be given re-orientation on attitudinal change in the course of their dealings with rural community members.

Main priorities for nursing research

7. Well-designed implementation and evaluation studies in the rural communities and context are essential to test the effectiveness of CEG in increasing the utilisation of healthcare facilities by pregnant women in the rural communities.
8. 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.

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List of Tables, Photo and Figures

Table 1: 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
WHO	World Health Organization
UNICEF	United Nation International Children Emergency Fund
TBA	Traditional Birth Attendants
SBA	Skilled Birth Attendants
FGDs	Focus Group Discussions
UNFPA	United Nations Population Fund
NPLC	National Population Commission
EmOC	Emergency Obstetric Care
CEG	Community Engagement Group
PAR	Participatory Action Research
FANC	Focused Antenatal care

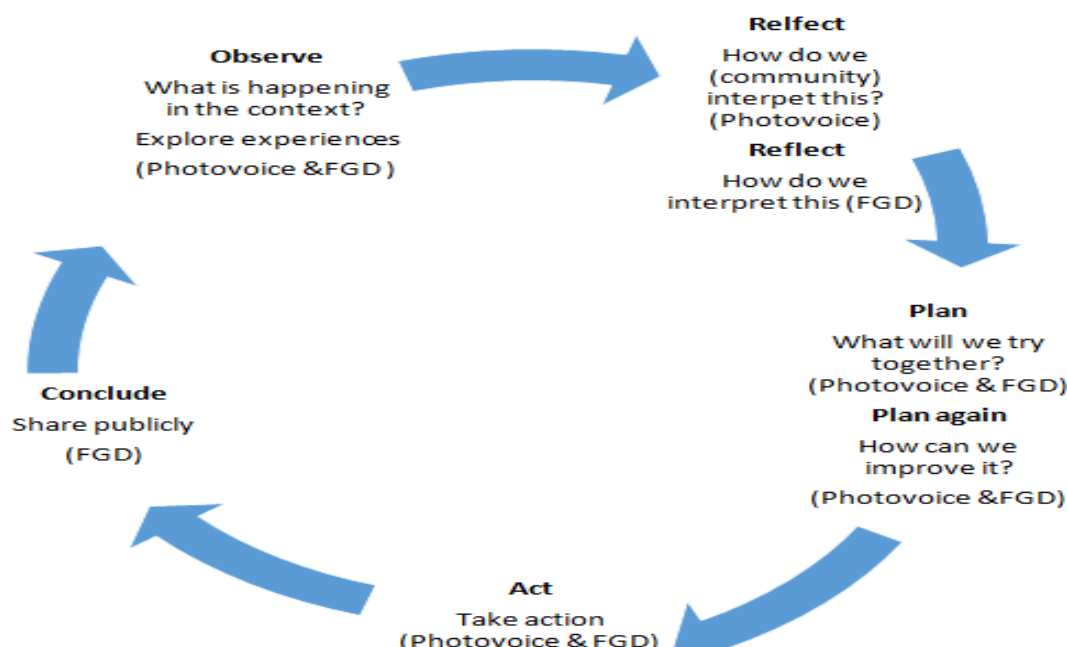


Figure 1: Participatory approach throughout study

The initial observation phase of this study (Figure 1) explored the experiences of the participants regarding birth practices and experiences during pregnancy and childbirth within their communities. These experiences were explored, described and reflected on by means of 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.

Table 2: Participants demographics


Demographics	Idundu (Community A) (n=10)	Anyanghanshe (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

A total of twenty (20) participants were purposively selected from Idundu and Anyanghanshe communities of Akpabuyo Local Government Area of Cross River State, Nigeria, ten (10) from each community. Participants comprised pregnant women and new mothers (mothers whose babies aged within 12months).



Photo 1: Pregnant women and new mothers during Photovoice FGD.

Photo voice FGD was held in Community A with the 15 participants. Five persons could not attend due to family reasons but 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 under two headings, namely (A). “Domestic activities and healthcare practices of pregnant women” and (B). “Attitude and access to healthcare services by pregnant women and nursing mothers”.

	<p><i>Mother with baby working on farm (Photo 2):</i> 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.</p>
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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.



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.



Figure 2: Domestic activities and healthcare practices of pregnant women (Group A photographs)

Photographs 2, 3, 4, 5, and 6 in Figure 2, illustrate the domestic activities and healthcare practices of pregnant women and new mothers within the study communities.

Table 3: 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Working to raise money for family • Lack of money for appropriate clothes
4. Lack of help and support for pregnant women	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Need for education on self-care

Based on the analysis of the data generated and transcriptions from the narratives of Figure 2 photos, the above four (4) themes with sub-themes and three (3) actions emerged.



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, 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)



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



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.



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.

Figure 3: Attitude and access to healthcare service (Group B photographs).

Photographs 7, 8, 9, 10, 11, 12, and 13 (Figure 3) were grouped together as they showed the attitude towards maternal health care and the issues impacting on access to healthcare services of pregnant women in the communities.

Table 4: 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 3

Themes	Sub Themes
5. Men are sole decision-makers regarding place of delivery	<ul style="list-style-type: none"> • Men escort their wives to the birth place for various reasons • Men bear the financial burden of healthcare services
6. High preference for TBAs	<ul style="list-style-type: none"> • 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 and belief that first place of birth is safe • Poverty and low cost of TBA services
7. Low preference for orthodox healthcare facilities	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 'Free' treatment should be free in the real sense • Community involvement in raising awareness of free health services
E. Involvement of husbands in ANC	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none">• Influence of community heads through levies and sanctions to emphasise importance of utilisation of healthcare facility• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Knowledge and skills for proper delivery practices of mother and childcare.• TBA/Facility collaboration

Based on the analysis of the data generated and transcriptions from the narratives of Figure 3 photos, ten (10) themes and sub-themes and seven (7) action recommendations emerged as shown in Table 3 above.