ASSESSMENT OF GROUP COMMUNICATION CAMPAIGN ON MIDWIFE SERVICE SCHEME AGAINST CHILD DELIVERY AT HOME IN NIGER STATE

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BY

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APRIL, 2015

DECLARATION

I declare that the work in this Thesis entitled "Assessment of Group Communication Campaign on Midwife Service Scheme against Child Delivery at Home in Niger State" has been carried out by me in the Department of Mass Communication. The information derived from the literature has been duly acknowledged in the text and a list of references provided. No part of this thesis was previously presented for another degree or diploma at any institution.

CHRISTIAN, Gloria _____ _____

Signature Date

CERTIFICATION

This thesis entitled ASSESSMENT OF GROUP COMMUNICATION CAMPAIGN ON MID-WIFE SERVICE SCHEME AGAINST CHILD DELIVERY AT HOME IN NIGER STATE by Gloria CHRISTIAN meets the regulations governing the award of the degree of Masters of Science of the Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

I dedicate this thesis to God Almighty, the Owner and Sustainer of Life; and to my beloved parents, Mr. and Mrs. Christian Aniebonam for their countless support and prayers.

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LIST OF ACRONYMS

MSS	Midwife Service Scheme
PHC	Primary Health Care
NPHCDA:	National Primary Health Care Development Agency
MDGs	Millennium Development Goals
TBA	Traditional Birth Attendants
SBA	Skilled Birth Attendance
WHO	World Health Organisation
HIV/AIDS	Human Immune Virus/ Acquired Immune Deficiency Sydrome
NGOs	Non Governmental Organisations
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nation Population Fund
MMR	Maternal Mortality Ratio

ABSTRACT

Nigeria ranks among the nations with the highest mortality rates in the world going by the current maternal mortality ratio (MMR) of 630/100,000 live births. The utilisation of maternal health services is known to be associated with improved and maternal health outcomes among women. In order to encourage the use of health services by women in various communities, the most prominent communication approach used by midwives to reach out to women in Niger State is the group communication approach. For this reason, this study examines how effective the group communication campaign carried out by the Midwife Service Scheme (MSS) in Niger State is able to address the problem of child delivery at home among women in Niger State. The study adopts Mixed Methods Research to collect data from respondents. Cluster sampling and purposive sampling techniques were used to locate where the target population (pregnant women and nursing mothers) are concentrated (primary health centres) as well as those interviewed as key informants (MSS focal person, midwives and nurses). In addition, participant observation was used in order to detect some information that the respondents may be shy to talk about or may not want to divulge at all. Three hundred copies of questionnaires were administered to pregnant women and nursing mothers drawn from three primary health centres of the three local government areas selected through balloting within Niger State. The study discovered that the group communication campaign carried out by the MSS in Niger State is effective in addressing the problem of child delivery at home. It also discovered that women are better reached by midwives and nurses through face-to-face communication approach by assembling them in various primary health centres within communities of Niger State thereby promoting attendance and participation of the exercise. Also, the study found out that most women's decision to visit the hospital for childbirth was influenced by the communication campaign carried out by the MSS. In other words, the campaign has positively changed the views and perceptions of majority of the women within the study area who do not visit health centers for childbirth. Again, the study discovered that distance was the major factor affecting women's attendance for the campaign as well as their utilisation of maternal health services. Therefore, the study recommends that more PHCs should be established in different locations across each community so as to complement the existing ones which may go a long way in solving the problem of distance. Also, there should be systematic evaluation of the campaign carried out by the MSS as well as other health cam-

paigns within Niger State and the country at large, through a regular assessment of the impact of such exercise on the beneficiaries.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

The desire to procreate is an obligation common to all human societies, particularly the female species except for some reasons that could prevent some from partaking in this responsibility. In an attempt to fulfill this desire, many women lose their lives during childbirth especially in developing countries. Pregnancy-related complications are among the leading causes of death and disability among women in Nigeria and for every woman who dies, other women suffer injury, infection or disease (Dahiru, n.d). Maternal mortality rate, according to United Nations International Children's Emergency Fund -UNICEF (2014), is higher in areas where women have many babies in short time spans under malnutrition, bad hygienically conditions and lack of access to medical treatment.

Abimbola, Okoli, Olubajo, Abdullahi and Pate (2012) posit that maternal, new born and child health indices in Nigeria vary widely across geopolitical zones. There are urban and rural variations with maternal mortality ratio (MMR) of 351/100,000 live births in urban areas compared to 828/100,000 in rural areas. This may be as a result of the variations in the availability of skilled attendance during child delivery. To improve these indices, the Midwives Service Scheme (MSS) funded under the MDGs-DRG, 2009 Appropriation Act; 2,488, deployed unemployed and retired midwives to 652 primary health care facilities in 332 Local Governments carefully selected in all the 36 states and FCT (MDG-DRG Funded Midwives Service Scheme, 2009). With a collaborative effort between the Federal Ministry of Health and core partners in the Maternal and Child Health efforts, the Midwife Service Scheme is an intervention designed to address shortage of skilled birth attendants at primary health care level in Nigeria.

According to the National Primary Health Care Development Agency (2013), several initiatives and programme have been introduced over the years to reduce mortality among women in Nigeria. Despite these efforts implemented by National Primary Health Care Development Agency (NPHCDA), poor maternal and child health indices has continued to be one of the most serious development challenges facing the country. NPHCDA established the Midwives Service Scheme (MSS), a public sector collaborative initiative, designed to mobilise midwives, including newly qualified, unemployed and retired midwives, for deployment to selected primary health care facilities in rural communities. It is aimed at facilitating an increase in the coverage of Skilled Birth Attendance (SBA), to reduce maternal, newborn and child mortality. Nigeria has had a very poor record regarding maternal and child health outcomes. An estimated 53,000 women and 250,000 newborn die annually mostly as a result of preventable causes. The NPHCDA, under the 2009 Appropriation Act, was tasked with establishing the MSS. The MSS is a public sector initiative and a collaborative effort between the three tiers of government in Nigeria. A memorandum of understanding (MOU) between the Federal, State and Local governments was signed by all 36 states of Nigeria and was set out clearly to define shared roles and responsibilities, which are supported by the strategic partners of the midwives (National Primary Health Care Development Agency, 2013). This intervention is aimed at bringing the midwives closer to the women to assist them with the necessary obstetric care needed before, during and after child delivery.

Receiving updates, reviewing progress and offering advice in order to provide strategic direction, support and guidance for the implementation of the MSS is done by a Technical Working Group (TWG). The secretariat of the MSS is responsible for day-to-day management, whilst state focal persons serve as a contact for the midwives in the MSS. The MSS is based on a clus-

ter model in which four selected primary healthcare facilities with the facility to provide Basic Essential Obstetric Care (BEOC) are clustered around a General hospital with capacity to provide Comprehensive Emergency Obstetric Care (CEOC). A midwife is deployed to each selected PHC, ensuring 24 hour provision of medical care services and access to skilled attendance at all births to reduce maternal, newborn and child mortality and morbidity. The MSS currently covers 163 clusters, which have 652 PHCs and 163 general hospitals. The MSS has established/reactivated ward development committees at all MSS PHCs to ensure community participation and ownership in its implementation (National Primary Health Care Development Agency, 2013). The midwives posted to various rural communities help to educate both the uninformed and the misinformed women about the need for them to be mindful of their health during pregnancy stage and child delivery stage and the need to avoid child delivery at home. MSS create a framework aimed at improving the skills and proficiency of midwives in provision of quality maternal and child health services.

The outcome of the MSS, according to Daniel**,** Usman and Stephen (2012) has been an uneven improvement in maternal, newborn, and child health indices in the six geopolitical zones of Nigeria which may be as a result of communication. Hence, there is the need for women, particularly in rural communities, to be aware of the prevailing issue of maternal mortality. Communities, particularly women, need to be educated about complications that may arise before, during and after childbirth at home. To bridge this gap, various face-to-face communication campaigns are being carried out in various communities. Communication, particularly verbal, occurs when one person speaks and another listens. Health workers uses range of verbal communication skills to respond to questions, find out about an individual's problems or needs, contribute to team meetings, break bad news, provide support to others and deal with problems and

complaints. According to MDG-DRG Funded Midwives Service Scheme (2009) there is shortage of skill attendants which may impact negatively on the utilisation of services by women. Despite the intervention of international organisation, gaps still exist. These gaps range from infrastructure, communication gap, access to services and human resource needs in many health facilities across Nigeria.

The enormity of the problems in the health sector and the realisation that nothing much could be achieved without convincing the people involved on some aspects of health have forced the stakeholders in the health sector to give premium to communication (Adeyanju, 2008). One of the major communication campaigns carried out Niger State is the group communication campaign where women are gathered in a group (within the primary health centers) to address the issue of child delivery at home through the orientation offered by the midwives. According to Smith (2011:2), "group communication refers to the communication that exists between two or more people". This type of communication is used in health and social care where issues and complaints are addressed in groups, particularly to improve maternal health by avoiding complications (like stillbirth after the start of labour, the child dying within the first week of birth, brain injury, fractures to the upper arm or shoulder during birth, and faeces in the lungs) arising from childbirth at home.

Igberase, Isah and Igbekoyi (2009) affirms that efforts should be directed towards educating women about the risk of delivering at homes of traditional birth attendants adding that providing information to women on prevention of maternal mortality and community participation and mobilisation will help prevent maternal mortality to some extent in Nigeria. Igberase, Isah and Igbekoyi (2009) added that informing and educating women will help create awareness that could reduce maternal mortality to the barest minimum. In group communication, patients are

likely to open up to a social worker about issues if they are around people of similar situations. Different languages, cultures and psychological factors exist which makes it difficult for every social worker to fully comprehend verbally what their patients are complaining about in a typical group communication; so in cases like this, effective communication and interaction (with the patients) can play an important role in the work of all health and social care professionals.

To help improve maternal health of women in Niger State in particular, the MSS carry out a group communication campaign where pregnant women and nursing mothers are gathered in a group, particularly in primary health centres, educating and enlightening them on the need to avoid child delivery at home by visiting health centres for proper check up.

1.2 STATEMENT OF THE PROBLEM

According to Boucher, Bennett, McFarlin and Freeze (2009), the top five reasons why women prefer home delivery are: safety, avoidance of unnecessary medical interventions common in hospital births, previous negative hospital experiences, more control and comfortable and familiar environment. For Titaley, Hunter, Dibley & Heywood (2010) physical distance and financial limitations were two major constraints that prevent most community members from accessing and using trained attendants and institutional deliveries. While Montagu et al (2011) reasons for women's preference to home delivery are; costs, access and facility.

As part of the efforts to help reduce maternal deaths in Nigeria, pregnant women are encouraged to give birth in healthcare centers under the supervision of a skilled birth attendant. To promote this, the NPHCDA made available nurses and midwives in primary healthcare centers in order to offer obstetric care to women, yet, some women particularly in rural communities still deliver their child at home leading to preventable complications. In most cases, when this occurs,

some women may experience normal delivery while some may also be at risk of pregnancy-related complications and resultant morbidity and mortality. It is for this reason that midwives were deployed to primary healthcare centers in various rural communities for the sole purpose of curbing this societal menace. A research conducted by Babalola and Fatusi (2009), shows that majority of women who deliver their child outside health centres delivered either in a separate room or inside the house and attended to by neighbours, traditional birth attendants or family members.

Despite the availability of skilled birth attendants at MSS facilities, according to Abimbola, Okoli, Olubajo, Abdullahi and Pate, (2012), women still deliver at home in some parts of the country which poses a major challenge to this scheme, particularly in achieving the objectives of MDG5—improving maternal mortality—by the year 2015. Therefore, in an effort to reduce mortality amongst women of Niger State, using the group communication campaign, women were educated and informed by midwives (in collaboration with the state government) on the dangers associated with child delivery at home. In carrying out this awareness campaign, women were gathered and educated in various primary health centers in diverse communities of Niger State. Yet, some women continue to die while some continue to encounter complications during childbirth at home. The question that came to mind as a result of the continued deaths and complications arising from child delivery at home bothers on whether the communication campaign carried out by MSS was not having a desired impact on the phenomenon. It is on this basis that this study was carried out to assess the effectiveness or ineffectiveness of the group communication campaign currently in use by MSS as a way of determining its adequacy in addressing the problem of child delivery at home in Niger State.

1.3 OBJECTIVES OF THE STUDY

This study was aimed at assessing the group communication campaign applied by MSS in creating awareness of maternal health issues among the rural women of Niger state. For this reason, this study was guided by the following objectives:

1. To find out the causes of child delivery at home among women of Niger State.
2. To assess how the campaign is able to address the problem of child delivery at home among women in Niger state.
3. To find out the challenges that are limiting the effectiveness of the campaign carried out by midwives in the fight against child delivery at home.
4. To determine how these challenges can be addressed, if any.

1.4 RESEARCH QUESTIONS

This study was guided by the following research questions;

1. What are the causes of child delivery at home among women of Niger State?
2. How is this campaign able to address the problem of child delivery at home among women of Niger State?
3. What are the challenges that are limiting the effectiveness of the campaign carried out by MSS in addressing the problem of child delivery at home in Niger State?
4. What should be done to address these challenges, if any?

1.5 SIGNIFICANCE OF THE STUDY

Without attention to the type, quality, and distribution of facilities, Nigeria will be unable to reduce maternal mortality to the degree it aspires (Daniel, Usman & Stephen, 2012). One of the factors that prevent women from seeking or receiving care during pregnancy and childbirth is lack of information (WHO, 2012) which the Niger State women are not lacking. This is because women in Niger State are informed and educated collectively (in a group) by midwives in PHCs

on the need to visit health centres for proper antenatal and postnatal care and to avoid childbirth at home. It is a common terrain for women, particularly in rural communities, to deliver at home. Some are successful while the unsuccessful ones encounter complications that ordinarily would have been avoided if they had visited health centres. Thus, a study of this context was seen as a significant ways of suggesting means by which this group communication campaign can be effectively carried out by the MSS to discourage child delivery at home.

This study is relevant to the MSS programme initiators and coordinators, the Niger State government and international organisations in order to understand the importance of group and face-to-face communication aimed at reaching out to women (particularly in rural communities) and to recognise the extent the MSS campaign will go in curbing maternal mortality in Nigeria, particularly in Niger State. Several studies on health communication campaign on malaria, family planning, polio vaccines, HIV/AIDS and others have been carried out by different researchers; but there are limited studies conducted in the area of the use of group communication approach and other forms of communication approach in addressing maternal mortality in Nigeria. Therefore, this study adds to the existing body of knowledge through its assessment of the group communication campaign currently in use by the MSS about health care visit by women in Niger State which will also serve as an empirical reference material for further study.

1.6 SCOPE OF THE STUDY

Various traditional societies, according to Aiyedun (1995), live in Niger State like the *Nupes, Gwaris, Kambaris* and the *Hausas*. Out of the estimated total population of 3,950,249 in 2006, eighty five percent are farmers while fifteen percent are involved in vocations such as white collar jobs, business, craft and arts (Niger State Geographic Information System, 2008).

This study covered women (pregnant women and nursing mothers) in Niger State. Three local government areas (Paikoro, Chanchanga and Lapai) were selected through balloting from the 33 local government areas in Niger State.

1.7 LIMITATIONS OF THE STUDY

Some of the limitations this study encountered were:

Language barrier/literacy level: due to the inability to speak the dominant language within the community, the researcher had to employ a woman who was domicile within the State as well as speak and understand English language and their dominant language so as to be able to interpret and communicate the researcher's message to the respondents within the study area. This woman went all places with the researcher which was very strenuous because there were occasions when the woman wanted restricting herself from moving further.

Other limitations encountered were: inability to extract adequate information from some mid-wives and nurses, inability to gain full access to the hospital's maternal record book, distance, bad roads and finance.

1.8 DEFINITIONS OF KEY TERMS

MSS Midwife Service Scheme

PHC Primary Health Care

NPHCDA: National Primary Health Care Development Agency

MDGs Millennium Development Goals

TBA Traditional Birth Attendants

SBA Skilled Birth Attendance

MMR Maternal Mortality Ratio

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

This chapter reviewed relevant works of different scholars and bodies on child delivery at home, thus setting the pace for assessing the effectiveness of group communication campaign used by midwives in addressing child delivery at home in Niger State which is the main root of this work. Also, this chapter looked at the theoretical framework which formed the base for this research.

2.2 THE EXTENSION OF THE COMMUNICATION FIELD

The term ‘communication’ has been defined by various scholars. According to McQuail (2005:551), in communication, “the central idea is the process of increases communality or the sharing between participants, on the bases of sending and receiving messages”. He added that the most important dimensions of communication concerns two points: the degree of response or feedback (one way versus interactive process); and the degree to which a communication relationship is also a social relationship. For Harold Lasswell (1948), he described communication as:

i. Who?

ii. Says what?

iii. Through which channel?

iv. To whom?

v. With what effect?

From Harold Lasswell’s definition, one can deduce that message or communication content must pass through a channel to the receiver and must arouse an effect. For Umueri and Galadima (2008), communication is central to the heart of any endeavour which cuts across all spheres of human activities.

The result of every communication is the feedback. According to Baran (2010), communication occurs when a source sends a message through a medium to a receiver producing some effect. With time, the process of communication gradually evolved from archaic cave paintings to new-age communication which continually changed over the course of time.

The study and teaching of communication, according to Wood (2006), dates back more than 2000 years where originally, the field focused almost exclusively on public communication. Aristotle, a famous Greek philosophy believed that effective public speaking was essential to citizens' participation in civic affairs. He taught his students how to develop a present persuasive speech to influence public affairs. Although public speaking remains a vital skill, it is no longer the only focus of the communication field. The modern discipline, Wood (2006) adds, includes seven major areas of research and teaching: intrapersonal, interpersonal, group communication, public communication, mass communication and new technologies, organisational communication and intercultural communication.

Intrapersonal communication deals with the communication that occurs within an individual while interpersonal communication deals with the communication that exist between two people (Ellis & Harper, 1977; Rusk & Rusk, 1988; Seligman, 2002; Wood, 2004). Group communication, on the other hand, deals with the communication that exists between the communicator and a group of people within a setting while mass communication and new communication technologies deals with the use of internet, new media, film, radio, newspapers, magazines and television to communicate to heterogeneous audiences. For Dominick (2011), communication between people is a fragile thing particularly where technology is concerned. Public communication deals with the communication that exists between the speaker/sender and the listener/receiver who may or may not be physically available while organisational communication, according to Murphy & Zorn (1996); Wood (2005), is an effective professional communication that requires one to understand and respect how different groups communicate and intercultural communication increases an awareness of different cultures and communication practices (Wood, 2006). It can also be seen as an academic field of study and research that deals with mak-

ing known an existing culture to the people. Also, this seeks to understand how people from different countries and cultures behave, communicate and perceive the world around them.

2.3 THE CONCEPTUALISATION OF GROUP COMMUNICATION

Group communication, according to Collins (2011), is seen as a process of giving, receiving, and interpreting information through verbal and non-verbal expression within a group. Effective communication occurs in a group when the speaker speaks and the message is interpreted by the members of the group receiving the message in the manner that the speaker intended sending and receiving messages which often takes place simultaneously due to the dynamic process of verbal and non-verbal communication. Collins (2011) added that group communication is either adaptive or maladaptive. Adaptive may include clarifying goals and the sharing of ideas, experiences, and feelings. Group communication that is maladaptive may include seeking to control the group by controlling the channels of communication, and avoidance of specific issues or persons.

According to Wood (2003:274) a group must have, "three or more people who interact over time, depend on each other, and follow shared rules of conduct to reach a common goal". Also, Wilson (2002:14) defines a group as, "a collection of three or more individuals who interact about some common problem or interdependent goal and can exert mutual influence over one another". He added that the three key components of a group are, "size, goal orientation, and mutual influence". Interpersonal communication can also be aligned with group communication because individuals may communicate interpersonally in pairs. Organizational communication might be thought of as a group that is larger than 12 people.

Group communication follows slightly different 'rules' from communication in one-to-one situations and can be seen as an extension of interpersonal communication. This is because information shared through interpersonal communication can be spread by an individual to a group and then the process continues. According to Collins (2011:6), "group communication deals with a number of different people trying to speak, get their point across and their voices heard". In the context of communication, Collins listed a number of benefits groups can have for participants:

1. A group can be an effective way of sharing responsibilities
2. Groups can improve decision-making and problem-solving because they draw on the knowledge and skills of a number of people
3. Groups tend to command more respect and have more power than an individual acting alone.

Furthermore, Collins (2011) highlighted a number of ways that can undermine the effectiveness of group communication if:

1. The power in a group is held by a single person or is misused by a small clique of people to dominate others and pursue their own agenda.
2. Power struggles and battles break out within the group, resulting in a loss of purpose and effectiveness.
3. The group loses sight of its main goal or purpose, drifting into a pattern of ineffective activity that doesn't have a real benefit or outcome (holding meetings for the sake of meetings, for example) and people find it hard to speak and contribute effectively or to challenge aspects of the group's thinking or practices. This can lead to poorly thought-out and unquestioned decisions being made.

2.3.1 Characteristics of Groups

Some of the characteristics of groups as outlined by various scholars are as follows:

1. **Interdependence**. To Lewin (1951), Cragon & Wright (1999) and Harris & Sherblom (2008), a primary characteristic of groups is that members of a group are dependent on the others for the group to maintain its existence and achieve its goals. For example, the group communication campaign in Niger state is interdependent when members of a group for maternal health recognise their needs from the needs of other members.
2. **Interaction**. For a group to be functional there must be interaction. Since communication is done on daily basis, there should be something that distinguishes group communication from other forms of communication and which is the issue of interaction. Cragon and Wright (1999:7) states that "the primary defining characteristic of group interaction is that it is purposeful."
3. **Synergy**. One advantage of working in groups, according to Harris & Sherblom (2008) is that it allows them to accomplish things they wouldn't be able to accomplish on their own. For example, the group communication campaign carried out in Niger state gives room for pregnant women to be checked thoroughly by the midwives (like the heartbeat of the mother and child, position of the child, etc).
4. **Common Goals**. Having interaction and synergy may be pointless in groups without a common goal. People who comprise groups are brought together for a reason. While most members of a group have individual goals, a group is largely defined by the common goals of the group. In reducing maternal mortality, for example, the group commu-

nication campaign carried out in Niger state has a common goal of reducing maternal mortality among women in rural communities.

2.3.2 Types of Groups and its Formation

Not all groups are the same or brought together for the same reasons. According to Umueri and Galadima (2008:46), "group communication is necessary in situations where people act as a body. People belonging to such body have common purpose and interests that have to be expressed in unison". Bilhart and Galanes (1998) categorised groups on the basis of the reason they were formed and the human needs they serve.

1. **Primary Groups**. Primary groups are ones formed to help realise human needs. They are not generally formed to accomplish a task, but rather, to help members meet their fundamental needs as rational beings like acceptance, love and affection. The group communication campaign in Niger State enables women (pregnant women) to feel loved, affection and acceptance in the society mostly when they interact with their counterpart.
2. **Secondary Groups**. Secondary groups are formed to accomplish work, solve problems and make decisions. Bilhart and Galanes; Harris and Sherblom; Cragan and Wright; and Larson and LaFasto (1989) states that secondary groups have a specific goal to attain; and coordination of activity among the members of the team is required for attainment of the goal. Furthermore, Bilhart and Galanes (1998) divided secondary groups into four different types:

    i. **Activity Groups**. Activity groups are ones that are formed for the purpose of participating in activities. For example, the group communication campaign in Niger

state enables women to participate in activities like strolling and walking as a recommended exercise educated by the midwives and nurses.

ii. **Personal Growth Groups**. Personal growth groups are formed to come together to develop personal insights, overcome personal problems, and grow as individuals from the feedback and support of others (Bilhart & Galanes).

iii. **Learning Groups**. Learning groups are concerned primarily with discovering and developing new ideas and ways of thinking (Harris & Sherblom). For example, the MSS organised a communication campaign where women are educated on the need to avoid child delivery at home by visiting health centers.

iv. **Problem-Solving Groups**. These groups are created for the sole purpose of solving a specific problem. The very nature of organizing people into this type of group is to get them to collectively figure out effective solutions to the problem they encounter.

This study observed that the category of group that is applicable in Niger State is the secondary group which is basically formed to accomplish work, solve problems (that is, visiting health centres and avoid child delivery at home) and make decisions. That is to say that this category of group is formed in order to tackle maternal mortality in Niger State.

2.3.3 Why groups are formed

Communication maybe seen as the central activity of every group depending on how the group is formed organised and maintained. Individuals may have both positive and negative stories to tell about being in groups, but how they are formed is an essential aspect to be considered. Sometimes, people join a group because they want to and not necessarily because they have an

objective to attain. Either way, Lumsden and Lumsden (1986) gave three reasons why groups are formed.

First, groups are formed because people want to share similar interests or attractions with other group members. In health care, groups that share similar interests or attractions are being formed. For example, groups that campaign against HIV/AIDS discrimination and other health related issues are formed to share similar interests or attractions. These groups may share similar interest and attraction when it comes to touching and affecting the lives of people.

A second reason a group is formed is called drive reduction. People may join groups so that their work with others may help them to fulfill their needs. As Maslow (1970) explains, people have drives for physiological needs, security, love, self-esteem, and self-actualization. Working with others may help in achieving these needs thereby reducing their obligation to meet these needs themselves.

A third reason a group is formed is for reinforcement. People are often motivated to do things for the rewards they bring. Participating in groups provides reinforcement from others in the pursuit of goals and rewards. For example, a group of women may successfully carryout a campaign on maternal mortality and other prevailing health issues, the group may likely be rewarded by NGOs, government, international organisations as well as other operating organisations. By this, the group fulfills the purpose of reinforcement.

2.3.4 Group stages

Most groups go through series of stages as they come together. These stages as listed by Fisher (1970); Tuckman (1977) and Harris & Sherblom (2002) are called forming, storming,

norming, and performing. Groups formed to achieve a task may go through a fifth stage called termination which may occur after a group accomplishes its goal.

1. **Forming:** For a group to exist and work together, its members must first form the group. During the forming stage, group members begin to set the parameters of the group by establishing what characteristics identify the members of the group as a group. During this stage, the group's goals are made generally clear to members, initial questions and concerns are addressed, and initial role assignments may develop. This is the stage when group norms begin to be negotiated and established.
2. **Storming:** The storming stage maybe used to compare the "first fight" of a romantic couple. After the initial politeness passes in the forming stage, group members begin to feel more comfortable expressing their opinions about how the group should operate and the participation of other members in the group. Given the complexity of meeting both individual goals as well as group goals, there is constant negotiation among group members regarding participation and how a group should operate.
3. **Norming**: As soon as a group survives a first fight, they may emerge on the other side of the conflict feeling stronger and more cohesive. Norming signifies that the members of a group are willing to abide by group rules and values to achieve the group's goals. For example, using the group communication campaign in Niger State, rules were set that every woman (pregnant and nursing mothers) should be in attendance (in PHCs) every day at 9.am.
4. **Performing**: Performing is the stage associated with the defining characteristic of groups. This stage is marked by a decrease in tensions, less conscious attention to norm establishment, and greater focus on the actual work at hand in order to accomplish the

group's goals. While there still may be episodes of negotiating conflict and re-establishing norms, performing is about getting to the business at hand.

5. **Terminating:** Groups that are assigned a specific goal and timeline may experience the fifth stage of group formation which is termination. Some groups terminate immediately they achieve their required assignment and earn an award. This is not to say that they do not continue relationships with other group members. But, the defining characteristics of the group established during the forming stage have come to an end and so has the group. For example, using the group communication campaign in Niger state, if the group decides to terminate its existence after attaining the goal of reducing maternal mortality to 85%, then, it may decide to terminate its operation.

2.4 APPLYING BEHAVIOURAL CHANGE COMMUNICATION (BCC) TO ADDRESS CHILD DELIVERY AT HOME

The act of child delivery at home is a behaviour mostly practiced by women in rural areas across the country (Nmodu 2012) which is also prevalent in Niger State. Behaviour, as simply put by UCADIA (2009), refers to the way and manner in which humans conducts themselves.

The complexity and unpredictable nature of human beings has made them the most difficult set to deal with and since the only thing that is permanent in life is change, the reality of this current time has dictated the design of the BCC (Adeyanju, 2008). Human behaviour may be influenced by certain factors like: environmental factors, psychological factors, culture, social norms, health policies, the quality of health services, and individual knowledge. Thus, BCC can

be an appropriate approach to discourage the act of child delivery at home among women in Niger State.

Behavior change communication (BCC), according to FHI 360 (2014), is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behavior change. BCC employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation. Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioral objectives. Hopkins (n.d), states that BCC promotes and sustains healthy changes in behavior in individuals and communities which is conveyed through a variety of communication channels.

According to UNICEF (2006), BCC is a consultative process among communication specialists, technical experts, local change agents and communities which addresses the knowledge, attitudes and practices of individuals, families and communities. It aims at sharing relevant and action-oriented information and to motivate programme specialists to work with communication specialists. UNICEF (2006) adds that health workers, midwives, women's representatives, counselors and other relevant stakeholders are trained on maternal nutrition and breastfeeding by applying BCC to communicate the importance of antenatal and postnatal care visits, clean and attended delivery, ensuring that nursing mothers, women and family decision makers know the components of maternal nutrition – a pregnant woman needs the best foods available to the family; should avoid food restrictions; needs iodised salt, vitamin A and iron supplements. Furthermore, the application of BCC entails that women are rightly communicated to understand the warning and danger signs during pregnancy through group discussions, women's shelters, ma-

ternity caregivers, health workers, counseling and IEC materials. In addition, UNICEF (2006) states that the application of BCC helps to focus on the limited number of practices that are proven to decrease infant and mother deaths which will result in women having the power to have healthy pregnancies, safe deliveries and positive birth outcomes.

Accordingly, Adeyanju (2008) affirm that field workers and program planners discovered that BCC is very effective in the issue of prevention. In other words, communication is useful not only in the area of prevention but also in the other program areas. BCC has been seen to target the individual change based on the assumption that individual changes are product of rational decisions. He added that BCC has been developed to be able to perform some basic roles which are:

i. To increase knowledge

ii. Stimulate community dialogue

iii. Promote essential attitude change

iv. Reduce stigma and discrimination

v. Create ad for information and services

vi. Advocate

vii. Promote services for prevention, care and support

viii. Improve skills and sense of self-efficiency.

Since BCC is targeted on the behaviour of an individual, it is important to note that the group communication campaign currently used by the MSS in Niger State is a BCC which is geared towards persuading women to practice child delivery in the hospital where they would be assisted by a skilled birth attendant and ensuring that vulnerable people (pregnant women and nursing mothers) in communities would know what action(s) to take in order to maintain and protect

their health, visitation of health centers for antenatal and postnatal care as well as the right person (midwife) to contact when emergency strikes. Thus, the importance of BCC should not be overlooked by communication specialists.

2.5 SOME HEALTH COMMUNICATION CAMPAIGNS USED TO CREATE AWARENESS ABOUT AN EXISTING HEALTH ISSUE

Health communication revolves around health promotion, disease prevention, health care policy, and the business of health care as well as enhancement of the quality of life and health of individuals within a given society. The U.S. Department of Health and Human Services (2010) defines health communication as the art and technique of informing, influencing, and motivating the individual, institutional, and public audiences about important health issues.

For Schiavo (2007), Health communication is a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging and supporting individuals, communities, health professionals, special groups, policy makers and the public to champion, introduce, adopt, or sustain a behavior, practice or policy that will ultimately improve health outcomes.

Noar (2011) cited in Rogers and Storey (1987:821) defined health communication campaign as "a campaign which intends to generate specific outcomes or effects in a relatively large number of individuals usually within a specified period of time, and through an organized set of communication activities". He adds that in carrying out health communication campaign, it is necessary for the campaigner to clearly understand the behavior of the audience and to know what channel of communication best suites the purpose.

According to the Centers for Disease Control and Prevention-CDC (2013), several health communication campaigns currently in place are aimed at creating awareness of an existing health issues as well as persuading people to accept it. Examples of such campaigns are:

a. **National Infant Immunization Week –**which focuses on promoting vaccines for infants. The campaign materials include media outreach materials, web buttons and banners, e-cards, and other materials. Resources also include print, radio, and TV PSAs in both English and Spanish that can be used year-round to highlight the importance of infant immunization.
b. **HIV/AIDS awareness campaign**—a campaign aimed at creating awareness of the existence of the virus which can be contracted through various blood contact. The campaign materials include posters, bill boards, jingles, TV programs and others.
c. **HIV Screening, Standard Care–** a campaign aimed at encouraging primary care providers, gynecologists, and other health care providers to promote routine HIV testing during patient visits.
d. **African American Women and Mass Media (AAMM) campaign**, which uses radio and print media to make more women aware of the importance of getting mammograms to find breast cancer early. The campaign also sought to increase the use of CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) screening services among African American women.
e. **One Test. Two Lives–** a campaign aimed at encouraging health care providers to test pregnant women for HIV infection and help reduce the number of infants born with HIV.

There are other health communication programmes organised by the Center for Communication Programs Nigeria (CCPN). According to CCPN (2011), CCPN is a registered Nigerian organisation specialising in the development and implementation of strategic health communication projects and programs. This initiative is supported by the Johns Hopkins Bloomberg School of Public Health's Center for Communication Programs (CCP) in Baltimore. CCPN was created as an innovative means to ensure the availability of high quality communication expertise in Nigeria and to support health and development programming. Examples of such initiatives carried out by CCPN are:

a. **Support to National Malaria Program (SuNMaP)**: CCPN is a project implementing partner on SuNMaP, a project funded by DFiD and led by Malaria Consortium. Working in states like Jigawa, Kaduna, Kano, Katsina, Niger, Yobe etc and providing support at National level. CCPN works closely with project partners, including JHU.CCP, Health Partners International (HPI) and GRID. CCPN brings strategic communication skills and technical expertise in program communication planning, materials development to the project's comprehensive fight against malaria in Nigeria.
b. **Nigerian Urban Reproductive Health Initiative (NURHI):** CCPN is a partner in this Gates-funded project led by the Johns Hopkins Center for Communication Programs (CCP). CCPN provides technical assistance and on the ground support for the project's goal of developing interventions for creating demand for and sustaining the use of contraceptives among marginalised urban populations. CCPN plays a key role in the capacity building efforts, developing the demand creation activities and selecting advocacy interventions.

c. **United Against Malaria (UAM):** United Against Malaria (UAM) is a global alliance of football (soccer) teams and heroes, celebrities, health and advocacy organisations, governments and corporations who have come together against malaria. SuNMaP is working in conjunction with the National Malaria Control Program and the Nigeria Football Federation. CCPN, a local implementation partner on SuNMaP supports this laudable effort providing strategic communication expertise from concept development. In its current effort, in the period leading up to the all popular African Cup of Nations football tournament, television and radio spots of the National team, Nigeria's "Super Eagles" promote malaria control and prevention with the footballers themselves serving as malaria ambassadors.

d. **NetWorks Care and Repair campaign:** NetWorks is a USAID-funded project led by JHU•CCP that focuses on increasing access to, and use of, insecticide treated mosquito nets among populations at risk for malaria.

The National Center for Chronic Disease Prevention and Health Promotion (2000) states that they use posters, handouts, public service announcements, discussion groups, workplace or clinic-based counseling, and in school presentations to address many of the most common causes of death in the United States, for example—poor diet, physical inactivity, tobacco use, alcohol consumption, microbial agents, and toxic agents as well as to create awareness to the intended audience.

Another campaign is the Ebola Awareness Campaigns in Liberia where the Ministry of Health and Social Welfare of Liberia carries out campaigns to check how the messages about Ebola resonate in the communities and to find out what information people need about Ebola.

Another example is the “Thinkwise - Don't Stigmatise” campaign in Bangladesh which is a partnership between the government, NGOs and the professional cricket league to raise HIV awareness in adolescents. Spectators of the girl's cricket tournament hear information on the nature of HIV and how to prevent infection as part of the match commentary. Pink t-shirts adorned with the slogan “Be aware, save yourself” were distributed to cricket fans throughout the competition. Cricket activities across India, Bangladesh and Sri Lanka joined the campaign and hoped that the informed youth will continue to reverse the global spread of HIV (United Nations International Children's Emergency Fund- UNICEF 2013).

2.6 NATIONAL HOSPITAL DISCHARGE SURVEY (NHDS)

The National Hospital Discharge Survey (NHDS), which was conducted annually from 1965-2010, was a national probability survey designed to meet the need for information on characteristics of inpatients discharged from non-Federal short-stay hospitals in the United States. Data from the NHDS are available annually and are used to examine important topics of interest in public health and for a variety of activities by governmental, scientific, academic, and commercial institutions (Centers for Disease Control and Prevention, 2014).

2.7 REVIEW OF STUDIES ON CHILD DELIVERY AT HOME

The move from birth at home to the hospital began in the 18th century, according to a study in the United Kingdom, approximately 40% of first time mothers and 10% of women who have previously given birth are transferred from home to the hospital for delivery. Some of the reasons women are transferred are: the mother feels exhausted and does not want to continue, premature

rupture of membranes, high blood pressure, no progress with labor, fetal distress, cord prolapsed and hemorrhage (American Pregnancy Association, 2013).

According to World Health Organisation (2010), the number of women dying due to complications during pregnancy and child delivery has decreased by 34% from 1990 to 2008. Though the progress is notable, but the annual rate of decline is less than half of what is needed to achieve the Millennium Development Goal (MDG) target of reducing the maternal mortality ratio by 75% between 1990 and 2015 which will require an annual decline of 5.5%. The 34% decline since 1990 translates into an average annual decline of just 2.3%. Hence, more needs to be done to achieve the sets targets. WHO added that UN agencies, donors and other partners have increasingly coordinated their assistance to countries by focusing on the countries with the greatest burden through their assistance to governments to develop and align their national health plans in order to accelerate progress in maternal and newborn health.

In order for Nigeria to succeed in achieving Goal 5 (improve maternal health) by 2015 a concerted effort is required to mitigate this growing in-country divergence. By comparison to progress in other Goal areas (for instance Goal 4 where progress is around 13% reduction per year), progress in Goal 5 is only a 4% reduction per year (Economic Confidential, 2013).

Several studies have been carried out on the use of skilled birth attendance (SBA) by women in Nigeria. Prata, Ejembi, Fraser, Shittu and Minkler (2012) found that of the 1,875 women enrolled in a community-based program to improve delivery outcomes in Zaria, Nigeria, 95% of who delivered at home, only 7% was attended by a skilled attendant.

Doctor, Findley, Ager, Cometto and Afenyadu (2012) in a survey of 6,882 married women in northern Nigeria, found that only 26% of the women surveyed had received any antenatal

care, 13% delivered in a facility attended by skilled birth attendant, and 86% gave birth at home under unskilled care.

Unsafe abortion, according to (Dahiru, n.d), is one of the causes of maternal mortality. Unskilled persons, in circumstances where the pregnancy is not wanted, often carry out the procedure usually in an unhygienic environment. After delivery, genital tract infection—which causes sepsis that can lead to death if left untreated—can occur especially if the delivery is not conducted in hygienic environment as in the case of home delivery. Other causes of maternal death include obstetric hemorrhage, obstructed labour, ruptured ectopic gestation, pulmonary and amniotic fluid embolism. Adelaja (n.d) cited in Prata, Ejembi, Fraser, Shittu and Minkler (2012), found that 67% of the 300 women studied delivered at home, and the majority utilized unskilled attendants. In the study, in Shagamu Local Government Area in South West Nigeria, 86% of all home deliveries used unhygienic surfaces, and most utilized unclean kitchen equipment (such as knives, scissors) for cord cutting, with higher risk of infection for both mother and child.

Delivery outcomes are adapted by the type of delivery attendance utilised. Lawoyin, Onadeko and Asekun-Olarimoye (2010) contrasted the likelihood of newborn child to die with skilled delivery assistance and other scenarios: newborn children were five times more likely to die if they had no attendance at birth, three times more likely to die if their births were attended by Traditional Birth Attendants (TBA), and four times more likely to die if they were delivered outside the health facility. A matched case control study of 56 infants with permanent congenital and early hearing loss (PCEHL) and 280 normal hearing controls also found that infants delivered with unskilled attendance were four times more likely to develop PCEHL than their peers who were delivered with skilled attendance.

Studies conducted by Erim, Kolapo and Resch (2012), found that 43% of the maternal deaths in Nigeria occurred at the TBA centers and most were associated with preventable causes while studies conducted by Bolaji and Nosakhare (2013) in the northern part of Nigeria revealed that not only are women using unskilled attendants, an unacceptable 1 in 5 births are delivered with no one present.

Idowu, Mafiana and Sotiloye (2003) states that the care given to women patronizing traditional birth homes does not include any haemotological investigations to reveal the conditions of newborn child thereby increasing the risk and complication of the child. This therefore falls short of standard requirements for antenatal care. This study indicated the need to educate the public on the dangers of patronising different birth homes aside health centers.

According to Envuladu, Agbo, Lassa, Kigbu and Zoakah (2013), despite the high level of antenatal care attendance among pregnant women in the study area, a good number of pregnant women still chose to deliver at home. Factors promoting the choice of a home delivery were age, education level, marital status, occupation and low family income. Their recommendation was that the government should take the issue of female education and empowerment more seriously in addition to regular health education on the danger of home delivering as a way of reducing maternal mortality in the country and achieving the millennium development goals (MDGs) 4 and 5.

Bukar and Jauro (2013) believed that unplanned home births are associated with adverse outcomes for both mother and baby; and planned home delivery is not associated with increased maternal death particularly in the Western world. They added that most respondents were uneducated and unemployed and the home births in most resource poor countries are unplanned and therefore associated with increased maternal death. Furthermore, studies carried out by Bukar

and Jauro (2013) at Madagali, Borno State revealed that a significant number of births take place in the home and supervised by unskilled persons.

Another study conducted by Idris, Gwarzo and Shehu (2006) in Zaria revealed that most of the home deliveries are not attended by skilled personnel thereby aggravating the risk of maternal mortality in the study area. Idris, Gwarzo and Shehu (2006) further discovered that the mother's literacy level was the most important determinant of place of delivery as those with non- formal education tends to deliver at home. Their findings further revealed that adequate antenatal care attendance during pregnancy did not significantly influence hospital delivery.

Okeshola and Sadiq (2013), in a study carried out in Kaduna State, shows that factors influencing maternal health services utilisation operate at various levels –individual, household, community and state. They added that the places of child delivery have some risks associated with it and the various determinants of home delivery within the study area were financial incapacity, safety of both mothers and babies, cultural practices.

Attending antenatal care offers women a unique opportunity to improve the health of their infants. Such opportunities may include weight and blood pressure measurement; but distance to health care facilities, inadequate transportation, socio-cultural beliefs etc have hindered women's ability to access these services in many less developed countries and northern Nigeria in particular (WHO, 2003).

The risk of a woman in a developing country dying from a pregnancy-related cause during her lifetime may be higher compared to a woman living in a developed country. WHO (2010) believes that to achieve the global goal of improving maternal health and to save women's lives, they need to do more to reach those who are most at risk; which means reaching women in

rural areas and poorer households, women from ethnic minorities and indigenous groups, and women living with HIV and in conflict zones.

In developing countries, according to Montagu, Yamey, Visconti, Harding, April, Yoong, Joanne, Mock & Nancy (2011), most poor women deliver at home. A home birth in developed countries is an attended or an unattended childbirth in a non-clinical setting, typically using natural childbirth methods, that takes place in a residence rather than in a hospital or a birth centre, and usually attended by a midwife or lay attendant with expertise in managing home births. Home births are either attended or unattended. They added that in developing countries where women may not be able to afford medical care or it may not be accessible to them, a home birth may be the only option available, and the woman may or may not be assisted by a professional attendant of any kind which may result to complication that could have been avoided. For Awom (2010), child delivery at home can be more vulnerable for both the mother and the child and proper care should be taken to avoid both occurrences particularly in the developing world. He added that the valuable assistance of nurses and gynecologists should not be washed away and there is always the possibility of a normal low risk pregnancy to become a high risk in just a few minutes.

Aminu (2014) revealed the establishment of a Working Group known as the 'Ending Preventable Maternal Mortality (EPMM)' for the post 2015 Agenda. The EPMM Working Group is aimed at mobilising global and country-level commitment for reducing maternal mortality, building consensus on targets and strategies to end preventable maternal deaths, and elaborating a framework for maternal health in the context of the reproductive, maternal, newborn and child health continuum of care within the post-2015 development agenda. Thus, a strategic

framework to achieve the targets was developed collaboratively under the leadership of the World Health Organization (WHO) and the US Agency for International Development (USAID) and in consultation with stakeholders from Cameroon, India, Indonesia, and Nigeria. He added that more women attend antenatal care but fewer come back to deliver in the health facilities.

Niger State Millennium Development Goals Report (2007) revealed that a large number of women make use of traditional birth attendants in Niger State, especially in the rural areas. Some of these TBAs use crude technology and sometimes harmful traditional practices which can lead to infections. According to United Nations Population Fund-UNFPA (2011), MDG5 can be achieved by urgently addressing the shortage of health workers and stepping up funding for reproductive health services. They added that every birth should be safe and every pregnancy wanted and that lack of maternal health care violates women's rights to life, health, equality, and non-discrimination.

Women who reside in rural areas mostly deliver their babies at home with or without the help of a family member or midwife, so, the risk of complications, specifically hemorrhage which is the leading cause of death is high. Nigerian women have a higher risk of dying from maternal causes; hence, the group communication campaign organised in Niger State serve as a medium by which these messages are communicated to women by the midwives. According to Dahiru (n.d), one of the harmful practices a pregnant woman in labour at home may be subjected to is "*Gishiri* cut" or "*Yankan Gishiri"* which is a traditional surgical cut performed on any aspect of the vaginal wall using razor blade or knife. The commonest site, according to him is the anterior vaginal wall or less commonly posterior and lateral walls. It is commonly practiced in many parts of Northern Nigeria especially during the first delivery as a 'remedy' to obstructed

labour. It is usually performed by traditional birth attendants, local herbalist or barber. Complications of this practice include severe bleeding leading to shock, excruciating pain, vesicovaginal fistula, and spread of infections like HIV, hepatitis and painful intercourse later.

After delivery, Dahiru (n.d) adds that another predominant harmful practice is "*wankan Jego*" which is the practice of taking hot bath, lying on hot bed and taking large amount of '*kunun kanwa'* (a lake salt rich in sodium). He added that this practice is still pursued with great vigour which is the reason why the practice is more predominant in rural areas where literacy level is low and firewood is relatively cheap and available. Immediately after delivery and continuing for 40 to120 days, the new mother takes two scorching hot baths each day to keep out 'the cold' using a bundle of leaves to splash very hot water on her body. After taking the bath, the mother remains in a well-heated room with a fire or fire glowing underneath a specially constructed dried mud bed, which can retain heat for several hours. A special gruel or *pap* is prepared from guinea corn or millet with potash (*kanwa)* and peeper is taken regularly as medicine to increase the quantity and quality of breast milk. The potash has high sodium content but very little potassium and can cause hypertension and heart failure. Dahiru (n.d) further stated that these practices do not have any benefit on the women who practice them and in contrast have hazardous effects, and hence our society should abandon them for the better.

To discourage these practices in rural communities of Niger State, health workers, religious and traditional leaders educate and enlighten women on the health implications of these practices performed by traditional birth attendants (TBA). This may go a long way in saving women and children from dying from preventable deaths and also increase pregnant women's access to qual-

ity care. Also, government at all tiers ensures that midwives are trained and deployed to rural areas in order to offer care and assistance to women before, during and after child delivery.

2.8 EFFECTIVE COMMUNICATION

Effective communication may occur when an information is shared resulting to a desired effect, which is interpreted between multiple entities and acted on in a preferred way. This effect may ensure that the message is not distorted during the communication process. Effective communication may generate the desired effect and maintain the effect, with the potential to increase the effect of the message on the recipient. Therefore, effective communication may serve the purpose for which it was planned or designed if changes occur. Barriers to communication can also limit and distort the effectiveness of a communication process. Communication, according to Brown (2010), is the process of sharing information, thoughts and feelings between people through speaking, writing or body language. Effective communication extends the concept to require that transmitted content is received and understood by someone in the way it was intended. Effective communication, for example, is said to occur when information that tends to discourage child delivery at home is effectively communicated and the result is positively achieved amongst the intended audience (that is, pregnant women). The goals of effective communication include creating a common perception, changing behaviors and acquiring information. Brown (2010) further explained using the following:

i. **Context:** considering the context of communication improves its effectiveness. Context takes into consideration the age, region, sex and intellectual abilities of the recipient. It is also useful to assess receptivity and the emotional state of the sender and receiver at the time of communication. For example, when speaking to illiterate women about childbirth

at home, it is preferred that the sender use simple and precise words and examples than when speaking to literate women.

ii. **Body Language:** also called nonverbal communication, body language includes posture, position of hands and arms, eye contact and facial expression. When speaking to women of Niger State, for example, about the type of cloth or shoes they should wear during pregnancy, illustrations and body language is paramount to inject an effect in their minds. This is because the body language can serve as a way of enhancing understanding of the speaker's intent. Body language that is consonant with the verbal content improves understanding. Body language that is inconsistent with content creates a question in the mind of the listener about the real message. For example, assuming the midwife is saying, "When you are pregnant, it is expected that you don't wear a shoe that is high as this…" However if the midwife is looking away, has her arms folded or punching a phone at the same time, her body language communicates an entirely different message. Effective communication requires that content and body language gives the same message.

iii. **Interference:** emotions can interfere with effective communication. If the sender is angry, his ability to send effective messages may be negatively affected. In the same way, if the recipient is upset or disagrees with the message or the sender, he may hear something different from what was intended by the sender. For example, in communicating to Niger State women, assuming a woman is upset or emotionally distressed from home, she may not see the need to accept the message. Considering emotions, language and conceptual barriers is essential to effective communication.

iv. **Active Listening:** effective communication is a reciprocal process that includes listening. Successful listening requires eye contact, objective processing and feedback to the speaker. Active listening may involve asking clarifying questions or restating what was heard to assure that the intent of the message sent was correctly received. Active listening becomes particularly important when the communication includes emotional content. For example, if a pregnant woman confides on the midwife saying; "My husband currently hates my look," the midwife (who might be an active listener) might ask for examples or paraphrase the emotional content by asking, "What look?"

2.8.1 Group Communication and its effectiveness to discourage child delivery at home in Niger State

Communication helps one to better comprehend a person or circumstances, to resolve differences, build trust and respect, and create environments where creative ideas, problem solving, affection, and care can flourish. As simple as communication may seems, much of what we try to communicate–and others try to communicate to us–gets misunderstood, which at times can cause conflict and frustration in personal and professional relationships. In this information age, according to Robert & Jeanne (n.d), messages are sent, received, and processed on daily basis. Communicating the message is not just enough to grasp the interest of the audience; rather, effective communication can enable acceptability of the message by the recipient which is more than just exchanging information. For example, effective communication may not occur when rural women are communicated via radio on the type of shoes to wear during pregnancy or the type of dress to wear unless it is communicated to them via television or face-to-face approach. This is because effective communication requires one to understand the emotion behind the information. It can improve relationships, in various setting, among the parties involved, by dee-

pening the connections to others and improving teamwork, decision-making, caring, and problem solving. It enables the individual to communicate even negative or difficult messages without creating conflict or destroying trust. Robert & Jeanne (n.d) adds that effective communication combines a set of skills including nonverbal communication, attentive listening, the ability to manage stress in the moment, and the capacity to recognize and understand one's emotions and those of the person he or she is communicating to.

Igberase, Isah and Igbekoyi (2009) suggests that efforts should be directed towards educating women about the risk of delivering in homes of traditional birth attendants and the concept of early transfer of women to the hospital should be reinforced. They add that providing information to women on prevention of maternal mortality and community participation and mobilisation will help to prevent maternal mortality in Nigeria.

Antenatal care tends to expose pregnant women to counseling and education about their own health and the care of their children. However, antenatal care may be of advantage in developing countries, where health seeking behavior is not enough, access to health services is minimal, and most mothers are poor, illiterate or rural dwellers. Considering the positive relationship that has been shown to exist between levels of care obtained during pregnancy and the use of safe delivery care, antenatal care also stands to contribute indirectly to maternal mortality reduction (Bloom, Wypij and Gupta, 2001). According to the 2003 Nigeria Demographic Health Survey (NDHS), 37% of women who deliver their child within the five years prior to the survey received no antenatal care for their most recent delivery while only 35.2% were assisted at delivery by a skilled attendant.

While effective communication is a learned skill, it is more effective when it's natural rather than unoriginal. A speech that is read, for example, rarely has the same impact as a speech that's delivered (or appears to be delivered) spontaneously (Robert & Jeanne, n.d). The group communication campaign, for example, organised by midwives in Niger state is an effective communication because information are delivered naturally (with illustrations) to women instead of following an outlined list of information scripted on paper.

Effective communication enables unbiased information on birth environment options to be provided as well as being transparent about the potential advantages or disadvantages of home birth. Also, information regarding place of birth are made available for women thereby encouraging them (through communication) to participate actively in the full range of antenatal and postnatal care (National Childbirth Trust, 2001). This awareness initiative and participation are made possible through the group communication medium which may serve as a convenient medium of communication. For example, information addressing child delivery at home cannot be communicated only via radio when the recipients (women) are either in the market or in their farms. Preferably, this type of message can be communicated to women face-to-face through the community leader, influential leader, religious leader or midwives who can readily observe them as the message is communicated.

In Nigeria the majority of women in urban areas give birth in the hospital. However those in rural areas are less educated women and they tend to use traditional birthing methods while others give birth at home, usually with a traditional birth attendant present, or with family members. About 40% of women who give birth in Nigeria choose to receive postnatal care within two days of the birth of their child with about 60% receiving no postnatal care at all. Also, Nigerian

mothers often find the frequent visits from the public health nurse invasive and unnecessary (Grainne, 2003). The group communication campaign is organised to educate women on the need to avoid home delivery and make do with the health centers made available for them.

According to United Nation Population Fund-UNFPA (2011), the developing world is recognised with poor quality of care in reproductive areas for women. Thus, midwives are deployed in order to provide health education and services to women in communities, promoting planned pregnancies and positive parenting. If communities, including fathers, husbands, village heads and religious leaders, are mobilized to support women in pregnancy and childbirth, many of the entrenched barriers to care may be broken down. Mobilisation efforts led by women can also empower women in poor and excluded communities. Negative attitudes from health care professionals or community perceptions thereof, can discourage women from seeking care.

2.9 THEORETICAL FRAMEWORK

For the purpose of this study, the Health Belief Model was used to explain this study and to analyse the findings.

2.9.1 Health Belief Model and its Assumptions

The Health Belief Model (HBM) was developed by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services in order to help understand why people did or did not use preventive services offered by public health departments in the 1950s. It evolved to address newer concerns in prevention and detection (e.g., mammography screening, influenza vaccines) as well as lifestyle behaviors such as sexual risk behaviors and injury prevention. The HBM explains people's beliefs about whether or not they are at risk of a disease or health problem and their perceptions of the benefits influence their readiness to take action (Glanz, 2008).

The HBM was spelled out in terms of four constructs which are:

- **Perceived susceptibility** (risk based on a person's behavior), for example, "am I at risk of death during childbirth at home?"
- **Perceived severity** (consequences of the risk and the condition), for example, "how serious is AIDS; how hard would my life be if I got it?"
- **Perceived benefits** (one's belief in the efficacy of the advised action to reduce risk. That is, by taking a recommended action, the individual will avoid a negative health condition.) For example, "if I start visiting hospitals before, during and after pregnancy, I can avoid complications or death that may occur during child delivery at home".
- **Perceived barriers** (barriers to taking action), for example, "my friend asked me to always visit the hospital now that I'm pregnant, but I don't think I can do that because my house is far from the hospital." These constructs were proposed as accounting for people's "readiness to act" (Muthaiyan, 2013).

Grizzel (2007) confirm that the model recently incorporated two additional constructs thereby allowing it to better account for habitual behaviors, such as a physically active lifestyle. These two construct are:

- **Self efficiency** (a person's confidence in his or her ability to successfully perform an action) for example, "There is no much I can do to prevent maternal death. If it's going to happen, then it will happen no matter what I do."
- **Cues to action** (for example, leaving a written reminder of one to take a recommended action for a positive health condition). For example, "My neighbour's wife who delivered her first child at home almost bled to death."

The HBM is based on the following assumptions:

a. It is assumed to be a good model for addressing problem behaviors that evoke health concerns. For example; high-risk sexual behavior and the possibility of contracting HIV. (Croyle, 2005)

b. HBM is a popular model applied in issues focusing on patients' compliance and preventive health care practices. It also addresses the relationship between a person's beliefs and behaviors. It provides a way to understanding and predicting how patients will behave in relation to their health and how they will comply with health care therapies.

c. According to this model, a person must hold the following beliefs in order to be able to change behaviour: *belief in effectiveness of the new behaviour* (for example, "avoiding child delivery at home can be effective against maternal mortality") and *cues to action* (for example, "witnessing the death of a close friend or relative resulting from childbirth at home).

d. The model postulates that health-seeking behaviour is influenced by a person's perception of a threat posed by a health problem and the value associated with actions aimed at reducing the threat.

e. HBM has been applied to a broad range of health behaviors as identified by Conner & Norman (1996). They include: *preventive health behaviours*, which include health-promoting (e.g. diet and exercise for pregnant women) and *health-risk behaviours* (e.g. smoking) as well as vaccination and contraceptive practices among women; *sick role behaviours*, which refer to compliance with recommended medical regimens. Usually, this follows professional diagnosis of illness and clinic use, like doctors' visits for a variety of reasons which includes offering obstetric care to women.

2.9.2 Criticisms of Health Belief Model

a. It emphasises mostly on the individual thereby ignoring the social and economic factors.

b. There is the absence of a role for emotional factors such as fear and denial (Nursing Theories, 2012).

c. Alternative factors may predict health behaviour, such as outcome expectancy (whether the person feels they will be healthier as a result of their behaviour) and self-efficacy (the person's belief in their ability to carry out preventative behaviour)

d. Despite Hochbaum (1958) and Rosenstock's (1959) call for increased communication research utilising the HBM, its use is rare. A search for the HBM in a communication research database retrieved few periodical articles. Thirty four articles were retrieved using a Boolean keyword search of "health belief model". A significant portion of these only

referenced the model. Subsequent searches using alternative databases and keywords resulted in less success. Tanner-Smith (2010) thus explained that in 39 studies reviewed on the use of the HBM in pap screening behavior, she found none to include the cues to action variable. "First, no studies included indicators of cues to action, which was a strong predictor of mammography behavior" (Tanner-Smith, 2010:117).

e. The HBM, according to Tanner-Smith (2010), also has shortcomings to explain and predict perceptions of risk. That is, perceived susceptibility and perceived severity. Perceived susceptibility and severity may be high, but if one is struggling with issues such as poverty, additional stressors may supersede actions to assure health. In other words, if someone is striving to feed the kids, one's concern to seek medical screening may be secondary.

f. The HBM also does not consider repeat behavior. Tanner- Smith (2010) posits that there is a perspective change between those undergoing a pap screening or mammogram for the first time and those who have made these visits routine. Perceived risks may influence the first visit but become less so thereafter. According to Lizewski (2010), Janz and Becker (1984) also discuss issues with perceived severity. According them, an illness such as cancer has a global perception of being very serious. This would account for little variance when measuring the perception of severity of those who comply with preventive health care and those who do not. Both may have similar perceptions.

Despite the obvious criticisms of this model, the study still adopt this model on the platform that its assumptions explains why some women would opt for homebirth despite the orientation given to them and while some women would consider being attended to by skilled birth attendant after the orientation given to them.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Studies conducted by Garba (2006) shows that 66.2% of women deliver their babies at home in Niger State, taken by traditional birth attendants thereby resulting to preventable complications while the rest deliver at modern health facilities. Maternal mortality rate, according to Saheed (2010), was revealed to be 948 per 100,000 live births overall in 2004, particularly from the rural areas. It is for this reason that Niger State was chosen as a case study. In addition, this chapter described the ways and procedures used in conducting this research and it is categorised based on the following sub-headings; research design, population, sampling and sampling techniques. Others include collection and procedure for data analysis, among others.

3.2 RESEARCH DESIGN

For the purpose of this study, a Triangulation or Mixed Method Research was used. Bryman (2008) states that triangulation uses more than one method or source of data in the study of a social phenomenon so that findings may be cross-checked. In carrying out this study, triangulation was used by comparing information from different sources (that is; different categories of respondents), different methods (that is; the descriptive survey method, key informant interviews and participant observation) in order to answer the various research questions earlier posed by the researcher.

In order to access the communication effect on the audience, the descriptive survey method was used. Wimmer & Dominick (2003) states that the survey method appropriates and reduces the universe in a way that provides the chance to check on the incident, distributions and interrelations of variables (demographics, information, attitude, motives, intentions and so on).

Also, for the purpose of clarity, key informant interviews schedule was used for this study. Key Informant Interviews, according to Johanna (2013), are interviews conducted with

key individuals within the community, schools, etc. Key Informant Interviews provide a researcher with detailed, qualitative information about impressions, experiences and opinions. Within the study area, health personnel were used to communicate messages on maternal health within the state. Therefore, stakeholders—a representative at Niger State Ministry of Health, six midwives (two from each local government area), six nurses (three from each local government area except for Paikoro that denied the researcher interviews), MSS focal person (only one MSS focal person is recognised within the State), fifteen pregnant women (five from each local government area) and fifteen nursing mothers—were interviewed in order to answer some of the research questions posed earlier by the researcher. Only one PHC is established in each of the three local government areas, therefore, the interviews were conducted within and outside the PHCs which were: Comprehensive Primary Health Centre at Paikoro, Comprehensive Health Centre at Lapai and Primary Health Centre Chanchanga as well as the Niger State Ministry of Health and questions were posed to them at different places and occasions.

Participant observation was equally used by the researcher. Participant observation, according to Macionis & Plummer (2005), refers to a form of research methodology in which the researcher takes on a role in the social situation under observation. The social researcher immerses herself in the social setting under study, getting to know key actors in that location in a role which is either *covert* (the social researcher participating fully without informing members of the social group of the reasons for her presence mainly in secret) or *overt* (the researcher being open about the reason for her presence in the field of study since the researcher is given permission by the group to conduct her research).

The study made use of both the covert and the overt type. The covert type was used in one setting while overt was used in another setting. The essence of using this methodology was to detect some information that the respondents may be shy to talk about or may not want to divulge at all.

3.3 POPULATION

The population of this study comprised of women in three selected local government areas of Niger state. According to the 2006 census figure, the total numbers of women in each local government areas were: Lapai= 53,687, Chanchanga = 105,263, Paikoro= 77,280 while the number of pregnant and nursing mothers of each local government areas, as at when this research was carried out, according to the nurses were: Lapai=800, Chanchanga=1200 and Paikoro=1000 with a total of 3000 population. The selection of the three local government areas was made through balloting.

3.4 SAMPLING TECHNIQUE

The probability and the non-probability sampling techniques were used. While the probability sampling techniques gives equal chance for every member of a population to be selected, the non-probability sampling technique does not give equal chance for every member of a population to be selected. However, these two sampling techniques were used to ensure that women (particularly expectant mothers and nursing mothers) in Niger State were selected and represented in order to respond to the questions earlier posed by the research. Therefore, for the probability sampling technique, the cluster sampling technique was used to locate and distribute the instruments where these women (pregnant women and nursing mothers) who are the main indices of this study are concentrated in population—particularly in PHCs where they are gathered in a group. While for the non-probability sampling technique, the purposive sampling

technique was used to satisfy the purpose of this study. That is, considering the specific characteristics of the selected sample who are basically the pregnant women and the nursing mothers; these respondents were purposively selected within the three local government areas outside the PHCs so that women outside the health centers can also be represented.

Forty four (44) key informant interviews were conducted in the course of this study. Analytically, they are—a representative at Niger State Ministry of Health, six midwives (two from each local government area), six nurses (three from each local government area except for Paikoro that denied the researcher interviews), MSS focal person (only one MSS focal person is recognised within the State), fifteen pregnant women (five from each local government area) and fifteen nursing mothers.

3.5 SAMPLING SIZE

The sample size of the study was chosen based on the accessibility of the respondents who included pregnant women and nursing mothers. In addition, a representative from Niger State Ministry of Health, one MSS focal person, six midwives and six nurses who are involved in maternal cases were interviewed. The reason behind the interviewees' selection was that they were core maternal coordinators in Niger State. According to Obasi (1979), the size of the sample is determined by a combination of a technical issue as well as human and financial considerations. Gay (1981) postulates that the study sample depends on the type of research involved. He recommends a minimum of 10% of population for a descriptive research and a 20% of population where the population is small. Thus, for the purpose of this research, the sample size for the survey was drawn from the three primary health centers in the three local government areas using the formula recommended by Gay (1981):

10% of the total population of 3000

Lapai=800, Chanchanga=1200 and Paikoro=1000.

For Chanchanga, 10% of 1200=120

For Lapai, 10% of 800=80

For Paikoro, 10% of 1000=100

Total sample size for the three local government areas= 300

3.6 METHOD OF DATA COLLECTION

Three hundred copies of questionnaires were administered by the researcher and other research assistants within the study area. In addition, key stakeholders (MSS focal person, midwives, nurses, pregnant women and nursing mothers) were interviewed and their responses were analysed using narrative analysis approach. Also, participant observation schedule (covert and overt) was used by the researcher to observe and collect data. Textbooks, internet and journals also served as guides in the collection of data.

3.7 INSTRUMENTS FOR DATA COLLECTION

Data were collected using questionnaire, participant observations schedule and interviews schedule. For the purpose of this study, the questionnaire (300 copies) contained close-ended questions in order to ease and save the time of the respondents. This questionnaire was categorised into two sections:

Section A: Consists of bio-data variables of age, marital status, occupation and educational qualifications.

Section B: Consists of questions that seek respondents' opinion on each of the research questions posed earlier by the researcher.

3.8 VALIDITY AND RELIABILITY OF THE INSTRUMENT

Testing the validity and reliability deals with measurement; that is, accurate and effectiveness of the instrument. It describes the extent to which an instrument measures what it's supposed to measure. For the purpose of this study, the Cronbach's alpha statistic was used to test the validity and reliability of the instrument:

Reliability Statistics

Cronbach's Alpha	No of Items
.887	11

Item Statistics

	Mean	Std. Deviation	N

SECTION B= 5. Are you aware of the ongoing communication campaign organised by midwives in primary health centres for pregnant women and nursing mothers?	6.8000	3.50338	20
6. If 'YES', how did you know about it?	5.8000	3.54816	20
7. Have you ever attended the campaign?	5.6000	3.43971	20
8. If 'NO', what is your reason?	6.9000	4.01182	20
9. If 'YES', how often have you attended the campaign?	3.0000	.00000	20
10. How do you find the campaign?	5.1000	3.44735	20
11. Do you deliver your child in the hospital?	6.2000	3.86073	20
12. If 'NO', why?	7.1000	4.17889	20
13. Your decision to deliver your child in the hospital is influenced by the campaign.	6.8000	3.50338	20
14. Do you intend to continue patronising the hospital for your subsequent child delivery?	5.8000	3.54816	20
15. How do you rate the campaign in addressing child delivery at home?	5.6000	3.43971	20

The instrument used for this study is valid. In other words, it comprehensively collected all the information needed to address the purpose and goals of the study. Also, it consistently measured what it intends to measure. According to Norland (1990), the reliability coefficient of .7 and above indicates acceptable reliability. Thus, the reliability coefficient (alpha) of .887, shown in the above table, is considered an acceptable reliability.

3.9 METHOD OF DATA ANALYSIS

Both quantitative and qualitative analyses were used. The quantitative analysis presented the responses derived from the respondents in frequency and percentage tables while the qualitative analysis discussed the information derived from the participant observation and interviews conducted within the study area.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

4.1 INTRODUCTION

This chapter presented and discussed the data gathered for the research titled: **Assessment of the Effectiveness of Group Communication Campaign of Midwife Service Scheme against Child Delivery at Home in Niger State.** Data was presented using both the qualitative and the quantitative method of analysis. The analysis of qualitative data included data gathered from key stakeholders (a representative from Niger State Ministry of Health, MSS focal person, midwives, nurses, pregnant women and nursing mothers) while the analysis of quantitative data included data derived from the total of 300 respondents from within and outside the three PHCs spread across the study area. Furthermore, the interpretation and discussion of findings came in the later chapter.

4.2 DATA PRESENTATION AND ANALYSIS

As part of the efforts of MDG to reduce maternal mortality in the country, midwives were deployed to rural communities across the country. Prior to the period when the Midwife Service Scheme commenced its operation in Niger State in the year 2009, the National Primary Health Care Development Agency (NPHCDA), the government and other stakeholders saw the need to organise a health campaign that informs and educate women (particularly in rural communities) on the need to avoid child delivery at home by visiting health centres for proper check up and child delivery. The campaign carried out by the MSS in collaboration with the government, NPHCDA, international health organisations and other stakeholders was aimed at achieving the objectives of MDG5—improving maternal health—by the year 2015. Thus, to attain this objective, midwives gather pregnant women and nursing mothers in a group in various PHCs across communities in Niger State, educating and informing them on the need to avoid child delivery at home by frequent visit of PHCs for antenatal and postnatal care.

According to Mrs. Nnenna Eze (*MSS Focal Person, Niger State Chapter***)**, the MSS uses the mass media to convey their messages to the women but it was discovered over time that women within the study area were better reached and informed via face-to face contact. It was for this reason that group communication campaign was given high priority than other medium of communication. Various stakeholders were involved in the implementation of the MSS in Niger State and they include: OSSAP (Office of the Senior Special Assistant to the President on Millennium Development Goals); FMOH (Federal Ministry of Health); NMCN (Nursing and Midwifery Council of Nigeria); NHIS (National Insurance Health Scheme); UNICEF (United Nations Children's Fund); WHO (World Health Organisation); UNFPA (United Nations Population Fund); NPHCDA (National Primary Health Care Development Agency); the State Government; PATHFINDER INTERNATIONAL; PRINN/MCH (Partnership for Reviving Routine Immunization in Northern *Nigeria*/Maternal and Child Health); PPFN (Planned Parenthood Federation of Nigeria) and ACCESS/JEPHIGO.

In addition, she added that the various stakeholders involved in carrying out the communication campaign were: the State Government, community leaders, women leaders, religious leaders, midwives, nurses and health workers. The aim of this campaign was to ensure that women visit health centers and avoid child delivery at home which may go a long way in attaining the objective of MDG5 of reducing maternal mortality by the year 2015.

This campaign was observed to be the major health campaign carried out by these stakeholders. This offered them the opportunity to interact and dialogue with women who were in attendance. A respondent spoke in this regard:

> …everyone is involved in this exercise that is aimed at reducing maternal mortality in our country. You know how stubborn some women can be. De-

> spite our persuasion, some women still continue to deliver their child at home. In most cases, these women die from preventable causes. The outcry is pathetic and disturbing so we use the available stakeholders like the nurses, community leaders, women leaders and even the religious leaders to persuade these women. We urge them to convince these women to stop giving birth at home and to visit the PHCs made available for them so as to receive proper attention before, during and after delivery… (A representative, Niger State Ministry of Health)

The sample of 300 respondents (basically pregnant women and nursing mothers) were drawn and given questionnaires. The researcher was a participant observer who applied both the covert and the overt participant observation type at different period within the study area. Data obtained from the questionnaires were used to compliment the qualitative data collected.

Table 4.1 Distribution of Respondents by Local Government Area

Local Govt. Areas	Frequency	Percent
Chanchanga	120	40.0
Paikoro	100	33.0
Lapai	80	27.0
Total	**300**	**100.0**

The above table shows the three local government areas of the respondents that constitute the study area. The table revealed that 300 respondents were sampled from Chanchanga, Paikoro and Lapai local government areas of Niger State. These figures were generated from the population sample earlier discussed in the previous chapter.

Table 4.2 Distribution of Respondents by Age group

		Frequency	Percent
Valid	No response	6	2.0
	18-25 years	65	21.7
	26-33 years	170	56.6
	34-41years	54	18.0
	42 and above	5	1.7

Total	**300**	**100.0**
	Frequency	**Percent**

Out of the 86.3% of women within the study area who attended the campaign, 56.6% of women fall within the age group of 26-33 which may mean that this category of women are matured enough to understand their body mechanism and quickly relate it to the educational messages communicated to them by the midwives.

		Frequency	**Percent**
Valid	No response	2	.7
	Single	50	16.6
	Married	248	82.7
	Total	**300**	**100.0**

Table 4.3 Distribution of respondents by Marital Status

Women's participation to the campaign depended on their conveniences. This study, however, discovered that married women had ample time to participate in the campaign than single mothers probably due to the fact a single mother who singlehandedly takes care of her child/children may have to go to farm, make some sales or other activities that would earn her some money compared to a married woman who may be assisted by her husband.

Table 4.4 Distribution of respondents by Occupation

Valid	No response	2	.7
	Farmer	78	26.0
	Trader	178	59.3
	Teacher	10	3.4
	Housewife	26	8.6
	Others specify	6	2.0
	Total	**300**	**100.0**

The nature of some women's occupation may have influenced their attendance for the exercise. It may be more convenient for a trader to attend the campaign than a teacher. In our contemporary society, for example, where a woman owns a shop or a table in a street, she may decide to open the shop or spread some valuable items on the table and leave someone behind while she attends the campaign. She may also choose to attend the campaign first before opening her shop. Her choice depends on her convenience.

Table 4.5 Distribution of respondents by Qualification

		Frequency	**Percent**
Valid	No response	12	4.0
	Primary School Leaving Certificate	241	80.3
	WASSCE/SSCE	31	10.3
	OND	14	4.7
	HND/BSC	2	.7
	MBA/MSC	-	-
	Others specify	-	-
	Total	**300**	**100.0**

From the above, it can be seen that the majority of women obtained a primary school leaving certificate which may have affected their literate level within the study area as some midwives rightly stated in the interviews conducted. Despite these set back, the study observed that majority of the women still availed themselves for the campaign in PHCs considering the fact that they are communicated in their indigenous language and Hausa language.

Mrs. Nnenna Eze, MSS Focal Person spoke in this regard:

> We send a midwife that can understand and speak the dominant language that is prevalent in that community, particularly Hausa language. And where it's impossible to get one, we assign a nurse within that particular PHC to interpret the messages to them.

Table 4.6 Distribution of respondents by their awareness of the campaign

		Frequency	Percent
Valid	Yes	255	85.0
	No	45	15.0
	Total	**300**	**100.0**

The above table indicates that majority of women were aware of the campaign. This clearly shows how well the stakeholders within Niger State have gone in using the campaign to create awareness about the use of health services by women for child delivery.

Table 4.7 Distribution of respondents by their knowledge of the campaign

		Frequency	Percent
Valid	From the community leader	16	6.3
	From a friend	56	22.0
	From the radio	1	0.4
	From the television	1	0.4
	From Rumor	20	7.8
	From Health Workers	161	63.1
	Others specify	-	-
	Total	**255**	**100.0**

Within the study area, the available health workers (including midwives) were employed to go round the communities using a wireless microphone to announce and invite pregnant women and nursing mothers to attend the campaign. The researcher covertly observed that there are few health workers and midwives carrying out this campaign exercise within the study area which

supports the statement made by Mrs. Nnenna Eze who affirms that there is low availability of midwives to carry out the exercise which poses a challenge to the scheme.

Table 4.8 Distribution of respondents by their attendance for the campaign

		Frequency	Percent
Valid	Yes	220	86.3
	No	35	13.7
	Total	**255**	**100.0**

It is one thing to be aware of a campaign; it is another thing to attend the campaign. From the above table, it can be seen that 86.3% of women within the study area have attended the campaign. This shows the compliance of the women to avail themselves for the exercise. The reason for the non attendance of the 13.7% of the women may be as a result of some determinants which were explained in the next table.

Table 4.9 Distribution of respondents by their reason for not attending the campaign

		Frequency	Percent
Valid	Lack of finance	9	25.7
	Distance	12	34.3
	Environment	2	5.7
	Not Interested	8	22.9
	Others specify	4	11.4
	Total	**35**	**100.0**

The above table clearly shows the major factors that affected their attendance for the campaign exercise. In order words, some respondents not attending the campaign was determined by the above factors (that is, lack of finance, distance, environment etc). The researcher covertly observed within the study area, that those who availed themselves in PHCs for the exercise were 5-10kms away from their homes while those who lived 50 kms away from home found it difficult to attend the campaign.

Table 4.10 Distribution of respondents by their frequency of the attendance of the campaign

		Frequency	Percent
Valid	Daily	6	2.7
	Once a Week	93	42.3
	Twice a Week	113	51.4
	Monthly	8	3.6
	Total	**220**	**100.0**

It can be seen from the above table that majority of the women attended the campaign twice a week and the reason could be that as a mother with the responsibility of catering for the needs of her family, she may be occupied with market or farming activities considering the fact that majority of the women within the study area are traders and farmers. According to a nurse, the PHC is usually scanty on market days.

Table 4.11 Distribution of respondents by their perception of the campaign

		Frequency	Percent
Valid	Interesting	42	19.1
	Educating	161	73.2
	Boring	4	1.8
	Stressful	2	0.9
	Enlightening	11	5.0
	Total	**220**	**100.0**

The above table outlined the perception of respondents who have attended the campaign. It can be deduced form the above table that majority of the respondents who attended the campaign found the campaign to be educative which may have positively influenced their behaviour to take a recommended action regarding their maternal health (including visiting health centers for childbirth). It was covertly observed that there was high rate of response and participation from women during the exercise. Also, the environment the health centers where the campaign is carried out was kept clean with pleasant air circulation. This was done in order to teach them the

importance of keeping and maintaining clean environment and good hygiene at their various homes before and after pregnancy.

For those that found the campaign to be interesting and enlightening, it was overtly observed that the midwives used dramatic and graphical illustrations to communicate their messages and meanings to women in attendance.

Table 4.12 Distribution of respondents by their child delivery in the hospital

		Frequency	**Percent**
Valid	Yes	200	66.7
	No	100	33.3
	Total	**300**	**100.0**

The above table shows that approximately 67% of the respondents deliver their child in the hospital. The reason for their not visiting health centers for childbirth may be as a result of any of the factors explained in the next table.

Table 4.13 Distribution of respondents by their reasons for child delivery at home

		Frequency	**Percent**
Valid	Lack of Finance	22	22
	Bad Hospital	4	4
	Lack of Awareness	10	10
	Distance	40	40
	My Culture/Religion do not encourage it	10	10
	My Husband/Relations do not encourage it	10	10
	Others specify	4	4
	Total	**100**	**100**

The above table covers only those that do not deliver their child in the hospital. The factors that influenced women within the study area to resort to homebirth were lack of finance, bad hospital, lack of awareness, culture and others. The study shows that distance was the major factor influencing homebirth within the study area probably due to the availability of only one PHC in

each local government area. It is on this base that the study made some recommendations in the next chapter aimed at addressing these challenge.

Table 4.14 Distribution of respondents by the influence of the campaign on their decision to deliver their babies in the hospital

		Frequency	Percent
Valid	True	180	90.0
	False	20	10.0
	Total	**200**	**100.0**

The above table covers only those that visit hospitals for child delivery. It was observed within the study area that the campaign has a positive influence on women to visit health centers for child delivery.

Table 4.15 Distribution of respondents by their continuity to patronise the hospital for their subsequent delivery

		Frequency	Percent
Valid	Yes	196	98.0
	No	4	2.0
	Total	**200**	**100.0**

The positive influence of the campaign on women's hospital childbirth has made those who already visit health centers for childbirth to continue. The above table clearly revealed that even those who were not influenced by the campaign, but were already visiting health center for child delivery, intend to continue patronising the hospital for their subsequent childbirth.

Table 4.16 Distribution of respondents by their rating of the campaign in addressing child delivery at home

	Frequency	Percent

Valid	Highly effective	88	40.0
	Effective	102	46.4
	Neutral	30	13.6
	Ineffective	-	-
	Less effective	-	-

Month	ANC	New Cases	Old Cases	Malaria	Normal Delivery	Still Birth	APH	PPH	BBA	Referral	Total
	Total			**220**			**100.0**				

The above response derived from the respondents that attended the campaign table shows that the campaign is effective in addressing child delivery at home. In addition, a record shown by nurses at Lapai and Chanchanga PHCs confirms that before the commencement of the campaign dated 2009, there had been low turnout of women in the hospital for antenatal and postnatal care. In Paikoro PHC, the researcher who was a participant observer covertly observed the attendance book. The researcher was denied access (by the nurses and admin) to maternal records and other valuable information. So, the researcher was only granted audience by the midwives when the admin was off duty. In Lapai and Chanchanga PHCs, the researcher overtly observed the attendance book and she was granted access to the antenatal and postnatal records. Accordingly, the attendance book showed the positive result the campaign has yielded going by the drastic increase from 30% of its previous attendance to 85% of attendance by women. A nurse at Chanchanga PHC, Miss Sarah Bako attested:

> As you can see, this register keeps record of the women's attendance for the exercise. Their attendance for the ongoing exercise has necessitated their high rate of attendance for the antenatal and postnatal care as well as childbirth here in the hospital. Indeed, this campaign has yielded great and positive result.

A midwife in Lapai A midwife in Lapai PHC, Mrs. Fatima Sheriff says that the campaign is effective and its effectiveness was already reflecting in women's hospital visitation and childbirth. She revealed a maternal record dated from January to December 2013 which is shown below:

Jan	269	132	137	2	16	-	-	-	1	-	**557**
Feb	246	98	148	2	15	1	-	-	-	-	**510**
March	220	74	156	4	17	1	-	1	-	1	**474**
April	249	93	156	3	21	-	-	-	1	-	**523**
May	269	77	192	3	19	-	-	-	-	-	**560**
June	173	81	92	4	7	-	-	-	-	-	**357**

Table 1: Maternal report for the year 2013, PHC Lapai, Niger State

Table 2: Maternal report for the year 2013, PHC Lapai, Niger State

4.4 Discussion of Findings

Month	**ANC**	**New Cases**	**Old Cases**	**Malaria**	**Normal Delivery**	**Still Birth**	**APH**	**PPH**	**BBA**	**Referral**	**Total**
July	301	122	139	1	11	1	-	-	1	-	**576**
Aug	296	78	158	2	15	-	-	-	-	-	**549**
Sep	324	87	139	2	18	-	-	1	-	1	**572**
Oct	256	84	200	4	19	-	-	-	1	-	**564**
Nov	278	89	193	3	25	1	-	-	-	-	**589**
Dec	190	90	89	2	9	1	-	-	-	-	**381**

Study conducted by Iyaniwura and Yusuf (2009) in Southern Nigeria revealed that out of the 84.6% of women who visited hospital for health care talk, 79.6% of women had their delivery in the hospital. Another study carried out by Envuladu, Agbo, Lassa, Kigbu and Zoakah (2013) in Jos Nigeria found that out of 74.3% of the women who visited hospital for care talk, 60% had their delivery in the hospital which rightly supports the findings of this study where out of the 86.3% of women within the study area who attended the campaign, 66.7% of women had their delivery in the hospital. This finding explains the campaign's effectiveness and its positive influ-

ence on women. This is because majority of the women attested to the fact that there decision to visit health centres for child delivery was influenced by the campaign. The study confirms that 13.7% of the women who never attended the campaign may have fallen within the 33.3% of women who do not visit PHCS for child delivery. Out of the 85% of women who were aware of the campaign carried out by midwives, 13.7% of the women never attended the campaign. Several factors such as environment, lack of finance etc were identified, but the major factor that affected their attendance was distance. The researcher observed within the study area that those who lived 50kms far from the PHC found it difficult to attend the campaign which may have inflated the figure to 33.3% who do not visit health centers for child delivery. The researcher believed that the problem of distance can be addressed if more PHCs are established within the study area.

THE GROUP COMMUNICATION CAMPAIGN IN NIGER STATE WITHIN THE PERIOD OF 2012-2014

Hogan and Foreman (2010) concluded in their study that between 1990 and 2008, the increase in the proportion of women who gave birth with a skilled attendant was a main explanatory factor in the decline in global MMR. This study, however, discovered that within the period of 2012-2014, there was a rapid improvement of healthcare visit by women as a result of the campaign. Within the study area, it was discovered that there was an increase of healthcare child delivery by women from 30% in 2012 to 60% in 2013. In 2014, there was an increase of healthcare visit to 85% as shown in the previous Tables 1 and 2.

RQ 1: Causes of Child delivery at Home in Niger State

Within the study area, the researcher found the following to be the causes of child delivery at home:

- **a.** Distance
- **b.** Lack of finance
- **c.** Bad hospital
- **d.** Lack of awareness
- **e.** Illiteracy
- **f.** Culture/Religion
- **g.** Disapproval from husband or relations

RQ 2: How the campaign is able to address the problem of child delivery at home among women of Niger State

The responses gathered from the three LGA as well as the attendance of women in the various PHCs have proven the campaign to have yielded positive results. Women saw the need not only to avail themselves weekly for the talk organised in the various health centers but also to practice what they were taught. Most women affirmed that the campaign has created high level of awareness which has brought about great reduction in home birth and increase in hospital visitation/birth. Some women in the PHCs within the three local government areas that constitute the study area spoke in this regard. One of them, for instance, said:

> This campaign is very important. At a start, I thought I was wasting my time but at a point, I saw the need to avail myself here at all times. These midwives have taught me a lot and I try as much as I can to practice what I am being taught, particularly the need to always visit the hospital for checkup before and after childbirth and most importantly, to avoid home birth because that is where I can say I fell a victim in the past. But it is not like that today because my previous childbirth was in the hospital and my current one will also be in the hospital (Mariam Yusuf-a pregnant woman).

Also, a nursing mother, Joy Banabas affirmed:

> I have benefitted a lot from this campaign. My five children were delivered at home by a TBA and I must confess it wasn't easy. At every birth, I was rushed to the hospital in a coma, bleeding heavily. It is God that has kept me alive, and today I am glad that I am a benefactor. This is my sixth child and I gave birth to her here in the hospital without any stress and fear of complication.

Looking at the rate of awareness of the campaign (255 respondents), their attendance (220 respondents), their level of perception (161 respondents), the number of childbirths in the hospital as a result of the campaign (180 respondents) and their feedback/response (102 respondents); data gathered from the field revealed that the group communication campaign is effective in addressing the problem of child delivery at home among women in Niger State. This supports the behavioural change theory of Health Belief Model which explains the positive expectation of women whom by taking a recommended action (hospital visitation and childbirth in the hospital), women will avoid a negative health condition (maternal mortality and child morbidity). Using the HBM to discuss the findings of this research, issues focusing on women's compliance to visit health centers for child delivery and preventive health care practices—before, during and after delivery—are identified which in turn provides a way of understanding and predicting how women will behave in relation to their health and how they will comply with health care therapies.

RQ 3: The challenges that are limiting the effectiveness of this campaign carried out by MSS in addressing the problem of child delivery at home

The challenges encountered in the three local government areas of Niger State that form the study area of this research are similar in most cases. In Paikoro, Chanchanga and Lapai local government areas for instance, the researcher observed that each community has only one PHC. Most of the households were situated far from the health centers where this campaign is carried out. The researcher also observed that there were few health workers and midwives carrying out

this campaign exercise. Mrs. Nnenna Eze (*MSS Focal Person*) further outlined the challenges encountered in the level of implementation of the campaign:

> As you have seen so far, our primary health centres have been renovated. Health facilities have also been provided for use. So, this shouldn't be an excuse for women not to visit the health centers for proper care. Despite this development, we still encounter some challenges that I believe can be tackled. One of such challenges is the issue of insecurity. With the current insecurity in our country and for the fear of the unknown, some midwives would not want to go to some of these communities to carry out this exercise. Also, language is another challenging factor as some of the midwives don't understand *Nupe, Gwari* or *Hausa* language which are however, the major languages of these dwellers. Again, there is low availability of midwives to maximally carry out this exercise.

In addition to the above challenges, some of the midwives who spoke in anonymity complained of low personnel, resulting in the difficulty in reaching out to these women (pregnant and nursing mothers) who are practically large and scattered across the community. The midwives also complained of the stress (due to their illiteracy) in convincing the women in attendance to accept the message of childbirth in the hospital and reject the act of childbirth at home.

A midwife in Chanchanga PHC, Mrs. Veronica James attests to this saying:

> The women are really responding but you know a good and fruitful project must have some challenges. One of the challenges we face in carrying out this campaign is lack of personnel. The midwives allocated to most of these communities are few and these midwives find it hard to go round the eleven or twelve wards of the slated local government areas. Again, most of these villages are far and reaching out to these women in the remote villages becomes very difficult. Also, we find it challenging, trying to persuade these women—particularly the pregnant women—to avoid farm work as well as every other rigorous work and use that time to attend this educating exercise. Another problem we encounter is convincing these women to accept our messages. Knowing the caliber of women we are dealing with, we have to crack jokes and talk for hours with illustrations just to create a friendly atmosphere and in most cases, it is not easy particularly when we have to maintain eye contacts with the women gathered in a group.

From the above, one can summarise the challenges affecting the campaign as lack of personnel, language barrier, distance, illiteracy and insecurity.

i. **Distance:** the study discovered that the major challenge affecting the effectiveness of this campaign is the issue of distance. Since only one PHC exist in each local government, most of the respondent complained of the distance that exists from their place of residence to the PHC which made it difficult for them to attend the campaign and visit health centers for child delivery.

ii. **Lack of personnel:** going by the interview conducted, the midwives complained of lack of personnel available to carry out the campaign exercise. This explains instances where two midwives are assigned to each local government with eleven or twelve wards.

iii. **Language barrier:** one of the challenges encountered as spoken by Mrs. Nnenna Eze is the issue of language. She complained that some of the midwives do not understand their dominant language. Unless an interpreter is attached to the midwife, this poses a great challenge in communicating to the women. In cases where the midwife on duty for the day understands and speaks none of the dominant language, a nurse was usually assigned to the midwife to interpret messages communicated by her either in *Hausa* and *Gwari* for easy understanding and assimilation. The study observed that a midwife on duty usually saturates the atmosphere with humor and graphical illustration to convey her messages thereby arousing high participation of the women gathered in a group.

iv. **Illiteracy:** the literate level of the women within the target population is very low which may be a contributing factor.

v. **Insecurity:** the MSS focal person complained of insecurity in our country which may be a determining factor that influences the midwives deployment.

RQ 4: How the challenges can be addressed

According to Mrs. Nnenna Eze (*MSS Focal person*), these challenges can be addressed by putting into consideration the major goals of this project which is targeted towards improving maternal health by the year 2015. Once this goal is placed at the utmost part of this scheme, these challenges can be reduced if not eliminated. She added:

> Currently, there is serious ongoing monitoring of this programme. PHCs and general hospitals are already connected with ICT in order to enable voice and data transmission through internet connectivity. More midwives are being trained. The major way forward is the sustainability of this scheme via the state and local government areas. In doing this, we can boastfully say that we have attained the MDG5 by the year 2015. Currently, we the MSS personnel are monitoring this programme adequately ensuring that the right thing is done to bring these women to accept this change earnestly.

Several steps have been taken to address these challenges. One of such is the provision and distribution of the ATT-Anti Tetanus Toxoid vaccines to pregnant women where those who lived 50kms far away from the PHCs fall a victim of home birth are administered the vaccine to avoid infection. Stakeholders employed ensured within their capacity that women who are situated far from the PHCs are given a vaccine such as ATT—Anti Tetanus Toxoid—which helps to prevent infection of the woman and the child during childbirth at home particularly in a dirty environment. A midwife in Lapai PHC, Mrs. Fatima Sheriff spoke:

> The government has made provision for ATT vaccines and each time the women gather here in a group for a talk, we try to encourage them to visit the PHCs for antenatal and postnatal care. From past experiences, we have observed that these women often give birth at home despite the orientation given to them. So, in order to avoid complications for those that fall under the category of home childbirth, majorly those that live far, we offer them ATT vaccines which can help to avoid infections particularly when a woman gives birth in an unclean environment.

Another step to address this challenge is that there should be establishment of more PHCs in different locations in each community so as to complement the existing ones which may go a long

way in solving the problem of distance. Another step is the serious monitoring of the programme by the international bodies. In doing this, PHCs and general hospitals are already connected to ICT in order to enable the update of the ongoing activities within each community through internet connectivity. In addition, more midwives are being trained and as the *MSS Focal Person*, Mrs. Nnenna Eze puts it: "The major way forward is through the sustainability of this scheme via the state and local government areas. In doing this, we can boastfully say that we have attained the MDG5 by the year 2015."

In summary, the interviewees from the sampled three local government areas attest to the effectiveness of the group communication campaign carried out by the MSS and the overall success of the campaign. The evidence of these claims was observed from some of the records revealed as well as the turnout of women during the exercise carried out in the PHCs within the three local government areas that constitute the study.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 SUMMARY

This study was conducted to assess the effectiveness of group communication campaign carried out by the midwife service scheme against child delivery at home in Niger State. Hence, the presentation, interpretation and analysis of both qualitative and quantitative data in the preceding chapter has led the study to establish some facts in respect to the key research questions raised in the introductory chapter.

To begin with, it was established from the beginning of this study that the MSS adopts the use of group communication where there is a form of face-to-face interaction and discussion between the midwives and/or the nurses and women (pregnant women and nursing mothers) of Niger State. Using this medium, women who were usually gathered in a group in PHCs were informed and educated on the need to visit health centers and to avoid the risk of complications and mortality resulting from childbirth at home.

Again, literature consulted revealed that childbirth at home is one of the leading causes of maternal mortality among women (Adebayo, 2012). Hence, measures (deployment of midwives to rural communities, awareness campaign and so on) have been put in place to ensure that the act of child delivery at home among women is discouraged.

In addition, the theory adopted for this study was the Health Belief Model (HBM) which explains why people would take a recommended health action based on what they tend to benefit from taking that health action.

Furthermore, in assessing the effectiveness of this campaign carried out by the MSS against child delivery at home in Niger State, descriptive survey, participant observation as well as interviews were carried out with the aim of collating the responses of respondents that constitute the study for further analysis and interpretation of data gathered from the field.

Hence, the findings of this research work revealed the group communication campaign carried out by the MSS to be effective. This is attributed to the level of awareness of the campaign, attendance, perception of the women towards the campaign exercise as well as their response/feedback. For instance, one of the interviewees initially misconstrued the exercise as a waste of time but after her few attendances, she saw the need to avail herself at all times for the exercise which she noted had a positive impact on her.

5.2 CONCLUSION

Randolph (1979) quotes: "It's easy to get people's attention, what counts is getting their interest." Getting people's attention and not getting their interest may go a long way in determining their level of participation. Considering the nature of people residing in a given locality, one may say that the effective use of communication has the ability to influence the awareness, acceptance, participation and the feedback of the listener. Therefore, this health communication approach continuously carried out by the MSS may improve the communication skills of the existing midwives as well as nurture the incoming midwives deployed to a given community.

The effective use of group communication can help the midwife to meet the needs of more than two women at the same time. Women are able to learn from their counterpart's experiences through discussions, questions and answers as well as contributions shared from their counter-

parts. To some extent, group communication may be disadvantageous because it may give little or no room for privacy since women are gathered in a group. Incorrect ideas maybe shared amongst themselves in a group and the ideas may cause havoc to some women particularly when they feel intimidated to openly raise their fears and desperation.

Furthermore, the group communication campaign employed by the MSS provides opportunities for dialogue and discussion which has the effect of mildly discouraging their existing beliefs and practices of childbirth at home. Thus, using demonstrations to show the practice detriment (that is, childbirth at home) and hospital birth benefits can induce positive response from the women.

It is paramount to note that the success of this communication campaign as well as other health campaigns aimed at reducing maternal mortality can also serve as a model for other developing countries within and outside sub-Saharan Africa who may need to redistribute their health personnel in order to reduce the imbalances that may exist between the urban and rural areas.

5.3 RECOMMENDATIONS

Based on the findings, the researcher provided the following recommendations:

i. It is vital to support the development of complete and accurate civil registration systems that include births, deaths and causes of death. Every maternal death needs to be counted (WHO, 2010). The researcher observed that the PHCs within the study area do not have a comprehensive list of pregnant women and nursing mothers within their locality. In addition, this study also observed that childbirths and deaths were not accurately documented within the study area. Hence, there should be a serious and accurate statistical documentation of data on maternal mortality in Nigeria.

ii. Findings of the study revealed that the major cause of childbirth at home is distance. Hence, instead of having just one PHC in each community (as the researcher observed), more PHCs should be established in different locations within each community so as to complement the existing ones which may go a long way in tackling the problem of distance.

iii. Other communication approach (like midwives visiting homes for interpersonal contact, contacting the women on phones and deployment of adequate midwives that can go round the women's remote homes and not only in the PHCs within the community) should be put in place in communities to enable these women—pregnant and nursing mothers—who are far from the PHCs to acquire the basic information, attention and assistance needed for their health.

iv. More importance should be placed by health personnel on the use of group communication in curbing maternal mortality because it can be seen as an easy way of dialoguing and solving the problems of more than one person at a time. Hence, government should critically monitor the campaign and also take ample steps to improve on the campaign in areas where low success is recorded.

v. Every communication is targeted at persuading the people to accept a particular message aimed at inducing change in the minds of the recipients. For any positive change to occur, the people must be properly informed and educated on any prevailing issue. There should be serious and massive campaigns particularly in rural communities across the country where some expectant mothers do not visit the health care centers, where early marriage is high and where teenage pregnancy is on the increase.

5.4 SUGGESTIONS FOR FURTHER STUDY

There is shortage of literature relating to the use of behaviour change communication to discourage child delivery at home. Thus, further researches should be carried out on this area to complement the existing ones. Researchers could also carry out further studies on this area of study using other forms of communication as well as other methods of data collection.

5.5 CONTRIBUTION OF STUDY

This research made the following contributions to study:

i. It helped to assess the communication campaign adopted to encourage health care visit by women in Niger State.

ii. The findings of this study can be used by World Health researchers who may wish to know the extent of decline in MMR within the country.

iii. Researchers carrying out a study in similar area can use the finding of this study to support the finding of their study.

iv. This study can also serve as an empirical reference material for further study.

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APPENDIX I

Month	ANC	New Cases	Old Cases	Malaria	Normal Delivery	Still Birth	APH	PPH	BBA	Referral	Total
Jan	269	132	137	2	16	-	-	-	1	-	**557**
Feb	246	98	148	2	15	1	-	-	-	-	**510**
March	220	74	156	4	17	1	-	1	-	1	**474**
April	249	93	156	3	21	-	-	-	1	-	**523**
May	269	77	192	3	19	-	-	-	-	-	**560**
June	173	81	92	4	7	-	-	-	-	-	**357**

Month	ANC	New Cases	Old Cases	Malaria	Normal Delivery	Still Birth	APH	PPH	BBA	Referral	Total
July	301	122	139	1	11	1	-	-	1	-	**576**
Aug	296	78	158	2	15	-	-	-	-	-	**549**
Sep	324	87	139	2	18	-	-	1	-	1	**572**
Oct	256	84	200	4	19	-	-	-	1	-	**564**
Nov	278	89	193	3	25	1	-	-	-	-	**589**
Dec	190	90	89	2	9	1	-	-	-	-	**381**

Maternal repot for the year 2013 ***(Source: PHC Lapai)***

Antenatal care (ANC)
New cases
Old cases
Malaria
Normal delivery
Still birth
Ante partum Hemorrhage (APH)
Post partum Hemorrhage (PPH)
Birth before Arrival (BBA)
Referral
Normal delivery

APPENDIX II

LIST OF INTERVIEWEES

1. Mrs. Nnenna Eze (MSS focal person)
2. Mrs. Veronica James (Midwife, PHC Chanchanga)
3. Hajiya Rukaiyatu Abdul (Midwife, PHC Chanchanga
4. Mrs. Fatima Sheriff (Midwife, PHC Lapai)
5. Mrs. Janet Bawa (Midwife, PHC Lapai
6. Mrs. Favour Timothy (Midwife, PHC Paikoro)
7. Mrs. Ruth Usman (Midwife, PHC Paikoro)
8. Miss Sarah Bako (Nurse, PHC Chanchanga)
9. Miss Mercy Jacob (Nurse, PHC Lapai)
10. Hajiya Mariam Yusuf (Pregnant woman)
11. Mrs. Joy Banabas (Nursing mother)
12. Mallama Rakiya Akilu (Nursing mother)
13. Mallama Sadiya Adamu (Pregnant woman)
14. Mrs. Blessing John (Pregnant woman)
15. Mrs. Glory Emenike (Nursing mother)

APPENDIX III

INTERVIEW SCHEDULE

1. When was the Group Communication Campaign implemented in Niger State?
2. Who are the stakeholders Involved in the implementation of the campaign carried out by the MSS?
3. What are the levels of employment of the communication campaign carried out by the MSS?
4. What are the results or outcomes of the communication campaign carried out by MSS in addressing child delivery at home?
5. What are the challenges encountered at the level of implementation of the campaign?
6. How can these challenges encountered be addressed?

APPENDIX IV

QUESTIONNAIRE

Department of Mass Communication,
Faculty of Social Sciences,
Ahmadu Bello University, Zaria,
Kaduna State.

Dear respondent,

REQUEST FOR FILLING OF QUESTIONNAIRE

I am a Masters student carrying out this research thesis on the **"Assessment of the Effectiveness of Group Communication Campaign of the Midwife Service Scheme against Child Delivery at home in Niger State"** in partial fulfillment of the requirement for the award of Master of Science (M.sc) in the above mentioned department and institution, Therefore, I request that you please complete the questionnaire objectively as any information collected will be strictly used for research purpose and will be treated confidentially.

Thank you.

Yours sincerely

Gloria Christian

Instruction:

This questionnaire is divided into two parts- Section A and Section B. Tick (√) in any of the bracket provided as appropriate.

Section A

Personal data

1. What age bracket do you belong to?

   (a) 18-25 years ( ) (b) 26-33 years ( )

   (c) 34-41years ( ) (d) 42 and above ( )

2. Indicate your marital status.

   (a) Single ( ) (b) Married ( )

3. What is your occupation?

   (a) Farmer ( ) (b) Trader ( ) (c) Teacher ( )

   (d) House wife ( ) (e) Others specify_____

4. What is your highest qualification?

   (a) Primary school Leaving Certificate ( ) (b) WASSCE/SSCE ( )

   (c) OND ( ) (d) HND/BSC ( )

   (e) MBA/MSC ( ) (f) Any other (specify) _____

Section B

Questions

5. Are you aware of the ongoing group communication campaign organised by midwives in primary health centres for pregnant women and nursing mothers?

   (a) Yes ( ) (b) No ( )

6. If yes, how did you know about it?

(a) From the community leader ( ) (b) From a friend ( ) (c) From the radio ( )

(d) From the television ( ) (e) From Rumor ( ) (f) From health workers ( )
(g) Others specify_____

7. Have you ever attended the campaign?

(a) Yes ( ) (b) No ( )

8. If 'NO', what is your reason?

(a) Lack of finance ( ) (b) Distance ( ) (c) Lack of awareness ( )
(d) Environment ( ) (e) Not interested ( ) (f) Others specify_____

9. If yes, how often do you attend the campaign?

(a) Daily ( ) (b) Once a week ( ) (c) Twice a week ( ) (d) Monthly ( )

10. How do you find the campaign?

(a) Interesting ( ) (b) Educating ( ) (c) Boring ( ) (d) Stressful ( )

(e) Enlightening ( )

11. Do you deliver your child in the hospital?

(a) Yes ( ) (b) No ( )

12. If no, why?

(a) Lack of finance ( ) (b) Bad hospital ( ) (c) Lack of awareness ( ) (d) Distance( )

(e) My culture/religion do not encourage it ( ) (f) My Husband/Relations do not encourage it ( ) (g) Others specify_____

13. Your decision to deliver your child in the hospital is influenced by the campaign.

(a) True ( ) (b) False ( )

14. Do you intend to continue patronising the hospital for your subsequent child delivery?

(a) Yes ( ) (b) No ( )

15. How do you rate the campaign in addressing child delivery at home?

(a) Highly effective ( ) (b) Effective ( ) (c) Neutral ( )

(d) Ineffective ( ) (e) Less effective ( )