
Pregnant women’s participation in support groups in Enugu State, Nigeria (2015-2016):
Experiences and influences on their intentions to deliver in a health facility.

By

Eki Osarenoma George

Supervisor:  Dr. Tintswalo Mercy Hlungwani
Co-supervisor:  Dr. Adebayo Fayoyin

A research report submitted to the Faculty of Health Sciences (School of Public Health),
The University of the Witwatersrand, in partial fulfilment of the requirements for the degree of
Master of Public Health in the field of Social Behaviour Change and Communication.

June, 2017
Declaration

I, Eki Osarenoma George, declare that this research work on: ‘Pregnant women’s participation in support groups in Enugu State, Nigeria (2015-2016): Experiences and influences on their intentions to deliver in a health facility’ is my own original work. Any other work done by other people quoted herein has been properly acknowledged in the report.

The report is being submitted in partial fulfilment of the requirements for the degree of Master of Public Health, in the field of Social and Behaviour Change Communication with The University of the Witwatersrand, Johannesburg. It has not been submitted for any other degree or examination in the mentioned institution or any other university.

Name: Eki Osarenoma George
Student No: 872367

Signature: 

Date: 14th June, 2017
Abstract

Introduction

Proper access to antenatal care services and skilled birth attendants during delivery is key to reducing maternal deaths. But studies show that women in rural communities in Nigeria, do not access Ante-Natal Care (ANC) and a lower proportion deliver in a health facility.

An internationally funded maternal and child health program in Enugu State, Nigeria introduced the concept of using the support group to improve uptake of antenatal care services and health facility delivery services. The support group comprised of pregnant women who encouraged and supported each other from pregnancy through to delivery in a health facility. However there was no documented evidence to show that the support groups actually influenced women’s intention to deliver in a health facility. This research work is being carried out to address this gap – by providing evidence on whether the support groups influenced women’s intention to deliver in a health facility.

Methods

Following informed consent, a qualitative study was conducted. Data was collected from women aged between 18 years and 49 years who were in a support group in seven health facilities in Nkanu West Local Government Area (LGA) of Enugu State, Nigeria. Seven Focus Group Discussions (FGD) and In-depth Interviews (IDI) were conducted. The data analysis was done using NVIVO software. All field notes were checked against translated interviews to ensure completeness and correctness. Inter-coding agreement, triangulation of data was done to ensure consistency. A descriptive analysis of the findings against theoretical framework was done and all findings also linked to objectives of the study.
Results

The pregnant women support group is shown to influence pregnant women’s intention to deliver in a health facility. Reasons for joining the group included; increasing knowledge about pregnancy and the benefits of ANC attendance and health facility delivery, socio-economic and spiritual support. However, the intention to deliver in a health facility is influenced by other factors such as; good and caring attitude of health workers, availability of qualified health workers, and better health infrastructure to respond to complications and emergencies. Other influences such as mother-in-law and spouses were also identified. The members of the group enjoyed benefits such as; visitation and presentation of gifts by support group members upon delivery, post-natal care and sometimes financial support. Despite these benefits, the goal of having a safe delivery remained the ultimate benefit of being a member of the support group. The existence, management and survival of the group other than by its members were dependent on the health facility workers.

Conclusion

The study demonstrated that the support group intervention did influence pregnant women’s intention to deliver in a health facility. But, the intention to deliver in a health facility was also driven by other factors such as; availability of skilled health workers, improved infrastructure and the cost of health services.
Acknowledgement

Firstly, I want to thank Jehovah for his mercies and blessings and for seeing me through this study. Without him nothing would have been possible.

Secondly, I want to deeply appreciate and thank my supervisors for their immense support and the effort put in to see me through this research. I want to particularly thank my supervisor Sara Nieuwoudt who guided me and provided the needed support to see me through this research. Despite her busy schedules, she still found time to make sure I was guided rightly. Sara was a huge source of inspiration to me and always believed I could pull this through. I also want to also express my profound gratitude to my able supervisors; Dr. Tintswalo Mercy Hlungwani and Dr. Adebayo Fayoyin for their unrelenting support to this research work. They provided me with valuable feedback, suggestions and guidance throughout this project work. Working under them was a knowledgeable and rewarding experience for me.

Thirdly, I want to thank my wonderful family; my wife Mrs. Patience Eki-George and my boys for their support throughout this study. Their encouragement gave me strength when I needed it most.

Lastly, I want to thank Chika Nwokeforo for her support and encouragement throughout the research. I will not forget to mention my colleagues; Ijeoma Iwuora, George Oluka, Inem Essien, Emmanuel Abor and Ifeoma Adigwe for their support throughout the study. Again, I would want to express my appreciation to my colleague Mrs Ijeoma Inen for painstakingly reviewing this work and ensuring that it was error free. Not also forgetting my very good friend Tosin Akibu whose encouragement got me to take up the program when I thought I was not ready for it. To all the officers in charge of the seven health centers in Nkanu West Local Government Area as well as the members of the support groups who made out time to be part of the research interviews. I say a big ‘thank you’.
Dedication

I dedicate this achievement to my son Umendu Eki-George who was born into this world as I prepared to round off my program. He is a bundle of joy and delight to my heart.
Table of Contents

Declaration  ........................................................................................................................................... i
Abstract  ............................................................................................................................................... ii-iii
Acknowledgement ................................................................................................................................. iv
Dedication ............................................................................................................................................... v
Table of content .................................................................................................................................... vi -viii
List of Abbreviations ............................................................................................................................. ix -xi

CHAPTER ONE: Introduction and Background Information

1.1 Introduction........................................................................................................................................... 1
1.2 Background to the study ......................................................................................................................... 1-2
1.3 Problem Statement ............................................................................................................................... 3
1.4 Justification of the study......................................................................................................................... 4
1.5 Study Aims and Objectives .................................................................................................................... 4
  1.5.1 Study Aim ...................................................................................................................................... 4
  1.5.2 Study Objectives ........................................................................................................................... 4
1.6 Theoretical Framework ......................................................................................................................... 5-6

CHAPTER TWO: Literature Review

2.1 Introduction .......................................................................................................................................... 7
2.2 Use of support group in health programs ............................................................................................. 7
2.3 Knowledge ........................................................................................................................................... 7-8
2.4 Self-efficacy ......................................................................................................................................... 8
2.5 Quality of life ..................................................................................................................................... 8
CHAPTER THREE: Research Methodology

3.1 Introduction

3.2 Study Design

3.3 Study Site

3.4 Study Population

3.5 Study Sample

3.6 Pre-testing

3.7 Data Collection

3.8 Scope of Study

3.9 Data Analysis

4.0 Ethical Consideration

4.1 Informed Consent

4.2 Confidentiality

4.3 Trustworthiness

CHAPTER FOUR: Data Analysis and Results

4.1 Introduction

4.2 Social Demographic Characteristics of the Respondents

4.3 Results

4.3.1 Description and Knowledge of the support group

4.3.2 Reasons for joining the support group

4.3.3 Role of health facility staff on membership of the support group
4.3.4 What the support group means to the women ................................................. 21-22
4.3.5 The support women get from the group ......................................................... 22-23
4.3.6 Activities of the support group ................................................................. 23-25
4.3.7 Most important type of support to members ............................................... 25
4.3.8 The support members need but are not provided by the group ................. 26
4.3.9 Influence beyond the support group - on choice of delivery place .......... 27
4.3.10 Intention to deliver in a facility ................................................................. 28
4.3.11 Influences on choice of delivery place .................................................... 28
4.3.12 Community views on choice of delivery place ........................................ 29
4.3.13 Decision making in Households on choice of delivery place ................. 30
4.3.14 Influence of support group members on choice of delivery place .......... 30
4.3.15 Point of decision making on place of delivery ........................................... 31
4.3.16 Activities in the group that support choice of delivery place ................. 31
4.3.17 Decision if not a support group member .................................................. 32
4.3.18 Influence of choices made by other women in the group ....................... 32-33

CHAPTER FIVE: Discussion of Results

5.1 Introduction ........................................................................................................ 34
5.2 Reasons why women join the support group .................................................... 34
5.2.1 Knowledge and how women join the support group .................................. 34
5.2.2 Activities and benefits from the support group .......................................... 34
5.3 Intention to deliver in a health facility .............................................................. 36
5.3.1 Influences on intentions for health facility delivery ..................................... 36-37
5.4 Choice of delivery place ................................................................................... 37
5.4.1 Decision making in household ..................................................................... 37-38
5.4.2 Community Influences on choice of delivery place .................................. 38
5.5 Influence of support group on choice of delivery place ----------------------------- 38

5.5.1 Choices made by other women in the group ---------------------------------------- 39

5.5.2 Decision – If not a member of a support group------------------------------------- 39

5.6 Implications and Limitations of the study ------------------------------------------ 40

5.6.1 Implication of study on Theory --------------------------------------------------- 40

5.6.2 Implication of study to Practice --------------------------------------------------- 41-43

5.6.3 Implication of study on Research --------------------------------------------------- 43

5.6.4 Limitations of study --------------------------------------------------------------- 44

5.7 Conclusion and Recommendation ------------------------------------------------------ 44

5.7.1 Conclusions ------------------------------------------------------------------------ 44-45

5.7.2 Recommendations-------------------------------------------------------------------- 45

5.7.2.2 Economic Empowerment programs ------------------------------------------------ 45

5.7.2.4 Production of health talks manuals ----------------------------------------------- 45

5.7.2.5 Proper documentation of group activities------------------------------------------ 46

Reference --------------------------------------------------------------------------------- 47-49

Appendices ------------------------------------------------------------------------------ 50-69
### List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
</tr>
<tr>
<td>CD</td>
<td>Compact Disc</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>FGDs</td>
<td>Focus Group Discussions</td>
</tr>
<tr>
<td>HBM</td>
<td>Health Belief Model</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno- Deficiency Virus</td>
</tr>
<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
</tr>
<tr>
<td>IDIs</td>
<td>In-depth interviews</td>
</tr>
<tr>
<td>IPC</td>
<td>Interpersonal Communication</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal and Neonatal Child Health</td>
</tr>
<tr>
<td>NDHS</td>
<td>National Demographic Health Survey</td>
</tr>
<tr>
<td>NGO</td>
<td>Non - Governmental Organization</td>
</tr>
<tr>
<td>OIC</td>
<td>Officer in Charge</td>
</tr>
<tr>
<td>PATHS2</td>
<td>Partnership for Transforming Health Systems phase 2</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother to child transmission</td>
</tr>
<tr>
<td>PLHIV</td>
<td>Persons Living with HIV</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TPB</td>
<td>Theory of Planned Behaviour</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Emergency Fund</td>
</tr>
<tr>
<td>WACOL</td>
<td>Women Aid Collective</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
CHAPTER ONE:
INTRODUCTION AND BACKGROUND INFORMATION

1.1 Introduction

This chapter outlines the background information on maternal health in Enugu, Nigeria. It presents the use of the support group model to improve uptake of antenatal care services and delivery in a health facility. The chapter also highlights the problem statement, objectives and the significance of the study.

The pregnant women support group was initiated by the Department For International Development (DFID) funded Health program implemented in Enugu state, Nigeria. The initiative was designed to support the state government to improve health outcomes and particularly that of women and children. By this, directly contribute to the reduction of maternal, neonatal and infant deaths in the state. The support group is usually formed with the support of the health worker in health facilities across local government areas (LGA) in the state. The group comprises of pregnant women registered in a particular health centre. The group is provided with basic orientation on the management of the group, and through the health worker are taught various health topics that directly improve the women’s knowledge on different pregnancy related matters and importantly get the women to support each other and achieve health facility delivery. The group upon being formed is allowed to be managed by the pregnant women themselves and becomes a social group to educate, inform and build knowledge around maternal and child complications and what to do to address them. It also help to reinforce the benefits of health facility delivery, but ultimately help the women to make informed choices of having their babies in a health facility.

1.2 Background of Study

Nigeria’s population according to the 2006 national population census is over 140 million people with women accounting for over 69 million of the entire population (NPC, 2013). Despite oil wealth (WorldBank, 2013), the human capital development indices for Nigeria is still low (UNDP, 2013). Health care service delivery remains a focus of the Nigerian government as evident from the various health policies formulated to strengthen the health care system to ensure
it provides quality, accessible and affordable health care to all its citizen (NPC, 2013). Like most developing countries, Nigeria, is still faced with maternal and child health challenges. Every year, over 500,000 women die from pregnancy and childbirth related complications, while about 4 million new-borns die less than 30 days after birth (UNICEF, 2009). Nigeria has one of the highest maternal and child mortality rates in the world, with India and Nigeria constituting one third of maternal deaths globally (UNICEF, 2009).

The 2013 Nigeria National Demographic and Health Survey (NDHS) puts the maternal mortality ratio at 576 deaths per 100,000 live births (NPC, 2013). Access to proper Antenatal Care (ANC) and availability of skilled birth attendants during delivery has been recognized as key to significantly reducing maternal morbidity and mortality. Antenatal care is the gateway to facility delivery as it supports early detection of anomalies and gives opportunities for accessing preventive services such as treatment of malaria and immunization against neonatal tetanus. It also has the advantage of early detection of pre-existing health conditions that could impact on pregnancy outcome (Villar and Bergsjo, 2002). The uptake of ANC and the use of the health facility for delivery can address many of the causes of maternal deaths; such are sepsis, haemorrhage, eclampsia and unsafe abortion (Ujah et al., 2005, Onah et al., 2005). However, the National Population Commission (NPC) report showed that 47% of rural women in Nigeria did not receive antenatal care before delivery and a lower proportion of women who received antenatal care in government health facilities eventually delivered there (NPC, 2013).

Despite known benefits of ANC and facility delivery, getting women to attend at least four recommended ANC visits and deliver at the health facility has been very challenging. These challenges are occasioned by a dearth in the number of health workers in the state, poor infrastructure, poor funding, and low capacity of health workers to provide quality services. For these reasons, the Partnership for Transforming Health Systems 2 (PATHS2) started the implementation of a support group intervention in rural communities in Enugu State. The pregnant women support group is a social marketing strategy to increase facility delivery, and increase social pressure on women to access ANC, and on their husbands and communities to support them to deliver in health facilities (PATHS2, 2015). This initiative is similar to the use of support groups in the Human Immuno-deficiency Virus (HIV)/Acquired Immune Deficiency
Syndrome (AIDS) response to improve health and wellbeing (Dageid, 2014). The support group intervention targets pregnant women registered with health facilities. The group meets monthly and provides health education for its members. They cover issues such as recognition of maternal danger signs and action to take, proper breastfeeding techniques, immunization, benefits of antenatal care, hygiene and planning for delivery. Members of the group are provided with phone contacts of health workers and health facilities in the event of an emergency for example, a need for caesarean session or blood transfusion. The group also supports its members with emergency transport through arrangement with local commercial tricycle riders in the community. As part of efforts to encourage members to stay in the support group - women who have delivered and have left the group are invited to share their success stories with new and old members. Lastly, the group works closely with the health facility staff to encourage their spouses to support the women during and after pregnancy. This study aims to describe the experiences of these support group members and how they may have influenced their intention to deliver in a health facility \(^1\) by pregnant women.

1.3 Problem Statement

The maternal mortality ratio in Enugu state is 772 maternal deaths to 100,000 live births (Onah et al., 2005), even higher than the national average. Part of this is attributed to poor health seeking behaviours, poor access to ANC services and low skilled birth attendants during delivery (Osubor et al., 2006, Uzochukwu et al., 2004). Many women do not access antenatal care and those that do, do so very late in pregnancy (Ndidi and Oseremen, 2010, Iyaniwura and Yussuf, 2009), while the number of women who deliver in the hands of TBAs is on the increase (Iyaniwura and Yussuf, 2009, Asuzu, 2005). The introduction of the support group intervention is expected to encourage women to access ANC and health facility delivery services. The group by design is meant to complement the services from the health facilities, but since the commencement of this intervention in 2013, it is unknown whether or not this intervention has had any influence on the intention by pregnant women in the group to deliver in a health facility. Similarly, while the activities of the support groups have been documented, little is known about

\(^1\) ‘Health facility delivery intention’ means intention of pregnant women to deliver or not in a health care facility. It does not track where they actually deliver.
the experiences of women in the support groups - in terms of practical support from the group and its impact on the intention of women to deliver in a health facility - which is the overall goal.

1.4 Justification of the Study

Studies have highlighted the problems associated with accessing ANC and facility delivery in Nigeria, but there is limited literature that deals specifically with the use of support groups in encouraging ANC or facility delivery, hence the need for this study. Support groups have been used in different forms to provide needed support to people going through similar challenges or to stay on treatment. Support groups have been used to provide support to PLHIV and other health issues have been evaluated. In an effort to contribute to this broader literature as well as to inform the specific intervention implemented by PATHS2, this study intends to explore the possible influence of the support group intervention on health facility delivery intention by pregnant women who are part of the group. The study hopefully could inform the design of interventions, as well as possibly point to policy formulation and health facility practices that could improve access to Maternal Neonatal and Child Health (MNCH) services in Enugu, Nigeria.

1.5 Study Aim and Objectives

1.5.1 Study Aim

The study aim is to explore pregnant women’s experiences in support group participation and the groups’ influence on intention to deliver in a health facility in Enugu State, Nigeria (2015-2016).

1.5.2 Study Objectives:

1. To explore pregnant women’s experiences and reasons for joining support groups in Nkanu West LGA, (2015-2016)
2. To identify and describe the type of support pregnant women get from the support groups in Nkanu West LGA, (2015-2016).
3. To explore pregnant women’s support group influence on health facility delivery intention in Nkanu West LGA, (2015-2016).
1.6 Theoretical Framework

Theory behind support groups and behavioural intention

As an intervention, the support group is meant to act as social influence on members of the group to increasing ANC attendance and facility delivery. It uses the construct of social cohesion as a vehicle to influence its members. The use of social cohesion to influence behaviour is in line with Berkman’s proposed social influence model (Berkman, 1995). According to Berkman, promoting healthy behaviour is influenced by norms developed through social influence and they either constrain or enable healthy behaviours (Berkman, 1995). This social influence comes about largely from the support group activities that promote a sense of commitment to following the goal of joining the group. This commitment, or intentions to carry out a behaviour is also linked to the Theory of Planned Behaviour (TPB), which sees intention to act as the best predictor of behaviour (Ajzen, 1985). The theory centres on individual beliefs and attitudes. It posits that intention is a combination of attitudes, subjective norm and perceived behavioural control towards the behaviour, in this case intention to deliver in a health facility. TPB from evidence can predict 20-30% of variance in behaviour and a large proportion of intention (Morris et al., 2012). Actions, therefore, are influenced by intentions, but not all intentions are executed. The TPB in this research was evaluated and used to understand the support group’s member’s attitude towards health facility delivery and to know what drives it. The same theory was also explored to understand how the influence of other women in the group contributed to decisions made about using health facility for delivery. The role played by significant others and in this case other women in the group were explored to see how much influence it had on the individual women in the group. TPB construct of subjective norm recognizes that peoples’ intention to carry out a behaviour is influenced by whether or not they believe significant others approve of it (Ajzen, 1985).

The behavioural control as posited by the theory was explored to determine how much control the women have over the decision to have health facility delivery. The support group model employs education as a way of building members self-efficacy. Self-efficacy is a construct of
Bandura’s theory that seeks to determine the level of confidence of an individual in performing a behaviour (Bandura, 2001). This construct was examined in the context of the various educational and knowledge building activities of the support group. The support group activities included capacity building for its members on maternal danger signs, benefits of health facility delivery and attendance of Antenatal clinics. These educational activities for its members were designed to strengthen efficacy to make decision to have health facility delivery.

The Health Belief Model was also explored in this study, while constructs such as perceived susceptibility, perceived severity, perceived threat, perceived barriers, perceived benefits, and how these lead to a health behaviour choice (Herbest et al., 2007) were given attention. The HBM suggests that people are more likely to take health-related action if they feel that by so doing they can avoid a negative health consequence (Herbest et al., 2007). The HBM in this study took a look at what the women perceived as threat if they do not deliver in a health facility, severity of their actions not to use the health facility for ANC and delivery and perceived benefits for joining the support group and likely benefits for having health facility delivery. The perceived beliefs by the women that a negative outcome could result from patronizing traditional birth attendants, such as inability to control bleeding or fitting that could result in unfavourable health outcomes. The HBM was applied in the study to draw a link between intentions of pregnant women to deliver in a health facility and perceived benefits of doing so.
CHAPTER TWO:
LITERATURE REVIEW

2.1 Introduction

This chapter examines studies with similar links in the use of support groups to improve health outcomes. It provides evidence on the use of the support group model in other interventions to achieve health outcomes. The aim of the chapter is to highlight the similarities and differences in the studies and draw implications for this research.

2.2 Use of support groups in health programmes

There is generally limited research on the role of support groups in health facility delivery by women. However, there are studies that have explored the use of support groups in improving health outcomes in different maternal and child health program interventions.

The use of Support groups in the management of various health issues have been documented in different literatures. Support groups have been used in the management of patients with sometimes chronic conditions such as cancer, diabetes or heart disease; while in some other cases have been used to encourage positive behaviours in achieving better health outcomes. Examples are support groups to encourage breastfeeding and uptake of other maternal and child health services. The use of support groups in some studies has been demonstrated to increase knowledge, self-efficacy, positive perception and overall health and wellbeing of individuals.

2.2.1 Knowledge

Knowledge about health conditions by the individuals and families is relevant in effective management of any health conditions. Individuals or family members who have good knowledge of the health situation have been shown to manage and respond more positively to their conditions (Milberg et al., 2005). A better Knowledge of the health situation have also been shown to be effective through support groups and in one study of postnatally depressed women (Chen, 2000), the support group approach accounted for improved psychological wellbeing of the women (Chen et al., 2000, Cain et al., 1986).
The result is also similar in another study which showed that the use of education to increase knowledge of individuals in a support group results in positive health outcomes (Roberts et al., 1997, Spiegel et al., 1981).

2.2.2 Self-efficacy

This refers to the level of confidence an individual has in his or her ability to successfully perform a behaviour. The ability and confidence to be able to effectively improve health and wellbeing by individuals is Important in actually engaging in behaviours that can improve health outcomes. This is one area that the support group interventions have also been able to improve. Self-efficacy is posited by Bandura’s theory, and is one important area that studies of support groups have shown to provide benefit to its members. A study of breastfeeding support group revealed an increased breastfeeding rate and self-efficacy to breastfeed (Ingram et al., 2005) as a result of the educational breastfeeding activities of the group. The self–efficacy of members of support group is linked to behavioural outcomes.

2.2.3 Quality of life

Improving the quality of life and general wellbeing remains one of the purposes of the support group activities in health care setting. Improved quality of life have being linked to support group activities, as some studies showed that membership of support group contribute to better quality of life by helping members deal with their health challenges better (Bekele et al., 2013, Abrefa-Gyan et al., 2015). One study of HIV positive pregnant women in a support group, found that the women adjusted quickly to their positive status and were better able to manage themselves and improve their quality of life (Mundell et al., 2011). The use of support group from studies is playing a role in improving the quality of lives of those who are its members.

2.2.4 Uptake of health services

Improving health outcomes especially for maternal and child health is largely a function of uptake of quality health services by both women and their families. One of the factors largely responsible for maternal and child deaths in developing countries is the non-utilization of safe, quality maternal health care services i.e. antenatal and delivery services by women. Uptake of antenatal care is the gateway to having safe delivery and reducing mortality (Simkhada, 2008).
A study of a women’s group in Nepal to improve use of MNCH services, showed that women were seven times more likely to attend antenatal once in their pregnancy and twice for four antenatal visits (Sharma, 2016). There are others studies that have also shown the effectiveness of support groups in improving uptake of MNCH services by women which ultimately impact on birth and survival outcomes by women and children.

2.2.5 Social Cohesion and Integration

In order for a social group to achieve its set objectives, there is a need for the group to develop strong social bond that promotes collective sense of purpose, cohesion and integration. This is largely essential to promote the ideas of the group. Social support groups like the pregnant women group could only be described as health promoting only when it provides a sense of commitment and belonging as well as build the self-efficacy of its members (Berkman, 1995). Support groups have the ability to create a sense of collective responsibility which helps its members forge ahead even through difficulty to achieve better health outcomes (Milberg, 2005). The health of the individual according to Berkman is related to the social relationship such individual is in. Support groups have demonstrated positive health result for members as the group serves as a platform for encouragement for members and directly or indirectly strengthen social ties and improve relationship which sometimes transcends beyond the group activities. Social network is also identified as pivotal in helping people carry out desired health behaviour. According to a WHO and UNICEF finding, many women and young girls are likely to develop positive attitude towards breastfeeding if they regularly see others in family or social groups do so (Organization, 1989). This particularly points to the role social or support group can play in influencing positive health choices.

2.2.5 Implications for this study

While there is limited literature that deals specifically with support groups as a strategy to encourage ANC or facility delivery, there have also been calls for studies on how to promote social support and develop community and family to strengthen interventions (Berkman, 1995). This study is in line with this call as it examined the role of the family and the community and how they affect the intention to deliver in a health facility by pregnant women.
This study critically interrogated the role played by health workers, members of the groups, the activities of the groups, role of the family and the community norms, and how it affects the decision by women intending to deliver in a health facility as against the use of traditional or other options that could put them in danger. This research also, went beyond the usual group interactions to examine the influence of family, community as well as the social network created by the support group. The benefits derived from the group activities were also examined in the context of social integration and support.

Other studies in the areas of maternal health has established that social network intervention can improve health outcomes through facilitating social support and social integration by establishing and improving strong and weak ties within the network while reducing the interaction that could bring about negative influences (Cohen, 2004). In particular, this study was concerned not just with activities of the members of the group, but also with how the social network created, goes beyond the health facilities, and how this played a role in influencing the intention by women to choose health facility delivery. The study also emphasised the need to understand who was actually benefitting from the social-connectedness and to what extent they benefitted.

Recognizing the role played by other factors in improving maternal care such as choice of delivery place (Parkhurst et al., 2006), absence of good health infrastructure, past experience with delivery (Anyait et al., 2012), distance from facilities, absence of skilled health care provider in a facility, and poor attitude of health workers (Uzochukwu et al., 2004), this study also examined these challenges in the light of finding out if they also contribute to influence the choice of pregnant women in the support group for health facility delivery.
CHAPTER THREE:
RESEARCH METHODOLOGY

3.1 Introduction
This chapter provides clear information on the research methodology that the researcher took into consideration in carrying out the study. These include; study design, study population, scope of study, study site, research instrument, data collection procedures, data analysis and ethical considerations.

3.2 Study Design
This is an exploratory study using qualitative methods to understand experiences of support group members within the group. It also seeks to determine whether membership of a group influences the intention of pregnant women to deliver in a health facility. This research data was generated from pregnant women who are members of support groups in seven primary health care facilities in Nkanu West LGA of Enugu State, Nigeria through Focus Group Discussions (FGDs) and In-depth Interviews (IDIs). The use of the FGD method was to get first hand experiences of these women in the group setting, while the IDI gave more personal experiences of selected individuals from the groups. The use of qualitative methods provided the opportunity for the researcher to probe more with a view to getting an in-depth understanding of women’s experiences in the group and factors that influence health facility delivery intention among pregnant women.

3.3 Study Site
The study was conducted in 2016 in Nkanu West LGA of Enugu State, Nigeria. Enugu State is located in the eastern part of country, with a population of 3,267,837 people (NPC, 2009). It has one district hospital, one tertiary health institution, 16 primary health care Centres, and 10 health posts. The research was initially planned for eight publicly owned health facilities
but was eventually conducted in seven facilities currently implementing the support group intervention as the pregnant women support group in the last facility was not functional due to community dispute with the health workers.

### 3.4 Study Population

The study population was pregnant women aged 18 to 45 years who were registered with the support groups in the seven selected health facilities between 2015 and 2016. The women were also those who had attended at least two meetings of the support groups. A typical support group meets monthly, with the first two meetings serving as platforms to educate members on the benefits of joining the group and how to plan for safe delivery at the health facility. New members were usually encouraged to ask questions during these meetings. Women not interested in staying with the group would usually opt out by the end of the second meeting. So attendance of two meetings was considered a good criterion for inclusion in the study. Each support group consisted of an average of six to 10 women. Participants in the study spoke Igbo or English language.

### 3.5 Study Sample

A purposive sampling was used, as the groups were already pre-determined. Participants were recruited from the seven selected primary health facilities that were implementing the support group intervention. The researcher worked closely with the health facility staff to contact the support group members as well as identify study participants. A schedule for appointments was developed with the support of the health facility staff.

At least six members from each of the support groups were invited for the FGD discussions. A total of seven FGDs were conducted. For the IDIs, a total of seven was conducted with individuals from the groups that showed willingness and felt comfortable to share their personal experiences. Since the researcher wanted a detailed explanation around the activities of the support groups, collecting primary data provided the opportunity for the researcher to probe better.
3.6 Pre-Testing of Tools:

The FGD and IDI guides were pre-tested prior to the commencement of the data collection process. The tools were pre-tested with the support group in Nara health facility. Nara health facility is located in Nkanu East LGA, one of the LGAs also implementing the pregnant women support group intervention, but not in the selected LGA for the study. The pre-test was conducted by the researcher with the support of a female research assistant. The pre-test showed that there was clarity, the guides were easy to understand, feasible to use and above all, acceptable by the participants. It clearly elicited the type of information that would be useful for the study.

3.7 Data Collection:

Interviews were initially scheduled for 8 support groups, but the researcher could not access one of the health centres due to communal clashes involving one of the communities. Hence the data collection took place in seven health centres. Data was collected by the researcher with support from a female research assistant who has experience with qualitative study and speaks Igbo and English languages fluently. The health facility staff supported the researcher with contact details of the support group members, while the researcher was responsible for scheduling the meetings and interviews with the participants. Participants were taken through the informed consent process. A FGD guide (Appendix 1) and IDI guide (Appendix 2) were used and basic demographic information about participants was collected. The data collected included; age, sex, marital status, occupation and educational level of participants. The interviews were conducted in Igbo and English languages. All interviews were audio taped and notes taken with the support of the research assistant. The average time for the FGD was one hour 30 minutes, while the IDI lasted between 30 minutes to one hour. None of the participants showed any sign of distress during the interviews, and as such there was no need for referrals. But the researcher had in place a plan to refer anyone who needed such services to ‘women aid collective’ (WACOL) a counselling organization based in Enugu that provides such services (appendix 4 & 5).
3.8 Scope of the study:

The study focused on pregnant women aged 18-45 years who were registered with a support group in the seven selected health facilities in Nkanu West LGA. The study provided reasons why the women chose to join the support groups, and the type of support they got from the groups. Lastly, the research explored the factors that influenced health facility delivery intention among pregnant women.

3.9 Data Analysis:

The data from the field was transcribed and translated into English. The researcher read the text thoroughly to ensure correctness and ensured that all transcriptions and translations were done correctly. All field notes taken during interviews were used to cross-check translations and transcriptions to ensure consistency and correctness of the data. The non-verbal cues captured by the research assistant were also used to ensure consistency with audio recordings of the interview sessions. The recorded interviews where translated into findings by coding and categorizing them by the researcher. NVIVO software was used to support the data analysis. Themes were identified and deductive codes developed along the line of the study objectives. Inductive coding was used to generate new themes as they emerged. For the inter coding agreement, data was reviewed by the female research assistant. This was done to ensure and establish consistency in coding. After the coding, the researcher established relationships across developed themes through triangulation. The demographic information collected was also used during analysis. The data helped the researcher establish relationships between the themes and intention to deliver in a health facility by pregnant women. A descriptive analysis of the findings was done by applying the data to theoretical framework, and also by comparing data from the various groups. The findings of the study were clearly discussed and linked to the aims and objectives of the study.
4.0 Ethical Considerations:

Ethical approval for this study was obtained from the Human Research Ethics Committee (HREC) of the Witwatersrand University, South Africa. The researcher also obtained clearance from the Enugu State Ministry of Health and Nkanu West Local Government Department of Health (See Appendix 3 and 8).

4.1 Informed consent:

The study was explained to the participants with the support of an information sheet and before data collection, written consent was signed by all participants (See Appendices 4 & 5). The study involved a separate written consent for all audio recording (See Appendix 6 and 7). The informed consent process emphasised that participation in the study was strictly voluntary and participants were free to withdraw from the study if they so wished at any point in time.

4.2 Confidentiality:

This was maintained by the researcher at all times during the study. The impossibility of promising full confidentiality for those participating in the FGDs was part of the consent process, as the researcher could not control what participants would during the FGDs. (See Appendices 4 & 5). All signed informed consent forms obtained for all the interviews were safely locked in a drawer, while the audio recordings was secured on a recordable CD and Dropbox and stored safely. These will be destroyed two years after the publication of the study or after six years, if not published. Participants’ anonymity was maintained at all times during and after the study. The researcher also acted in all honesty by collecting objective and accurate data. Only the researcher will have access to the raw recordings, while the supervisors have access to the transcripts from the research through a Dropbox in order to assist with analysis.

4.3 Trustworthiness

The study followed and got all relevant ethical approval necessary for executing the study. As part of ways to ensure the credibility of the results or findings from this study, the following were put in place; adoption of a well-established technique of sampling i.e purposive sampling for this study as the participants in the study were already defined by virtue of the support groups. This use of this method is also in line with similar studies conducted in the past around
the use of support groups for improving maternal health. Participation of the members of the group in the interviews was voluntary. The findings from the study were triangulated through the use of audio recording, notes from the research assistant, transcript and translated materials from the interviews. This was done to ensure consistencies and correctness of data. Inter-coding was also employed to ensure that the researcher is consistent and correct with developed themes from the findings. The study also provided adequate information on the context in which it was carried out i.e. study population, data collection methods, time frame for the study, inclusion and exclusion criteria, number of support groups and individuals involved and a description of the settings. This was to allow for the result of this study to have transferability effect as well as allow for comparability with other similar settings. The use of the in-depth interviews and focus group discussion was also to give depth to the findings and to provide detailed information about the data gathering process and to show the rigours followed to obtain the results which can be relied upon. The researcher has also in the course of carrying out this study provided details of the data gathering, analysis and results with all objectivity and also acknowledged biases. Results and discussion of findings have been provided based on the results of the findings rather than the researchers personal stand point.
CHAPTER FOUR: DATA ANALYSIS AND RESULT

4.1 Introduction

The result of the study is presented in this chapter. A detailed analysis was carried out using deduced categories and common themes. The thematic analysis of verbatim transcript was done using NVIVO software (Miles and Huberman, 1994). The data analysed were also situated within some of the theoretical constructs in order to fully explore the women’s intention to deliver in a health facility.

4.2 Social Demographic characteristics of the respondents

All respondents in the study were pregnant women belonging to a support group in seven health facilities in Nkanu West LGA, Nigeria. Out of the 45 women interviewed, only two were in formal employment while the others were either full time house wives or petty traders. All of the 45 women were married except one. The ages of the women interviewed were between 19 and 37 years. Only 4 out of the 45 women had tertiary education, while others either completed primary or secondary education or did not have formal education.

4.3 Result

4.3.1 Description and knowledge of the support group

All the women understood fully the purpose of setting up the support groups. They described the support group as a gathering of pregnant women brought together for the purpose of improving their health and wellbeing as well as that of their families. They also described the group as self-help group that helps its members financially, materially, spiritually as well as providing members with skills for income generating activities for financial empowerment. One of the women described the group as ‘The pregnant women support group is a kind of family that offers welfare services. This welfare service has to do with knowing the wellbeing of every member in the support group. In this welfare services there is; financial help, material help, spiritual help; you get all, any help you need. (IDI woman in Amodu support group).
Another woman from a group described it as ‘an organization, where we women, are taught about, how to take care of ourselves, how to care for our children, both when they are delivered. Certain things we see, and are able to recognize them as danger-signs’ (FGD woman in Obe support group)

The knowledge of the existence of the support groups was mainly from the health facility staffs who usually encounter the pregnant women when they come to register for ante-natal services. Most women said they heard about the support groups from health facility staff while some said they heard about the groups from friends or other women who were members in the past. One woman puts it this way ‘immediately I got pregnant, I came to register for antenatal services. This was when I heard about the group. So I joined immediately because I have heard and seen the benefits of joining the group’ (IDI woman in Obuoffia support group).

Some of the women have been in the group as far back as 2012 and were in the group with their second pregnancy, while some started attending the support group meetings months into their pregnancy

4.3.2 Reasons for joining the support group

The women gave different reasons for joining the support groups. The women joined the groups because apart from personal benefits, it also benefitted their families. Some said they joined because of the health knowledge they got from the group, while others said that the groups’ micro skill building activities that enabled them earn income was a source of motivation to join. The social bond the group created that enabled individuals get care and support from other members of the group was also a reason for joining the groups. The women described the support groups as place where love abounds and a place where the women are able to find help for health issues, family issues and some other personal issues bothering them. A woman from one of the groups said ‘Another reason why I joined this group is that, they are a group that lives in peace. They are united in everything they do. If they want to do something, they will contact themselves and inform all about what they want to do. They are united in peace. They never leave each other in times of need. And if they want to do anything, they make sure that each other must know’ (FGD woman in Amodu support group).
Experience sharing that takes place in the group enabled the women lift psychological burden and provided relief ‘Another one is that, whenever we gather here, we share our problems, and when I go home, I get relieved from my problems. Each time we come here and go back home, I feel like all my problems have been dealt with, and taken away from me, because I’ve had time to share with my fellow pregnant women’ (FGD woman in Nduuno-uwani support group).

The income generating and skill building activities of the groups is a reason for some women joining the group. Many of the women acknowledged how the skill building activities had empowered them financially, and how they were now able to take care of themselves and their families. A woman had this to say ‘I joined this group because some pregnant women do nothing, they are just house wives. But those of us who joined the group have something doing. Here in the group, we have learnt how to make buns and Soya-beans milk. We learnt these things and can now afford certain things to help ourselves. Sometimes, our men leave the house for work without leaving any kobo (money) for the women. But through the making of buns, we can now take care of ourselves from it. You can also help your husband; by sometime paying for the food items you’ll cook in the house for dinner without waiting for your husband to give you money’ (FGD woman in Obuoffia support group).

Health knowledge women got from the group was also a reason why women joined the group. According to the women, the need to come for antenatal services and delivery at the health facility was highly promoted by the support group. Many of the health knowledge centres around recognizing at least nine maternal danger signs, benefits of antenatal care and facility delivery services. Others are around child care, personal and household hygiene and also nutrition in pregnancy. A member of one of the groups said ‘I joined it because, this is my first pregnancy. I don’t know, I have not experienced it before and do not know how it’s going to be. But this group taught me a lot. It taught me..., I haven’t experienced convulsion, I haven’t experienced headache. I learnt that headache can kill or fitting can kill during pregnancy or during child delivery. But this group taught me, that during my labour, this can occur. They advised me to deliver at health Centre, so that I can be prevented from having those things’ (FGD woman in Nduuno-uwani support group). In the words of another member, she said ‘I joined because they are doing well and I appreciate what they are teaching.'
When I had my third child I had a problem, and it was here that I came. Some people were telling me to stay in the house that it would be alright. I had bleeding and my delivery date was fast approaching. I remembered those teachings and rushed to this hospital. By the Grace of God, they took good care of me, and I delivered my baby safely and peacefully’ (FGD woman in Ozalla support group)

4.3.3 Role of Health Facility Staff on membership of the support group

Majority of the women interviewed said they got to know about the support group through the health workers. While others said they found out about the support group from women who have been in the group or delivered in the health facility ‘I got to know about the group, when I came to the clinic Then secondly, the people in the group, the way they talk about it – you know. When something is good, and whenever it’s being mentioned, especially where women are, they shout, they talk about it joyfully. So I was just sitting down looking at them when they were talking. And the way, they were joyfully saying it’ (FGD woman in Obe support group).

The role of the health workers in encouraging women to join the group came out clearly in the discussions with the women. The health workers according to the women played a large role in getting them to join the support group. According to some women, the friendly and welcoming attitude of the health workers and how they treated them was a strong factor in getting them to join the support group. Some health workers even call the women on the phone or send text messages to convince them about joining the group while also promoting available health services ‘another reason I have for joining the group is the fact that the nurses are doing fine in terms of how they communicate. They relate with everyone on phone, always calling to know how everyone fairing, asking how are you? Hope you are alright, and hope nothing wrong. When there is a need for a meeting, through phone calls they bring everybody together for the meeting’ (FGD woman in Oejindiuno support group)

The health workers spend time to explain the benefits of joining the support group to women who come to the facility, and they do this in a persuasive manner – this, encouraged the women to join the group.
A woman from the group said ‘She (health worker) played a role because my husband and the health worker are friends. She sometimes comes to our pharmacy shop to buy medicines. When she comes, she uses the opportunity to speak to my husband about the support group and the reason why I should join the group. She was very persuasive and gentle towards me anytime she comes. So because of that I also made up my mind to join the group’ (IDI woman in Ozalla support group).

Another woman explains the role of the health worker this way ‘It is as a result of the explanation given by the health worker about the benefits I will get from the group that made me decide to join the group’ (IDI woman in Obuoffia support group).

4.3.4 What the support group mean to the women

All the women acknowledged the important role the support group played and how the group had been of tremendous help to them. Some women said the group had helped to build their confidence in talking about health issues concerning pregnancy as they had learnt a lot from the health discussions in the group. Key among the things learnt from the health discussion was the danger signs in pregnancy, personal hygiene, nutrition and management of diarrhoea in children under 5 years. They appreciated the fact that they could now recognize these maternal danger signs and knew what to do when they observed them. The knowledge gained from the support groups had also helped allay fears usually associated with pregnancy. ‘The support group means a lot for me, from the support group I have learnt even how to sing some new health songs. The songs taught me many things, the things am supposed to know when I am pregnant. How to recognize the maternal the danger signs and what to do about it’ (IDI woman in Oejindiuno support group). The support group influenced the socialization skills of the women as they claimed they were better able to associate with people. They also learnt some etiquette - such as how to comport themselves in public places. The skill acquisition program in the group was valued as some were able to make and sell local foods like chin- and buns, and drinks such as ‘zobo’ or soya milk as well as make petroleum jelly cream. This, they acknowledged was helping them earn money in the absence of their husband providing. A woman puts it this way
'They taught us how to do petty business and not to depend on somebody for everything. At least to earn even when our husbands are not there’. (IDI woman in Oejindiuno support group).

The support group has also built the capacity of the members to provide the health talks as some women said they were able to teach other members what they had learnt. ‘I taught this so that they will know that it is not good for a woman to have convulsion or bleeding during pregnancy. Also it is not good for a child in the womb to come out with the leg or hand. That it’s always good for the child to be delivered with the head. Also, that a pregnant woman should not be lying down flat, but rather should lie with her side. Either with the right or left side, so that the baby will be alright when delivered. These were the things I have been able to teach the group. I have also taught the members how to take care of children that are having Diarrhoea. I taught them how to manage the situation first at home before bringing the child to the hospital. These were also things I learnt from women who were once in the group’ (IDI woman in Akegbeugwu support group).

Another member of a support group who has benefitted from the health discussion said ‘We have been told that health is wealth. We were taught what we need to eat healthy and I find it very helpful. My confidence is raised whenever I am are being taught. When I go out and see people who do not have the knowledge, I begin to see myself as a queen, because I will keep correcting the wrong things they are doing. The group has made me learn so much that it looks as if, I go out to give to others and returns to take more’ (FGD woman in Obe)

**4.3.5 Support women get from the group**

The skill acquisition activities in the groups were recognized as a major form of support they derived as members of the support groups. Many acknowledged the benefits this had not only brought to them as members, but, also to their families. The skill acquisition has empowered them financially and they were now able to care better for themselves and their families. The women learnt how to make local foods and drinks such as buns, ‘chin-chin’, soya beans milk and ‘zobo’. These apart from being consumed by their families, also provided a source of income for the women.
A woman had this to say ‘It is in this group that I learnt how to make buns. I got home and started making buns and getting money from it. So it wasn’t only for the family that I made the buns for. I started making and taking to the market for sale and I make money from it’ (IDI woman in Obuoffia support group).

In addition, it was also mentioned by the women that the group taught them how to manage their limited resources through bulk buying and other practices that save money ‘what I have benefited in this group are the teachings they give us. We are taught so many things, how to organize ourselves as women, how to be prudent, even in your house-hold, how to do bulk buying to save money instead of buying in piece meal. All these are being taught in this group. I practice what I learnt, and I have benefitted from it even in my house’ (FGD woman in Obuoffia).

The support group through its various activities have been able to support women who initially did not want to belong to the group to become full members. They got convinced to stay in the group and even made the decision to deliver in the health facility. ‘The support I received from them is that I had initially decided I will not deliver here because it is a health centre. But now I am fully decided that I will deliver here’ (IDI woman in Ozalla support group).

Spiritual support was also identified by the women as another form of supports they get from being members of the group. Some women mentioned that prayers by the group strengthen them. This they do regularly before the commencements of their meetings or when they go visiting a member who had a baby or is sick at home. Through these prayers members said they drew strength ‘the first benefit I would say I’ve gotten is spiritual strength. You know, most times, you’re pregnant, you don’t really have time and strength to pray, and you’re weak. But in the Support Group, whenever we all come together, you find the strength. So, I really gained spiritual help. I have also gained enlightenment in the Support Group’ (FDG woman in Amodu support group).

4.3.6 Activities of the support group

There are different activities carried out by the support group to keep its members busy. The group carries out health talks during meetings. These health talks cover topics such as maternal danger signs, personal and family hygiene, nutrition, benefits of drinking water and the need to
monitor the baby through scanning. ‘One of the activities that take place in the group is that they urge us to go for scanning of our babies. So many women overlook that issue of scanning, or going for ultra-sound. But in this group, they will urge you’. (IDI woman in Obe support group).

The group members learn from each other through experience sharing during their meetings. The less experienced women benefit from the experiences of women who have had children before. This helps allay their fears and clarify misconceptions related to pregnancy. ‘We use to have a discussions and experience sharing sessions where women share their experiences and we learn from each other. Women who have had babies before share their experiences for others who are pregnant for the first time to learn from’ (IDI woman in Ozalla support group)

Physical activities also form part of the activities of the support group. They take part in light physical exercises, such as dancing. They also share jokes and have fun when they come for meetings ‘We also do exercises. That’s why it’s good to join the group so that when you come and find fellow pregnant women do those things, one would be encouraged to do same ’(FGD woman in Amodu support group)

The group also teaches its members the benefits of safely working within the physical limit that the pregnancy would allow. Example is the teaching not to lift heavy objects as pregnant women as this could have negative consequences. In the words of one of the women, ‘example is lifting heavy objects. As a pregnant woman you may always be busy, and you don’t really get someone to help, you may do things that are tedious. But we are made to know in the support group that even if you don’t have someone to help you out with things that are tedious, you shouldn’t do things that are too tedious.’ (IDI woman in Amodu support group)

The skill acquisition training conducted by the group forms a large part of the activities implemented. The groups as part of activities for new members conduct skills training to ensure that the new member is able to earn an income. Both old and new members are taught new skills such as soap making, how to fry buns, how to make ‘zobo’ drink, make body creams, and to produce soya beans milk and chin-chin. Most times, the cost of teaching the new skills are borne by the members as they acknowledged that the new member may not be able to afford the cost of
the materials for the training. The group believes that the women should not depend on their husbands solely but needed to contribute to the family. A woman sums it up like this ‘again if we have a new member, we do ask if the person has a job or not. If the person says no, I will let the person know that she has to learn some skills as she cannot depend solely on the husband. At that point, there is a call for contribution of money for the skill building and the woman is given the opportunity to choose from the list of skill building programs available. The reason for the contribution is to support the woman with materials needed for the learning as we know that the woman might not be able to provide the money for the materials needed’ (IDI woman in Akegbeugwu support group).

Lastly the group members pray together and this creates a spiritual bond between them. Prayers form an integral part of the activities in the support group meetings. The women believe that with God all problems can be solved. ‘We also pray, even when we gather in the morning before anything, we have to conduct prayers. You have seen it here, before we have to take what is presented to us, we have to put it in the hands of God because without God this Support Group cannot be in existence. We thank God for everything’ (IDI woman in Ndiuno-uwani support group).

4.3.7 Most Important Type of support to members:

Health and wellbeing was placed as the most important among the support the women derive from the group. The women see their lives and that of their babies as more important than any other support the group will provide. More than 80% of the women in the research believe that the support from the group targeted at improving their health and leads to safe pregnancy and delivery are the most important ones to them. This support includes lessons learnt from the health talks about benefits of physical exercise, knowledge on maternal danger signs and the appropriate action to take, prompt attention from health workers in the health facility, knowledge of nutrition in pregnancy and hygiene. One of the women said ‘the most important among them are two things: one, as I said earlier, is cleanliness. They said health is wealth, that’s what we are made to understand. That what we take in, really matters, because of the baby we are carrying. And secondly, the maternal danger signs in pregnancy’ (IDI woman in Obe support group).
Another woman from one of the groups also said ‘ I value my life. My life is the most important thing because I can’t do anything without my life and I thank God for making me to know this Support Group. That’s the most essential thing because it has taught me that coming to Health Centre to deliver my baby will save my life. That’s the most important thing along with other things. But my life is the most important for me’ (IDI woman in Ndieuno-uwani support group).

The skill acquired that generates income for the women was also identified as one of the most important support from the group. They acknowledged that the products from the skill building apart from supporting the family, also provides income for them ‘I have learnt a lot of things from this group, since I joined them. The most important of them all is that when I lack money or when there’s no money with me, I make Vaseline to sell and raise money. At least I can also make buns and sell to raise money’ (FGD woman in Ndieuno-uwani).

4.3.8 Support members need but not provided by the group

The skill acquisition activities does appear not to be happening across all the groups as some women in a group complained that they do not have jobs or businesses and would welcome if the women could become more productive and therefore would want the group to support its members financially. Some women in the group requested that they be provided with financial support to set up their small businesses, while those already in business requested for financial support to improve their businesses ‘what I want just like my sister here has said, has to do with money. Because there are businesses you could want to start and lack of money could hinder or stop you from doing it. So I advocate for money (FGD woman in Oejinduno support group).

Another woman in one of the support groups also captured it in her words ‘they are not really providing financial support, yes because most of the women in the support group are not financially buoyant. Others amongst us do not really have jobs to earn money. Financial support has been a problem in the support group. So that has been one of the challenges of the support group’ (IDI woman in Amodu support group).

Some women said they would need certain services provided for them at the facility such as scan services and the services of a doctor. ‘There are some things we still need in the support group; because we are pregnant sometimes we are sent for scan. They ask us to go and scan our baby.'
Though we have a laboratory here but we are in need of a scanning machine so that we do not have to go far to get the services. It will be nice to see that all the pregnant women are able to access all services here at the health centre’ (IDI woman in Oejindiuno support group)

Some women also feel that the support groups should do more for their members especially when they go visiting a member who has just had a baby. They want the group to organize members and raise money as part of what will be presented to the member. ‘Yes like I said before, when a woman gives birth as a member of the group, we all go to visit her. Usually she will provide some refreshment to members such as kola or drinks. We all eat, drink and pray for the member then leave. I think it will be better if the members can contribute some money and put in an envelope to give to the member. When we finish with the eating and drinking we then present it to the person’ (IDI woman in Akegbeugwu support group).

Lastly the need for more skills building was stressed by some women. They believe there is a potential to expand the range of skills that currently exist. Some said they would want to acquire skills for the production of local disinfectants ‘Another thing I want us to introduce in this our group is to bring those, who can teach us how to make disinfectants, such as Dettol. So that we use it in our individual homes, for protection from germs’ (FGD woman in Ndiuno-Uwani support group).

4.3.9 Influences beyond the support group on choice of delivery place

According to the women in the groups, the choice of delivery place beyond the influence of the support group is largely determined by factors such as cost, availability of qualified health care providers, attitude of health workers and the cleanliness of the health facility. According to one of the women, ‘One of the factors that can influence a woman’s choice of delivery place is where you can get quick service, where you have experienced midwives and nurses around, where the cost will not be much and where discount can be given too. Because everyone’s pocket is not the same. So one of the reasons is also the cost’. (IDI woman in Amodu support group).
4.3.10 Intention to deliver in a health facility

All women in the research said they intend to deliver in a health facility. These decisions, they attributed to the influence of the support group, attitude of the health workers, ability of the health facility to handle complications and cleanliness of the health facility. They feel the care, support, prayers, visits and encouragement from members are motivating factors for the choice made. In the words of one of the members ‘here in the health centre. My decision was influenced because of the love I found among the women in the support group; the care, the prayer, encouragement, and the personal visits. Most times when one is weak to come may be for antenatal, they call you to know if you are coming. If you say yes, someone will arrange to wait for you at the junction. Even when you have decided not to go, the influence from the support group is ok’ *(IDI woman in Amodu support group)*

4.3.11 Influences on choice of delivery place

The influences on choice of delivery place varied with group members as some women mentioned their spouse and other family members as having major influences on their choice ‘It is from what my husband observed about how the nurses took good care of me, that when I suggested I was going to give birth here that he agreed. So, when we got home, I explained everything to my mother and father-in-laws and they also agreed with me’ *(IDI woman in Obuoffia support group)*

Some women mentioned their mother as a primary influence on their choice of delivery place ‘what really influenced my decision was that, number one, is the experiences my mother has had in the health centres. That’s one of the major things that influenced my decision. She compared between the health centres service and the services in the private hospitals. So she was the major influence on my decision’ *(IDI woman in Amodu support group)*.

Women in the groups also said the support group had an influence on their choice of delivery place as they gained knowledge about managing pregnancy and caring for themselves through the group’s health talks ‘there are many things that made me reach my decision. What I have learnt in this Support Group is that the Health Centre is the best place for any pregnant woman
to deliver her baby. It is meant to save life. I have seen so many people that lost their lives because of convulsion, bleeding that they could not stop. But with the help of the Government and this Support Group that I was introduced to, I have been taught many things’ (IDI woman in Ndiuno-Uwani)

Some of the women said they were influenced by the fact that they have seen other women deliver safely in the health facilities ‘the things that influence me is that I have seen women deliver safely here. So it implies that if one comes to the hospital, the delivery will be safe’ (IDI woman in Ozalla support group).

While other women said the quality of services at the facility contributed to what influenced their decision about choice of delivery place ‘and then another thing that influenced my decision was the quality of the services I found here which was quite different from the services we get from other hospitals’ (IDI woman in Amodu support group).

4.3.12 Community’s view on health facility delivery

More than 90% of the women interviewed in the research said the community no longer hold negative views about women using the health facility for delivery. Though in the past, some said the communities were favourably disposed to home deliveries than health facility delivery. Some women believe that the norms and culture of the people still affects some people, but attributed this to illiteracy and the belief that it is more cost effective. In the words of one of the women ‘most times they see it as expensive; most of them are not literate. Most times they don’t have time to listen to someone trying to enlighten them about it. So they see it as something very expensive. They feel they can easily call a neighbour or any nurse who is not a professional to even handle the delivery. So they see it as being expensive’ (IDI woman in Amodu support group).

The women also agreed that cultural norms and beliefs about place of delivery exist, but that many people have now embraced health facility delivery because of observable benefits. Despite the changes, some said there is still pressures to deliver at home especially from uneducated community members, but the women said it is now their responsibility to educate people on the benefits of facility delivery ‘those people that are not learned, sometime, they will ask you not to
visit the hospital, that if you go to the hospital you will have problem. But you are the one to convince them and tell them why you have to go to hospital’ (IDI woman in Ozalla support group).

4.3.13 Decision making in households on choice of delivery place

Many of the women said their spouses were the major decision makers in the households on choice of delivery place with them playing a supporting role. Despite the fact that the women are responsible for naming a place of choice for delivery, their husbands are the ones with the final decision on place of delivery ‘coming to the family, it is the husband that will decide, but I am the one to determine where I will go. I am the one to go through the delivery process. So when I visited the facility, I went back home to relate with my husband that what I saw is ok. My husband just said that if I like the place then he is in support. He is the one to pay the hospital bill’ (IDI woman in Oejindiuno support group).

There were other decision makers identified by the women such as mothers of the pregnant women. A woman said ‘one of the things that motivated my coming here is my mum. She talked about how well the health workers attend to people. You know they attend to people very well here’ (IDI woman in Amodu support group).

Another woman also said ‘my mother most especially. She insisted that I must not have my baby in a TBAs place. That I must go to the Health Centre, because there are capable hands there that can handle any situation’ (FGD woman in Ndiuno-uwani support group)

4.3.14 Influence of support group membership on choice of delivery place

More than 90% of the women in the groups agreed that the support group has influenced their decision on choice of delivery place. Some recalled all the support and benefits they derive from the group such as the health talks, the social bond, the love and care expressed towards each other and the platform it created for them to interact all contributed to the decision on where to deliver their babies. A woman puts this influence this way ‘it has really played a role, because
when you have a friend and decide to follow your friend, it will mean that your friend has influenced you positively or negatively. But, in our group, I’ve been influenced positively’ (IDI woman in Obe support group).

Another member of the support also said ‘reasons why I said that I will give birth in the Health Centre, is because of this group. I joined the support group because of the teaching they give us, and also because of the check-ups I was given here, to determine the position of my baby. This support group has taught us so many things. I now know there are danger signs. So, since I have learnt all these things here, I concluded, that I will deliver my child here’ (FGD woman in Ozalla support group).

4.3.15 Point of decision making on place of delivery

There were varied responses as to when the women made their decision on where to have their babies. Some said it was a gradual decision making process which involved them comparing the services at the health facility with that provided by the traditional birth attendants ‘I must tell you, I have been attending this meeting. I didn’t just make up my mind that I must deliver here, it was a gradual process. I have been able to compare what I have seen here with what I have seen in the TBA’s place’ (IDI woman in Ndiuno-Uwani support group)

For others the decision on where to deliver was made within months of joining while others said they made their decisions immediately they joined the group ‘Ok, it’s at the early stage of my pregnancy, when my pregnancy was about three months old. That was when I took the decision that I’ll give birth here’ (FGD woman in Ozalla community)

4.3.16 Activities in the group that supported choice of delivery place

The activities mentioned by the women as contributing to the decision on choice of delivery place were not different from the activities carried out in the support group. The women mentioned that care and support from members, the follow-up visits, calls, skill acquisition and health talks all contributed to the decision on choice of delivery place ‘yes, the attitude of the health workers. The way the group members use to call people that did not come for antenatal. And when they come together, we dance and play and enjoy other things. (IDI woman in Ozalla support group).
Another woman also puts it this way ‘Yes their support and their teachings are what made me decide that I will deliver my baby here’ (FGD woman from Ozalla)

4.3.17 Decision if not a support group member

The responses were divided among the women on this issue. Many of the women said they would have decided differently if they were not members of the support group on where they would have their babies. They said the support group was their greatest incentive and as such, if the group did not exist they would have gone elsewhere. This decision according to some comes from the fact that members enjoy a whole range of support from its members including post-natal care which women consider valuable. A woman said ‘yeah, I would have acted differently because I know that my mum can’t really handle the post-natal care for me. She is not feeling well at the moment ok. I would have acted differently by may be going to join my younger sister in Onitsha (another city that is two hours away) so that she can assist me. But with the women in the support group and with the way we have been going, they will certainly come around after the delivery to help at least for the first three months. Am ok, So that’s a nice thing’ (IDI woman in Amodu support group).

Some of the women however said they would have still made the decision of delivering in the health facility even if the support group did not exist. Some said the health talks at the health facility, radio messages on benefits of health facility delivery and also having had safe deliveries or seen the benefits through other women who have had safe deliveries in the health was a reason for them to still deliver in the health facility ‘like my friend I told you about earlier, she told me how nice this place is and how she has had all her deliveries safely here. That is a huge influence on me deciding to stay here’ (IDI woman in Ozalla support group).

4.3.18 Influence of choices made by other women in the group

Though there were mixed responses by the women, but many of the women said they were not influenced by choices made by other women in the group. They attributed their choices rather to the activities of the group. The health talks and other health messages passed in the group were identified as the key influence on their decision ‘It is what you observed that will influence your decision. So it is what I see and observed in this favour group that made me decide that I will
deliver my child here. It is not because of what one does, or says’ (FGD woman in Obuoffia). The women said the choice of a delivery place is a personal matter and is not dependent on the choices made by other women. The choice made according to the women was based on what they had seen and experienced and not necessarily because another person made a decision to deliver in the health facility ‘Mm! the choice I made, is a personal choice. I made that choice, because of what I saw. We are not the same. Some people might not take the issue seriously. But personally, I’ve seen beyond what some have seen. Experience will show you what could possibly happen. So I concluded from the little things they are able to do that they will be able to do more for me. So it’s a personal choice, a personal decision that I will deliver here’ (IDI woman in Obe support group)

While some of the women said they were influenced by the decision made by other women in the group. They said they have seen members deliver safely in the health facility and that had impacted on their decision about where to deliver their babies ‘Of course it did influence. It is because of them that I stick to this place. Because of what they do in the group, how they teach people and how they gave birth. If I was in the group and what they do is gossip and I do not find anything useful, I would have left the group. I could see that they have focus and there is result to show for it. Again they influenced through the delivery by women in the group. They gave birth safely without any problems. That for me was the biggest encouragement for me to stay and give birth to my second baby here’ (IDI woman in Akegbeugwu support group)
CHAPTER FIVE:
DISCUSSION OF RESULTS

5.1 Introduction
This chapter will discuss the reasons why women join the support group and what they benefit. It will also discuss what drives intention for health facility delivery, current intention of delivery place by the women and the support group influence on delivery place intention. The result in the study will also draw on health theoretical construct in reaching conclusions.

5.2 Reasons why women join the support group

5.2.1 Knowledge and how women join the support group
The purpose of forming the support group is basically to improve the health outcomes of women through regular antenatal service attendance and having health facility delivery by its members. The support group are able to educate their members to recognize the benefits of using the health facility for safe deliveries.

The study revealed that all the members clearly understood the purpose of the existence of the support group and were happy to be members of the group. Membership was voluntary and women did not pay any fee to be members. The knowledge of the existence of the support group is mainly made known to the women by the health facility workers during antenatal visits, while other women found out about the group from current members or from those who were once members of the group. The health workers apart from the members of the group also took time to convince women in the communities to join the group and as such - are major drivers of membership for the group. This they did through interactions with pregnant women, their husbands and even through phone calls and text messages. The knowledge of what the group stands for and its activities also contributed to why women joined the group. The support groups from the findings get its members through active persuasions and showcasing of the benefits members have derived. The group use current or ex-members who have had safe deliveries or have been supported in an income generating skill building activity as evidence of why other pregnant women should join the group. These beneficiaries become role models that other
women look up to and would want to join the group. The use of the role model approach to get members into the group is consistent with the Social cognitive theory, which posits that people learn certain behaviour by watching others carry out that behaviour (Bandura, 2001). Once in the group, self-efficacy of the pregnant women to use health facility for delivery is built through the various educational programs done in the group. These educational programs include health talks that stress the benefits of receiving antenatal care, health facility delivery and caring for the newborn. This knowledge received also strengthen collective efficacy through the various interactions that take place between women in the group. These interactions provide room for women to share experiences. The more experienced women also share experiences with first time pregnant women to benefit from. This experience sharing process becomes a good learning opportunity and which members actually use to get other pregnant women into the group.

5.2.2 Activities and benefits from the support group

The support group was formed to provide health information to members and act as social pressure group that will help women access antenatal care services and ultimately deliver in a health facility (PATHS2, 2015). This way the maternal and child morbidity and mortality rates are reduced. This aim of setting up the group remained the major benefit members got, aside from other benefits. Other benefits members got included post-natal support, skills for income generating activities, social support such as visitations to members when they were ill, or had a baby, reminders for ANC visits through personal visits and phone calls, and knowledge of managing maternal and child health emergencies. Members of the support group through active participation in the group activities i.e. health talks, group physical exercises, experience sharing by members and group visitations to members, group prayer sessions and skill acquisition activities for income generation, are able to clearly see benefits of being members. Through the health education program, the members also identify perceived susceptibility, threats and severity of not using the health facility e.g. possibilities of infection from unsafe delivery or inability of TBA to handle complications. Through this socialisation in the group, members are able to weigh the benefits of having a facility delivery as to not having and the consequences that could result. This is consistent with the HBM which explains that individuals are likely to carry out behaviour if the benefit of the desired behaviour outweighs the barrier.
Some activities like prayer sessions by the group, visitations to members and skill building, does help to strengthen cohesion and bond by members of the group. Social bond brings trust and more commitment to the goals of the group and in this case-intention to deliver in a facility. Literatures have outlined benefits such as better health outcomes for individuals involved in social networks that promote health (Cohen, 2004). Also Berkman said in one of the literatures that the health of an individual is linked to the social network the individual kept (Berkman, 1995). The finding from this study revealed that the women in the group had strong social tie that directly benefited them and strengthened their bond as well had a positive outcome for them. These activities explains part of the reason to a large extent why women join the group and also addresses objective one of this study which seeks to know about women’s experiences and reasons for joining the group as clearly outlined by the testimonies of the women.

5.3 Intention to deliver in a health facility

5.3.1 Influences on intentions for health facility delivery

The best predictor of behaviour is intention to carry out the behaviour according to the TPB. The study revealed that the intention to deliver in a health facility was influenced by factors beyond the women support groups. The attitude of the health facility workers and the state of the health facility were identified as key factors to deciding whether to deliver in a health facility or not. A past finding also showed that friendly and caring attitude of the health facility staff, availability of trained health workers in a clean health facility that had equipment to handle maternal complications were factors that drove the intention of women to deliver in a health facility (Kiwanuka et al., 2008). This is consistent with this study as many of the women in the study described the services offered at the facility and the caring attitude of the health workers towards them as key in driving their intention to want to have their babies in the facility. The women also recognized the need for the health facility to be equipped to handle complications. These they said, were available in the health facilities and also accounted for why they intended to deliver their babies at the health facilities.

The issue of timely referral in the event of any emergency from the health facility to a higher hospital was identified by the women as a reason for intending to use the health facility for delivery.
The cost of services at the health facilities was also considered, but interestingly women still intend to deliver in a health facility but preferably a government health centres which they considered cheaper than private health facilities.

Despite the structural issues identified by the women as influence for intending to deliver in a health facility, many women in the study likewise acknowledged that the influence of the support group was vital in the decision of intending to deliver in a health facility. Many said if the group did not exist, they would have not decided in favour of health facility delivery. This clearly shows that even in a situation where health infrastructures was good, decision not to deliver in a health facility may still abound as there is an established poor perception of health workers and their services (Uzochukwu, 2004). But with a social network bond like the one that exist with the pregnant women support groups, intention to deliver in a health facility like shown in this study could be high. According to the TPB, intention to deliver in a health facility can rightly predict actual delivery. The findings of this study do establish that intention to deliver in a health facility by the pregnant women is rightly influenced by activities of the support group and rightly responds to the objective of the study.

5.4 Choice of Delivery Place

5.4.1 Decision making in Households

The choice of delivery place was usually made in the home and initiated by the women as shown in this research. But the final decision about where to go for delivery was largely made by the spouses of the women. Though a joint decision, the men give the seal of approval on the final choice. In some cases, the study found out that the men initiated the discussion on the place of delivery and an agreement was reached by the couple. This finding is in line with findings from another study which identified men as playing a key role in the choice of health care service taken by women (Dudgeon and Inhorn, 2004, Fayoyin).

The decision of other family members was also found to determine the choice of delivery place by the women. This study found that mother-in-law’s played a role in the decision making process - about where the women went for delivery. However, in this study, the mother-in-law’s favoured the decision of having health facility delivery by the women. This is also consistent
with other studies that found the mother-in-laws as playing a key role in the choice of delivery place by women (Peltzer et al., 2007). The importance of ‘significant others’ in key decision to carry out behaviour clearly played out in this study. The influence of spouses and mother-in-law’s contributed to influencing decisions by some of the women to contemplate health facility delivery. Subjective norm according to the TPB recognizes that peoples’ intention to carry out behaviour is influenced by whether or not they believe significant others approve of it. In this study, the support of the spouses and the mother-in-law’s to use health facility for delivery contributed significantly to influencing decisions of the women in the support group to contemplate facility delivery. The study therefore, recognizes that the activities of the support group e.g. health education on the benefits of antenatal and health facility delivery played a role in opening up discussions between the members of the group and their spouses and mother-in-law’s on the choice of using health facility for delivery. This indirectly influenced the women position on choice of delivery place and provided basis for having informed discussions with their spouses and the mother-in-law’s.

5.4.2 Community influence on choice of delivery place

A shift in cultural norms was observed in the study as it concerns choice of delivery place. The women acknowledged that the choice of health facility delivery is now largely accepted but there were still pressures in some instances for women to deliver at home rather than use the health facility. This is largely attributed to poor knowledge of available services, and poverty, as some community members according to the women felt it was cheaper to deliver at home, rather than spending money in the health facility. However, women’s increased knowledge of the benefits of health facility delivery was providing confidence for the women to stand by their choice of health facility delivery when issues of delivery place were raised. The study showed the role of self-efficacy to have facility delivery clearly displayed by the members of the group. This is largely attributed to the activities of the support group through the health education activities of the group. Again the study revealed that despite changing position of community members on the choice of using health facility for delivery, there were still pushing for home delivery occasioned by the need to reduce cost of health facility services. Many of the women in the group according to the study were able to make decision on likelihood of having health facility delivery due to the health talks they have benefitted from in the group. The health talks built their self-efficacy on the use of antenatal and health facility delivery.
5.5.1 Choices made by other women in the group

The choices made by other women in the group influenced decision on choice of delivery place. The findings revealed that some of the respondents said the choice of delivery place though personal, but was also influenced by activities of other women in the group such as a member delivering in the health facility safely. This type of activity usually had significant impact on the women as they hoped to have the same safe delivery as their colleagues in the group. Again, the social bond that existed between members in the group tended to affect or influence the decision made by individuals in the group. This is consistent with the literatures that identified social cohesion, bond that exist in group as having influence on health outcomes of members. This again also speaks to the influence members of a social network have on other members. The activities of the group such as visitations to the homes of members whom have had babies, further re-enforced the benefits of staying in the group and also significantly impacted on other members who also wanted the same health outcome – safe delivery.

5.5.2 Decision if not a member of the support group

The women demonstrated knowledge of the key benefits of joining the group as they recognized the benefits of health facility delivery even in the absence of a support group. Many women in the study said they would still have had facility delivery even if they were not members of the support group. The reasons given for this included; positive experience from having a facility delivery in the past, perceived benefits of facility delivery, fear of traditional birth attendants not being able to handle complications or emergency cases when they arose and good knowledge of available services in the health facility. The position of some of the women in the group is consistent with the HBM, which identifies that people are more likely to behave in a certain way if they know that the benefits of that behaviour outweighs the barrier. Many of the women were scared of negative health consequences if they did not make the choice of having health facility delivery. This standpoint is an indication of the knowledge gained from past experiences and the health education activities of the support group.
The benefits from the health education activities of the group were responsible according to some members for their choice of likelihood of health facility delivery. Some in the study said out rightly that they would have decided differently were it not for the influence of the support group. Indicating that the support group to a great extent was responsible for intentions by many of the women to choose health delivery.

5.6 Implications and Limitations of the study

5.6.1 Implication of the study on Theory

The study applied theories and constructs in explaining how the activities of the pregnant women support group influenced the intentions of the women to have health facility delivery. The HBM was used in the study to understand how the activities in group contribute to influence intention to use health facility for delivery. The constructs of perceived threat, susceptibility, benefits and barriers explained some of the reasons influencing intentions by the women. Women in the group remarked that their perceived susceptibility to a negative health outcome motivated them to want to have facility delivery. The health education done by the group increased their knowledge and self-efficacy. Self-efficacy is a construct from the Bandura’s Social cognitive theory and this was clearly seen its application in the study to explain the confidence exhibited by the women both in making decision to stay in the group and also in discussing with their spouses and mother-in-law’s in making decisions on choice of delivery place i.e. health facility delivery. HBM could be used to predict the behaviour of the women in the group and ultimately influence design of interventions.

The social influence model was also applied in the study to understand how the interaction of members in the group supports the development of group norms that positively impact on the decisions made by the women. The study revealed that choices made by members were influenced by others in the group. The social interactions strengthen social bonds and positively impacts health outcomes (Cohen, 2004). The support group promoted healthy behaviours and this gradually became a norm for the group and then influenced intentions to have facility delivery. This is in line with Berkman’s social influence model (Berkman, 1995). This model posits that promoting healthy behaviour is influenced by norms developed through social influence and they either constrain or enable healthy behaviours (Berkman, 1995).
The commitment, or intentions to carry out a behaviour is also linked to the Theory of Planned Behaviour (TPB), which sees intention to act as the best predictor of behaviour (Ajzen, 1985). This is one of the behavioural frameworks which are known to predict behaviour through intentions of individuals. The TPB centres on individual beliefs and attitudes. It posits that intention is a combination of attitudes, subjective norm and perceived behavioural control towards the behaviour, in this case intention to deliver in a health facility. The members of the support group over time have been able to develop a positive attitude towards the use of the health facility for ANC and delivery services. This is largely credited to the range of activities in the group which had helped to increase the women’s confidence in the use of health facility. Through their social activities like visitations to members, showing love and care and supporting each other, they have also been able to gain trust for each other. This trust also translated to the women having a sense of purpose and working towards a common goal of having a healthy outcome i.e. safe delivery in a health facility.

TPB from evidence can predict variance in behaviour and a large proportion of intention (Morris et al., 2012). Actions, therefore, are influenced by intentions, but not all intentions are executed. Whether the women eventually delivered in a health facility is not within the scope of this study. However the TPB theory is shown to predict the behaviour of women in the group as the social cohesion that exist in the group and other group activities have been linked to the women’s intention to have facility delivery.

Lastly, the study showed that the application of behaviour theories such as the social influence model, TPB, HBM and other constructs can help predict likely intentions of women in the support to have facility delivery.

5.6.2 Implication of the study to Practice

The support groups’ activities over time became expanded to cover other areas which were initially not planned for. Activities that covered spiritual support, social support, i.e. follow-up visits to members, visits to members who had just delivered, phone calls and text messages to members and other forms of social support which was to encourage members to continue antenatal care and ultimately get them to deliver at the health facility were introduced. These activities increased member’s knowledge of pregnancy issues such as recognizing and knowing
what to do when a maternal danger sign occurs, types of food to eat, usefulness of physical exercise in pregnancy, and the benefits of using the health facilities. This knowledge helped remove unnecessary fear and worry about pregnancy. This singular reason became the reasons why many women joined the support groups. This implies that the use of support groups as a strategy for improving health outcomes, and especially in maternal health, could be expanded to provide other forms of support beyond clinical support, as a way of improving the psychosocial wellbeing of members. The low uptake of health facility delivery services are sometimes linked to unnecessary fears, misconceptions about facility health services, poor perception of services in government health facilities, and the perception that facility utilization was only meant for women with maternal complications (Griffiths and Stephenson, 2001, Titaley et al., 2010). These reasons sometimes led to home deliveries and uptake of services in the hands of unskilled and untrained birth attendants. The support groups’ activities if expanded - as it was observed in this study could build the confidence of its members, and continuously promote the benefits of having facility delivery.

However, the findings show that some groups at some point introduced the income generating skill acquisition program as part of their activities. This resulted in members being taught how to make buns, local pastry called chin-chin’, local drink called ‘zobo’ and soya beans milk. Making of local body cream which the women referred to as ‘Vaseline’ was also taught. The introduction of the skill acquisition activities boosted membership of the groups and became a motivating factor for women to join the support groups. The skills translated into financial gains for the women and their families - as they were able to feed their families from it, as well as make extra money to enable them procure health services in the absence of their husbands. The skill building activity is now a huge attraction for women to join the support group as the benefit from it helps support the women’s households and reduce over dependency on their husbands. The introduction of the income generating skill training for women in the group, has the potential to strongly impact on their health outcomes as they were more likely to continue in the group and eventually deliver in the health facility. There are studies that have clearly shown the link between economic empowerment status and maternal health service utilization. An analysis of demographic and health surveys of 31 countries showed a significant association between the
economic empowerment status of women and use of maternal services (Ahmed et al., 2010).

This is also in line with another study that have shown that health outcomes could be improved through economic empowerment (Laverack, 2006). This therefore implied that the introduction of an economic empowerment activity to the support group had the potential to clearly impact on ANC attendance and health facility delivery choice. It also showed that the introduction of an income generating activity helped remove the financial burden and the barriers associated with ANC and health facility delivery uptake, and improved the wellbeing of the women and their families. This indicates that income generating activities do clearly complement other activities of the support groups and helps in increasing membership of the group.

This research also revealed that despite the economic benefits the women were deriving from the skill building activities of the group, the health benefits were still considered the most important. Having safe delivery remained the most important reason for joining the support group. They considered the financial or economic benefits as secondary while their health and wellbeing and that of their babies’ remained a top priority for members. This showed that the ultimate aim of using the support group model to improve health outcomes remained achievable even in the face of introducing other incentives such as skill acquisition to motivate membership. This is consistent with other studies which showed that activities in the support group ultimately was geared towards improving the health and wellbeing of its members (Abrefa-Gyan et al., 2015).

The social and interactive skills of the women were improved through the activities of the group. The confidence of the women in discussing health issues, and in making life saving decisions was improved through the activities of the group. This implies that support groups could be used to improve women’s self-efficacy to use health facility for ANC and delivery. This, they simply did through the educational activities of the group - such as health talks, experience sharing and other social interactions between members. With improved self-efficacy, the women are more likely to have control over their decision on choice of delivery place.

5.6.3 Implication of the study on Research

The research suggests that the pregnant women support group intervention indeed influenced the intention of women to have health facility delivery. But there is a need that future studies are
conducted to find out whether this intention by the women in the support groups eventually translates to actual health facility delivery. This study only examined the intention to deliver in a health facility, but intentions do not always translate to actual health behaviours, hence, the need for future research.

5.6.4 Limitations of the study

This study had several limitations as the interview environment (Health centres) could have affected the responses. The environment could have made respondents speak favourably about health workers and the services provided at the health centres. The respondents therefore, may not have fully and honestly expressed their views. This however was controlled by the fact that the health workers and other staff of the facility did not sit in during the interviews and the discussions took place in the centre away from all health workers hearing and eye view.

The researcher being a staff of the organization that implemented the pregnant women support group model could have also introduced bias. But since the study was a qualitative one with seven FGD and IDI each, rich data was collected which gave a thorough and in-depth explanation of the objectives of the study.

The researcher worked with an interpreter which would have limited the opportunity for the researcher to further interrogate responses where needed.

5.7 Conclusion and Recommendation

5.7.1 Conclusion

The study found out that the pregnant women support group does influence women’s intention to deliver in a health facility. But the intention to deliver in a health facility is also influenced by other factors such as attitude of health workers, availability of skilled health workers, good health infrastructure, cost of health services and decisions of spouses and mother-in-law’s. The experiences of the women in the group through the various social activities such as the health education, experience sharing, visitations, economic strengthening all had a role in women joining and remaining in the group.
The knowledge of maternal danger signs and what to do, social bond (experiences sharing, and home visitations), spiritual awakening and economic strengthening skills are clear benefits to the members of the group. However, the health benefits according to the women in the group remains the most important. The knowledge of these benefits fits into one of the objectives the study set out to achieve. Lastly, the influence of the support group on intention to deliver in a health facility as an objective of the study was shown to be a positive influence. Many women believed that the activities of the support group influenced their intention to deliver in a health facility.

5.7.2  Recommendations.

5.7.2.1 Economic Empowerment programs

This study showed that financial barrier hindered access to quality maternal and child health services as most women were financially dependent. But the introduction of the income generating skill building activities, completely changed the over dependency on their spouse and partners, and created opportunity for the women to earn income and also contribute to the finances of their families. This has had significant impact on the health of the women as they were able to afford quality health services. This program should be strengthened and supported. There is also need to expand the range of skills being currently provided. This recommendation is also consistent with other studies that showed the link between economic empowerment and health care utilization by women (Ahmed et al., 2010, Laverack, 2006)

5.7.2.2 Production of health talks manual

The women expressed confidence about their ability to conduct health talks and talk to other women about health and other pregnancy related issues. Though, this is been done at the moment, but not in a coordinated and structured manner. There is a need for a manual for health talks to be developed for the group and members trained on how to use it. The use of health talk manual or jobaid was also found in a study in Benin among women attending ANC to increase knowledge on birth preparedness, recognition of maternal danger signs knowledge of clean delivery (Jennings et al., 2010). When this is provided, there will be consistency in messaging and also the quality of health information is assured. This will ensure correctness of messages and eliminate the possibility of wrong health messages being passed to members of the group.

45
5.7.2.3 Proper Documentation of group’s activities

Most of the activities and programs by the support groups remain largely un-documented. This could be explained by the nature and composition of the group as well as the disengagement from the group after delivery. There is a wealth of knowledge that abounds that could form researchable topics for the future, but this knowledge would continue to remain residual as there is a dearth of documentation of the support group’s activities. The groups could be supported to document most of their activities and this could form part of the data to evaluate its impact on maternal health outcomes.
References


Appendix 1

Focus Group Discussion Guide

FOCUS GROUP DISCUSSION GUIDE

A. FGD Preparation Checklist

The following preparations should be completed and materials obtained before each FGD:

• 12 copies of study information sheets
• 12 copies of consent forms
• 12 copies of audio-recording consent forms
• Box of pens
• Digital audio-recording equipment (tested for working condition)
• Backup batteries for audio recorder(s)
• Notebooks for facilitator
• Private room with at least 12 seats and enough space to arrange seats in a (semi)circle
• Food and drinks for participants

Name and Signature of Study Staff: ______________________ Date: _____________________

B. Checklist for Facilitator and Note taker

The FGD will only progress once the following are confirmed:

• All study consent forms have been signed and copies given to participants
• All participants have signed audio-recording consent form
• At least 6 participants in the group
• No more than 10 participants in the group
Note: Participants without the appropriate consent/assent forms or not meeting the inclusion criteria will be excluded.

Name and Signature of Study Staff: _______________________  Date:____________________

C. Introduction Exercise

Note: Start recording

Once the consent process is complete, and all participants seated, they will be requested to introduce themselves in turns using a Nickname (false name for FGD purpose), her age, and something about her that nobody else in the room knows.

Note: Stop recording

Facilitator will go over ground rules, e.g. respect, speaking one at a time, no phones on, etc. while the audio check is happening.

Note: During ground rules, note taker should ensure that the recording equipment is working and that everyone is audible.

D. Discussion question guide – (Just a guide – let conversation flow)

Note: Start recording

Opening question

Key Area: Reasons for joining the support group

Main Question1

Tell me about the pregnant women support group
Main Question 2

What are your reason(s) for joining the pregnant women support group?

Probing Questions;

✓ How did you hear about the support group?
✓ When did you start attending the support group meeting?
✓ What made you join the support group?
✓ What role did the health facility play in you becoming a member of the support group?
✓ What is your experience with the support group?

Key Area: Support Women get from being members of the group

Main Question 3: What does the support group mean to you?

Probing Question

✓ Describe the type(s) of support you get from being members of the group
✓ Can you tell me what kind of activities take place in the support group
✓ What type(s) of support are most important to you, and Why?
✓ What type(s) of support do you need from the support group that you do not get?

Key Area: Factors that influence intention to deliver in a health facility

Main Question 4:

What influences women’s choice of delivery place beyond the support group?

Probing Questions;

✓ Where do you intend to deliver your baby?
✓ What has influenced your choice of delivery place?
✓ What is the community’s view (norms, culture and traditions on delivery) about places of delivery and particularly health facility delivery
✓ How is the decision on where to deliver made in households?
✓ Who are the key people involved in decision of where to deliver?
✓ What factors could influence women’s decision to deliver in a health facility?
Main Questions 5.

How has membership in the support group influenced your decision about choice of delivery place?

Probing Questions

✓ At what point did you decide where to deliver your baby?
✓ Where there activities in the group that helped you decide on place of delivery?
✓ Would you have decided differently if you were not a member of the group?
✓ Did the choices made by some members of the group influence your decision on delivery place?

Wrap up summary:

If I have understood you correctly you have said that (summarize the salient points from the discussion). Have I understood you correctly?

Is there anything else you would like to say about the pregnant women support group?
Appendix 2.

In-depth Interview Guide

IN DEPTH INTERVIEW GUIDE

A. IDI Preparation Checklist

The following preparations should be completed before each IDI:

• 1 extra copy of study information sheets
• 1 extra copy of consent form
• 2 copies of audio-recording consent forms
• Digital audio-recording equipment (tested for working condition)
• Backup batteries for audio recorder(s)
• Notebooks for interviewer
• Private room
• Food and drinks for interviewee

Name and Signature of Study Staff: _______________________  Date: ____________________

B. Checklist for Facilitator and Notetaker

The IDI shall only progress once the following are confirmed:

• Study consent form has been signed and copy given to interviewee
• Interviewee has signed audio-recording consent form

Name and Signature of Study Staff: _______________________  Date: ____________________

54
C. Introduction Exercise

Note: Start recording

Once the consent process is complete, to build rapport, have the interviewee introduce a little bit about herself without using her name, e.g. age, number of siblings and what she does for a living

Note: Check that recorder is working before proceeding

D. IDI guide

**Key Area: Reasons for joining the support group**

Main Question 1

Tell me about the pregnant women support group

Main Question 2

What were your reason(s) for joining the pregnant women support group?

Probing Questions;

☐ How did you hear about the support group?
☐ When did you start attending the support group meeting?
☐ What made you join the support group?
☐ What role did the health facility play in you becoming a member of the support group?

**Key Area: Support Women get from being members of the group**

Main Question 3: What does the support group mean to you?

Probing Question:

☐ Can you tell me what kind of activities take place in the support group?
☐ What type(s) of support are most important to you, and Why?
☐ Describe the type(s) of support you get from being a member of the group.
☐ What type(s) of support do you need from the support group that you do not get?
Key Area: Factors influence intention to delivery in a health facility

Main Question 4:

What influences your choice of delivery place beyond the support group?

Probing Questions;

☐ Where do you intend to deliver your baby?

☐ What has influenced your choice of delivery place?

☐ Does the support group play any role in influencing your intention to deliver in a health facility? Describe.

☐ What is the community’s view (norms, culture and traditions on delivery) about places of delivery and particularly health facility delivery?

☐ How is the decision on where to deliver made in your household?

☐ Who are the key people involved in decision of where to deliver?

☐ What factors could influence your decision to deliver in a health facility?

Main Questions 5.

How has membership in the support group influenced your decision about choice of delivery place?

Probing Question

☑ At what point did you decide where to deliver your baby?

☑ Where there activities in the group that helped you decide on place of delivery?

☑ Would you have decided differently if you were not a member of the group?

☑ Did the choices made by some members of the group influence your decision on delivery place?
Appendix 3.

Enugu State Ministry of Health and Nkanu West Local Government Department of Health Clearance

ENUGU STATE MINISTRY OF HEALTH
ETHICAL COMMITTEE ON RESEARCH PROJECTS

Ref. No.: MH/MSD/EC/0193
Date: 7th September 2015.

The Researcher,
Eki Osarenoma George,
Witwatersrand University,
Johannesburg South Africa.

Re: Experiences of support group participation and health facility delivery intention among pregnant women in Enugu State, Nigeria.

I refer to your request for permission to carry out a study/research on the above health issue and to inform you that approval has been granted to you.

Ethical Guideline

1. You are to keep to the principles of informed consent by obtaining a signed/thumb printed informed consent of subjects, parents/legally accepted representative.
2. You are to deposit two (2) copies of the result of your study to the ethical committee of the State Ministry of Health.

Dr. Ejieh M.N.
Chairman, Ethical Committee on Research
Appendix 4.

Information Sheet and Consent Form - Focus Group Discussions

Participant Information and Consent Form for Focus Group Discussions

1. Introduction

Good day. My name is Eki George. I am a student from the University of the Witwatersrand in Johannesburg. I would like to invite you to consider volunteering to participate in the above mentioned research study. This study is being conducted as part of my Master’s degree in Public Health.

Before volunteering to participate in this study, it is important that you read and understand the following explanation of the purpose of the study, the study procedures, benefits, risks, and your right to withdraw from the study at any time.

This information leaflet is to help you decide if you would like to volunteer. You should fully understand what is involved before you agree to take part in this study. If you have any questions, do not hesitate to ask me.

We are inviting you to take part in a research study. This research study seeks to understand the experiences of support group participation and its influence on intention to deliver in a health facility by pregnant women. This study involves participating in a discussion with between eight to ten other pregnant women in the support group. In this study, we would like to learn more about you, what you think about the support group, the type of support you get from the group and factors that influence choice of delivery in a health facility.

3. Length of the Study and Number of Participants

This study is being conducted in eight health facilities in Nkanu West LGA. The total amount of time required for your participation in this study is no more than 90 minutes. The group discussion will take place in a convenient venue and is a one-time event.

Up to 10 women from the support group will take part in these discussions, but there will be no more than 10 people in total in the group discussion that you are being invited to join.

4. Study Procedures

If you take part in this study, we will ask you to participate in a group discussion on one occasion. This should take about 90 minutes. The researcher will facilitate the discussion, introduce the discussion topics and will ensure that everyone has a chance to speak, but for most of the time the focus of the discussion will be between you and the other participants.
The discussion topics you will be asked about will be used to help us:

a) To explore pregnant women’s experiences and reasons for joining support groups in Nkanu West LGA, (2015-2016)

b) To identify and describe the type of support pregnant women get from the support groups in Nkanu West LGA, (2015-2016).

c) To explore pregnant women’s support group influence on health facility delivery intention in Nkanu West LGA, (2015-2016)

While we hope that you will participate actively throughout the discussion, you may skip any questions you don’t want to answer.

5. Will any of these Study Procedures Result in Discomfort of Inconvenience?

While the group facilitator is trained, the discussion may raise issues that are personal and of a sensitive nature that may make you feel uncomfortable or upset. While there are not right or wrong answers in this type of discussion, you may disagree with what other people in the group are saying or others may not share your opinions or experiences. You may skip any questions that you don’t want to answer or leave the group discussion at any point. Furthermore, as this is a group setting, it is not possible to promise confidentiality. There may be other risks and discomforts that are not known at this time.

6. Benefits

You will not benefit directly from taking part in this study. Information gathered from this study may help us learn more about how to improve the support group intervention in Enugu State, Nigeria.

7. Costs and Reimbursement

There is no cost to you for being part of the study.

8. Right as a Participant in this Study to refuse to take part

Taking part in the study is your choice. If you decide to take part, you can always change your mind. You can stop taking part at any time.

9. Ethical Approval

• This study protocol has been submitted to the University of the Witwatersrand, Human Research Ethics Committee (HREC) and written approval has been granted by that committee. A written approval has been granted by the Enugu State Ministry of Health’s ethics committee.
10. Confidentiality

We ask that you keep anything that is shared in the discussion confidential. However, as this is a group discussion, we cannot guarantee that other participants in the discussion will keep what is said confidential. However, the researcher will make every effort to ensure that your comments are confidential in any reporting on the discussion, as follows:

- I will use a code instead of your name for any quotes transcribed directly from an audio recording.
- Audio recordings and transcripts of the conversations will be stored in locked and/or password protected files and destroyed three years after the study is complete.
- All information obtained during the course of this study, including personal data and research data will be kept strictly confidential. Data that may be reported in scientific journals will not include any information that identifies you as a participant in this study.
- This information will be reviewed by authorized representatives of the study team.
- The information might also be inspected by the University of the Witwatersrand, Human Research Ethics Committee (HREC).

11. Distress protocol

Should you in the course of the study show any sign(s) of distress, necessary information as to where to get help will be provided for you. Psychological services could be gotten from the following contact;

Organization: Women Aid collective (WACOL)
Address: 9, Umuezebi Street, Upper Chime, New Haven, Enugu, Nigeria
Contact Person: Nkechi Nwabueze
Phone: +234-806806-3470
Email: nnwabueze@wacolnigeria.com

12. Sources of Additional Information

If you have any questions about this study, you may contact Mr. Eki George (+234 8036467108), or Prof Peter Cleaton-Jones at the University of the Witwatersrand, Human Research Ethics Committee: Secretariat (011 717 1234)
INFORMED CONSENT:

• I hereby confirm that I have been informed by the study staff (___________________________) about the pregnant women support group Study.

• I have also received, read and understood the above written information (Participant Information Leaflet and Informed Consent) regarding the study.

• I am aware that the results of the study, including any personal details such as those regarding my age and residential area will be anonymously processed into a study report.

• In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher or on her behalf.

• I may, at any stage, without prejudice, withdraw my consent and participation in the study.

• I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

PARTICIPANT:

Printed Name            Signature / Mark or Thumbprint            Date and Time

I, ______________________ herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

STUDY STAFF:

Printed Name            Signature            Date and Time

TRANSLATOR / OTHER PERSON EXPLAINING INFORMED CONSENT (if applicable):

Printed Name            Signature            Date and Time
Participant Information and Consent Form for In-depth interviews

1. Introduction

Good day. My name is Eki George. I am a student from the University of the Witwatersrand in Johannesburg. I would like to invite you to consider volunteering to participate in the above mentioned research study. This study is being conducted as part of my Master’s degree in Public Health.

Before volunteering to participate in this study, it is important that you read and understand the following explanation of the purpose of the study, the study procedures, benefits, risks, and your right to withdraw from the study at any time.

This information leaflet is to help you decide if you would like to volunteer. You should fully understand what is involved before you agree to take part in this study. If you have any questions, do not hesitate to ask me.

This consent form may contain words that you do not understand. Please ask me or other study staff to explain any words or information that you do not clearly understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

If you agree to take part in this study, we will ask you to sign this form to show that you want to take part. We will give you a copy of this form to keep.

It is important that you understand the following:

- Taking part in this study is completely voluntary.
- You may refuse to take part in this study or leave it at any time. By doing so, you will not lose any benefits you receive now or have a right to receive.
- Your decision to leave this study will not affect the medical care you get now or in the future.
- Your decision will not affect your ability to take part in other research studies.
2. Purpose of the Study

We are inviting you to take part in a research study. This research seeks to understand the experiences of support group participation and its influence on intention to deliver in a health facility by pregnant women. This study involves participating in an interview with one interviewer. In this study, we would like to learn more about you, what you think about the support group, the type of support you get from the group and factors that influence your choice of delivery in a health facility.

We are inviting you to take part in this study because you were a participant in the focus group discussions that were held on the same subject and you made some contributions which we would like to explore in more depth so that we can better understand your experiences and views.

3. Length of the Study and Number of Participants

This study is being conducted in eight health facilities in Nkanu West LGA, in Enugu State. The total amount of time required for your participation in this study is no more than one hour. The interview will take place in a convenient place and is a one-time event. No other interviews are required.

You will be one of not more than eight individuals interviewed. All the individuals being interviewed were participants in the group discussions on the same topic.

4. Study Procedures

If you take part in this study, we will ask you to participate in an interview which should take one hour or less. You will be interviewed in English or Igbo but if there is anything you do not understand or if you would prefer to use your home language there will be someone on hand to assist with this. With your permission, the interview will be audio-recorded so that the interview does not miss anything that you say. The interviewer will ask you a series of questions about the topics already mentioned earlier. Your honest answers to the questions will be used to help us:

a) To explore reasons why pregnant women join the support group in Nkanu West LGA, Nigeria.

b) To identify and describe the type of support pregnant women get from the support group in Nkanu West LGA, Enugu.

c) To explore factors that influence pregnant women’s health facility delivery intentions in Nkanu West LGA, Enugu.

While we hope that you will feel comfortable enough to answer freely, you may skip any questions you don’t want to answer.
5. Will any of these Study Procedures Result in Discomfort of Inconvenience?

The interviewer may ask questions or raise issues that are personal and of a sensitive nature that may make you feel uncomfortable or upset. There are no wrong answers in this type of interview. We are interested in your experiences and thoughts. However, you may skip any questions that you don’t want to answer or discontinue the interview at any point. There may be other risks and discomforts that are not known at this time.

6. Benefits

You will not benefit directly from taking part in this study. Information gathered from this study may help us learn more about how to improve the pregnant women support group intervention.

7. Costs and Reimbursement

There is no cost to you for being part of the study.

8. Right as a Participant in this Study to refuse to take part

Taking part in the study is your choice. If you decide to take part, you can always change your mind. You can stop taking part at any time.

9. Ethical Approval

- This study protocol has been submitted to the University of the Witwatersrand, Human Research Ethics Committee (HREC) and written approval has been granted by that committee. A written approval has been granted by the Enugu State Ministry of Health.

10. Confidentiality

Anything that you share in the interview will be kept confidential in the following ways:

- We will use a code instead of your name for any quotes, which will be transcribed directly from a translated transcription from the audio recording.
- Audio recordings and transcripts of the interview will be stored in locked and/or password protected files and destroyed three years after the study is complete.
- All information obtained during the course of this study, including personal data and research data will be kept strictly confidential. Data that may be reported in scientific journals will not include any information that identifies you as a participant in this study.
- This information will be reviewed by authorized representatives of the study team
- The information might also be inspected by the University of the Witwatersrand, Human Research Ethics Committee (HREC).
11. Distress protocol

Should you in the course of the study show any sign(s) of distress, necessary information as to where to get help will be provided for you. Psychological services could be gotten from the following contact;

Organization: Women Aid collective (WACOL)
Address: 9, Umuezebi Street, Upper Chime, New Haven, Enugu, Nigeria
Contact Person: Nkechi Nwabueze
Phone: +234-806806-3470
Email: nnwabueze@wacolnigeria.com

12. Sources of Additional Information

If you have any questions about this study, you may contact Mr. Eki George (+234 8036467108), or Prof Peter Cleaton-Jones at the University of the Witwatersrand, Human Research Ethics Committee: Secretariat (011 717 1234)
INFORMED CONSENT:

- I hereby confirm that I have been informed by the study staff (___________________________) about the pregnant women support group Study.

- I have also received, read and understood the above written information (Participant Information Leaflet and Informed Consent) regarding the study.

- I am aware that the results of the study, including any personal details such as those regarding my age and residential area will be anonymously processed into a study report.

- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher or on his behalf.

- I may, at any stage, without prejudice, withdraw my consent and participation in the study.

- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

PARTICIPANT:

Printed Name    Signature / Mark or Thumbprint    Date and Time

I, ______________________ herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

STUDY STAFF:

Printed Name    Signature    Date and Time

TRANSLATOR / OTHER PERSON EXPLAINING INFORMED CONSENT (if applicable):

Printed Name    Signature    Date and Time

66
CONSENT FORM- AUDIO RECORDING FOCUS GROUP DISCUSSION

Permission to audio record the focus group discussion

I am aware that the focus group discussion will be tape recorded and transcribed for data analysis purposes.

I understand that these recordings will be preserved for two years after the study results have been published or three years if there is no publication, after which they will be destroyed.

I give permission for my contributions to the focus group discussion to be audio-recorded.

PARTICIPANT:

__________________________________________  _______________________________________
Printed Name      Signature

__________________________________________
Date and Time
Appendix 7:

Consent form for audio recording of In-depth Interviews

CONSENT FORM- AUDIO RECORDING INTERVIEW

Permission to audio record the interview

I am aware that the interview will be tape recorded and transcribed for data analysis purposes.

I understand that these recordings will be preserved for two years after the study results have been published or three years if there is no publication, after which they will be destroyed.

I give permission for my interview with Eki George to be audio-recorded.

PARTICIPANT:

____________________________     _________________________________________
Printed Name      Signature

__________________________
Date and Time
Appendix 8:

Ethical Clearance from HREC

R14/49 Mr Osareona George Eki

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M160242

NAME: Mr Osareona George Eki
(Principal Investigator)

DEPARTMENT: School of Public Health
Ojindi-Uni, Obuaoffia, Ozalla Model, Akegbe, Ezioke, Obe, Ndiuno Uwani and Amodu Health Centres

PROJECT TITLE: Pregnant Women's Participation in Support Groups
Eungu State, Nigeria (2015-2016): Experiences and Influences on their Intentions to deliver in a Health Facility

DATE CONSIDERED: 26/02/2016

DECISION: Approved unconditionally

CONDITIONS: Sara Nieuwoudt

APPROVED BY: Professor P. Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 15/04/2016

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and ONE COPY returned to the Research Office Secretary in Room 10004, 10th floor, Senate House 2nd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/we fully understand the the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to resubmit to the Committee. I agree to submit a yearly progress report. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially review in February and will therefore be due in the month of February each year.

Principal Investigator Signature

Date 18-04-2016

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES