

**FACILITATION OF BEHAVIOUR CHANGE COMMUNICATION PROCESS FOR
MATERNAL, NEWBORN, AND CHILD HEALTH AT PRIMARY HEALTH CARE
LEVEL OF MIDWIFERY PRACTICE IN KADUNA STATE, NIGERIA**

BY

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DEGREE OF DOCTOR OF PHILOSOPHY (NURSING)**

SUPERVISOR: PROFESSOR BUSISIWE ROSEMARY BHENGU

MARCH, 2012

DEDICATION

This work is dedicated to the glory of the Almighty God, in whom I live and move and have my being; my Ebenezer; the God of all flesh with whom nothing is impossible; the Glory and the Lifter up of my head; my Hiding place.

DECLARATION

I, **Bridget Omowumi Akin-Otiko** hereby declare that the research reported in this dissertation titled *Facilitation of Behaviour Change Communication Process for Maternal, Newborn, and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State*, is my original work.

The dissertation is submitted for the award of PhD Nursing by the University of KwaZulu-Natal, Durban, South Africa, and has never been submitted for any degree or examination at any other university or institution.

Every work used or cited in this dissertation has been duly acknowledged in the text and the references.

Signature



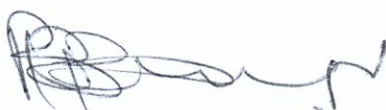
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Supervisor

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ABSTRACT

Background: Nigeria's unacceptably high maternal and child mortality rates are related, among other things, to the people's lack of access to appropriate information to assist them in making decisions about their health, and to promote their utilization of available services. Midwives' skills for result-oriented client education and friendly services are fundamental to women's behaviour change for favourable maternal and child outcomes.

Aim: The purpose of the study was to appraise and facilitate behaviour change communication (BCC) by midwives at primary health care level of maternal, newborn, and child care.

Methods: Action research, with concurrent transformative mixed method data collection strategy, was adopted for the study, and the maximum variation sampling technique was employed to recruit participants. Fifteen, representing sixty-eight percent of the twenty-two recruited midwives continued through the three phases of the study. The diagnostic, intervention, and monitoring phases of the study were arranged in line with the objectives of the study, and each succeeding phase built on the findings of the previous one. At the diagnostic phase, the strengths and weaknesses in behaviour change communication by midwives in the facilities, and the appropriate solution to bridge the gaps were identified at a three-day search conference. At the intervention phase, a training manual was developed. A capacity building programme, made up of a training component for the midwives, and an interactive session between the government and the midwives, was designed and implemented at a three-day workshop. The monitoring phase comprised the midwives' hands-on practice, using the developed training manual, core messages, and interpersonal communication (IPC) observation checklist for three months. The implementation of the

midwives' action plans in their respective work places was also monitored. Both qualitative and quantitative data collection and analysis methods were utilized at each phase of the study.

Results: The diagnostic phase revealed that midwives lacked the essential knowledge, skills and attitudes for effective behaviour change communication activities in the facilities. Health talks were seen as midwives' responsibility, however, they were unplanned, difficult, and given routinely, providing inadequate information, and without focus on behaviour change. Socio-cultural and environmental factors such as inadequate staff, material and time were barriers. The midwives' knowledge, attitudes, and skills responded positively and significantly to the training, to hands-on practice, and to the use of reminders at their workplaces. In addition, midwives were able to network for support from the community and other workers in the facilities, to implement their action plans. Through exhibition of innovative behaviour in the implementation of their action plans, the midwives in most of the facilities were able to effect changes to facilitate utilization of maternal and child health (MCH) services. The gross shortage of staff, staff transfers, lack of drugs and supplies, heavy workload, and midwives' lack of trust in their employers, however, hindered optimum implementation of some of the plans.

Conclusion: The women living in the communities where the midwives worked, desired to know more about the role of midwives and to have competent ones; while the midwives were willing to assist their clients to adopt desired health and health-seeking behaviours, because they were duly recognized and empowered during the project. The study showed that the grave disconnection between the midwives and the government policies / programmes to facilitate behaviour change, and promote maternal and child health, can be corrected. The findings and recommendations have implications for practice, education, research and policymaking in Kaduna State and similar settings.

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LIST OF ABBREVIATIONS

- ANC - Antenatal Care
- BC - Behaviour Change
- BCC - Behaviour Change Communication
- BOEC - Basic Obstetric Emergency Obstetric Care
- CBO - Community Based Organization
- CHEW - Community Health Extension Worker
- CHO - Community Health Officer
- COEC - Comprehensive Emergency Obstetric Care
- CRR & WARDC - Center for Reproductive Rights/Women Advocates Research and Documentation Centre
- CSO - Civil Society Organization
- DHS - Demographic Health Survey
- DNS - Director of Nursing Services
- DPHC - Director of Primary Health Care
- DRH - Division of Family and Reproductive Health (WHO)
- EmOC - Emergency Obstetric Care
- EmONC - Emergency Obstetric and Neonatal Care
- EPH - Encyclopedia of Public Health
- FGD - Focus Group Discussion
- FGN - Federal Government of Nigeria
- FIGO - International Federation of Gynaecology and Obstetrics
- FMCH - Free Maternal and Child Health drugs
- FMI&C - Federal Ministry of Information and Communication
- F.M.O.H - Federal Ministry of Health
- FP - Family Planning

- HIV/AIDS - Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
- ICM - International Confederation of Midwives
- IDI - In-Depth Interview
- IEC - Information, Education, and Communication
- IMNCH - Integrated Maternal, Newborn, and Child Health
- IMR - Infant Mortality Ratio
- IPC - Interpersonal Communication
- IPCC - Interpersonal Communication and Counselling
- ITN - Insecticide Treated Net
- JCHEW - Junior Community Health Extension Worker
- JHU - Johns Hopkins University
- HCP - Health Communication Partners
- LG - Local Government
- LGA - Local Government Area
- LSS - Life Saving Skills
- MCH - Maternal and Child Health
- MDG - Millennium Development Goal
- MF - Key Informant Midwife in Facility
- MLG - Ministry for Local Government
- MMR - Maternal Mortality Ratio
- MNC - Maternal, Newborn and Child
- MNCH - Maternal, Newborn and Child Health
- MOH - Ministry of Health
- MSS - Midwife Service Scheme
- NGO - Non-Governmental Organization

- N&MCN - Nursing and Midwifery Council of Nigeria
- NPC & ICF - National Population Commission, Nigeria and ICF Macro Calverton, Maryland, USA.
- PHC - Primary Health Care
- NPHCDA - National Primary Health Care Development Agency
- PMTCT - Prevention of Mother To Child Transmission of HIV
- RH - Reproductive Health
- SCHEW - Senior Community Health Extension Worker
- SDSS - Sustainable Drug Supply Scheme
- SMS - Short Message Services
- TBA - Traditional Birth Attendant
- U-5MR - Under-5 Mortality Ratio
- UNFPA - United Nations Population Fund
- UNICEF - United Nations Children's Fund
- WF - Women in Focused Group Discussion
- WHO - World Health Organization

CHAPTER ONE INTRODUCTION

1.1 Background to the Problem

More than halfway to the 2015 target set by the United Nations for the achievement of the Millennium Development Goals (MDGs), a review of the world situation in 2008 showed that the targets for the MDGs 4 ‘Reduce child mortality’ and 5 ‘Improve maternal health’ were far from being achieved (UNICEF, 2008:1; United Nations, 2008:20,24; WHO, 2008b:3). The maternal, newborn and child death rates were still very high in sub-Saharan Africa, with many countries in the region recording higher rates than before (UNICEF, 2008:1; United Nations, 2008:20,24; WHO, 2008b:3). Some factors responsible for this ugly trend include: lack of political will, lack of access to skilled provider and quality care, unaffordable cost of available services, lack of quality essential obstetric care, and lack of essential information to inform life-saving decisions (Maine, 2007:1380-1382).

Among the World Health Organization’s (WHO) 191 member states, Nigeria’s overall health system performance was ranked 187th in 2000 (F.M.O.H, 2004b:4). The country has one of the highest maternal mortality rates in the world (F.M.O.H, 2005b:iii) with an estimated maternal mortality ratio of 545 maternal deaths per 100,000 live births (NPC & ICF Macro, 2009:238). Nigeria’s demographic health survey (DHS) of 2008 puts the neonatal mortality at 46/1,000 live births; infant mortality at 87/1,000 live births; and child mortality at 92/1,000 children aged 12-59 months (NPC & ICF Macro, 2009:121). According to the DHS (NPC & ICF Macro, 2009:121), the North West zone of the country where Kaduna State is, has neonatal, infant, and child mortality rates of 47/1,000; 91/1,000; and 139/1,000 respectively. The maternal mortality ratio (MMR) for Kaduna State was 1000 deaths per 100,000 live births in 2003 (Kaduna State Government, 2008b:2), which is more than the country’s value.

Direct causes of maternal deaths in Nigeria are haemorrhage (23%), infection (17%), unsafe abortion (11%), obstructed labour (11%), toxæmia / eclampsia / hypertension (11%), malaria (11%), anaemia (11%), and others including Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS), contribute about 5% (F.M.O.H., 2007:15). For neonatal deaths, 37.3% are caused by severe infections such as neonatal tetanus, diarrhoeal diseases, and pneumonia, while 23.4% are due to preterm birth, and birth asphyxia accounts for 25.6% (F.M.O.H., 2007:16). In 2004, malaria was responsible for 24% of the under-5 deaths, pneumonia 20%, diarrhoea 16%, measles 6%, and HIV/AIDS 5% (F.M.O.H., 2007:16). It is painful to note that all these causes of deaths of mothers and children in Nigeria are preventable and manageable with early detection in an efficient health system.

The underlying factors which predispose women and children to these deaths are social, political, religious, cultural, economic, and the lack of correct and sufficient information to encourage required change in behaviour and practices to promote good health (F.M.O.H, PATHS, DFID, & WHO, 2005:1). The Federal Ministry of Health - F.M.O.H (2004a:5), informed that levels of consumers' awareness of their right to quality health care and of their responsibility for health behaviours, are low. According to a safe motherhood needs assessment in Nigeria, cost, distance, inaccessibility, poor interpersonal communication of health care providers, preferential use of unskilled providers, and the lack of decision-making power of the woman within the family, militate against the utilization of health services (F.M.O.H & WHO, 1999:1) thus contributing to the high death rates. In South Africa, one of the leading sub-Saharan countries with allegedly adequate emergency obstetric care, free health care services and triennial confidential enquiries into maternal and child health, the increasing maternal mortality rate is still a great concern (Tlebere et al., 2007:347; Tshabala-Msimang, 2006:2). This continual occurrence of maternal and child deaths even where

reasonable care is provided, suggests that the underlying causes of these deaths must also be attended to, if efforts at the direct causes are to make meaningful impacts (Campbell & Graham, 2006; United Nations, 2008; WHO, 1994:13; 2008b).

A positive change in health behaviour is fundamental to the improved health status of any population, including women and children (F.M.O.H, 2005c:1). Adeniyi (1996) referring Guy Stuart's statements informed that "All behaviours are health related" and that "There can be no ultimate control of any disease or health problem whose aetiology is well defined without addressing the associated behavioural patterns involved". All stakeholders in maternal, newborn, and child health (MNCH) services require some form of behaviour change or the other (Middlestadt et al., 2003:1). Behaviour change strategies are essential components of a complete package for maternal, newborn and child health. According to the World Bank (2006) health promotion and communication strategies have made significant impact on maternal newborn and child health at provider and consumer levels. To reduce maternal, newborn and child mortality rates successfully in Nigeria, related behavioural patterns among the providers of care, the women, the men and the entire community must be reviewed.

Maternal, newborn and child morbidity and mortality issues are of great concern to the Nigerian government and are being given priority attention (F.M.O.H, 2005c:1). A national survey of household practices on safe motherhood in Nigeria was conducted in 2005. It was to provide a blueprint for developing MNCH related Information Education Communication / Behaviour Change Communication (IEC/BCC) messages for promoting maternal, newborn and child health, and to ensure that interventions are evidence-based among other reasons (F.M.O.H, 2005c:1-2). Utilizing the findings of the household survey and other related

studies, a behaviour change communication (BCC) strategy for the national reproductive health policy and framework in Nigeria was developed in 2005. The framework was aimed at three levels of intervention (socio-political, health system, and the community / individual) covering the three priority areas of reproductive health in Nigeria (safe motherhood, family planning, and adolescent reproductive health), see Figure 2:1 on page 32 in chapter two. Nigeria's BCC strategy was to promote positive practices and discourage negative ones, as well as help to achieve the vision of absolute intolerance of maternal mortality in the entire country (F.M.O.H, 2005c:i). In line with the Delhi declaration (WHO/AFRO, 2005a), and Nigeria's consequent adoption of the integration of maternal, newborn and child health (IMNCH) to provide a continuum of care for mothers, neonates and children (F.M.O.H., 2007:4; WHO/AFRO, 2005a), the safe motherhood component of the BCC framework was revised to include newborn and child related issues (F.M.O.H, 2009).

Behaviour change communication is a process whereby individuals, families and communities are provided with relevant information and assisted to gain sufficient understanding of issues pertaining to their health, to be able to assume responsibility for, and take, meaningful and deliberate actions to promote their wellbeing, and maintain healthy lifestyles. BCC is a component of health promotion which focuses on the underlying determinants of health (WHO/AFRO, 2005b:1). Health promotion became a matter of interest in the 1980s, in realization of the role of positive changes in lifestyles, and improved physical, psychosocial, cultural, and economic environments for the wellbeing of individuals, families and communities (WHO/AFRO, 2005b:1). Health promotion is known to reduce morbidity and mortality rates in developed and developing countries (WHO/AFRO, 2005b:1).

A widely accepted evidence-based global strategy for the reduction of maternal mortality is the presence of skilled attendant(s) at every delivery (United Nations, 2008:25; WHO, 2002:1; 2006c:1; WHO, ICM, & FIGO, 2004:1). Skilled attendants are essential because they can recognize danger signs, prevent and manage obstetric complications or refer for further expert care, as well as provide appropriate information to assist women with their decisions and health behaviours before and after delivery (WHO et al., 2004:3,4). Doctors, nurses and midwives are World Health Organization (WHO) / International Federation of Gynaecology and Obstetrics (FIGO)/ International Confederation of Midwives' (ICM) approved skilled attendants for maternal health (WHO et al., 2004:1). Professional midwives in Nigeria are those who have successfully completed a recognized training programme in midwifery, either as a direct three year or post-basic eighteen-month training, or as part of a degree nursing programme; and have been registered by the Nursing and Midwifery Council of Nigeria (N&MCN) to care for women throughout their lifecycle including the care of their children. Training of nurses in Nigeria also includes some exposure to the theory and practice of maternity care, but nurses are not registered in Nigeria as midwives, though by virtue of their training they are also considered as skilled attendants by WHO, FIGO and ICM (WHO, 2008c:1-2).

Midwives serve at the primary, secondary and tertiary levels of the health system in Nigeria. Availability of health facilities and skilled personnel are not, however, all that makes for safe motherhood. Campbell and Graham (2006:1292) emphasized that staff in the facilities must possess the necessary interpersonal skills to assist women. Similarly, WHO (2005:71) stated that first-level maternal and newborn care requires among other things, building a personal relationship between the pregnant woman and the professional. The need to develop the providers' capacity for result-oriented interactions has been repeatedly emphasized by

researchers (Ariba, Thanni, & Adebayo, 2007:296; Labhardt, Schiess, Manga, & Langewitz, 2009:200).

Interaction between midwives and their clients is critical for successful BCC interventions aimed at encouraging change in behaviours and promoting maternal, newborn and child health. Although women may have many sources of health information, Devine, Harrison, and Buettner (2008:108) observed that they rely on midwives and nurses for correct and up-to-date information. Nurses and midwives in Nigeria have been described as the key health care providers for efficient maternal and child care, particularly at the grassroots level (F.M.O.H, PATHS, et al., 2005:v). Women need midwives who can relate to and assist them in making informed choices (WHO, 2008b:48). Change in behaviour and attitude of health workers through training in interpersonal communication and counselling (IPCC) has been documented to be absolutely critical to successful BCC (Seidel, 2005:4; WHO, 2001:6).

Studies have demonstrated that effective training strategies assisted professionals to develop their counselling skills with potentials for behaviour change in the population (Mesquita et al., 2010:147). A systematic review of interventions to alter relationship between clients and practitioners revealed that such interventions changed the process of interactions significantly in the intervention group in 74% of trials (26 of 35); and the positive effects on health outcomes were significant in 44% of trials – 11 of 25 (Griffin et al., 2004:595). An educational intervention to build the capacity of nurses and midwives to discourage mothers from exposing themselves and their infants to sunlight for therapeutic reasons in Australia, improved the professionals' knowledge, ability to furnish mothers with essential information, and to produce relevant educational materials (Devine et al., 2008:107). Similarly, with enhanced provider-client interaction, Subramanian, Cisek, Kanlisi, and Pile, (2010:6)

recorded improved knowledge and acceptance of no-scalpel vasectomy (NSV) by both clients and providers, even in areas where culture was a major threat to acceptance.

Quality maternal health services, according to WHO, involve:

Accessibility, availability and acceptability of services; technical competence of health care providers; essential supplies and equipment; quality of client-provider interaction; information and counselling for the client; involvement of clients in decision-making; comprehensiveness of care and linkages to other reproductive health services; continuity of care and follow-up; and support to health care providers. (APHRC, 2006:x)

Most of the activities of the government and the development partners (non-governmental organizations – NGOs) are focused primarily on developing the professional midwives' technical competence such as life saving skills (LSS) and integrated management of childhood illnesses (IMCI). The focus of this study is towards the BCC related components of quality maternal, newborn and child health services in Kaduna State: that is, client-provider interaction; information and counselling for the client; involvement of clients in decision-making; and support to health care providers (APHRC, 2006:x).

1.2 Motivation for the Study

At almost every gathering of professional nurses and midwives in Nigeria, the concern for the attitude of professionals to clients, and its implication for the image of the profession and service utilization is featured. During the 2007 stakeholders' forum to improve midwifery education and practice for reduction of maternal mortality and morbidity, [jointly organized by the World Health Organization (WHO), the Federal Ministry of Health (F.M.O.H) and the Nursing and Midwifery Council of Nigeria (N&MCN)], it was reiterated that the attitudes of midwives to the public should be positive, to encourage utilization of facilities by clients. One of the resolutions was that workshops on interpersonal relationship in nursing should be organized frequently (N&MCN, 2007:2). The researcher then wondered what sort of

workshops could be organized and where their focus should lie since interpersonal relationship is incorporated into all levels of nursing and midwifery education in the country (N&MCN, 2004), and it constitutes the heart of quality midwifery practice (Thompson, 2004:179). She then thought of working around *behaviour change communication*. She found out that within the health system where the midwife works in Nigeria, training health workers to enhance their skills in interpersonal communication and counselling (IPCC) and how to provide friendly services that promote utilization, had already been identified as part of the behaviour change communication (BCC) framework for reproductive health in the country (F.M.O.H, WHO., et al., 2005).

... it is crucial that skilled health care providers are continually employed, trained, retrained and supervised to provide comprehensive and factual information and quality RH (sic) services that are user-friendly to their clients, families and communities. With adequate skills, and operating within an enabling work environment, providers are more motivated to address the needs of their clients and communities, especially in the rural and hard to reach areas. (F.M.O.H, WHO., et al., 2005:5)

The idea of appraising and facilitating the midwife's performance of her behaviour change communication roles within the overall framework for reducing maternal morbidity and mortality in Nigeria was thus conceived by the researcher. This was with the assumption that BCC involves much interpersonal relationship and partnership (The LINKAGES Project, 2004:v), and if the midwife does this well, the issue of interpersonal relationship would have been addressed to some extent. This idea was shared with professional colleagues who affirmed that it was necessary and that not much work had been done to enhance the capacity of midwives with regard to the BCC framework for reproductive health (RH) developed in 2005. One of the nurses suggested the use of the revised BCC framework (F.M.O.H, 2009) which integrated maternal, newborn and child care, in line with the new global trend of continuum of care, rather than the old framework which excluded the newborn and child. Since the researcher works in Kaduna, though not with Kaduna State government, the issue

was discussed with nurse leaders in Kaduna State who shared the idea of facilitating behaviour change communication roles of midwives in the state. It was agreed that midwives at the grassroots should be the focus. The nurse leaders suggested that the work should cover public primary health care facilities, and the rural hospitals which also provide primary level maternity services.

1.3 Statement of the Problem

According to the Kaduna State Government (2008b:2), people who require preventive interventions (information, insecticide treated nets (ITNs), and so forth), to promote health and prevent deaths, have no access to them. Many women go through pregnancy with limited knowledge and give birth to babies without knowing where to get help or how to handle related problems such as danger signs in pregnancy, labour and puerperium; breastfeeding problems and care of the cord; family planning and so forth (Couillet et al., 2007:692; Ibidapo, 2005:214; Kumbani & Mc Inerney, 2002:43). Some women do not seek help early because they see the problems as not severe (F.M.O.H, 2005c:34). When complications arise, they go from traditional healer to spiritualists or quacks before finally coming to any health facility. Improper or delayed care predisposes women and their babies to morbidity and mortality (Abdulraheem & Parakoyi, 2009; Ibidapo, 2005:214).

Professionals in the rural areas and at the primary health care level often complain of being isolated, forgotten, and denied opportunity for continuing education programmes (Koblinsky et al., 2006:1383; UNFPA, 2006b:23; UNICEF, 2008:76). The government is also aware of skilled personnel issues at the primary health care level in the state, such as shortage of health workers, refusal of rural postings, poor housing, isolation, brain drain, and so forth (Kaduna State Government, 2008b:2).

Currently, there is a high level of political commitment in Kaduna State. The government, in collaboration with development partners is working towards improving maternal, newborn and child health. To promote utilization of health facilities and ultimately reduce maternal and child morbidity and mortality rates in the state, the government introduced the free fee policy for pregnant women and young children in year 2007 (THISDAY, 2010). This supportive political climate is a challenge to nurses and midwives in the state to explore every opportunity for increased professional empowerment and improved quality of client care. This includes improving their BCC practices for health promotion and prevention of maternal, newborn and child morbidity and mortality (F.M.O.H, WHO., et al., 2005:65; Kaduna State Government, 2008b:2).

Health promotion is one of the items in the client's obstetric and perinatal records booklet introduced recently, for use by health care providers in Kaduna State. It seems to assume that every health worker using the booklet knows what to counsel the client about as it reads "Health promotion: Counsel pregnant woman about:" (Kaduna State Government, 2009:2). It does not state the details of what to counsel about and how to do it. It is usually assumed that professionals know what and how to communicate with their clients. Yet, over the years, several studies across developed and developing regions of the world have shown that health workers lack required fundamental IPCC skills to communicate appropriate and correct messages, that could facilitate behaviour change by consumers (Boyd & Shaw, 1995:5; Casey, 2007:580; de Negri, Brown, Hernández, Rosenbaum, & Roter, 2005:7; Hoving, Visser, Mullen, & van den Borne, 2010:275; Roberts et al., 1995:Q23-12; Rowan, 2008:404; Senarath, Fernando, & Rodrigo, 2006:1449; Waisbord & Larson, 2005:13; WHO, 2008a:2). In view of the critical role of midwives in maternal, newborn and child health, there is the need to empower midwives to be able to adapt their practice to the need of their clients,

providing appropriate information and resources to enable the people take responsibility for their health and utilize available health facilities (WHO, 2008a:1). Many midwives have not participated in any formal training on the use of the perinatal record booklet since they were introduced in 2007, hence the need to assess the strengths and weaknesses of the midwives, with respect to behaviour change communication at their respective workplaces.

The issue of health promotion with particular reference to behaviour change is in Kaduna State Government's health policy thrust for 2008-2011, and the state intends to collaborate with other sectors to achieve the set goals (Kaduna State Government, 2008b:13). The state's health policy road map / milestones indicates that Knowledge, Attitude and Practices (KAP) of clients and communities on priority health issues are expected to have been increased by 60% in 2011 - that is, 20% (2008), 40% (2009), 50% (2010) and 60% (2011) - (Kaduna State Government, 2008b:13). Midwives are expected to be actively involved in behaviour change communication for maternal, newborn and child health, especially at the health system level where they operate (F.M.O.H., 2007:42). There is however, currently no exclusive behaviour change communication capacity building programme specifically for midwives in the state.

The need to organize frequent workshops on interpersonal relationship for nurses and midwives to promote friendly service and enhance utilization of facilities was also expressed at a one-day stakeholders' meeting on improving the quality of midwifery education and practice in Nigeria. The meeting was jointly organized by the World Health Organization, the Federal Ministry of Health and the Nursing and Midwifery Council of Nigeria (N&MCN, 2007:2). There is clearly a need to discover an effective way of teaching interpersonal relationship and professional ethics pre- and post- professional qualification in Nigeria.

In view of the fact that interventions for maternal, newborn and child health need to be context-specific, considering the peculiarities of the community (DIGEST, 2006; Ujah et al., 2005:27), the focus of this study, is to examine the ability of the midwives to promote friendly services and influence behaviour change in their clients for maternal, newborn and child wellbeing in Kaduna State, and to utilize appropriate capacity building approaches and support services to empower the midwives for behaviour change communication in their respective units.

1.4 Delimitation / Scope of the Study

At the health system level of the behaviour change communication framework for maternal, newborn and child health in Nigeria, the audience segmentation is into: *Primary Audience* - administrators, programme managers, heads of departments (HODs); *Secondary Audience* - health care providers (skilled attendants); and *Influencers* - traditional birth attendants (TBAs) and other community health workers (see Figure 2:1 on page 32 in chapter two). The strategic approach at the health system level in Nigeria is both *service oriented* and *interpersonal communication focused* (F.M.O.H, WHO., et al., 2005:64,65). This approach aims to empower providers to make available to clients, required information and support, for the latter to effect appropriate lifestyle changes to promote their health and enhance their utilization of services (F.M.O.H, WHO., et al., 2005:i). Amin, Das, and Goldstein (2008:13,28,29), however, noted that the estimation of impact takes a long time, and utilization of services is not exclusively in the power of the practitioners. They therefore made the point that the proper index of measurement of a facility's output is its capacity to provide services (Amin et al., 2008:13).

Considering the limited time and funds available to the researcher, the scope of this study was limited to the *process* of behaviour change communication for maternal, newborn and child care which can be purposefully manipulated by the midwife within the health facility, concentrating on the core messages, interpersonal communication and counselling skills of the midwives, and their attitudes. It was limited to provider and client behaviour concerns which are within the professional responsibilities of the midwife in the facility where she works. Furthermore, in line with the Delhi declaration on integrated maternal, newborn, and child health, which recognizes that the health of mother and child is inseparable (WHO/AFRO, 2005a), and the fact that client education in midwifery practice, especially in pregnancy is not limited to the woman, the study covered maternal, newborn, and child health. Similarly, with the global recognition of the professional midwife as the ideal skilled attendant for first-level maternal and newborn care (WHO, 2005:70) the study was limited to professional midwives.

1.5 Purpose of the Research

The main purpose of the study was to appraise and facilitate behaviour change communication process for maternal, newborn and child health in collaboration with midwives at the primary health care level in Kaduna State, Nigeria.

1.6 Research Objectives

1. To assess the strengths and weaknesses of midwives in relation to behaviour change communication process at the primary health care level in Kaduna State.
2. To work in partnership with midwives to identify appropriate strategies / mechanisms for promoting behaviour change communication process at the primary health care level in Kaduna State.

3. To support midwives in developing the capacity for behaviour change communication at their respective workplaces in line with the appropriate strategies / mechanisms identified.
4. To support midwives in developing plans of action to facilitate the behaviour change communication process for maternal, newborn and child health at their respective workplaces.
5. To establish a support network with the midwives to facilitate behaviour change communication process for maternal, newborn and child health at the primary health care level in Kaduna State
6. To monitor the implementation of the midwives' developed action plans for behaviour change communication.

1.7 Research Questions

1. What are the strengths and weaknesses of midwives in relation to behaviour change communication process, at the primary health care level in Kaduna State?
2. What strategies / mechanisms can be used by midwives to promote behaviour change communication at the primary health care level in Kaduna State?
3. How can midwives be supported to develop their capacity for behaviour change communication in line with the identified strategies and mechanisms, to facilitate behaviour change communication for maternal, newborn and child health in Kaduna State?
4. What plans of action do the midwives need to facilitate the process of behaviour change communication at their respective workplaces?
5. How can the midwives' implementation of their plans be supported?
6. How are the midwives implementing their plans at their work places?

1.8 Conceptual and Operational Definition of Terms

The conceptual and operational definitions provided here were derived from literature and applied to the study as explained.

1.8.1 Behaviour Change Communication:

Behaviour change communication (also referred to as programme communication in UNICEF) attempts to bridge the gap between information, a person's knowledge, attitudes and subsequent behaviour ... addresses the knowledge, attitudes, practices and skills of individuals, families and communities as they relate to specific programme goals. Within a participatory communication framework, individuals and communities gain knowledge, appreciations and skills that motivate them to develop positive, healthy and protective practices (UNICEF, 2006:40).

In this study, behaviour change communication involves midwives' utilizing appropriate interpersonal communication and counselling (IPCC) skills within a supportive environment to enhance the knowledge, attitudes, practices and skills of their clients for maternal, newborn and child health and improved utilization of available services within the facilities.

1.8.2 Facilitation of behaviour change communication process therefore refers to the activities undertaken by the researcher in collaboration with midwives to make the behaviour change communication process easier and more achievable by the midwives, in line with their developed action plans and agreed criteria for midwife-client interaction.

1.8.3 Capacity Building: According to the United Nations Population Fund (UNFPA) and ICM (2006:2), "In addition to training, capacity building requires attention to structure, systems, roles, staff and facilities, skills and tools." In this study, capacity building refers to attending to what the participating midwives identify as essential for the effective execution of their behaviour change communication activities within their respective workplaces.

1.8.4 Collaboration or partnership: This refers to the type of cooperation between the researcher and participants whereby the participants work with the researcher to decide on what they prefer while the researcher has and retains sole responsibility for the research and directs its course (Herr & Anderson, 2005:40). According to Polit and Beck (2008:55,238), participants cooperate with the researcher and are actively involved in studies such as this which have significant qualitative components, without necessarily being co-investigators. Hence, the midwives, (the participants in this study) were active participants, provided opportunities to determine their priorities in line with the principles of adult learning (Freire, 1973:5), and to have a voice in the change process as required by the research design (Creswell, 2009:215), while the researcher was responsible for and directed the entire process of the research.

1.8.5 Maternal Health refers to the physical, mental, social and spiritual wellbeing of a woman throughout pregnancy, labour and puerperium.

1.8.6 Newborn Health refers to the total health of a new born baby up to the first month after delivery or postnatal visit, and includes the baby's physical and developmental wellbeing.

1.8.7 Child Health here refers to the total health of a child from the first month of birth or the first postnatal visit to five years, and includes the nutritional, physical, mental and social wellbeing of the child.

1.8.8 Midwives (including nurse-midwives):

Persons who, having been regularly admitted to an educational programme duly recognized in the country in which it is located, have successfully completed the prescribed course of studies in midwifery and acquired the requisite qualifications to

be registered and / or legally licensed to practise midwifery. (Fraser, Cooper, & Nolte, 2006:5; WHO et al., 2004:7)

In Nigeria, professional midwives are those who have successfully completed a recognized training programme in midwifery and have been registered as midwives by the Nursing and Midwifery Council of Nigeria. In this study, where *skilled attendant* is used the phrase includes midwives, however, where *provider* is used in cited materials, it refers to health professionals.

1.8.9 Primary Health Care Level of Midwifery Practice: WHO (2005:71) describes *first-level maternal and newborn care* as that which is accessible, affordable, professional, provided by midwives preferably, and available to all mothers and newborns in midwife-led facilities and in all hospitals with maternity wards. In this study, *primary health care level of midwifery practice* refers to the first-level of essential midwifery care in pregnancy, labour and puerperium including the care of the child from 0 – 5 years, and prompt /efficient referral where indicated. It includes midwifery practice at primary health care facilities and rural hospitals.

1.8.10 Strengths are the findings or observations that favour or are likely to support and encourage the midwives' practice of behaviour change communication for MNCH in their respective facilities.

1.8.11 Weaknesses are findings or factors which do not favour or are likely to hinder, and discourage midwives' practice of behaviour change communication for MNCH in their facilities. They are the problems or gaps that must be addressed to enhance the process of behaviour change communication in all facilities.

1.9 Significance of the Study

This study could sensitize the midwives in Kaduna State to the need for behaviour change communication and increase their capacity for BCC to promote desired behaviours in their clients. Bilaterally improved behaviours (in the provider and the consumer of health services), could support utilization of health facilities, early detection of problems, and facilitate appropriate and timely intervention to save the lives of mothers, babies and children.

Similarly, as this study focuses on practitioners at the primary level, the morale of the midwives at this level might be boosted. They may have a stronger feeling of group identity, better understanding of their roles, and be better motivated to work at the primary level, thus reducing migration and promoting retention. The midwives could be better equipped to make nursing diagnoses associated with knowledge / skills deficits in an individual, family or community and intervene appropriately. In the same vein, the midwives' interest and skills for research might be enhanced through their active participation in the project.

In addition, the study might assist the researcher who is a nurse-educator to have an update on the training needs of professional nurses and midwives at the primary level, and serve as a guide in the planning, implementation and evaluation of education programmes for professional nurses and midwives in Nigeria. The researcher may be able to try out a way of teaching interpersonal relationship and professional ethics in midwifery. Similarly, the study might provide an opportunity to explore the possibility of a more holistic approach to attracting and retaining skilled attendants at the primary level of maternal and child care in Kaduna State.

The Nursing Division of the Federal Ministry of Health, Nigeria, designs and runs evidence-based continuing education programmes for nurses and midwives in the country but none currently focuses on nurses / midwives at the primary health care level. The researcher's unit is one of the centres for the implementation of such programmes as an adjunct to the unit's primary role of training nurse and midwife educators. The unit and the Kaduna State's Nursing Division collaborate on nursing matters. Kaduna State Government trains midwives. Carrying out this study in collaboration with midwives in Kaduna State would be a direct contribution of the unit's 'federal presence' in Kaduna State that has hosted it for over three decades.

Moreover, literature is replete with the recognition of fewer related studies in developing countries than in the developed world, and thus calls for further studies in the area of provider-client interaction for improved professional performance and better client health outcomes (Freda, 2004:208; Jewkes, Abrahams, & Mvo, 1998:1781; Labhardt et al., 2009:200; Parry, 2008:186). de Negri, Brown, Hernández, Rosenbaum, and Roter (2005:38) noted that researchers were usually afraid, and these writers commented that since results documented after training programmes to assist professionals in developing IPCC skills are impressive, such results should be reassuring and dispel every fear of possible failure or lack of interest by professionals. This study would contribute to the body of knowledge in promoting maternal, newborn and child health through midwife-led behaviour change communication. Similarly, the collaborative nature of the research approach could empower the participating midwives and narrow the gap between research and practice, making utilization of findings feasible.

1.10 Outline of Chapters

This report is made up of five chapters as outlined below:

Chapter One presented the background to the study, how the researcher was motivated to embark on the study, the problem statement, the scope of the work, study objectives, the questions answered by the study, and the significance of the study.

Chapter Two, which is the next chapter, summarizes major findings in literature pertinent to the project under three broad sections as follows: overview of the burden of maternal and child mortality, behaviour change communication, and the theoretical underpinnings including the conceptual framework.

Chapter Three explains the philosophical basis for the approach adopted for the study. It describes the research design and the procedures employed for sample selection, data collection and data analysis. It presents the blueprint of activities at the various phases of the action research and ended with the ethical considerations observed in the course of the work.

Chapter Four: Results of the analysis of data collected during the three phases of the project - the diagnostic phase, the intervention phase and the monitoring phase - are presented in this chapter. They are organized and presented in form of narratives, tables, descriptive summaries, and charts according to the three phases, which were determined based on the objectives of the study.

Chapter Five: This final chapter of the report discusses the major findings of this study at the various stages in relation to previous researches. It presents the researcher's recommendations in the light of the implication of the findings for policymaking, midwifery practice and education as well as for future research. It also explains the limitations of the study.

CHAPTER TWO LITERATURE REVIEW

2.1 Introduction

Literature review was done throughout the period of the project. The search was made to gain a general understanding of the field of the researcher's interest and what had been done earlier in the field. The search provided the theoretical and methodological bases for the study. It continued all through the course of the work till the researcher could not access additional materials. Searches were conducted in the following search engines, using the Boolean method: Academic Search Complete, Cochrane, CINAHL Communication and Mass Media Complete, ERIC, Health Source - Consumer Edition, MEDLINE, PsycINFO, and Scholarly (Peer Reviewed) Journals from 1999-2010. The following search terms were used in various combinations at different times during the search: behaviour change communication, health information, patient-education, prenatal education, midwife-client interaction, interpersonal communication, interpersonal relationship, and friendly service; midwife, skilled attendant, and midwifery; maternal, newborn, and child health; capacity building, training, professional development, and continuing education; and, community, local, rural, and primary health care.

References were also made to Government documents (published and unpublished), books especially by theorists, dictionaries, encyclopaedias and relevant conference reports. Pertinent cited references in accessed articles were also used to expand the database, using the Google Scholar. Major findings from the review of literature are presented in this chapter in three broad sections: overview of the burden of maternal and child mortality, behaviour change communication, and theoretical underpinnings.

2.2. Overview of the Burden of Maternal and Child Mortality

This section presents an overview of maternal, newborn, and child mortality from the global, sub-Saharan Africa, and Nigerian perspectives, some socio-cultural issues in maternal and child health, and initiatives to promote maternal, newborn and child health.

2.2.1 Maternal and Child Mortality

Maternal mortality was expected by the United Nations (2010:30) to reduce at the rate of 5.5% annually to meet the MDG target in 2015, but it remains a big challenge with sub-Saharan Africa and Southern Asia responsible for 86% of the 500,000 maternal deaths recorded globally in 2005 (United Nations, 2008:24). A woman in sub-Saharan Africa has a 1:22 lifetime risk of maternal death compared with her counterpart in the developed regions with a risk ratio of 1:7,300 (United Nations, 2008:24). In Nigeria it is 1:18, worse than the sub-Saharan ratio, and for every pregnancy related death in the country, twenty other women experience grave pregnancy-related health problems (CRR & WARDC, 2008:13). According to Bailey, Paxton, Lobis, and Fry (2006:286), and the WHO (2006c), direct obstetric complications such as haemorrhage, obstructed labour, eclampsia, sepsis and unsafe abortion are responsible for about four-fifths of all maternal deaths.

Bradshaw et al. (2008:3) reported that at least 1,600 mothers die annually due to complications of pregnancy and childbirth in South Africa. Although Nigeria has two percent of the world's population, ten percent of all maternal deaths are recorded in the country, being second only to India (Abdul'Aziz, 2008; CRR & WARDC, 2008:13). The distribution of maternal mortality in Nigeria is significantly related to geopolitical zones, areas of residence, and maternal education. The latest estimate of maternal mortality rate in the country is 545 per 100,000 live births (NPC & ICF Macro, 2009: xxvii), but according to

the Center for Reproductive Rights / Women Advocates Research and Documentation Centre - CRR and WARDC (2008:13), the risk of maternal deaths is higher in the northern part of the country, where it is often more than 1000 per 100,000 live births. In Kaduna State in 2003 it was estimated to be 1000 deaths per 100,000 live births (Kaduna State Government, 2008b).

In sub-Saharan Africa, 1 in 7 children is likely to die before the fifth birthday (United Nations, 2010:27). In the Western African sub-region, the child mortality rate is 169 deaths per 1,000 live births, and 1 in 6 children die before the fifth birthday (United Nations, 2010:27). According to the United Nations Report (2010:27), the main causes of death among children under-5 include neonatal causes (41%); malaria (8%); pneumonia (14%); diarrhoeal diseases (14%); injuries (3%); AIDS (2%); measles (1%); and other causes (16%). According to Bradshaw et al. (2008:3), in South Africa, 20,000 babies are stillborn, another 22,000 die before they reach one month of age, and in total, at least 75,000 children die before their fifth birthday annually. In Nigeria, childhood mortality rates are related to the geopolitical zones and whether or not an area is rural or urban. Nigeria's demographic health survey (DHS) of 2008 puts the neonatal mortality at 46/1,000 live births; infant mortality at 87/1,000 live births; and child mortality at 92/1,000 children aged 12-59 months (NPC & ICF Macro, 2009:121).

2.2.2 Socio-cultural Issues in Maternal and Child Health

The WHO (1994:13), stated that the immediate cause of maternal deaths is the absence, inadequacy, or underutilization of the health care system, and the organization emphasized that, it is important to acknowledge the impact of social and cultural factors on maternal and child health. According to the WHO (2006b:10), cultural beliefs and practices have serious

implications for maternal and child morbidity and mortality, and the WHO observed, that this aspect of MNCH is under-researched. A catalogue of socio-cultural issues that have implications for the health of mothers and babies were presented by the WHO (2006b:10), and included taboos, beliefs and harmful traditional practices related to the care of women in pregnancy and during delivery, the immediate postpartum care of mothers and neonates including the nutrition of both mother and baby, the lack of knowledge of danger signs, and poor care-seeking behaviours. Ngomane and Mulaudzi (2012:8) also documented some socio-cultural beliefs and practices related to maternal and child health, among women in Limpopo, South Africa. They included the fear of bewitchment which made the women hide their pregnancy and delay seeking antenatal care, the use of protective herbs, and dietary restrictions in pregnancy (Ngomane & Mulaudzi, 2012:8).

In the same vein, in Nigeria, the poor socio-economic status of women, some taboos, beliefs, and other harmful practices still threaten maternal and child health (FGN, 2004:41). The national survey on household practices on Safe Motherhood in Nigeria (F.M.O.H, 2005c:xiii-xix) revealed that some pregnant women patronize TBAs, some do not attend ANC clinics because they feel they are healthy, many avoid foods rich in protein such as eggs, liver, and beans and reduce carbohydrate intake for fear of having big babies, though a few still took alcohol. The survey also showed that most women's decisions to seek care when they had complications in pregnancy or labour and for postnatal care was influenced by their spouses or head of the family while some did not seek care because the danger signs were perceived as not severe. The majority of those who sought for help did so from government health facilities, while others sought for care from private health facilities, spiritualists, and TBAs (F.M.O.H, 2005c:xiii-xix). The majority of the women had poor knowledge of the causes of complications and danger signs in pregnancy and labour, and attributed maternal and

neonatal morbidity and mortality to the will of God and witchcraft; some women attributed the causes to mismanagement by TBAs and professionals, obstetric and neonatal complications. Some of the women discarded the colostrum because they felt it was bad, and some did not take the newborn for follow-up care because of poverty, ignorance, and belief that the baby was fine (F.M.O.H, 2005c:xiii-xix).

The recent Nigeria's demographic health survey 2008 (NPC & ICF Macro, 2009:138), showed that out of the 8,022 women aged 15-49, from the North West zone of the country who took part in the survey, 80.3 % gave at least one reason for not accessing appropriate care. Some of the reasons given by the women include getting money to pay for treatment (57.8%), the long distance to health facility (37.7%), having to take transport (37.4%), the lack of drugs in the facility (57%), the absence of a female provider at the health facility (39.4%), getting permission from the spouse to go for treatment (20.4%), and 18.7% said they did not want to go to the health facility alone (NPC & ICF Macro, 2009:138). Ozumba and Nwogu-Ikojo (2008:358) observed that avoidable factors were responsible for 70.2% of maternal deaths in a tertiary hospital in the eastern part of Nigeria, with failure of clients to recognize problems, and delay in seeking and accessing care being some of the patient related avoidable factors. Similarly, according to MacDonagh, (2005:7) 70% of the avoidable newborn deaths could be prevented, through efficient maternal health services in pregnancy, labour, and puerperium.

2.2.3 Initiatives to Promote Maternal, Newborn and Child Health

Issues of maternal interest used to be considered along with child health as in the Alma Ata declaration on primary health care in 1978, until 1985, when an article subtitled 'Where's the M in MCH?' was published (Maine & Rosenfield, 1999:480). The article pointed out the

problems of greater focus on infants' and young children's health, and the neglect of maternal deaths (Maine & Rosenfield, 1999:480). So the Safe Motherhood Initiative (SMI) was begun in Nairobi, Kenya, in 1987, with the main goal of reducing maternal morbidity and mortality (Maine & Rosenfield, 1999:480). For decades, however, there was no significant progress in reducing maternal mortality (Graham, Foster, Davidson, Hauke, & Campbell, 2008:426) using the SMI strategies (WHO, 1994:5). Later, the United Nations millennium declaration of September 2000 was adopted as a framework for the development activities by member countries, in ten regions (United Nations, 2008:4). Although all the eight millennium development goals (MDGs) have implications for maternal and child health, Goal 4 'Reduce Child Mortality' and Goal 5 'Improve Maternal Health' are directly MNCH oriented and Goal 6: 'Combat HIV/AIDS, Malaria and other diseases' also has implications for maternal and child survival, especially in sub-Saharan African countries where these diseases are prevalent (United Nations, 2008:20,25,28).

Furthermore, in realization of the fact that the health of the mother and her child are inseparable (Filippi et al., 2006:1535), the Delhi declaration on maternal, newborn and child health (MNCH) of April 9, 2005 charted a new course of integrated approach for maternal, newborn and child health (DRH, 2005). Originally, the four pillars of safe motherhood were family planning, antenatal care, clean/safe delivery and essential obstetric care (WHO, 1994:5). The 2005 Delhi declaration, however, prescribes an integrated approach to reproductive, maternal, newborn, and child health in a continuum of care spanning across pregnancy through childhood (WHO/AFRO, 2005a). It prescribes that in designing integrated maternal, newborn, and child health (IMNCH) strategies, countries should take cognizance of evidence-based interventions and design country and context-specific MNCH programmes to achieve MDGs 4 and 5 (WHO/AFRO, 2005a). The Delhi declaration also expects equity,

respect for the rights of all, including the disadvantaged, partnership, and high level of commitment to funding and strengthening of the health systems (WHO/AFRO, 2005a).

Strategies aimed at promoting the health and reducing mortality of mothers and children range from preventing pregnancy, through antenatal and intrapartum care, to postnatal and newborn care (Bullough et al., 2005:1183). According to Campbell and Graham (2006:1290), the best strategy for a given context is one that is acceptable, expandable and sustainable. Bullough et al. (2005:1180-1188) presented a review of strategies adopted over the years to reduce maternal mortality since the safe motherhood initiative was launched in 1987. These included: community mobilization, training of traditional birth attendants (TBAs), service quality improvements, family planning, micro-nutrient supplementation, antenatal care, and skilled attendance at delivery, emergency obstetric care, post-abortion care, postnatal care, and making pregnancy safer.

A review of maternal and newborn interventions in sub-Saharan Africa and South East Asia (two WHO regions) by Adam et al. (2005:1), revealed a number of cost effective strategies for maternal and neonatal health in developing countries. These included: a community-based newborn package, efficient antenatal care, skilled attendance at birth, and emergency obstetric and neonatal care (Adam et al., 2005:1). The authors added that the community-based newborn care, and the provision of immediate essential care to mothers and newborn at the first-level were very cost effective (Adam et al., 2005:1). Yet, ten years after the MDGs and five years after the IMNCH approach, the state of maternal and child health, as earlier discussed showed that the achievement of the MDGs in the target year 2015 remains a mirage, especially in sub-Saharan Africa (UNICEF, 2008:1; United Nations, 2008:20,24; WHO, 2008b:3).

In Nigeria, it was recognized that poverty and the lack of access to credible sources of information and services were major obstacles to making progress in the area of reproductive health (F.M.O.H, WHO., et al., 2005:3), hence the incorporation of behaviour change communication into the country's reproductive health policy for accelerating the attainment of the MDGs related to maternal and newborn health in the country (F.M.O.H & WHO, 2005). The behaviour change communication strategy was expected to improve knowledge, create positive attitudes and promote positive health behaviour among the people (F.M.O.H, WHO., et al., 2005:vii). According to UNFPA (2006a:8) people must be empowered to know their rights and to appreciate, utilize and insist on quality MNCH services. Authors have also noted that for strategies to be effective, health workers must be adequately trained (United Nations, 2008:4) and possess the required interpersonal skills (Campbell & Graham, 2006:1292) to promote utilization. The BCC strategy in Nigeria aimed at enhancing the skills of health care workers in the health system on IPCC and how to promote consumers' utilization of health services (F.M.O.H, WHO., et al., 2005:65).

2.3 Behaviour Change Communication

The behaviour change approach is fairly new to the field of maternal and child care (CHANGE, 2005:20; Middlestadt et al., 2003:2), though the underlying principles are familiar (Middlestadt et al., 2003:2). A behaviour change strategy is usually developed to guide the process of behaviour change at individual, family, or community levels (Middlestadt et al., 2003:7). Middlestadt et al. (2003:7) maintained that a behaviour change strategy could include among others: awareness creation by the community, skills development, training of professionals in interpersonal communication and counselling, and structural changes to encourage utilization (Middlestadt et al., 2003:6). Communication is fundamental to behaviour change programmes in the health sector (UNICEF, 2006:39) hence

behaviour change strategies have the communication component known as behaviour change communication (BCC) or programme communication. The Nigerian Government believes that an effective behaviour change communication strategy could increase knowledge, create positive attitudes, improve the practice of positive health behaviours and ultimately contribute to increased utilization of MNCH services and the reduction of maternal morbidity and mortality (F.M.O.H, WHO., et al., 2005:4). Behaviour change communication is thus one of the components of Nigeria's maternal and child health policy and it aims at helping the nation record significant progress in her bid to achieving zero tolerance for the unacceptably high mortality rates.

2.3.1 Definition of Behaviour Change Communication (BCC)

Kalita (2006:14) broadly defined behaviour change communication as:

a process of understanding people's situations and influences, developing messages that respond to the concerns within those situations, and using communication processes and media to persuade people to increase their knowledge and change the behaviours and practices that place them at risk.

Global Health Communication (2010) also defined behaviour change communication as the:

strategic use of communication to promote positive health outcomes, based on proven theories and models of behavior (sic) 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.

2.3.2 Development of a Behaviour Change Communication Strategy

A behaviour communication strategy is a policy statement developed at the national level by the appropriate government agency, and all health education and communication interventions by the other tiers of government, programme planners, and researchers are based on the national standard and adapted for local relevance (Barker, Bird, Pradhan, &

Shakya, 2007:85; WHO, 2008a:5,9,26). United Nations Children's Fund -UNICEF (2006:127) advocates that there is no point reinventing the wheel but communication support by interested individuals and organizations should be linked to, and support, the national maternal and child health strategy, providing whatever was missing. The BCC framework provides a logical, standardized and evidence-based platform for interventions relevant to people's context (F.M.O.H, WHO., et al., 2005:1). In Nigeria, the BCC strategy was developed as part of the key strategies adopted for the implementation of the country's reproductive health (RH) policy (F.M.O.H, WHO., et al., 2005:vii). Nigeria's BCC strategy 2005-2008 (F.M.O.H, WHO., et al., 2005) is currently being revised (F.M.O.H, 2009).

It is essential to conduct a communication need assessment from existing information and formative research, using a combination of data collection techniques and involving every stakeholder. The results of the exercise are analyzed to identify the audience, understand the behaviour of interest, and decide on the other components of the BCC strategy (CHANGE, 2005:5; MotherCare, 2000:4; The LINKAGES Project, 2004; UNICEF, 2006:168; WHO, 2008a:5,9,26). If the need identification is not undertaken, the developed BCC strategy could be irrelevant to the needs of the audience and fail to meet the objectives (Kalita, 2006:15; WHO, 1994:56). Development of the strategy should be participatory, involving behavioural experts and representatives of the audience (MotherCare, 2000:4). To develop the BCC strategy for Nigeria, the health ministry with its health communication partners (HCP), representatives of the Johns Hopkins University (JHU), United States Agency for International Development (USAID), NGOs working in the field of reproductive health, consultants (experts in related fields), and representatives of the six geopolitical zones of the country worked together (F.M.O.H, WHO., et al., 2005:vii). Nigeria's BCC strategy was based on findings from the national survey on HIV/AIDS and reproductive health, and the

national essential obstetric care facilities study among others. A participatory approach was adopted, having technical and financial support from partners, and the document was pre-tested before adoption (F.M.O.H, WHO., et al., 2005:vii).

Audience identification and segmentation is a vital component of a BCC strategy. For MNCH, the audiences that might be considered at various levels include all those in the community who have influence on mothers' behaviour and MNCH. These are, the mothers, their spouses or partners and families or households, elders, religious leaders, key decision-makers in relevant development sectors such as the ministries of health, education, social welfare, information and the media, women's organizations, NGOs, religious organizations and all those working in the health system - community health workers, nurses and midwives, doctors and community health extension workers (CHANGE, 2005:5; MotherCare, 2000:6). The audience segmentation for Nigeria's BCC strategy (F.M.O.H, WHO., et al., 2005:4), is shown in Figure 2:1 on page 32. For effectiveness BCC interventions are usually targeted at a few feasible behaviours based on the analysis and interpretation of the findings of the preliminary formative research (Kalita, 2006; MotherCare, 2000:3,6; Roberts et al., 1995:Q16-4; UNICEF, 2006:168). The original BCC strategy for reproductive health in Nigeria had only three priority areas – family planning / child spacing, safe motherhood, and adolescent reproductive health as shown in Figure 2:1 on page 32. However, with the focus now on MNCH the safe motherhood issues are being reorganized under maternal, newborn, and child health in the one currently under development. The key household practices (KHHP) or issues that have implication for MNCH in Nigeria, and are therefore being addressed in the revised communication plan (F.M.O.H, 2009) are listed in Box 2:1 on page 33.

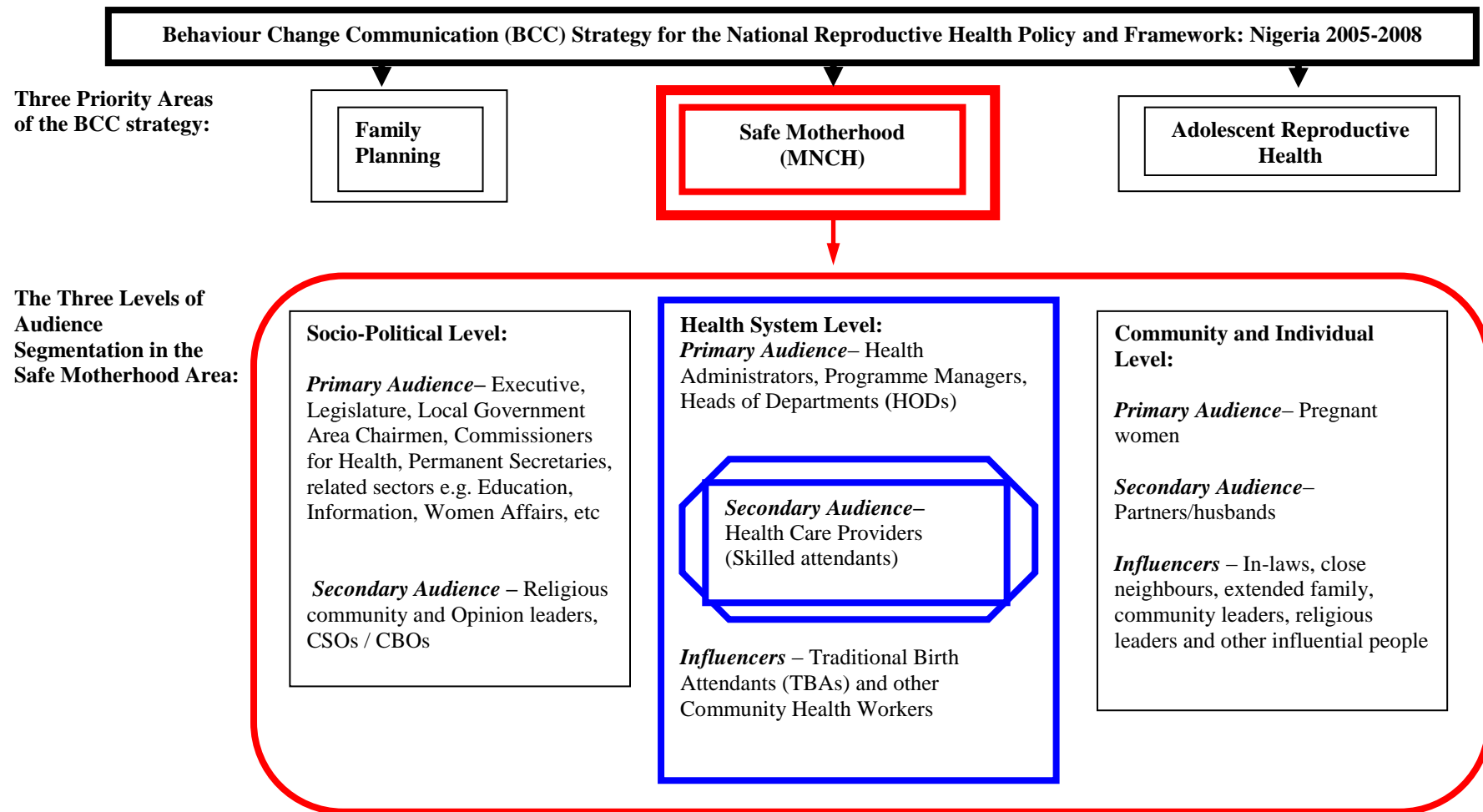


Figure 2:1 Diagrammatic location of the study population within the national BCC strategy (Adapted from FMOH (2005:45-50). *The highlight shows the location of midwives (skilled attendants), who are the focus of the study, within the health system audience segmentation for BCC intervention.*

Box 2:1 Maternal, newborn, and child health (MNCH) key household practices (KHHP) or issues to be addressed by behaviour change communication (BCC).

Maternal:

1. Antenatal attendance
2. Practice of Intermittent Preventive Therapy (IPT) for malaria
3. HIV counselling and testing (HCT)
4. Identification of danger signs in pregnancy
5. Use of insecticide treated nets (ITNs)
6. Tetanus Toxoid Immunization during pregnancy
7. Birth preparedness and complication readiness
8. Delivery by skilled birth attendants
9. Recognizing danger signs in the postnatal period
10. Family planning practice (FP)
11. Male involvement in maternal care
12. Utilization of health services

Newborn

1. Immediate newborn care
2. Clean delivery practices
3. Care of the cord
4. Care of the eye
5. Immunization
6. Breast feeding of the newborn
7. Disease Prevention
8. Care of the low birth weight baby, using Kangaroo Mother Care (KMC)

Child

1. Exclusive Breast Feeding (EBF) for 6 months
2. Energy-rich and nutrient-dense complementary foods for children from 6 months, while continuing breastfeeding up to 24 months
3. Growth Monitoring and Promotion (GMP)
4. Psycho-social and mental development
5. Adequate micro-nutrients through diet and supplementation
6. Take child to complete full course of immunization
7. Home management of infections

(Source: F.M.O.H. (2009). *Programme Communication Plan for Maternal, Newborn and Child Health* (Draft): Federal Ministry of Health, Abuja (Unpublished).

The medium for sharing BCC messages is known as the tool or channel and it is ideally identified in the process of developing the BCC strategy (Kalita, 2006:15). The same channel would not be suitable for all the different audiences, so it is advisable to use the most effective channel for getting to the particular intended audience (Kalita, 2006:15; WHO, 1994:56); and it is preferable to use more than one communication channel, for reinforcement (UNICEF, 2006:41). The possible channels are the mass and small media, interpersonal communication (Kalita, 2006:16; Middlestadt et al., 2003:8; The World Bank, 2007:14; UNICEF, 2006:41; WHO, 1994:56) and participatory community-based media (The World Bank, 2007:14; UNICEF, 2006:41). Each channel has its advantages and disadvantages (Roberts et al., 1995:Q17-3) and a time during the intervention that its use is most appropriate (Kalita, 2006:16; WHO, 1994:56). For instance when an audience has been reached through the mass media and wants answers to some of their queries, or are ready to initiate behaviour change and prefer a more trusted person, interpersonal communication becomes key (Kalita, 2006:16; Maxfield, 2004:17). Similarly, where there is no or limited access to mass media and the level of literacy is very low, interpersonal communication channel is the preferred option (Kalita, 2006:16). The selected channels for the safe motherhood component of Nigeria' BCC strategy are:

Interpersonal Channels: Interpersonal Communication and Counseling (sic) Training, training support materials such as counseling cue cards, job aids (performance improvement tools) for service providers; provider counseling for example development of planning aids for the community and family members on developing a safe birth plan during clinic and community health sessions; advocacy meetings with policy makers and decision makers, development of advocacy packages including video tapes, fact sheets, cassettes, VCDs, CDROMs, (sic) etc for leaders

Community Based Channels: Community events, community durbars, market day events, talks with community groups and religious meetings, folk dramas etc, community mobilization

Mass Media: TV and radio programmes such as radio drama series on roles and responsibilities of family members; communities and service providers for safe births;

magazine programme and radio spots promoting family planning/child spacing, other programmes such as radio debate, TV and radio spots, jingles; production of print materials such as booklet/leaflets, poster for clients, opinion leaders etc. (F.M.O.H, WHO., et al., 2005:44)

At the health provider level, the strategy is to improve interpersonal skills and create helpful job aids (Seidel, 2005:4). Boyd and Shaw (1995:5) noted that the most influential way of communicating is through a trusted individual with a valued opinion, who could be a health worker, or a family member. The authors discovered over the years that the voice of the respected health worker is the most powerful (Boyd & Shaw, 1995:5). The *strategic approach at the health system level in Nigeria* is both service oriented and interpersonal communication focused (F.M.O.H, WHO., et al., 2005:64,65). The *service oriented strategy* includes “improving the image of the service providers for increased client confidence; holding health talks or sessions at the clinics; and creating opportunities for integrated service approach.” (F.M.O.H, WHO., et al., 2005:64) The *interpersonal communication focused* strategy involves “training the health workers to enhance their skills on IPCC and patronage; as well as developing and producing job aids for them.” (F.M.O.H, WHO., et al., 2005:65)

According to Yeshi, Wangdui, and Holcombe (2009:397), the concern of BCC is more than merely creating awareness, it includes achieving observable and sustainable changes in behaviour. Similarly, Seidel (2005:x) expressed the need for communication to focus more on behaviour change than mere marketing of services. It is pertinent to state that a desired change in behaviour may take time and efforts need to be sustained using appropriate and realistic mechanisms (MotherCare, 2000:6). According to the WHO (1994:57), because communication alone is barely sufficient for behaviour change, behaviour change communication is integrated into the services provided for MNCH at the health facility.

2.3.3 Enabling Environment for Behaviour Change Communication

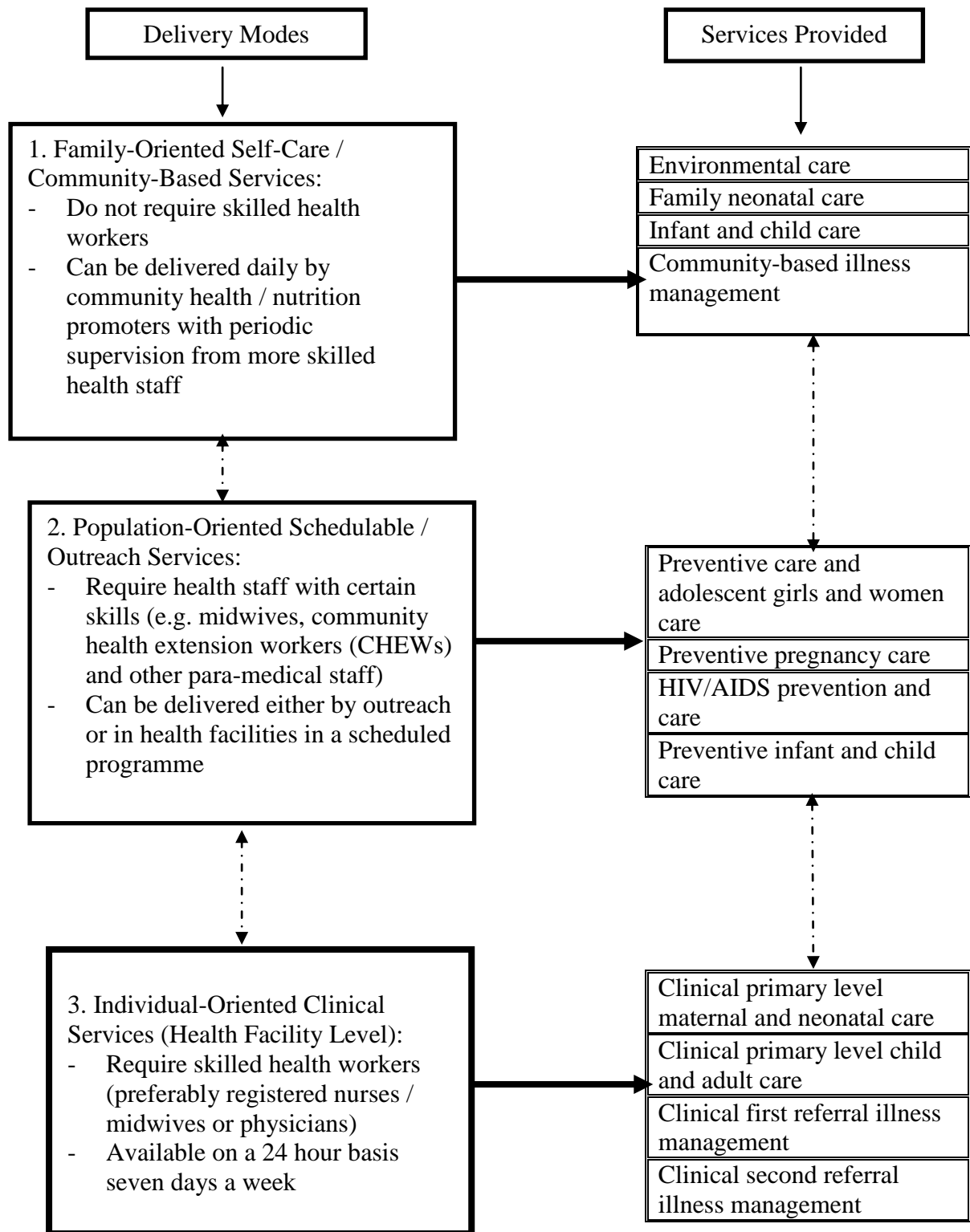
The environment for behaviour change communication in the facilities refers to the human, material, time, and financial resources involved. In line with Michie et al's (2005) *Integrative Framework for Studying the Implementation of Evidence Based Practice*, the conceptual framework adopted for this study, the environmental context and resources for behaviour change communication include: "availability and management of resources, environmental stressors, people-environment interaction, and knowledge of the task environment." (Michie et al., 2005:30-31) The following discussion is about the health care system, the skilled attendant, provider-client interaction, and supportive supervision.

2.3.3.1 The Health Care System

The health system, like any other organization, is made up of human, material and financial resources, guided by policies (Bullough et al., 2005:1181; Mbonye et al., 2007:286). An efficient health care system is crucial for the success of major MNCH interventions including behaviour change communication (Mathai, 2008:468). A functional health system provides among other things, a protective and supportive health policy, clear guidelines on quality care, adequate and efficiently managed human resources with sufficient pay and opportunities for continuing professional development, available drugs and supplies, adequate and well maintained infrastructures and equipment (WHO et al., 2004:14). The goal of Nigeria's health policy is a comprehensive health care system based on primary health care - PHC (F.M.O.H, 2004b:11). The third tier of government (local government) in Nigeria is the closest to the people and provides the PHC services. Some of the ten components of PHC in Nigeria in line with the Alma Ata declaration of 1978 are "education concerning prevailing health problems and the methods of preventing and controlling them" "maternal and child

care including family planning” “immunization against the major infectious diseases” and “provision of essential drugs and supplies” (FMI&C, 2005).

In view of the need to ensure that services are effective, relevant and directed at meeting MNCH care needs in the Nigeria context, evidence-based interventions were selected for the integrated maternal, newborn and child health (IMNCH) strategy in the country (F.M.O.H., 2007:41-42,47-49). These interventions were organized for delivery within three modes – family-oriented self-care / community-based services; population-oriented schedulable / outreach services; and individual-oriented clinical services at the health facility level (F.M.O.H., 2007:41-42,47-49,82) see Figure 2:2 on page 38. The individual-oriented clinical services require skilled health workers (preferably registered nurses / midwives or physicians), and are expected to be available 24 hours daily (F.M.O.H., 2007:41-42,47-49,82). Midwives in Nigeria work at the health facility level as shown in Figure 2:2 on page 38.



***Midwives work at the Health Facility Level

Figure 2:2 Diagrammatic representation of the health service organization / delivery modes for IMNCH in Nigeria (adapted from: Integrated Maternal Newborn and Child Health Strategy (F.M.O.H., 2007:41-42, 47-49,82).

According to UNICEF (2008:53,55), a PHC system that is supportive of MNCH services is adequately funded, provides emergency obstetric and newborn care, and has efficient referral services. Similarly, participants at the first international forum of midwifery in the community concluded that:

All midwives, including those working in the community, must function in an enabling environment, including a supportive legal and policy framework, and have back-up from a supportive fully-functioning EmONC facility; adequate housing; provision for children's education and personal security, and be part of the overall maternity care team. (UNFPA et al., 2006:37)

UNFPA (2006a:8) pointed out that strengthening health systems is all-encompassing covering all the human and material resources, the tasks, and relationships within the organization. A well-functioning health system that meets the WHO et al.'s (2004:14) requirements would support MNCH, promote utilization and timely management of complications, as well as contribute to reduction of morbidity and mortality among women and children (Ruiz-Rodríguez, Wirtzb, & Nigendab, 2009:2). A prototype first-level maternal and child health care facility is women friendly, culturally relevant, affordable, accessible, and professionally adequate (Donnay, 2000:95; WHO, 2005:71).

Rosenfield and Min (2007:202) observed that the health systems in many parts of the world are not functioning, and in most developing countries they are not ideal. According to F.M.O.H (2007:3) about 71% of Nigerians have a PHC facility within a 5 km radius of their homes though many of the PHC centres lack human and material resources; and emergency obstetric care (EOC) is available in fewer than 20% of the health facilities (F.M.O.H., 2007:2). Studies from Malaysia, Sri Lanka and Honduras, revealed improved quality and utilization of MNCH services with significant reduction in maternal mortality, when health systems were strengthened (Maine, 2007). In Nigeria, the National Health Act 2008 (FGN, 2008) has adequate provision for strengthening the health system, and the PHC in particular,

although it is yet to be fully implemented. It has been reported that the lack of the enabling environment required by skilled attendants to function optimally is largely responsible for the professionals' negative attitudes (Asuquo, Etuk, & Duke, 2000:69; CRR & WARDC, 2008:48). According to F.M.O.H, WHO., et al. (2005:5), health care providers are usually committed to educating and assisting their clients when the work environment is supportive.

2.3.3.2 Skilled Attendants

WHO, ICM, and FIGO (2004:2) recognize skilled attendants (midwives, doctors and nurses) as the only category of health professionals qualified or legally charged with full responsibility for all aspects of care of women, their babies and family at every phase of the childbearing and rearing cycle. In spite of the influence of culture, poverty and TBAs on women's utilization of health facilities, studies show that most women who have access to skilled attendants prefer them for their maternity care (Koblinsky et al., 2006:1377; Mbaruku, Msambichaka, Galea, Rockers, & Kruk, 2009:10). It is required of all skilled attendants to have the core midwifery skills in Box 2:2 on page 41 and the additional skills required vary from country to country, and even within a country, taking cognizance of local variations (WHO et al., 2004:3). All midwives in Nigeria are expected to have skills and abilities to perform all the core functions in Box 2:2 on page 41. Every midwife-client interaction could provide an opportunity for client education and support focused on behaviour change. The specific skills underlined in Box 2:2, however, are directly related to client education to promote behaviour change for favourable maternal, newborn and child outcomes.

Box 2: 2 Core Skills and Abilities for Skilled Attendant

All skilled attendants *must* have the core midwifery skills. The additional skills required will vary from country to country, and possibly even within a country, to take account of local differences such as urban and rural settings.

All skilled attendants, at all levels of the health system, must have skills and abilities to perform *all of the core functions* listed below.

1. Communicate effectively cross-culturally in order to be able to provide holistic “women-centred” care. To provide such care skilled attendants will need to cultivate effective interpersonal communication skills and an attitude of respect for the woman’s right to be a full partner in the management of her pregnancy, childbirth and the postnatal period.
2. In pregnancy care, take a detailed history by asking relevant questions, assess individual needs, give appropriate advice and guidance, calculate the expected date of delivery and perform specific screening tests as required, including voluntary counselling and testing for HIV.
3. Assist pregnant women and their families in making a plan for birth (i.e. where the delivery will take place, who will be present and, in case of a complication, how timely referral will be arranged).
4. Educate women (and their families and others supporting pregnant women) in self-care during pregnancy, childbirth and the postnatal period.
5. Identify illnesses and conditions detrimental to health during pregnancy, perform first-line management (including performance of life-saving procedures when needed) and make arrangements for effective referral.
6. Perform vaginal examination, ensuring the woman’s and her/his own safety.
7. Identify the onset of labour.
8. Monitor maternal and fetal well-being during labour and provide supportive care.
9. Record maternal and fetal well-being on a partograph and identify maternal and fetal distress and take appropriate action, including referral where required.
10. Identify delayed progress in labour and take appropriate action, including referral where appropriate.
11. Manage a normal vaginal delivery.
12. Manage the third stage of labour actively.
13. Assess the newborn at birth and give immediate care.
14. Identify any life threatening conditions in the newborn and take essential life-saving measures, including, where necessary, active resuscitation as a component of the management of birth asphyxia, and referral where appropriate.
15. Identify haemorrhage and hypertension in labour, provide first-line management (including lifesaving skills in emergency obstetric care where needed) and, if required, make an effective referral.
16. Provide postnatal care to women and their newborn infants and post-abortion care where necessary.
17. Assist women and their newborns in initiating and establishing exclusive breastfeeding, including educating women and their families and other helpers in maintaining successful breastfeeding.
18. Identify illnesses and conditions detrimental to the health of women and/or their newborns in the postnatal period, apply first-line management (including the performance of life-saving procedures when needed) and, if required, make arrangements for effective referral.
19. Supervise non-skilled attendants, including TBAs where they exist, in order to ensure that the care they provide during pregnancy, childbirth and early postpartum period is of sound quality and ensure continuous training of non-skilled attendants.
20. Provide advice on postpartum family planning and birth spacing.
21. Educate women (and their families) on how to prevent sexually transmitted infections including HIV.
22. Collect and report relevant data and collaborate in data analysis and case audits.
23. Promote an ethos of shared responsibility and partnership with individual women, their family members/supporters and the community for the care of women and newborns throughout pregnancy, childbirth and the postnatal period.
24. Skilled attendants working at the primary care levels in remote areas with limited access to facilities should also be able to do the following:
 - I. Use vacuum extraction or forceps in vaginal deliveries.
 - II. Perform manual vacuum aspiration for the management of incomplete abortion.
 - III. Where access to safe surgery is not available, perform symphysiotomy for the management of obstructed labour

(Source: WHO, ICM, & FIGO. (2004). *Making pregnancy safer: the critical role of the skilled attendant* A joint statement by WHO, ICM, and FIGO. Geneva: World Health Organization pp 3, 4)

*** The underlined skills are directly related to client education to promote behaviour change for favourable maternal, newborn and child outcomes.

The midwife and the woman share responsibilities for the outcome of the pregnancy. The woman is responsible for seeking proper care based on appropriate information, and the midwife is responsible for providing relevant and adequate information to enable the client make informed decisions that would lead to the intended outcomes (Thompson, 2004:180). Midwives require both verbal and non-verbal communication skills for establishing rapport and influencing positive client health behaviours (Collins, Schrimmer, Diamond, & Burke, 2011:1). They need to listen carefully, provide appropriate information comprehensibly, show respect, spend enough time with their client, and ensure that the client participate actively in every decision concerning her care (Haean, Marks, & Allegrante, 2008:637, 651).

Detman, Quinn, Ellery, Wallace, and Jeffers (2008:291) observed that one of the major reasons why providers failed to educate or assist clients with appropriate behaviours to promote MNCH was their feeling that they did not have sufficient training on such issues. Haruna et al. (2010:23) also reported that doctors and midwives in Tokyo expressed their lack of expertise in behaviour change communication. Studies have indicated the urgent need to pay more attention to developing providers' abilities for interpersonal relationships (Ariba et al., 2007; WHO, 2006c:21), and effective client education (Freda, 2004:208). Midwives may be aware of their clients' need for health promotion or education, but lack the essential competencies to meet the need, hence their own need to be assisted to develop the capacity (Al-Motlaq, Mills, Birks, & Francis, 2010:476).

Years ago, Boyd and Shaw (1995:31) found out that training of midwives often focused on technical skills and not on interpersonal relationship with their clients. This, according to the authors, was based on the assumption that talking was natural, hence interpersonal communication and counselling skills training was not part of the training required to qualify

to practice (Boyd & Shaw, 1995:31). Similarly, at the multi-agency pre-congress workshop on midwifery education for safe motherhood, interpersonal communication and counselling skills were identified as the major gap in midwifery education and training (Kwast, 1998:133). A close look at the core skills and abilities of a skilled attendant in Box 2:2 on page 41, however, reveals a current recognition of the important role of behaviour change communication in MNCH care, through effective communication, education and support throughout pregnancy, labour, and postnatal period. Yet, de Negri et al. (2005:7) noted that interpersonal communication (IPC) is still not given sufficient consideration in pre-service training of health care providers, including midwives.

UNFPA and ICM (2006:9) attributed the problem to curricula that assume attainment of competence with simulations in the classrooms, without adequate real life exposure and testing, and to the gaps in theory and practice that need to be context-specific. According to the two agencies, essential knowledge, attitude and experience are developed to the required standards by professionals with constant hands-on practice in real life situations, under appropriate supervision, and with supportive evaluation (UNFPA & ICM, 2006:9). Lanning, Brickhouse, Gunsolley, Ranson, and Willett, (2011:4) examined communication skills development among dental students in United States of America and reported that inadequate resources and heavy workload militated against effective development of professionals' communication skills in the clinical area. MacDonagh (2005:4) emphasized that in addition to the training of skilled attendants being competency-based, interpersonal skills development should be prioritized and provided by skilled trainers. Bernstein, Rieber, Stoltz, Shapiro, and Connors (2004:87) found that although maternal and child health educators were positive about their ability to integrate and teach health promotions most of them still desired to develop their personal skills further.

Training nurses on health promotion for MNCH has been shown to be effective in improving nurses' knowledge, attitude, and skills in functioning as clients' educators, counsellors and advocates (Dodgson & Tarrant, 2007:865). Hlahane, Greeff, and du Plessis (2006:82) observed that the more effectively professionals were trained, the more positive they were about their work. Competencies in interpersonal communication should be prioritized based on local needs assessment, academic significance, and should be teachable and assessable (Doyle, Copeland, Bush, Stein, & Thompson, 2011:6). For example, midwives working in rural areas require more skills to function effectively at the facility and in the community (Abwot, 2005:274). Not only do midwives need to be trained, but they must continually be re-trained (Bradshaw et al., 2008:8; F.M.O.H, WHO., et al., 2005:5) to meet contemporary standards and it is part of the professional responsibilities of midwives to remain current on MNCH issues (Schneider, 2001:20).

2.3.3.3 Provider-Client Relationship

The service-oriented strategic approach to BCC at the facility level in Nigeria includes "improving the image of the service providers for client confidence" (F.M.O.H, WHO., et al., 2005:64). The PHC reforms recommend people-centred care as an obligation and not a luxury (WHO, 2008b:41-56), therefore maternal and child care should not only be context-specific and universal, it should be friendly (F.M.O.H, WHO., et al., 2005:5). The midwife and her clients require a degree of relationship that would breed mutual trust between them and allow the midwife to gain an understanding of her clients to enable her provide culture-sensitive, relevant and acceptable information and care (Mathai, 2008:469). Only a few midwives have the essential skills for person-centred care (WHO, 2008b:47). Gottlieb, Sylvester, and Eby (2008:37) noted that when services are people-centred everything changes

positively - the health team is known to the client and there are no barriers of “space, attitude, language and time” to their seeking care when required.

In addition to the skilled attendants possessing interpersonal communication and counselling skills, they need to be able to build relationships (Gottlieb et al., 2008:36). The need for change in the behaviour and attitude of health workers is well documented (WHO, 2001:6) and provider-client interaction can be improved. Griffin et al. (2004:595), found that planned interventions significantly changed the process of interactions between providers and their clients. Interpersonal skills make midwives appreciate the clients’ rights and culture (CRR & WARDC, 2008:46); enable midwives to provide services respectfully and appropriately (Favin & Shafritz, 2000:11); and counsel their clients effectively, maintaining confidentiality (Bradshaw et al., 2008:14). Consumers desire a mutual relationship where the provider and client respect and trust each other, and clients are treated as individuals who have rights and not as beggars (WHO, 2008b:14).

Ratanawongsa, Wright, Vargo, and Carrese, (2011:5) examined how providers and clients in challenging relationships perceived each other and found out that the clients considered as frustrating by the providers because of their non-compliance to instructions, were more positive in their perception of the relationship than the providers. Professional midwives need to consider their clients’ socio-cultural and educational backgrounds in making their relationship efficient (Falcon, Segura, Perez-Carceles, Osuna, & Luna, 2010:137). The midwife needs to understand herself, clarify her values, and appreciate her own rights to be able to appreciate and respect others. Midwives treating others the way they would like to be treated, according to Thompson (2004:179), is the nucleus of ethical midwifery practice. The categories of caring behaviours identified by CHANGE (2005:17) were: “attend to physical

needs; be accessible to clients; attend to emotional needs; respect human dignity/rights; inform/explain/instruct; involve family; and incorporate cultural context.” Consumers want providers with integrity, who are knowledgeable, competent, and impartial (WHO, 2008b:16). Clients in a qualitative study in Cape Town, South Africa, described supportive midwives as understanding, open, concerned, approachable, friendly, competent, sincere, and providing feedback (Petersen, Nilsson, Everett, & Emmelin, 2009:385).

De Brouwere and Van Lerberghe (2001:3) reviewed evidence in safe motherhood strategies and noted that there were facilities with enough professionals, yet their mortality rates remained unabated because of the level of their responsiveness to their clients. Lin and Wang (2008:699) noted that previous experience of unsatisfactory care determined whether or not women used or continued to use health services. CHANGE (2005:17) also observed that health workers’ behaviour toward their clients influenced the latter’s use of skilled care and could have greater negative effect on utilization than access or cost related factors. Barker et al. (2007:85) noted that bad attitudes of providers could put off poor and socially marginalized women from accessing services. According to Ngomane and Mulaudzi (2012:8), the unpleasant attitudes of midwives was mentioned as one of the barriers to utilization of the health facilities by pregnant women in a district in Limpopo, South Africa. Professionals were also aware that poor behaviour toward clients significantly hindered utilization of MNCH services (CHANGE, 2005:8). Positive attitudes and good interpersonal communication skills of some health workers significantly promoted long-term compliance to immunization schedules, while the rudeness and insensitivity of the others made mothers or guardians feel discouraged and belittled, and they ceased to attend (Waisbord & Larson, 2005:7).

2.3.3.4 Supportive Supervision

The professional and personal welfare of midwives especially in the rural and remote areas (F.M.O.H, WHO., et al., 2005:5) is fundamental to their optimal performance, hence it is important for their employers to be interested in how they feel about and perform their job (Takase, Yamashita, & Oba, 2008:295). Studying how to retain older nurses in primary care and the community, Storey, Cheater, Ford, and Leese (2009:1403) noted that what was most important to older nurses included the relationship with their clients and supportive colleagues. Supportive colleagues could make professionals behave responsively and accountably (De Brouwere & Van Lerberghe, 2001:3). Professional associations (MacDonagh, 2005:4), colleagues and competent midwives' support, as well as networking of staff, have been encouraged especially in remote or rural areas (UNFPA & ICM, 2006:12). Supportive supervision ensures that midwives' interests are guaranteed (UNFPA, 2006c:39). It is necessary that there be a supervision structure in the health system for all skilled attendants, to have access to regular supportive supervision and professional development, to sustain their competencies and ensure quality of services (WHO et al., 2004:12-13).

Midwives need to be trained and re-trained on technical, interpersonal communication, and interpersonal relationship skills for effective behaviour change communication for maternal, newborn and child health (F.M.O.H, WHO., et al., 2005:5). Although continued professional development is encouraged as one of the mechanisms for re-licensing midwives (WHO et al., 2004:12-13), Kildea, Barclay, and Brodie (2006:9) identified factors militating against continuing education for professional midwives in isolated areas as including the high cost of travel and lack of relief staff. UNFPA (2006b:23) suggested the assistance of donors such as non-governmental agencies, however, according to Solomon, Ballif-Spanvill, Ward, Fuhriman, and Widdison-Jones (2008:35,36) this should be done in a way that allows

ownership and sustainability by the benefiting country or agency. The possibility of using the internet and mobile phones is also being explored globally to provide resources to midwives in remote areas (Kildea et al., 2006:) and to maintain supportive links.

Midwives require an enabling work environment and supportive supervision to exhibit innovative behaviour that promotes behaviour change communication in the facilities. According to Knol and van Linge (2009:361), *innovative behaviour* involves “recognition of problems, generation of ideas, mobilization of support, and the realization of ideas” (Knol & van Linge, 2009:361,362). Similarly, Pettersson, Johansson, Pelembe, Dgedge, and Christensson (2006:165) encouraged midwives to change their perception of themselves as victims of unfavourable circumstances, to one of seeing themselves as people who can make a difference and take appropriate actions to do so. Occasionally, however, the senior midwives hindered the client-centred approach favoured by innovative midwives (Martin & Bull, 2005:126). According to WHO (2008b:14-15) people want to contribute to what happens in their workplace, in the communities in which they live, and also in important government decisions that affect their lives. Supervisors must treat midwives the way midwives are expected to treat their clients and they must be allowed to participate freely and fully in the operations of the facility and community (Boyd & Shaw, 1995) so that they can efficiently support their clients’ behaviour change efforts (F.M.O.H, WHO., et al., 2005:5).

2.3.4 Facility-Based Behaviour Change Communication (BCC) for Maternal Newborn and Child Health (MNCH)

UNFPA and ICM (2006:3) reported that midwives’ counsel is sought in the community on various health issues by both men and women. Although midwives over the years consider client education as one of their priority duties, it has become more challenging for them do it

effectively (Freda, 2004:203). An ethnographic study of encounters between midwives and breastfeeding women in postnatal wards in England showed that midwives delivered client education as a routine under pressure of time, without considering whether or not their clients understood the information (Dykes, 2005:247). Shortage of staff and heavy workloads shorten client education sessions during antenatal care (ANC) with midwives focusing more on services and jeopardizing counselling and provision of information (Couillet et al., 2007:293; Seidel, 2005:21). Al-Motlaq et al. (2010:476) also found out that behaviour change activities by nurses in remote and isolated areas of Queensland were unplanned because of the nurses' heavy workloads. Some studies however, reported that despite the workload and difficulty in having insufficient time, some midwives were committed, giving their clients the attention, information and support required (Dykes, 2005:248; Freda, 2004:208). Another hindrance to effective client education was lack of appropriate job aids and guidelines - care management tools, operational tools, cue cards, posters, real objects, and so forth (Freda, 2004:203; Haruna et al., 2010:25), thus limiting midwives' counsel to only their personal experiences (Haruna et al., 2010:25).

Dykes (2005:247) also mentioned frequent transfers as a problem. According to WHO (2008b:50,51) continuity is one of the essentials of care that produces satisfactory outcomes because trust, understanding and respect in client-provider relationship usually develop over time - about two to five years. The United Nations Report (2008:5) affirmed that those who use the same source of health care for most of their needs, comply better with advice given, depend on emergency services less, and are more satisfied with care. According to Detman et al. (2008:292), providers sometimes fail to educate or assist clients with appropriate behaviours to promote MNCH because they see it as a waste of time and energy. This is because of their belief that clients would not benefit or make use of the information, or that

the clients and / or community lacked the resources to support the desired behaviour (Detman et al., 2008:292).

There is increasing need to empower clients through health information and education to assume responsibility for their wellbeing (Couillet et al., 2007:292). Several studies have revealed the urgent need to improve BCC by midwives in health facilities (Hoque, Kader, & Hoque, 2007:16d). Studies show that women lack the essential information and education about MNCH related issues (Couillet et al., 2007:292). Primigravidae in rural Malawi were found to lack essential information about possible complications in pregnancy, labour and puerperium (Kumbani & Mc Inerney, 2002:43). Artieta-Pinedo et al. (2010:194) remarked that in spite of changes in intrapartum care, midwives have not improved the information they provided to clients on childbirth over the years. Similarly in a qualitative study with Reitmanova and Gustafson (2008:101) looking at immigrant Muslim women in Canada, it was documented that client education lacked relevance to clients' cultural, religious, linguistic and other socioeconomic diversities.

Studies indicate that the messages delivered by midwives have been quite inadequate and sometimes irrelevant to the needs of the target audience. According to Detman et al. (2008:291), in a case study on consumer and provider perceptions of offered anticipatory guidance during prenatal care, less than two-thirds of providers talked in prenatal classes about important topics that have serious implications for maternal and child health. Providers and clients differed on what is said to have been told the clients or heard from providers (Detman et al., 2008:291). In line with the core competencies expected of professional midwives (ICM, 2002:4-11; N&MCN, 2004:2,3; WHO, 2006a:10,19), it is required that information provided to clients be correct, culturally relevant, and adequate (CHANGE,

2005:20). The key household practices (KHHP), constituting the focus of Nigeria's behaviour change communication plan are presented in Box 2:1 on page 33.

The African regional consensus on the role of skilled attendants emphasized the importance of health education, including counselling, as part of maternal health services throughout pregnancy, childbirth and the postpartum period (WHO, 2006a:13). The time of pregnancy, however, has been severally described as a critical period in a woman's life when she needs behaviour change to produce favourable outcomes for her and her baby (Detman et al., 2008:293; Fraser et al., 2006:920). The Federal Government of Nigeria - FGN (2004:42) stated that there is need for more awareness programmes, especially for pregnant women. It is known that women search for information and are more responsive to BCC activities in pregnancy (Detman et al., 2008:293; Fraser et al., 2006:920). Antenatal care is the most utilized of the maternal health services (compared to childbirth and postpartum care) hence the suitability of the antenatal period for BCC on MNCH (Bhutta, Darmstadt, Haws, Yakoob, & Lawn, 2009; FGN, 2004:42; Mathai, 2008:469). In view of the fact that client education during antenatal care is the critical source of information for most women (and sometimes their spouses), it should provide counselling opportunities for client's fears and questions to be adequately attended to (Schneider, 2001:20; Stanton, 2004:181). Furthermore, because of the benefits of effective antenatal care, counselling about the care of the newborn, is also incorporated into BCC programmes for pregnant women (Seidel, 2005:22).

Interpersonal communication is the behaviour change communication channel recommended for and employed by midwives within the health facility (Boyd & Shaw, 1995:5; Seidel, 2005:4). A cross-sectional survey by Soltani and Dickinson (2005:636) focused on both hospital and home births in United Kingdom, showed that the women had multiple sources of

health information including the midwife. Where communication by health providers was effective, women preferred health providers as their source of health information (Leslie, 2004:155). Women prefer one-to-one discussion (Soltani & Dickinson, 2005:636) and that midwives provide privacy, give them enough time, encourage them, build their confidence, and provide individualized and practicable education (Dykes, 2005:242). An integrative review of women's prenatal care by Novick (2009:232) revealed that women were pleased to receive information, be listened to, be allowed to ask questions and benefited from experiences of the professionals. A user-centred study among English and non-English speaking Somali women in United Kingdom, however, revealed that poor interpersonal communication between provider and client made clients doubt the competence of the provider and not ask her for information (Davies & Bath, 2001:242,244). Women who do not speak the same language as the provider, those in minority groups, uneducated, poor, in rural areas, or in disadvantaged groups seldom ask questions, may not express dissatisfaction with the provider, and may feel discriminated against (Jensen, King, Guntzville, & Davis, 2010:34,35; Tsianakas & Liamputtong, 2002:25). This being so, they may lack the essential information needed to influence positive MNCH health behaviour (Katz, Jacobson, Veledar, & Kripalani, 2007:782).

Authors advise that the preparation and presentation of messages must show cultural sensitivity by the midwife (Couillet et al., 2007:292; Steinman et al., 2010:68) and be context-specific if they are to make meaningful impact, especially in developing countries (Say & Raine, 2007:816). The messages should be straightforward, plain and without medical jargon (Reed & Jernstedt, 2004:1). To implement BCC programmes effectively for MNCH, midwives must encourage clients to open up and discuss freely (Jensen et al., 2010:30), be understanding and non-judgemental (Reed & Jernstedt, 2004:1), and be careful about

discussing sensitive topics like danger signs and birth preparedness which may provoke undesirable emotions (Seidel, 2005:22).

It is pertinent to report that clients are also exposed to other sources of information on MNCH through printed media - booklet, pamphlet, leaflet, poster, mother's card; and electronic media - radio, TV jingles, drama programmes (Leslie, 2004:155; Seidel, 2005:22; Stanton, 2004:181). As revealed by a descriptive cross-sectional study in mid-Sweden, women in developed countries searched for more information on what they were told by the midwives (Larsson, 2009:17). Women in rural areas, especially in developing countries, have little or no access to print and electronic media (Liu et al., 2006) hence, the health provider is usually their only / major source of health information on maternal and child health issues (Davies & Bath, 2001:241).

Some of the printed materials are designed as adjuncts to facility-based education, to promote understanding, encourage retention or serve as reminders (Freda, 2004:207). Soltani and Dickinson (2005:636) observed, however, that the majority of women, particularly the non-professional mothers, did not understand all the information provided in the printed materials. Similarly, Detman et al. (2008:291) observed that brochures or written materials handed out in place of verbal communication, in order to save provider time, may not be remembered or understood by women with poor education. In view of the incompleteness and inconsistency of information from the alternative sources, women still consulted their provider to have their doubts clarified or to verify the information (Johnson et al., 2010:264; Leslie, 2004:155). Where midwives fail to consider clients' culture, level of education, and circumstances, women may appreciate the counsel of close friends and relatives more than the midwife's (Detman et al., 2008:292). Client education and counselling is an important aspect of client

care hence, Kriebs and Shannon (2008:266) emphasized the importance of recording discussions and counselling sessions, including favourable and unfavourable outcomes of such sessions.

The WHO's Department of Making Pregnancy Safer (2006b:18) reported that interventions that improved health practices and utilization of MNCH services, ultimately influenced maternal and newborn health outcomes. Some of the outcomes, according to the World Bank (2006) included reduced risky practices and improved positive behaviours. Schneider (2001:20) observed that women sought help when they were equipped with appropriate information to enable them to gain an understanding of their condition. An education intervention to prevent postpartum depression in a regional hospital in Taipei was reportedly effective (Ho et al., 2009:71). Utilization of health professionals at delivery by women was documented to be strongly related to the education they received at antenatal clinic about danger signs and the use of skilled attendants (APHRC, 2006:xvii; Stanton, 2004:181-182). Similarly, adequate information provided to pregnant women was related to their increased knowledge of the danger signs in pregnancy (Stanton, 2004:181-182), to increased knowledge and ability of primigravidae to seek appropriate care and take necessary actions about their health (Kumbani & Mc Inerney, 2002:43), and influenced their nutrition, health care knowledge, behaviour and attitude toward postpartum practices (Liu et al., 2006) .

Women who benefited from smoking cessation / reduction intervention by midwives demonstrated a significant likelihood of stopping or sustaining changes than those who were not involved in the programme (McLeod et al., 2004:37). Mullany, Becker, and Hindin (2007:171) reported that an educational intervention provided to women and their spouses antenatally in a randomized trial enhanced greater utilization of postnatal services in women

in the intervention group, and the women exhibited a higher probability of preparing for birth. Similarly, women who had pleasant prenatal care were more likely to use paediatric and preventive health services consistently (Detman et al., 2008:293). Creating awareness on prevention of mother to child transmission of HIV made some women decide to be tested (Kriebs & Shannon, 2008:266).

Contrarily, women who failed to use MNCH services had problems identifying danger signs, seeking prompt medical intervention, and deciding on appropriate intervention options (Ozumba & Nwogu-Ikojo, 2008:355). Poor or inadequate information from health providers was responsible for the high dropout rates and negative attitudes towards immunization services observed by Waisbord and Larson (2005:7). According to Waisbord and Larson (2005:7), children did not complete their immunization because health providers did not provide the guardians with correct information about vaccine effects and schedules, and did not bother to ensure that they understood the information, or to allow them ask questions.

Although the midwife works in the facility, and with women mostly, success in behaviour change communication for MNCH is also possible where partners, spouses and significant members of the community are also empowered with messages to promote MNCH, and are able to identify danger signs, prepare birth plans, manage minor childhood illnesses, demand quality MNCH care; and provide financial and other necessary assistance to women and children (Adeleye & Chiwuzie, 2007:76; CHANGE, 2005:20; WHO, 2006b:21).

2.3.5 Empowering Midwives for Behaviour Change Communication

Whitehead (2001:822) observed that nurses were more of traditional “health educationalists” than “health promotionalists”, and needed assistance to perform their behaviour change

communication functions in a result-oriented manner. Kalita (2006:14) emphasized that IPCC is critical because there would be no behaviour change without communication. According to Boyd and Shaw (1995:31), interaction with mothers is not only equally important, but not as easy as the technical aspect of the skilled attendants' work. Boyd and Shaw (1995:49) stressed that one of the priority steps to change the behaviour of mothers for favourable child health outcomes is to change the behaviour of health workers.

Nigeria's health sector reform project (F.M.O.H, 2004a:8), the country's programme to accelerate the attainment of the maternal and child related MDGs (F.M.O.H & WHO, 2005), and the behaviour change communication plan for Nigeria (F.M.O.H, WHO., et al., 2005:65), identified training of health care providers on interpersonal communication / counselling (IPCC) and enhancing their skills to promote friendly service and utilization of services, as critical. Most capacity building programmes are designed by the initiators or engaged experts in alignment with the country's national MNCH policies, guidelines and protocols (WHO, 2008a:9). According to Turan et al. (2009:46) who investigated the relationship between communication skills of medical students and their clinical visits, purposefully planned learning activities promote acquisition of clinical communication skills. The WHO's Department of Reproductive Health and Research (2001:9) stated that a competency-based curriculum to guide training should be produced and utilized for effective skills development. The objectives should be clearly and measurably stated, indicating the knowledge, attitude and skills to be acquired or improved (Boyd & Shaw, 1995:32). Studies have shown that there is no magic curriculum or absolute training manual that fits all categories of learners in every country of the world, and so where there is an existing curriculum, there is the need to adapt it creatively for information, cultural and contextual relevance (de Negri et al., 2005:20; Visser & Wysmans, 2010:407; WHO, 2008a:5,9).

Interventions must be appropriate to the specific context, considering both the midwives and their clients (Couillet et al., 2007:293). Parry (2008:193) noted in the review of studies on communication skills training, that interventions were more effective when tailored to specific communication needs in specific clinical areas, based on evidence. Need assessment to identify the gaps in the objectives of the training programme and the existing knowledge, attitudes, skills and practices of prospective participants must be conducted to arrive at the content of the curriculum (Koblinsky et al., 2006:1380; Roberts et al., 1995:Q7-4). Need assessment surveys in previous studies revealed both strengths and weaknesses of professionals with respect to their communication skills (de Negri et al., 2005:62; Jangland, Gunningberg, & Carlsson, 2009:201) and revealed clients' preferences (Novick, 2009:232,233). According to Haruna et al. (2010:24), nurse-midwives admitted that they had difficulties finding effective ways to advise women on lifestyle related issues because they were not adequately prepared in school and the textbooks did not provide what they needed for their daily experiences with women.

Doyle et al. (2011:6) observed that teaching communication skills in natural settings was essential. Subramanian et al. (2010) demonstrated the enormous value of whole-site training. To acquire and sustain essential competencies, practice must be repeated and objectively assessed (UNFPA & ICM, 2006:9). Students in Licqurish and Seibold's (2008:487) study, learnt best by hands-on practice with the support of helpful midwife preceptors and real life opportunities for critical thinking and practice.

According to de Negri et al. (2005:51), clients cannot effect lifestyle changes or comply with treatment if they cannot access drugs and essential supplies. In previous studies, providers suggested reorganization of clinics, provision of equipment, and improved facilities, in addition to interpersonal communication training (de Negri et al., 2005:62). Midwives

emphasized the critical role of supportive supervision in reinforcing learning and motivating them, especially in rural areas where midwives work alone (WHO, 2008a:26). Smith (2000:16S) also recommended complementing training with evidence-based guidelines and action plans on how to implement the gains of the training. Professionals could be provided with job aids or guides (Devine et al., 2008:110; The LINKAGES Project, 2004:vii) which must be adapted and made context relevant (Smith, 2000:15S). Where they were provided, professionals used them and saw them as useful reminders in improving their interaction with the clients (de Negri et al., 2005:36; Devine et al., 2008:110).

The duration and pattern of IPCC / BCC training varied from study to study depending on the objectives, participants' knowledge and their skills gap, and whether or not the target audience had participated in an IPCC skills training before. It is however, important that sufficient time be provided for discussion and practice (Berkhof, van Rijssen, Schellart, Anema, & van der Beek, 2011:9; de Negri et al., 2005). This was reiterated by Mathai (2008:471) who observed that shorter duration of training and less hands-on practical training yielded poor long term results.

Studies indicate that midwives require a functional knowledge of their clients' behaviour and how the clients perceive and appreciate the midwives so that they can respond appropriately and acceptably to the need of their clients for information and support (Crafter, 1997; Ratanawongsa et al., 2011:6; Reitmanova & Gustafson, 2008:101; Roberts et al., 1995:Q14-4). Similarly, it is important that midwives appreciate the positive attributes of every stakeholder in the community and maximize them, including the capabilities of their clients (Ansari, Phillips, & Zwi, 2002:156). In line with the service oriented BCC strategic approach at the health system level, midwives should hold health talks at the clinics (F.M.O.H, WHO., et al., 2005:64). Therefore to be able to provide relevant information, midwives need access

to evidence-based, correct and up-to-date information on the core messages they are expected to share with their clients (Schneider, 2001:20; Waisbord & Larson, 2005:9; WHO, 2008a:2). It is documented that midwives are motivated when they have an understanding of their vital role within the global, national, regional, and local programmes for MNCH (Boyd & Shaw, 1995:38). Knol and van Linge (2009:359) also recommended *networking* as an essential skill to be promoted in training. Midwives need to be able to recognize and utilize available legal, environmental, and managerial supports to enhance their practice (UNFPA & ICM, 2006:2). Seidel, (2005:5) suggested that it is also good to encourage midwives to appreciate data and know how to use data effectively to motivate and gain support of their consumers.

Midwives must examine their values understand their own behaviours and the implication of these, to enable them to develop appropriate attitudes and coping strategies in favour of client-oriented professional practice (Boyd & Shaw, 1995:20; CHANGE, 2005:18; Favin & Shafritz, 2000:18; WHO, 2008a:4). Furthermore, midwives need to appreciate and adopt essential attributes of effective interpersonal relationship which studies have shown to be valued by clients. (CHANGE, 2005:17; Cheraghi-Sohi et al., 2006:278; Schooley, Mundt, Wagner, Fullerton, & O'Donnell, 2009:419). Appropriate attitudes of health workers would “improve the image of the service providers for increased client confidence” (F.M.O.H, WHO., et al., 2005:65). Interpersonal communication and counselling skills (IPCC) have been severally described as the crux of midwifery practice and behaviour change communication, and as such must be part of the curriculum (Crafter, 1997; F.M.O.H, WHO., et al., 2005:65; Favin & Shafritz, 2000:18). According to Doyle et al. (2011: 6), skills to be acquired could be selected based on the objectives of the programme, available time and resources, the local context, and the national programme. For example the training in Nigeria is aimed at training the health workers to enhance their skills on IPCC and providing friendly

services to promote utilization by clients (F.M.O.H, WHO., et al., 2005:65). As adult learners, midwives would prefer skills that are relevant to their daily activities and can be applied in their contexts (Boyd & Shaw, 1995:32)

There is need for midwives to state their goals in terms of what they expect to see as a result of their BCC activities in the facility (Roberts et al., 1995:Q15-6,7). LaFond et al (2003:101,102) recommended that an action plan be developed, indicating that the plan could include introducing new activities to encourage a desired behaviour and the appropriate authorities should be involved to ensure sustainability. Yeshe et al. (2009:397) informed that trainees at a BCC programme developed their plan of action. Hence, midwives could also create opportunities for the integrated service approach identified in the service oriented strategy to promote their BCC activities at the health system level (F.M.O.H, WHO., et al., 2005:65).

Student midwives and qualified midwives who would participate in this empowerment programme would usually be adults, so adult learning principles should be employed (Boyd & Shaw, 1995:32; WHO, 2001:9). It is known that the participatory approach achieves more for adult learners - from need identification, through planning, implementation, monitoring and evaluation (Roberts et al., 1995:iii; Yeshe et al., 2009:397) and enhances sustainability (Ajayi, Oladepo, Falade, Bamgboye, & Kale, 2009:236). Changes in behaviours of care providers and their clients in favour of maternal and newborn health are possible if they are involved at every stage of the programming cycle (CHANGE, 2005:20). Participants are to be involved in the initial need assessment, participate in review of the baseline data on their performance (Boyd & Shaw, 1995:34), determine the training objectives, and identify the gaps between the objectives and their performance (Boyd & Shaw, 1995:32). They are also

to be involved in determining what they think is feasible and should be included in the curriculum (CHANGE, 2005:19; WHO, 2001:9). The focus should be on the professionals' preferences within approved professional and national standards (Boyd & Shaw, 1995:20). Participants should be treated with respect, and their background knowledge and experiences should be drawn upon (Boyd & Shaw, 1995:32).

Berkhof et al.'s (2011:10) critical appraisal of reviews of strategies employed in training communication skills to physicians revealed that using oral presentation (e.g. lecture), modelling (imitating another), or written information showed no evidence of effectiveness, and should only be used to support other strategies. The authors, however, observed that feedback and small group discussions appeared to be effective evidence-based communication skills training strategies (Berkhof et al., 2011:10). Studies show that professionals score higher on knowledge than skills (Harvey et al., 2007), hence attitude and skills must be given sufficient attention. Lectures (Koblinsky et al., 2006:1380), educational meetings, conferences, and use of printed materials alone are not effective (Forsetlund et al., 2009:16; Smith, 2000:15S) in promoting changes in professionals' practice. To encourage development of IPCC skills, midwives should be provided with sufficient opportunities for active learning, practice and corrective feedback (Mesquita et al., 2010:145; Rowan, 2008:404; The LINKAGES Project, 2004:vii). This can be achieved through case discussions, hands-on practice sessions, and interactive workshops (Devine et al., 2008:108; Koblinsky et al., 2006:1380). In addition, Mesquita et al (2010:145,147) found that the use of simulated clients helped participants to be confident and overcome communication anxiety.

Self-directed learning strategy has been proposed for midwives, especially those in rural areas, to work in groups, with or without the assistance of a trained colleague (Engels,

Verheijen, Fleuren, Mokkink, & Grol, 2003:251; WHO, 2008a:2). WHO's (2008a:25,26) evaluation of this approach for developing midwives IPCC skills for MNCH, however, showed that midwives still wanted an initial orientation and brief periodic facilitated training sessions to ensure that they were on the right track. In view of shortage of staff, migration, irregular shifts, the time and cost-intensive nature of interactive and participatory in-service training methods, it has been recommended that IPCC skills curriculum should be incorporated into midwives' pre-service training (Devine et al., 2008:110; WHO, 2008a:26) and could also be a component of orientation package for newly recruited staff (Devine et al., 2008:110) in health promotion facilities. Boyd and Shaw (1995:31,49) observed the frequent absence of human focus in most training programmes and emphasized the importance of workers being trained in the way they are expected to treat their clients. According to Licqurish and Seibold's (2008:487), facilitators who were seen as positive role models, were more effective in encouraging skills development by midwives.

Although de Negri et al. (2005:63) observed no significant difference in satisfaction levels between patients of trained and untrained providers in one of their study sites, patient satisfaction was significantly in favour of trained physicians at their other study sites. The average visit with trained physicians lasted five minutes, compared to three minutes with the untrained physicians (de Negri et al., 2005:47,53). Client satisfaction led to improvement in patient compliance and health outcomes (de Negri et al., 2005). With enhanced provider-client interaction, Subramanian et al. (2010:6) recorded improved knowledge and acceptance of no-scalpel vasectomy (NSV) by both clients and providers, even in culturally difficult areas. Similarly, Griffin et al (2004:295) reported that positive health outcomes were in favour of intervention groups, and interventions seldom had negative effects. Even among women with low educational levels, increased client participation and improvements in health

outcomes have been documented (Willems, De Maesschalck, Deveugele, Derese, & De Maeseneer, 2005:145).

Interpersonal communication and counselling (IPCC) training raised the awareness of participant providers, making them appreciate the critical role of improved IPCC skills and positive provider attitude in client care and the gains were sustained (de Negri et al., 2005:36,63). Some of the gains reported by the participants included: improved relationship with patients; improved listening skills; consideration for the human aspect of work; better client care; improved organization; better non-verbal communication; improved counselling; access to more information from clients; and a better understanding of the clients' point of view (de Negri et al., 2005:36,49,53). IPCC training led to observable improvement in nurses' knowledge, communication skills and preparedness (Lamiani & Furey, 2009:272). The nurses gave clients sufficient time to talk and were able to talk about psychosocial issues as well (Lamiani & Furey, 2009:272).

In the same vein, Helitzer et al. (2011:1) found that the skills of providers in their intervention group improved significantly immediately after the training and the improvement was sustained during subsequent assessments. Parry (2008:193) confirmed that communication skills interventions positively influence participants' behaviour. According to Boscart (2009:1823), practitioners significantly became less authoritative, more purposeful, and appreciated the critical role of effective communication in providing client-centred care. Subramanian et al. (2010:4) also reported that interaction time increased, clients were promptly and well attended to, information, education, and communication (IEC) materials were used, the information provided was correct and was presented non-judgmentally, though some of the practitioners were still uncomfortable discussing some issues. The David and

Lucile Packard Foundation and Johns Hopkins Bloomberg School of Public Health Centre for Communication Programmes (2006a, 2006b) developed an *Interpersonal Communication and Counseling (IPCC) Skills Training Manual for Health Care Providers* focusing on reproductive health among youths. The draft report of using the training manual in two northern states of Nigeria revealed improvements in provider-client interactions and services provided at the study facilities (Idris, 2009:30).

Before commencement of training, a baseline survey should be conducted against which to measure post-intervention findings (WHO, 2008a:26). An effective training programme does not end with the workshop, because participants must continue to practise what they learned, to sustain the gains of the training in the field (Berkhof et al., 2011:10; The LINKAGES Project, 2004:54). Therefore, during the intervention, implementation in service areas and at the end of a specified period, evaluation is conducted to see how the knowledge, attitudes and skills acquired were being utilized and if set objectives were achieved (Devine et al., 2008:110; Schneider, 2001:20). Monitoring and evaluation reveal problems and achievements and provide materials for reviewing the strategy (de Negri et al., 2005:35-36; Subramanian et al., 2010:5; The LINKAGES Project, 2004:vii). Knowledge and attitudes were assessed using pre- and post-test questionnaires (Subramanian et al., 2010:3; Theron, 1999:67). For skills assessment, reminders (Eccles, Grimshaw, Walker, Johnston, & Pitts, 2005:110) checklists and other standard forms related to the skills of interest (Boyd & Shaw, 1995:34; The LINKAGES Project, 2004:54; WHO, 2008a:27), audio and video tape recording of encounters (de Negri et al., 2005:41) were useful for baseline assessment, follow-up formative evaluation or corrective feedback, and for post-intervention evaluation (WHO, 2008a:27). Evaluation could also be by self-reporting (de Negri et al., 2005:63).

Self-assessment of skills by the professional (de Negri et al., 2005:24) was useful for critical self reflection and to encourage improvement (Lanning et al., 2011:1,3,4; Tiuraniemi, Laara, Kyro, & Lindeman, 2011). Through peer assessment (Engels et al., 2003:251), professionals understood that others had weaknesses similar to theirs (The World Bank, 2007:37), they learned and developed together professionally, encouraging one another (Lanning et al., 2011:1,3,4; The World Bank, 2007:37). Assessment by the educator or supervisor provided opportunity to demonstrate the proper skills and assisted trainees with whatever problem they had (de Negri et al., 2005:24; Lanning et al., 2011:1,3,4). Supportive, non-judgemental, and purposeful supervision is of the utmost importance to strengthen the new knowledge, attitudes, and skills and enhance implementation in the workplace (de Negri et al., 2005:24; The LINKAGES Project, 2004:vii). Supervisory visits helped to improve providers' work, to attend to any problems, to motivate and support the workers (The LINKAGES Project, 2004:54). It is also important to document the processes and take the impression of participants on the training programme. Such assessment, according to de Negri et al. (2005:35-36,45), revealed, among other things, that participants recommended more time for practice, that practice should be with real patients, and that follow-up support should be provided.

A capacity building programme could be scaled up to cover more providers at different sites, or stepped down by those who benefited from it to other providers in the same facility, if evidence from the evaluation is positive (Casey, 2007:580; WHO, 2001:9). By practising and teaching others to do what they learned, midwives remember what they gained from the training when they are in the field (The LINKAGES Project, 2004:53). To scale up interpersonal communication and sustain the drive generated by a BCC programme, Maxfield (2004:18,19) suggested combining e-learning with the face-to-face approach when health

workers were back in the field. This, according to the author, would help cut cost, avoid or reduce travel and other logistical problems (Maxfield, 2004:18,19).

2.4 Theoretical Underpinnings

Health behaviour refers to “any activity undertaken for the purpose of preventing or detecting disease or for improving health and well being” (Conner, 2002:1). It is common knowledge that many theories and models of human behaviour and health behaviour have identical or overlapping constructs though they may differ in terminology and emphasis (Michie et al., 2005:26; Redding, Rossi, Rossi, Velicer, & Prochaska, 2000:181). Frost (2008:1) suggested, however, that relevant constructs from different theories could be brought together to produce an audience-specific programme. In the same vein, Eccles et al. (2005:108) suggested that different theories might be applicable to the same intervention at different stages. Theories are useful in research to: give a framework and direction to research (Baume, 2002:5; Eccles et al., 2005:109; Noar & Zimmerman, 2005:275; Redding et al., 2000:181); help in arriving at and making sense of results (Baume, 2002:5; Eccles et al., 2005:109; Noar & Zimmerman, 2005:275); prepare and present results in a logical and orderly manner (Baume, 2002:5); and design evidence-based, context-specific and relevant intervention (Baume, 2002:5; Eccles et al., 2005:109; Frost, 2008:1; Noar & Zimmerman, 2005:275; Redding et al., 2000:181). Programme planners and educators also find theories valuable in comprehending and discussing the rationale for their specific design of behavioural intervention aimed at enhancing contextual relevance and increasing effectiveness (Frost, 2008:1; MotherCare, 2000:3).

According to Michie et al. (2005:27), professionals usually have problems choosing the most suitable theory for their purposes from the abundant theories available. For health behaviour

theory to be applicable to intervention research, the variables must be observable, amenable to experimental manipulation, (Eccles et al., 2005:109; Jeffery, 2004) and have evidence of suitability from previous studies (Jeffery, 2004). Such variables include: knowledge, beliefs, attitudes, motivation, actual or perceived external constraints (Eccles et al., 2005:109), norms and self-efficacy (MotherCare, 2000:3). Jeffery (2004) maintained that in addition to having observable variables that can be manipulated experimentally, the theory of choice must have strong empirical support. Eccles et al. (2005:108) also stated that it is important to examine the relevance of the theory to the study target population – “individual health professional”, “health care groups or teams”, “organization providing health care”, and “larger health care systems or environment”. It is pertinent to remark that human behaviours are multi-determined and an appropriate theory for planning BCC interventions must be able to predict and provide explanations for the influence of social, economic and systemic variables on BCC, for the intervention to be effective (Kalita, 2006:15).

A number of theories and models were found useful by the researcher in the course of the work. These include: health behaviour theories; educational empowerment theory; interpersonal communication and counselling model; change theory; and the integrative framework for studying the implementation of evidence based practice (EBP). The conceptual framework adopted for the study, however, is the *Integrative Framework for Studying the Implementation of Evidence Based Practice - EBP* (Michie et al., 2005). The role of the theories and models in shaping the study is presented below.

2.4.1 Health Behaviour Theories

The health belief model, the transtheoretical model of behaviour change, theory of reasoned action, and the social cognitive theory were the health behaviour theories considered in this study.

2.4.1.1 Health Belief Model - Godfrey Hochbaum, Stephen Kegels, Irwin Rosenstock 1952:

This model has been in existence since the 50s and has been reviewed over the years to attend to the limitations in its original form (EPH, 2009). It deals with perceived susceptibility to a health problem or condition, the perceived seriousness of the issue, perceived benefit of taking a particular action and the perceived barriers associated with taking the action (Current Nursing, 2008; EPH, 2009). Numerous health-related studies are based on the model (DeJoy, 1996:63). Other constructs that have been added over the years include the mediating factors, self-efficacy, general susceptibility to illness, value of health and motivation (Redding et al., 2000:182-3).

This model is more suitable for health-seeking behaviour and is frequently used in nursing to understand a client's compliance and health preventive behaviour (Current Nursing, 2008). It was considered by the researcher in understanding how women, who are the midwives' primary audience, behave with respect to maternal and child health issues and what would most likely stimulate them towards an appropriate behaviour (Current Nursing, 2008). Since the model deals with cognitive factors predisposing a person to a health behaviour (EPH, 2009), the researcher also considered understanding the value the midwives may place on their behaviour change communication functions based on their perception of its importance, associated threats, benefits and costs. The model was not adopted as the theoretical framework for the study, however, because it is more relevant to understanding clients'

perception and response to a health problem than to understanding the professionals' performance of their duties which is the focus of this study. According to Eccles et al. (2005:108), relevance of the theory to the study target population, in this case the midwives, is critical to its selection for behaviour change interventions.

2.4.1.2 The Transtheoretical Model of Behaviour Change (TTM) - James Prochaska, Carol DiClemente 1979: This model has been widely used for termination of high risk behaviours and adoption of healthy ones (Kraft, Sutton, & Reynolds, 1999:434). The five stages of change (pre-contemplation, contemplation, preparation, action and maintenance) identified by the model, and its recognition of the fact that change is a process and not a one time experience is worthy of note. The major drawback of the model, according to Redding et al. (2000:190), is the description, measurement and validation of the constructs because, they are not as clear as explained and practised by the original theorists. Similarly, in Bandura's (1998:9) remark about stage theories, he indicated that human functioning is too "multifaceted" and "multidetermined" to be distinctly classified. The theory, however, was useful to the researcher in appreciating the need to follow up any immediate positive change in the target midwives' BCC practices beyond an initial intervention, and that midwives too would need to support their clients as they moved through the stages of change which might not be linear in pattern. In view of the difficulty of defining and measuring the key constructs in this model as noted by Redding et al. (2000:190), the model was not selected as the framework for the study.

2.4.1.3 Theory of Reasoned Action (TRA), Theory of Planned Behaviour (TPB) or Theory of Planned Action (TPA) - Icek Ajzen, Martin Fishbein, 1967-1970: This theory was introduced in 1967 originally as TRA but reviewed to TPA to accommodate the concepts that limited it

(Ajzen & Fishbein, 1980:5). It was to predict behaviour from intention and it is based on the assumption that behaviour is under volitional control and people are rational beings (Redding et al., 2000:183). The inventors recognize that there may not always be a perfect conformity between intention and behaviour and have taken the theory beyond mere intention to include self identity, self-concept and perceived behaviour control that is self-efficacy (Ajzen & Fishbein, 1980:6). Redding et al. (2000:184) observed that most TPA interventions concentrate on intention instead of behaviour, and the relationship between behaviour and intention has not been remarkable, nullifying the benefit of such studies. According to Bandura (1998:12), intention is ineffective without the ability to manipulate one's motivation and behaviour. The purpose of this study goes beyond the intention of the midwives to the actual performance of behaviour change communication for MNCH. Hence the theory was not chosen as the conceptual framework for the study. The theory was, however, found useful in appreciating the fact that failure of clients to utilize available facilities may not be suggestive of lack of intention but may be due to other factors which professionals need to understand to support clients through, effectively, with desired behaviours. Similarly, the researcher appreciated the fact that midwives may have positive intentions towards their BCC for MNCH activities but lack the capability to influence their own behaviour.

2.4.1.4 Social Cognitive Theory (SCT) or Social Learning Theory (SLT) - Albert Bandura

1986: SCT is a comprehensive model which addresses the socio-structural and personal determinants of health (Bandura, 1977:vii; 1998:2). It presents a reciprocal interaction between behaviour, the person and the environment (Redding et al., 2000:185). According to Redding et al. (2000:184-185), SCT is widely applied to health promotion, preventive strategies and modification of behaviour. The theory recognizes that self-efficacy is a major basis of action and people are motivated to persevere in spite of all odds if they believe there

would be a desired outcome (Bandura, 1998:3). The self-efficacy component of this theory has been adopted in the revised versions of most theories of human behaviour. This model is relevant to the study because it focuses on the person operating within an environment to produce a positive influence. It recognizes the reciprocal interaction between the midwife, the environment and her professional responsibility for behaviour change communication. The theory was not adopted as the theoretical framework for this study, however, because the preferred *Integrative Framework for Studying the Implementation of Evidence Based Practice* is more oriented towards health professionals' practice and provided model questions to guide non-psychologists in the health sector to understand correctly the behaviour of interest.

2.4.2 Educational Empowerment Theory – Paulo Freire

Freire (2009) describes the disadvantaged as oppressed by the advantaged oppressor. He, however, saw man as being more than whatever seemed to limit him, and possessing a whole world of resources to alter his world in his favour (Freire, 1973:4). Freire (1973:vii,viii) believed that awareness of self is key to freedom, hence the oppressed relentlessly tries to free himself from the prison he was cast into by the oppressor. This theory of educational empowerment recognizes the leading role of the learner and the need for dialogue between the teacher and learner for effective learning (Freire, 2009). The learner is seen as the oppressed and disadvantaged who seeks to free himself by making sense of the reality around him through meaningful and purposeful interaction with his environment and establishing an order (Freire, 1973:5). According to Freire (1973:ix), both the teacher and learner benefit from this participative educational approach. While the learner discovers and appreciates himself, the teacher is freed from being the only one talking and learns to interact. Freire (1973:xiii) suggested that the successful educator is one who engages the “educatees” as

partners in a mutual relationship. Freire (2009) encourages self-development rather than imposed development. Therefore, he recommended that the content of any educational intervention be taken from the daily experiences of the learners (Freire, 2009). He suggested that one uses one's real experiences as the problem to be able to gain an understanding of the situation, appreciate the need for solution, and when solved to attain a new status, equal to the oppressor (Freire, 2009).

In this study, which used the action research approach, both the participants (midwives) and the researcher were learners, working together towards improved practice. Neither was seen to be superior (oppressor) to the other (oppressed) though the researcher facilitated the process. The model relates to the study to the extent that this research process was adapted to the real world of the participants drawing from their experiences. It is also related in that the learners in this study, being adults and professionals, were active participants bringing their experience and expectations to the study. According to Kuokkanen and Leino-Kilpi (2000:237), women, patients and nurses (being in a female-dominated group of employees) among others, are considered as oppressed groups in social research. Midwives, through the opportunity for professional development provided in this study, should be able to work with women (their primary audience for BCC) for the latter's empowerment and freedom with regard to MNCH matters. This theory was not chosen as the theoretical framework for the study, however, because it does not provide variables to be examined in understanding the underlying factors predisposing the oppressed to oppression. Hence it was not considered suitable for identifying and understanding the factors responsible for midwives' performance or failure to perform BCC activities in their facilities.

2.4.3 Interpersonal Communication and Counselling (IPCC) Model (Nigeria)

The Federal Ministry of Health (F.M.O.H) Nigeria has a standardized IPCC model which is usually adapted and presented to professionals as adjunct during training programmes on family planning; breastfeeding options for HIV positive mothers; life saving skills (LSS) and so forth. The model defines communication as “a two-way process whereby a person or group of persons (SENDER) pass a message through a CHANNEL to another person or group of persons (RECEIVER) and get a FEEDBACK that acknowledges the receiver’s understanding of the message” (F.M.O.H, PATHS, et al., 2005:16). Interpersonal Communication (IPC) is described as “face-to-face, person-to-person, verbal or non-verbal, exchange of information, feeling or opinion between individuals” (F.M.O.H, PATHS, et al., 2005:21). The verbal communication skills or criteria are represented by the acronym CLEAR, standing for: Clarity, Listen, Encourage, Acknowledge, Repeat/Reflect, and Keep It Simple and Sensible (KISS). The acronym for the non-verbal communication skills is ROLES meaning: Relax, Open Up, Lean Forward, Eye Contact, and Sit Squarely (and Smile appropriately). Counselling is defined by the model as “a person-to-person interaction in which the provider gives adequate information that will enable a client to understand her feelings and deal with her specific personal concerns. Effective counselling empowers a client to make her own decision” (F.M.O.H, PATHS, et al., 2005:23). The counselling skills are also represented by the acronym GATHER, that is, Greet, Ask, Tell, Help, Explain, and Return. Where the model is utilized in training professionals, possible barriers to effective communication and counselling, and the need for value clarification and tackling misconceptions are often considered (F.M.O.H, 2005a:81-83).

Communication is fundamental to behaviour change programmes in the health sector (UNICEF, 2006:39) and at the health provider level, part of the strategy for behaviour change

communication (BCC) is to improve providers' interpersonal skills and create helpful job aids (Seidel, 2005:4). At a forum on midwifery education for safe motherhood organized by ICM/WHO/UNICEF the Nigeria IPCC model was acknowledged as adequate (Kwast, 1998:133). The model could not be used as the framework for this study, however, because it addressed only the IPCC skills required for BCC, and not other issues such as the knowledge of the midwives, the environment, the social influence, the midwives' beliefs and so forth. The second domain in the theoretical framework used in this study is related to interpersonal skills, hence the components of the IPCC model were used to develop the IPCC observation checklist one of the instruments used during the intervention and monitoring phases of the study [Annexure 2(e)].

2.4.4 Change Theory - Kurt Lewin 1946

Lewin intervened in organizational, institutional, and individual relationship problems within social, educational, government and non-governmental settings, and observed the “great amount of good-will, of readiness to face the problem squarely and really to do something about it” (Lewin, 1948:201). He stated that the failure to transform the observed goodwill to efficient action was the bane of interactions, as people were usually confused and needed to understand the situation, the associated dangers and most importantly what to do (Lewin, 1948:201). Lewin's change theory emphasized direct professional-client collaboration, acknowledging the active involvement of the client, if change was to be sustained (O'Brien, 2001:8) . He explained a spiral rather than linear change structure in which change proceeds in spiral steps of circles of planning, action, and fact-finding (evaluation) at each stage (Lewin, 1948:206; O'Brien, 2001:8). Lewin in his 1946 paper titled ‘Action Research and Minority Problems’ used the term ‘action research’ for the first time (O'Brien, 2001:8), and explained that action research was not less scientific or “lower” than requirements for pure

research in social events (Lewin, 1948:203). Action research has been described as an attempt by professionals to investigate what they are dissatisfied with, in order to improve their performance (IDEAS for Action Research, 2002:2).

Lewin's spiral change structure and recognition of active involvement of all participants are in line with the principles and pattern of action research which is the research approach for this study. Each of the three phases of the study had planning, action, and feedback components (see Figure 3:4 on page 151 in chapter three), and the processes of 'fact-finding' throughout the study were carefully and purposefully executed (Lewin, 1948:205). The change theory does not provide a universal procedure for identifying and understanding the problem that led to the desire for change. Identification and adequate description of the problem is fundamental to meaningful planning and intervention in behaviour change programmes. Hence, the theory was not considered as the conceptual framework for the entire study.

2.5 The Conceptual Framework - Integrative Framework for Studying the Implementation of Evidence Based Practice - EBP (Michie et al., 2005)

The integrative framework for studying the implementation of evidence based practice (EBP) was the conceptual framework chosen for this study. The authors stated that there is no "magic bullet" to changing professional practice, and that the effectiveness of guidelines is sensitive to context (Michie et al., 2005:26). They postulated that failure to employ a theoretical understanding of the underlying series of actions involved in changing the behaviour of healthcare professionals may be responsible for unsuccessful execution of guidelines (official suggestions on what and how some activities should be undertaken), and for the failure to achieve desired health outcomes (Michie et al., 2005:26). The framework

was developed through a rigorous process of clarification, simplification, and validation of constructs from motivation, action, and organization theories (Michie et al., 2005:28). The teams of experts were made up of eighteen health psychology theorists, sixteen health services researchers, and thirty health psychologists (Michie et al., 2005:26).

The integrative or consensus framework is made up of twelve theoretical domains of behaviour change (Michie et al., 2005:26). The authors defined a domain as “encompassing a set of similar theoretical constructs” (Michie et al., 2005:28). The twelve domains identified are: (1) knowledge (2) skills (3) social/professional role and identity (4) beliefs about capabilities (5) beliefs about consequences (6) motivation and goals (7) memory, attention and decision processes (8) environmental context and resources (9) social influences (10) emotion (11) behavioural regulation (12) nature of the behaviours (Michie et al., 2005:30-31) see Figure 2:3 on page 77.

All the specific constructs under each domain are presented in Annexure 6. In addition to the twelve domains, the framework provides sets of interview questions (see Annexure 6) related to each domain to help identify and understand problems associated with the professional practice under study, and also to ensure that no domain is unobserved by the researcher (Michie et al., 2005:31,32). The primary concern of the domains goes beyond predicting behaviour, to guiding researchers in arriving at appropriate explanation of the current practice and what could influence a behaviour change for the better by professionals (Michie et al., 2005:27,31). It is required that the behaviour of interest in any behaviour change intervention must be properly diagnosed and clarified (Michie et al., 2005:31). An accurate description of the behaviour in the guideline, makes it easy to identify construct domains to explain the underlying behavioural processes and the possible change (Michie et al., 2005:31).

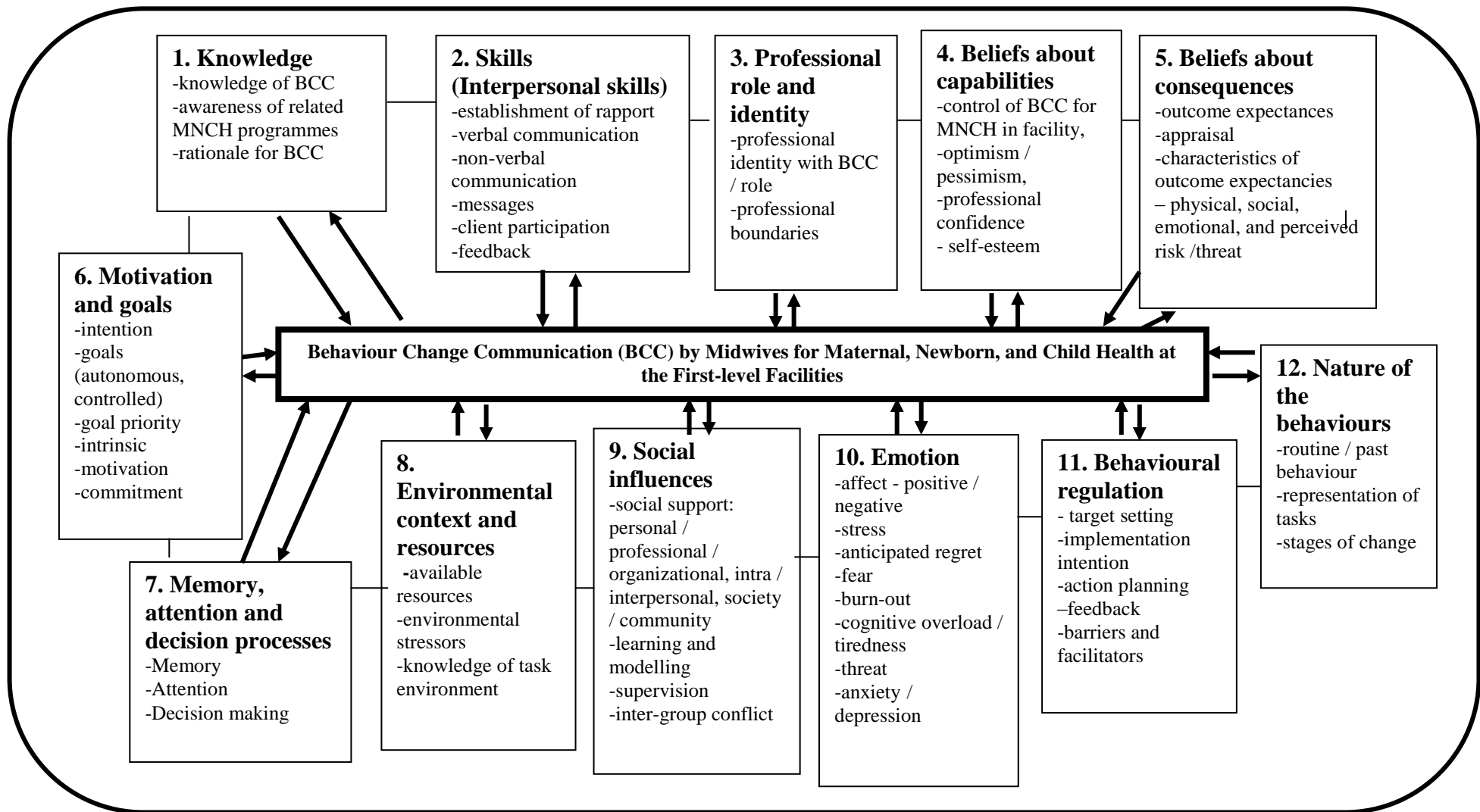


Figure 2:3 Diagrammatic representation of the twelve domains in Michie et al's (2005) *Integrative Framework for Studying the Implementation of Evidence Based Practice* applied to Midwives' Behaviour Change Communication for MNCH. Weaknesses in the domains could hinder BCC activities (indicated by arrow pointing to the centre box), while contextually relevant capacity building programmes to address the weaknesses, and implementation of feasible local action plan could affect the domains positively and make BCC for MNCH result-oriented and effective (indicated by arrows pointing away from the centre box to the domains).

The framework is useful in studying how an evidence-based practice is being implemented and developing strategies for its effective implementation (Michie et al., 2005:27). It is appropriate when seeking explanations of the failure of professionals to behave in a specified manner and/or designing interventions to facilitate implementation of the desired behaviour (Michie et al., 2005:29). It allows logical selection and combination of effective behaviour change techniques and methods (Michie et al., 2005:32). Where interventions had been undertaken without a theoretical basis, the domains could provide greater understanding and better explanations for the documented successes and future planning (Michie et al., 2005:31). The framework has been found useful by health service researchers and relevant in relation to evaluating behaviour change interventions (Michie et al., 2005:28). It was used to understand the behaviour of midwives with respect to clinical guidelines such as: cardiotocograph monitoring and ruptured membranes; and to suggest approaches for effective implementation of the guidelines (Michie et al., 2005:29,31). Similarly, it has been successfully used by nurse-researchers investigating the implementation of an integrated care pathway for community mental health teams (Michie et al., 2005:29).

This framework was chosen by the researcher because of its relevance to the objectives of the study, which are related to understanding the BCC practice of midwives and developing appropriate interventions for effective BCC practice by the midwives to promote MNCH. The variables (the twelve domains) in this framework are clearly defined, observable, and can be manipulated as required of any theory to be applied in behaviour change intervention (Eccles et al., 2005:109; Jeffery, 2004). Furthermore, as it is expected that a framework to guide this research must have evidence of effectiveness in previous studies (Jeffery, 2004), the framework has been used in midwifery practice and other nursing settings (Michie et al., 2005:29,31). In line with Eccles et al.'s recommendation (2005:108) that the framework of

choice should be relevant to the study target population, the researcher saw that this integrative framework addresses professionals' behaviour with respect to the implementation of guidelines, unlike the other behaviour change models which were applicable mainly to clients' health behaviour or health-seeking behaviour. Midwives in this study are health professionals and have behaviour change communication to implement in line with the expectations of the national behaviour change communication strategy (F.M.O.H, WHO., et al., 2005:64,65). Kalita (2006:15) maintained that a suitable model would be able to predict and provide explanation for the influence of social, economic and systemic variables on BCC for any planned intervention to be effective. The domains in Michie et al.'s (2005) *Integrative Framework for Studying the Implementation of Evidence Based Practice* include the above variables highlighted by Kalita (2006:15). The framework was also preferred because of the model questions provided to guide researchers in conducting interviews. One of the data collection methods employed in this study was an in-depth interview and the model questions were adapted in the design of the interview guide. Findings at the diagnostic phase of the study were organized in line with the twelve theoretical domains, and the intervention was made relevant to the context by addressing the gaps identified from the understanding gained using the framework.

The researcher believes that using a framework that provides a comprehensive set of concepts would enhance comparison of findings from this study with similar studies. By combining constructs from many theories and models in this consensus or integrative framework by Michie et al. (2005), the researcher is relieved of the dilemma of choice of appropriate theory often faced by researchers of behaviour change. Eccles et al. (2005:109) remarked that a theory of choice should be useful in predicting and explaining behaviour change in multi-settings. Developers of the *integrative framework* recognized that many researchers in

various health fields are non-psychologists, and have made the framework accessible and useable for “(a) understanding and changing behaviour in interdisciplinary research and (b) intervening to change the behaviour of healthcare professionals” in particular (Michie et al., 2005:28). Figure 2:3 on page 77 presents a diagrammatic summary of the researcher’s expectations by using this framework. By deciding to use this integrative framework, the researcher *assumed* that:

1. The twelve domains would reveal the strengths and weakness related to midwives’ behaviour change communication for MNCH in the facilities (related to research question 1).
2. Clear and comprehensive identification of the weaknesses using the twelve domains would simplify the process of identifying appropriate strategies to address hindrances to BCC activities in health facilities (related to research question 2).
3. If the weaknesses are correctly identified and the suggested solutions are appropriate then the intervention would be successful (related to research question 3)
4. Utilization of skills acquired during the intervention by midwives, to implement action plans that address weaknesses identified in the domains in the various facilities, would strengthen the domains and enhance the process of behaviour change communication in the facilities (related to research questions 4 and 5).
5. The domains could provide a framework for the feedback (evaluation) component of each cycle during the various phases of the study (related to research question 6).

2.6 Conclusion

This chapter presented the literature review under three broad sections and ended with the theoretical underpinnings for the study. The next chapter presents the methodology employed for the research.

CHAPTER THREE RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains the philosophical basis for the study approach. It describes the research design and the procedures employed for sample selection, data collection and data analysis. It presents the blueprint of activities at the various phases of the action research.

3.2 Philosophical Underpinning

The philosophical underpinning or ideological framework for this study is the critical praxis theory (Cohen, Manion, & Morrison, 2008:302). The focus of critical theorists is to critique the traditional way of doing things with an intention to make a positive change where possible (Polit & Beck, 2008:238) or make the method more effective (Cohen et al., 2008:302). Critical praxis ideology is action oriented and combines theory and practice (Polit & Beck, 2008:238). In this study, a lot of performance and application of skills took place in the attempt to reflect the strengths and weaknesses in behaviour change communication functions of midwives, and in the implementation of strategies to effect changes for better practice. Ontologically, the process of behaviour change communication by midwives at the primary level is not a fixed phenomenon. The process is complex in nature, and changes with the context. It is capable of being manipulated by midwives in their respective work places, to meet the need of their clients. Because the researcher knew that the participants were human beings like herself, and, like herself, capable of personal actions, she recognized that they could not be treated or manipulated as impersonal objects or things.

Epistemologically, in search for the much desired new knowledge, the researcher worked together with the midwives being researched in their real world, and the final outcome is a

product of working together in addressing the phenomenon of common interest. Unlike in the positivist paradigm where objectivity is fundamental, axiology within the philosophical view of this study recognized that subjectivity and values are unavoidable and acceptable (Polit & Beck, 2008:14). This is because the study entailed a lot of interactions between humans whose individual and collective behaviours were products of complex bio-psycho-social factors. According to McNiff (2009:7), action research, which is the chosen design for this study, begins with values. As a self reflective practitioner in action research, one needs to be aware of what drives one's life and work, and be clear about what one is doing and why one is doing it. The researcher in this study was motivated because of her concern for the standard of practice as a professional midwife and educator, and it was important that all the participants involved in the study, shared the same interest. The interest of all participants and the researcher was required to promote commitment to and identity with decisions taken, as these wholly endorsed decisions make for sustainability of professional gains learned in the study.

The methodology within the critical praxis framework is qualitative, involving, and appropriate for socio-environmental situations as is the case with this study (Polit & Beck, 2008:14,15). This is unlike in the positivists' world where methodology relies more on the quantitative approach. The methodology for this study adopted an inductive process, using the action research approach to gain an understanding of the midwives' work experience, and to work out what needed to be done to attend to the unsatisfactory aspects of their role performance. The methodology did not seek to prove a *cause-effect relationship* between variables examined in the study as in the positivists' paradigm (IDEAS for Action Research, 2002:3). Data were collected using the *concurrent transformative mixed method strategy* in

which both qualitative and quantitative data are collected at the same time being guided by a theoretical framework (Creswell, 2009:216).

3.3 Research Approach – Action Research with Concurrent Transformative Mixed Method Data Collection Strategy

O'Brien (2001:3) simply describes action research as “learning by doing”. It is both an orderly and learning process (McNiff, 2009 :6). Dick (2009:3) opined that action research is valuable for investigation and to arrive at a diagnosis. This study reflected on the process of behaviour change communication by midwives, and worked to effect changes for better practice where indicated. Both the researcher and the participating midwives were learners in the interactive processes of inquiry and professional development at the various phases of the study.

3.3.1 Why Action Research was the Preferred Approach for this Study

There is an increasing shift among researchers from using the positivist approach for nursing and public health research (Bradley, Curry, & Devers, 2007:1; Herr & Anderson, 2005:25). Researchers using the action research approach are able to utilize qualitative data to overcome the limitations of exclusive quantitative designs (Meyer, 2000:178). Action research is particularly applicable in studies that have to do with socio-cultural aspects of health and behaviour like this study thus providing a firm basis for meaningful reforms for better service delivery and utilization (Bradley et al., 2007:6). According to Meyer (2000:180), action research has been particularly useful in hospital settings, to facilitate the relationship between professionals and their clients. IDEAS for Action Research (2002:2) stated that action research is most valuable when practitioners are reacting to or need to effect a change in practice or training programmes. The need to train health workers to meet the

objectives of the behaviour change communication framework for Nigeria at the health system level is stated in the policy document (F.M.O.H, WHO., et al., 2005:64,65). No specific training programme for midwives, however, was developed to that effect. Most continuing education programmes for professional development used the traditional training approach, where the expert or teacher brought the subject content and delivered it to the learners, with little or no contribution from the latter. Contrarily, fundamental to action research is a situation where practitioners are challenged, supported and helped to find new ways of doing things (McNiff, 2009:16). McNiff (2009:13) informed further that the action research approach to capacity building assumes that the professional is not a novice who needs to be dependent on trainers, rather, she needs a supporter or critical friend, who is also learning in the process of facilitating the professional's development. The ability of midwives to continue to learn from their current field experiences is essential for continuous professional development. Therefore the purpose of this study which is to appraise and facilitate the behaviour change communication process by midwives, at the primary level of midwifery practice in Kaduna State, using the action research approach is in line with the current patterns of professional development.

Action research is useful to nursing because it allows practitioners to identify problems, proffer solutions to the problems, reflect on the effectiveness of the solutions, and makes the practitioners learn more about research in the process (Avison, Lau, Myers, & Nielsen, 1999:94; Webb, 1989:404). Action research connects theory, research and practice, using multiple data collection and interpretation approaches (Holter & Schwartz-Barcott, 1993:299). This makes action research relevant to nursing, which is both an art and a science and cannot be sufficiently understood exclusively by quantitative approaches. The work in this study was undertaken with the active participation of the study participants, thus

considerably narrowing the possible gap between this work and utilization of its gains. Cohen et al. (2008:297) informed that action research is important for modifications in local practice. Action research favours continuing professional development of midwives at the primary health care level by improving their interpersonal communication, counselling, research and teaching skills. By using the action research approach, the researcher aimed at encouraging more positive values and attitudes in midwives with regard to the promotion of maternal, newborn and child health in line with the service oriented strategy of the BCC framework (F.M.O.H, WHO., et al., 2005:64,65).

3.3.2 Approaches to Action Research

There is no consensus on the approach to action research (McNiff, 2009:2); as there is no absolutely right or exclusive approach to it. Rather, action research allows the researcher to consider and work on what is appropriate in her particular circumstances (McNiff, 2009:4). Authors have, however, described four models of action research as: (i) traditional, technical or scientific action research; (ii) practical, mutual collaborative, deliberative or contextural action research; (iii) radical, enhancement or emancipatory action research; (Ferrance, 2000:9; Holter & Schwartz-Barcott, 1993:301-302; IDEAS for Action Research, 2003a; Newton & Burgess, 2008:21; O'Brien, 2001:8-9) and (iv) educational action research (Ferrance, 2000:9; O'Brien, 2001:8-9). The primary focus of traditional, technical or scientific action research is to acquire more knowledge about an area of interest. The researcher only engages other participants at the implementation stage, while trying out an intervention that was pre-determined without the involvement of the participants. In the practical, mutual collaborative, deliberative or contextural action research, all the people involved participate actively in the process of defining the problem, identifying appropriate intervention and charting the way forward. In addition to being practical, and actively

involving the people concerned, the major focus of radical, enhancement or emancipatory action research is social and sometimes political. Attempts are made to create a socio-political awareness that allows for equity and social change to the benefit of the previously disadvantaged. Educational action research is one in which educational experts work inside or outside an educational setting to attend to problems relating to curriculum, professional and social development or improvement with the active participation of the people affected or to be affected by the phenomenon of interest. This study is an educational action research. Although the research protocol was developed and the preliminary data collection undertaken by the researcher, subsequent aspects of the study involved the researcher (an educator) and the midwives (professionals in the field) working together in a co-learning and professional development process, intended ultimately to lead to better client care.

3.3.3 Guiding Principles / Characteristics of Action Research

Researchers differ in their approaches to action research. Literature, however, is replete with consensus on the following fundamental principles or characteristics of action research which were also considered in the design of this study:

3.3.3.1 Principle 1: Action research process is cyclical / spiral – Some steps of action research recur in the same pattern at various stages of the research process (Dick, 2009:3; IDEAS for Action Research, 2002:2). This work was executed in three major phases – the diagnostic phase, intervention phase, and the monitoring phase. Each phase consisted of identification of the activity for that stage, planning how to go about the activity, executing the activity and collecting/analyzing data about what was done. The second phase built on the findings in the first phase and the third built on the second as shown in Figure 3:4 on page 137.

3.3.3.2 Principle 2: Action research is collaborative and participative – The researcher and other participants working together is of utmost importance in action research (IDEAS for Action Research, 2002; O'Brien, 2001:3). Although the degree of participation expected from the researcher and the participants differs from one project to another, it ranges from a total absence of difference between role players to obvious separation of roles (Dick, 2009:3), and the nature of the collaboration could be periodic or continuous (Holter & Schwartz-Barcott, 1993:300). Cohen et al. (2008:301) described the researcher in action research as the facilitator, guide, formulator and summarizer of knowledge, and raiser of issues. Similarly, to achieve mutually agreeable goals for all participants and to promote sustainability, O'Brien (2001:11) indicated that the researcher in action research may adopt many roles at various stages. These roles according to him include being a planner, leader, facilitator, catalyzer, teacher, listener, synthesizer, designer, observer, reporter, and producing professionals capable of sustaining the evidence-based changes (O'Brien, 2001:11). The need to recognize, appreciate and respect the rights and values of all participating individuals and their goals and aspirations in the process was, however stressed by McNiff (2009:2,5). In spite of the possible differences in their responsibilities and professional expertise, partners in action research should appreciate each other as colleagues (McNiff, 2009:16). The role of the researcher in this study was that of a facilitator, supporter and co-learner. Although the entire research process was directed by the researcher, there was no researcher-monopoly at any of the sessions. The whole process was democratic, fair and just. The participants (professionals) made critical inquiry into the major issues of concern in their own practice, with constructive sense of ownership, responsibility and accountability.

3.3.3.3 Principle 3: Action research accommodates mixed methods – Action research works more frequently with language than numbers (Dick, 2009:3; IDEAS for Action Research, 2002:2), although, some research may be a combination of qualitative and quantitative data

collection methods (Dick, 2009:3), as was the case in this study. Some of the data collected in this study was qualitative, through in-depth interviews, focus group discussions, observation, and open ended questionnaire; and some was quantitative, through participants' personal data and workplace questionnaire, pre- and post-tests, and the facility data.

3.3.3.4 Principle 4: Action research is reflective – Each cycle in action research is analyzed to see the results produced by the planned activities (Dick, 2009:3; IDEAS for Action Research, 2002:2; McNiff, 2009:5). This critical reflection on the cycles of planning, action and evaluation at each phase of the research process is fundamental for moving towards the desired change for improved practice, in action research. In this study, the researcher and the participants undertook the critical reflection process together at each phase as part of their learning / professional development process. The reflection at each phase led to the next set of actions in the succeeding phase, towards promoting behaviour change communication for maternal, newborn and child health at the facilities.

3.3.3.5 Principle 5: Action research solves practical problems and leads to change in practice – The desire for change was the key motivating force that led the researcher into looking at this area of practice. Dick (2009:2) sees action research as a methodology with the ability to produce action and research outcomes by one and same project. Action research focuses on specific problems within specific settings for the purpose of improving practice, and benefiting the people (Holter & Schwartz-Barcott, 1993:300). McNiff (2009:8) pointed out that if the desired change is outside the researcher's scope she should be realistic, and cautioned the researcher not to give up altogether, but aim to address some smaller aspect of her work. The scope of behaviour change communication at the primary health care level of midwifery practice is quite broad and involves the facility / administrative structure, the process, and the outcome, and the impact would take a long time to be measurable. Amin et

al. (2008:13) suggested that focus should be on the capacity of the facility to provide services (the processes). The scope of this study was therefore limited to the aspect of behaviour change communication for maternal, newborn and child care within midwives' duty.

3.3.3.6 Principle 6: Development of Theory – Action research starts with an idea that the researcher works on through the various stages of the research process to see if it satisfies his / her desire, rather than starting with a rigid assumption (McNiff, 2009:3). From the findings, the researcher either develops a new theory or works on a previous one (Holter & Schwartz-Barcott, 1993:300) in real work situations (Avison et al., 1999:95). For this project, a number of theories were considered for understanding and analyzing participants' characteristics, and for developing some of the research instruments. The overarching framework (Creswell, 2009:15) which guided and was reflected at every stage of the work was the conceptual framework, that is, Michie et al.'s (2005) *integrative framework for studying the implementation of evidence based practice*.

3.3.4 Steps of Action Research

Steps of action research have been analyzed and described in many ways. McNiff, (2009:6) prescribed eight basic steps of action research process as follows: review your current practice; identify an aspect that you want to investigate; imagine a way forward; try it out; and take stock of what happens; modify what you are doing in the light of what you have found; and continue working in this new way (try another option if the new way of working is not right); monitor what you do; review and evaluate the modified action. Cohen et al. (2008:304) suggested two phases viz: a diagnostic phase in which the problems are identified, analyzed and goals set; and the intervention phase in which the plan is intentionally executed towards achieving the set goals.

This study consisted of the diagnostic, intervention and monitoring phases arranged in line with the objectives of the study. The first stage (diagnostic stage) attended to the first two objectives of the study. Here, the researcher, working with the participants, assessed the strengths and weaknesses of midwives with respect to behaviour change communication, and identified strategies / mechanisms that midwives could use to promote behaviour change communication at the primary level of midwifery practice in Kaduna State. The second phase (intervention stage) focused on the third, fourth and fifth objectives of the study. At this stage the researcher and the participants worked together to bridge identified gaps in the behaviour change communication practice of the participants. The participants were supported to develop the capacity for effective behaviour change communication in their respective units. A support network was established through a facilitated interaction between the study participants and their employers. The third phase (monitoring stage) addressed the sixth objective of the study. Here, the researcher and the midwives monitored the implementation of the planned changes in practice, documented and discussed the observations.

3.3.5 Concurrent Transformative Mixed Method Data Collection Strategy

According to Creswell (2009:15,62), the focus, data collection and analysis, and the organization and utilization of findings, in studies with transformative mixed methods are guided by a theoretical framework; and the studies have both qualitative and quantitative data. The collection of the qualitative and quantitative data could be one after the other according to the phases of the study - sequential, or together at the same time in each phase of the study - concurrent (Creswell, 2009:14-15). The qualitative and quantitative data may be equal or unequal in terms of weight or relevance to the study (Creswell, 2009:216). Therefore, description of the approach for this study as *action research with concurrent transformative mixed method data collection strategy* was caused by the extensive role of the

conceptual framework in the study, and the fact that both qualitative and quantitative data were collected simultaneously at each phase of the study (Creswell, 2009:216).

3.4 The Study Setting

The study took place in Kaduna State. The state is one of the 36 states in Nigeria (see Figure 3:1 on page 92). It was created in February 1976 and has a political significance as the former administrative headquarters of the north during the colonial era (FMI&C, 2007). Kaduna State is located in the centre of northern Nigeria. It shares boundaries with Niger state to the west, Zamfara, Katsina and Kano states to the north, Bauchi and Plateau states to the east, and Nassarawa state and the Federal Capital Territory (FCT) Abuja to the south. It is one of the six states which constitute the North West geopolitical zone of the country. It is made up of three senatorial zones and twenty-three local government areas –LGAs (see Figure 3:2 on page 93). Zaria and Soba (Northern Senatorial Zone), Chikun, Igabi, and Kaduna South (Central Senatorial Zone), and Jama'a, Kaura, and Kauru (Southern Senatorial Zone) were the eight LGAs involved in this study.

Kaduna State occupies an area of approximately 48,473.2 square kilometres and has a population of more than six million, with a near 1:1 male/female ratio (Kaduna State Government, 2008a). The state was ranked third in population in the 2006 national census (N.B.S, 2006:6).



Figure 3:1: Map of Nigeria showing the six Geo-political zones, the 36 States and the Federal Capital Territory (FCT) - Kaduna State is in the North West Zone.

(Source: NPC, & ICF Macro (2009) *Nigeria Demographic Health Survey 2008*. Abuja, Nigeria: National Population Commission (NPC) [Nigeria] and ICF Macro Calverton, Maryland, USA) pp xxx.

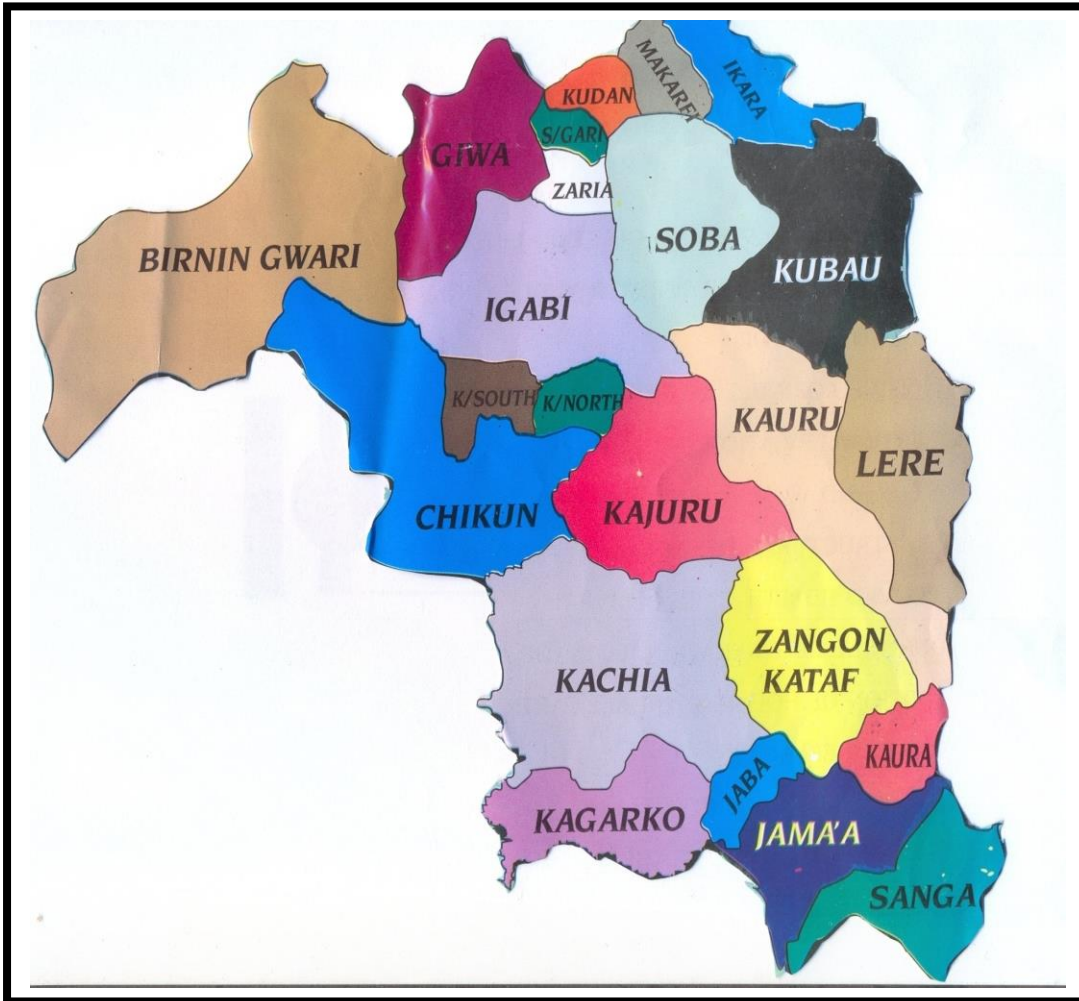


Figure 3:2: Kaduna State map showing the 23 Local Government Areas - K/South = Kaduna South, K/North = Kaduna North, S/Gari = Sabon Gari (Kaduna State Environmental Protection Authority, 2009)

Although the majority live in and depend on the rural areas, about a third of the state's population is located in the two major urban centres of Kaduna and Zaria (Kaduna State Government, 2008a). There are about forty ethnic groups in Kaduna State with diverse religions, arts, culture and languages. Hausa and English are, however, the two most common languages spoken in the state (Kaduna State Government, 2008a). In the northern part of the state, the Hausa and some immigrants from the southern states of the country practice Islam while the majority of the people in the southern part of the state are Christians (Kaduna State Government, 2008a).

The people are predominantly small scale farmers, producing both food and cash crops (FMI&C, 2007; Kaduna State Government, 2008a).

Like most states in the northern part of the country, the health indices in Kaduna State are generally poor. Retention of health professionals in the state has been a great challenge particularly in the rural areas, where social facilities and access roads are very poor. Primary health care facilities in the state are under local government administration and are made up of comprehensive health centres, primary health centres and health clinics. Not all the facilities under the local government are functional or have midwives (F.M.O.H., 2007:2). Many of them were political appointments and currently non-functional. As at 2008, on record there were about 741 such health care facilities in the state. The rural hospitals are under the administration of the state government and because of their locations and maternity units, they also provide first-level maternal and child care services to the community (WHO, 2005:71). There are about 11 rural hospitals in the state. The exact number of midwives in Kaduna State is not known. Nurse to population ratio in the state (irrespective of specialty), is put at 1: 4,230 (Kaduna State Government, 2008b:3) and the entire population of the state is 6,066,562 (N.B.S, 2006:6), giving an estimate of 1,434 nurses in the state.

The government prioritised maternal and child health services in the 2008-2011 policy thrust. The State Ministry of Health anticipated working with other ministries, departments and agencies (MDAs), especially on issues like health promotion (Kaduna State Government, 2008b:13) which is the focus of this study. The state health policy milestones indicated that the knowledge, attitude and practices (KAP) of clients and communities on priority health issues were expected to have increased by sixty percent by 2011.

3.5 Appointment of Validation Group Members (Critical Friends)

Herr and Anderson (2005:60) maintained that the subjectivity inherent in action research should be recognized and critically analyzed with the help of one or more critical friends. Critical friends or members of the validation group should provide critical feedback to the researcher (IDEAS for Action Research, 2002:3; McNiff, 2009:12). According to McNiff (2009:22), a validation group consists of a few people who critically review the work and offer suggestions from time to time, though the researcher is fully responsible for the final decision. Hence, in September 2009, before the actual fieldwork for this research study commenced, some professionals in related fields were consulted and requested to participate as validation group members (researcher's critical friends). A housewife was also involved, to provide feedback from the women's perspective.

All the people invited (see Table 3:1 on page 96) were given copies of the research proposal and the research blueprint. They were duly informed about their roles verbally and through the information sheet. They were also informed of the fact that they could withdraw from the project at any time, without any fear of recrimination. They completed the informed consent form individually, as an indication of their willingness to be in the validation group, except the professor, who gave a verbal consent, and provided feedback on phone or via the e-mail. The researcher and the validation group members met once as a group and members sometimes visited during the interactive sessions the researcher held with the study participants; only one of them attended all the sessions. The researcher did, however, have scheduled discussions with individual members when necessary and considered their suggestions (McNiff, 2009:12). Possible bias from the validation group was borne in mind and prevented. Input from each member of the group is presented in Table 3:1 on page 96.

Table 3:1 Profile of and Input by Validation Group Members

Status	Address	Mode of Contact	Input By Group Member
Professor	Dean, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.	E-mail and telephone (Ibadan to Kaduna is about 8-10 hours drive)	Reviewed the instruments and the procedure. Suggested Pre- and Post-Tests
Chief Lecturer	Department of Mass Communication, College of Administration and Social Studies, Kaduna Polytechnic, Kaduna	Direct contact during the meeting or individual consultations	The only combined validation group meeting was held in his office. Reviewed instruments. Visited briefly during the search conference and the capacity building workshop.
Chief Lecturer	Department of Social Development, College of Administration and Social Studies, Kaduna Polytechnic, Kaduna	Direct contact during the meeting	Reviewed instruments. Suggested FGDs should be conducted in Hausa (main local) language and that the researcher should dress like the northerners to enhance acceptance by the community. Visited briefly during the search conference and the capacity building workshop.
Assistant Chief Midwife Educator	School of Post Basic Nursing Programmes, ABUTH, Zaria (Fellow West African College of Nursing (FWACN), Maternal and Child Health Faculty; Examiner with the Nursing and Midwifery Council of Nigeria)	Direct contact during the interactive sessions or individual consultations	Absent at the combined validation group meeting but present at every interactive session. Validated the Hausa version of the FGD guide, validated the transcribed FGD texts both English and Hausa versions, managed the secretariat at the interactive sessions, presented a paper during the workshop, worked with researcher on the simulated patient, trained and rehearsed with research assistant, and followed researcher on some of the monitoring visits.
Housewife	15, Surame Road, U/Rimi GRA, Kaduna	Direct contact during the interactive sessions or individual consultation on phone	Attended the search conference and capacity building workshop.

3.6 Population of the Study

The study was interested in professional midwives registered by the Nursing and Midwifery Council of Nigeria (N&MCN) who were thus authorized to provide first line care for mothers, newborn and children in the country. It included all midwives and nurse-midwives working at the 11 public rural hospitals and 741 primary health care facilities in Kaduna State. It is estimated that there are 1,434 nurses (including midwives) in the state owned health facilities (Kaduna State Government, 2008b:3).

3.7 Sampling and Sampling Technique

In view of the non-positivist philosophical orientation and the critical praxis ideology adopted for this study, a qualitative sampling approach was considered suitable for the study (Polit & Beck, 2008:14,15).

3.7.1 Sampling

Sampling in the qualitative approach is purposeful (Byrne, 2001:2; Law et al., 1998:6). Marshall (1996:524) expressed the need for qualitative sampling to be flexible and realistic in methodology. Some qualitative sampling approaches include stratified purposeful sampling, snowball sampling (Miles & Huberman, 1994:28; Ploeg, 1999:36), maximum variation sampling (Byrne, 2001:2; Miles & Huberman, 1994:28; Ploeg, 1999:36), criterion sampling (Byrne, 2001:2; Miles & Huberman, 1994:28), convenience, judgment or purposeful and theoretical sampling (Marshall, 1996:523; Miles & Huberman, 1994:28). To have a useful sample, and because of the interest in real people in their real and natural settings, Marshall (1996:524) recommended that sampling must of necessity consider individual and contextual characteristics that have implication for the relevant study. According to Byrne (2001:2),

criterion sampling considers criteria of interest to the study while the maximum variation sampling goes beyond criterion sampling to include the different socio-cultural differences in the population. Similarly, Miles and Huberman (1994:29) suggested that maximum variation sampling should be encouraged because it intentionally takes into consideration the possible variations and similarities to increase representativeness and confidence.

The people in the northern senatorial zone of Kaduna State are predominantly Muslims while those in the southern zone are predominantly Christians (Kaduna State Government, 2008a) and in the central zone, where the state capital is, the beliefs are mixed. The study participants were therefore selected from facilities located in communities across the three senatorial zones. Liu et al. (2006) recognized variations in the lifestyles of people in the urban, suburban and rural areas. Similarly, African Population and Health Research Centre - APHRC (2006:xii) documented variations in the patterns of utilization of health facilities by the urban slum population and those in the rural areas. In Nigeria, there are primary health care facilities in all the local government areas irrespective of whether they are predominantly urban, urban slum or rural. Hence, midwives involved in this study came from the three settings. For the purpose of this study: *Urban area* refers to the city where there are basic infrastructures, offices, industries, and which is inhabited predominantly by workers in the public and private sectors of the economy. *Urban slum area* refers to parts of the metropolis that are overcrowded, have poor housing, lack basic sanitation and are often in bad condition. They are usually inhabited by people of Kaduna State origin and poor city dwellers. *Rural area* refers to local communities away from the cities and development. They are mainly inhabited by people of Kaduna State origin and lack basic infrastructures.

3.7.2 Sample size

Sample size in a qualitative approach is usually small (Ploeg, 1999:36), focused, and purposeful (Law et al., 1998:6). Byrne (2001:2) stated that there is no single method to arriving at the sample size. Byrne (2001:2), however, suggested that the researcher could consider sample sizes used in previous published studies, the scope of his / her study and the resources available to him / her. Guiles (1989) in her study of the nurse as health educator in the modification of health promotion behaviours of hospitalized patients had seven nurses. In his study, Euliano (2001:37) worked with ten medical students in the workshop group. Devine, et al. (2008:108) had a total of seven 1-hour in-service workshops and eleven individual educational sessions (for those who could not attend the workshops) to be able to cover the sixty-eight midwives and nurses in their intervention study, implying that they had fewer than ten professionals per contact. In Ratanawongsa et al.'s (2011:1) qualitative study, the researchers used a purposive sample of primary providers from twelve clinics and looked at seventeen pairs of providers and the providers' patients. For their study on communication training with primary care providers, Helitzer et al. (2011:2) recruited twenty-six providers who agreed to participate in the study, representing 43% of the sixty suitable providers in their study setting. Similarly, Lamiani and Furey (2009:270) examined the effect of a two-day patient education workshop on fourteen nurses.

A sample size not fewer than ten midwives at the different phases of the study was decided upon by the researcher. A small sample size was preferred for this study because the researcher could not predict the intervention phase, which, according to action research depended on the outcome of the diagnostic phase (Lewin, 1948:206). Discussing collaborative learning, Davis (2002:1) advised that a group be limited to six members, saying that groups larger than six have a number of disadvantages which include passivity and lack of sense of responsibility on the part of learners. According to Euliano (2001:36), learners'

knowledge and interpersonal relationship skills are not only enhanced in small groups, but learners' interest and creativity are stimulated and sustained in the learning environment, and in future new circumstances. Similarly, Davis (2002:1), observed that no matter the area of interest, learners learn more when they are intensely involved in small groups, and retention is usually higher than when the regular lecture approach is used. Using the maximum variation sampling approach the facilities and participants were selected as discussed below.

3.7.3 Selection of Facilities

Authors have indicated that it is important for the researcher to provide the details of the selection process for others to understand and appreciate why he / she made such choices (Byrne, 2001:3; Law et al., 1998:6) and also for the credibility of the findings (Byrne, 2001:3). After deciding on not fewer than the ten in Euliano's (2001:37) study, the researcher contacted the Primary Health Care (PHC) Department of the Ministry for Local Government and the Nursing Division of the Ministry of Health Kaduna State for their input. It was assumed that there would be at least a midwife at the primary health care facilities and more than one at the rural hospitals. It was decided that midwives be selected from two rural hospitals and seven primary health care facilities across urban, urban slum and rural areas as in Table 3:2 on page 101.

Table 3:2 Stratification of Local Government Areas (LGAs) into the Three Senatorial Zones and Selection of LGAs, Facilities and the Midwives

State	Senatorial Zone	Local Government Areas (LGAs)	LGAs Selected by Ministry for Local Government	Primary Health Care (PHC) Facilities Selected by Ministry for Local Government	Number of Midwives Recruited from Selected PHCs	Rural Hospitals (RH) Selected by Ministry of Health	Number of Midwives Recruited from Selected RHs	Total Number of Midwives Recruited from PHCs and RHs	
Kaduna State Nigeria	Northern Senatorial Zone	1. Ikara							
		2. Kubau							
		3. Kudan							
		4. Lere							
		5. Markafi							
		6. Sabon Gari							
		7. Soba	Soba	Gamagira (Rural)	1			1	
		8. Zaria	Zaria	Babandodo (Urban Slum)	3			3	
	Central Senatorial Zone	1. Birnin Gwari							
		2. Chikun	Chikun	** Dande (Rural)	1				1
		3. Giwa							
		4. Igabi	Igabi	Zango Aya (Rural)	2	Turunku (Rural)	4		6
		5. Kaduna North							
		6. Kaduna South	Kaduna South	Barnawa (Urban)	6				6
		7. Kajuru							
	Southern Senatorial Zone	1. Jaba							
		2. Jama'a	Jama'a	Emir's Palace (Urban Slum)	2				2
		3. Kachia							
		4. Kagarko							
		5. Kaura					Kaura (Rural)	2	2
		6. Kauru	Kauru	** Barwa (Rural)	1				1
		7. Sanga							
		8. Zango-Kataf							
	Total	3	23	7	7	16	2	6	22

**** No midwife in the initially selected facility in LGA**

To identify the primary health care centres, the PHC Department made the researcher appreciate the government's policy that studies like this must be spread across the three senatorial zones in the state. As such, the twenty-three local government areas in the state were stratified into the three zones. Knowing that many of the PHC facilities have no midwives, the researcher asked that facilities to be selected must have midwives, as the study was not considering other cadres of health workers. Seven local government areas (two from the northern, two from the southern and three from the central senatorial zones) were selected and from these, facilities were later selected from the rural, urban slum and urban communities (see Table 3:2 on page 101). On arrival at two of the selected facilities – Buruku and Dandaura – there were no midwives, the ministry was informed and they were replaced with other facilities from same local government areas, as indicated in Table 3:2 on page 101.

The selection of the two rural hospitals by the Nursing Division was need-driven. The researcher learnt that the state would like the two facilities to be model institutions as the study covered an area of interest to the state, that is, interpersonal relationships. The researcher was informed that the state was about to open a school of midwifery and that one of the two facilities would be the state's choice for community experience for future student midwives on rural posting. The second preferred facility was, however, undergoing major renovation and could not be chosen. The two hospitals selected by the division were Turunku and Kaura Rural hospitals (see Table 3:2 on page 101). The choice of Kaura made the study cover eight local government areas as Kaura was not among the seven LGAs selected by the PHC Department (see Table 3:2 on page 101). Facilities selected by the two agencies of government are as in Table 3:2 on page 101. Seven (77.7%) of the facilities were primary health care centres and the other 2 (22.2%) were rural hospitals (Figure 3:2 on page 101). Six

(66.7%) of the facilities were from rural settings, 1 (11.1%) from urban setting and 2 (22.2%) from urban slum as shown in Figure 3:3 below.

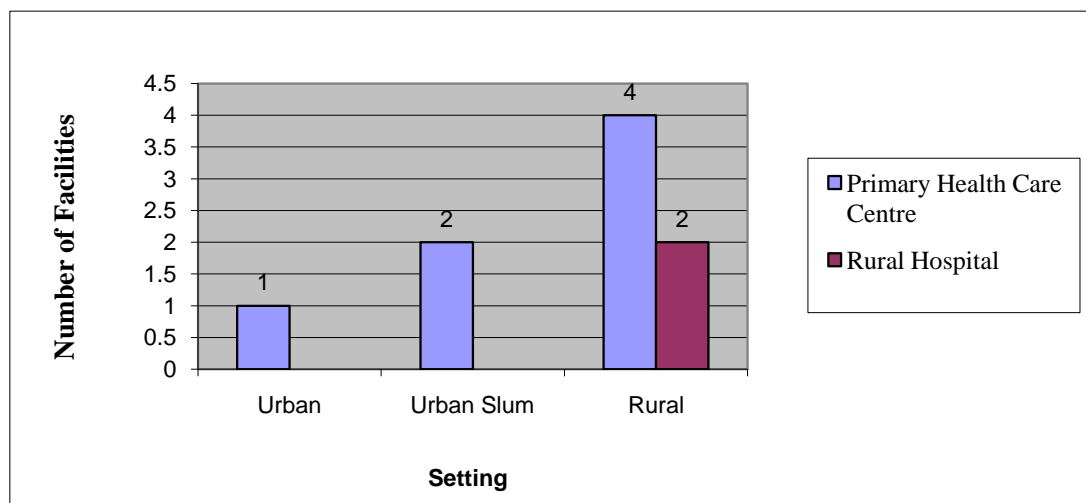


Figure 3:3 Facility type and setting

3.7.4 Recruitment of Midwives (Study Participants)

Midwives in selected facilities (see Table 3:2 on page 101) were approached personally by the researcher and provided with a copy of the information sheet to read and, where required, verbal explanations were also provided, for example on the phases of the project. Interested midwives working at the selected rural hospitals and primary health care facilities who would be fully available during the period of the project were requested to express their consent in writing on the provided consent form. All those who indicated their desire to participate by signing the informed consent form, were thus considered recruited for the study, though they were informed that they could withdraw from the project at any time without any fear of recrimination. The total number of participants recruited was twenty-two, representing 66.7% of the thirty-three qualified midwives in all the nine facilities at the time of the recruitment exercise (see Table 3:3 on page 104).

Table 3:3 Percentage of participants selected from each of the nine facilities

Facility Code (Type – Setting)	Midwives and Nurse/Midwives		
	Total	Interested in Participating	
	Number	Number	%
F1 (Primary Health Care Centre – Rural)	1	1	100
F2 (Primary Health Care Centre – Urban Slum)	4	3	75
F3 (Primary Health Care Centre – Rural)	4 ***	2	50
F4 (Primary Health Care Centre – Urban)	7	6	85.7
F5 (Primary Health Care Centre – Rural)	1	1	100
F6 (Primary Health Care Centre – Urban Slum)	5	2	40
F7 (Primary Health Care Centre – Rural)	1	1	100
F8 (Rural Hospital – Rural)	6	4	66.7
F9 (Rural Hospital – Rural)	4	2	50
Total	33	22	66.7%

*** Three were interns

The number however, dropped to 15 by the final phase of the project due to withdrawal by participants on the grounds of ill-health, transfer from Kaduna State, and heavy workload. The distribution, transfer and withdrawal of participants at the various stages of the study are as in Table 3:4 on page 105.

Table 3:4 Distributions of Participants at Different Phases of the Study

Senatorial Zone	Local government Areas	Facility (Code)		Setting	Number of Participants Recruited	Number of Participants From Each Facility Who Participated At Each Phase Of The Study		
		PHC	Rural Hospital			Diagnostic Phase	Intervention Phase	Monitoring Phase
Northern Senatorial Zone	Soba	Gamagira (F1)		Rural	1	1	1	1
	Zaria	Babandodo (F2)		Urban Slum	3	2 (1 sick and withdrew)	2	- (1 too busy officially, 1 transferred below)
		Angwan Alkali (F12)		Urban Slum	-	-	-	1 (transferred from Babandodo above)
Central Senatorial Zone	Igabi	Zango Aya (F3)		Rural	2	1 (1 withdrew)	1	- (1 transferred by * MSS outside Kaduna State)
			Turunku (F8)	Rural	4	2 (1 transferred to Rigasa below)	3 (1 absent at diagnostic phase joined)	3
			Rigasa (F10)	Rural	-	1 (1 transferred from Turunku Above)	1	1
	Kaduna South	Barnawa (F4)		Urban	6	5 (1 withdrew)	4 (1 very sick withdrew)	3 (1 transferred to Kinkinau)
		Kinkinau (F11)		Urban	-	-	-	1 (transferred from Barnawa above)
	Chukun	Dande (F5)		Rural	1	1	1	1
Southern Senatorial Zone	Jama'a	Emir's Palace Kafanchan (F6)		Urban Slum	2	- (1 withdrew, 1's daughter had surgery)	1 (1 whose daughter had surgery at diagnostic phase joined)	1
	Kaura		Kaura (F9)	Rural	2	1	2 (1 absent at diagnostic phase joined)	2
	Kauru	Barwa (F7)		Rural	1	1	1	1
Total	8	9	3		22	15	17	15

* MSS = Midwives' Service Scheme – A national programme to ensure the presence of a midwife at every delivery and reduce maternal mortality in rural areas

3.8 Data Collection Techniques and Instruments

In action research, an assortment of research tools are employed for data collection and analysis (O'Brien, 2001:9). According to Dick (2009:2), some of the data collection tools and techniques and the approach to data analysis, recur in all the phases of the study, while some are employed in only a number of the phases. This study utilized an assortment of data collection approaches. The type of data collected and data collection techniques employed at each phase of this study were determined by the specific research questions being answered at that phase. In line with the *concurrent transformative mixed method data collection strategy* adopted for this study, and also to enhance openness and have rich data to work with, both qualitative and quantitative data were collected concurrently at each phase of the study. The researcher maintained field notes of observations during all visits to the participants and facilities, from the beginning of relationship to the end of the project. Similarly a diary of daily activities was maintained and sent to the supervisor monthly to help the researcher remain focused and keep the supervisor adequately informed about what the researcher was doing in the field in Nigeria.

3.9 The Diagnostic Phase

The diagnostic phase lasted four months, from the beginning of the phase to the end of the search conference. The purpose of data collection at the diagnostic stage of the study was to show the current state of behaviour change communication practice of midwives at the primary health care level in Kaduna State. This was to assess the strengths and weaknesses of the midwives in relation to the behaviour change communication process and suggest appropriate strategies to attend to the weaknesses (objectives one and two). McNiff (2009:9) recommended at this stage to collect as much data as was deemed appropriate, using different data gathering methods.

3.9.1 Self-administered Questionnaire for Participants' Personal Data

It was important for the researcher to understand the participants with whom she would work on various issues over a long period of time. Because of this need, each participant completed a structured self-administered questionnaire to provide information about her personal data, education, years of experience and workplace challenges [see Annexure 1(a)]. The questionnaire was prepared by the researcher with the support of the supervisor. It was reviewed by the school statistician, and piloted by the researcher on three midwives – two at the PHC Centre, Kakuri and one at the Rural Hospital, Doka. To avoid bias or contamination, neither facility was part of those included in the study. Observations during the pilot were later reviewed by the validation group. The pilot exercise was to remove any ambiguity, and promote ease of administration and data analysis. Adjustments to the instrument included: Insertion of a participant code and facility code to be able to link responses to codes as advised by the statistician. Numerical variables such as age, years of experience and so forth, that were initially grouped, were separated and specific years requested, as advised by the statistician. To the initial question 11 - “Please give reason for your answer to 10 above” the midwives were asking the researcher what to write there. So question 10 was restated as “10. Do you live in the same community where you work? a. Yes b. No.; and a. If Yes, Why do you live in the community where you work? b. If No, Why do you not live in the community where you work?” Question 12 which asked for years of experience as a midwife at PHC level did not specify the rural hospital, so the midwife at the rural hospital could not answer it. It was restated as: “12. Years of Experience as a Midwife at PHC / Rural Hospital level.” The general comment section at the end of the personal data questionnaire was deleted as none of the three midwives involved in the pilot provided additional information.

The questionnaires were administered to the participants after obtaining their consent and collected on the same day, except for the Emir's Palace PHC facility, where one of the two

interested midwives was too busy to fill in the questionnaire, and the researcher paid for the completed questionnaire to be received through the post. At Barnawa PHC some of the midwives were either off duty or on another shift so the officer in charge requested that copies of the information sheet, consent form and the questionnaire be left with her for any interested midwife. This was done, and completed forms were collected two weeks later from the facility by the researcher. At Kaura, forms were also given to the senior midwife on request, for those who were either off duty or on another shift.

3.9.2 Facility (Workplace) Data Form

All the items in the initial participant personal data questionnaire that had to do with staffing in the facility, hours of service, utilization of services and so forth, were removed to form a separate facility (workplace) data form [see Annexure (1b)]. This was because the facility data were not participant's personal data.

3.9.3 In-Depth Interview (IDI)

Knowing that qualitative methods reveal relationships between concepts and behaviours and are most appropriate for appreciating experiences within their context (Bradley et al., 2007:1), information about the behaviour change communication practice of midwives was collected from the midwives using the in-depth interview (IDI) approach. The choice of this method was in view of the shortage of staff, and the possibility of not having an adequate number of midwives in any of the health facilities to constitute an acceptable minimum number for a focus group discussion. Michie et al. (2005:26) observed that without a theoretical understanding of the series of actions involved in a desired behaviour, recommendations on related best practices may not be executed by healthcare professionals. The authors' integrative framework adopted as the conceptual framework for this study

provided a set of structured in-depth interview questions (Michie et al., 2005:30-31), see Annexure 6. These were therefore adapted to develop the IDI semi-structured questions [see Annexure 1(c)] used for interviewing the key informants in this study. The tool was adapted by the researcher in collaboration with the researcher's supervisor. In its adapted form, the instrument consisted of questions related to the practice of behaviour change communication, arranged under Michie et al.'s (2005:30-31) twelve theoretical domains: knowledge, skills, social / professional role and identity, beliefs about capabilities, beliefs about consequences, motivation and goals, memory, attention and decision processes, environmental context and resources, social influences, emotion, behavioural regulation, and nature of the behaviour [see Annexure 1(c)].

The pilot revealed the need to move item 12 a. "What is health behaviour change communication for MNCH?" to 1a. This was because the question was considered as being fundamental to the whole interview. The change was effected in the final IDI Guide. The written consent of the recruited participants who served as key informants was obtained to allow an in-depth interview to be conducted with them, and also for the interview to be tape-recorded. The participants were interviewed personally by the researcher. Where there were more than one participant in a facility, one of them was chosen by the participants themselves, for the in-depth interview in the facility. A total of nine IDIs were conducted. The duration of each interview is presented in Table 3:5 on page 110 with the average duration being 15 minutes. Probe questions were used appropriately, to improve responsiveness.

Table 3:5 Focus Group Discussions and In-Depth Interviews

Senatorial Zone	Local government Areas	Primary Health Care	Rural Hospital	Period: 9 th – 23 rd November 2009 (11 working days)					Dates in November 2009
				FGD			IDI		
				Number of FGDs	Number of Women	Duration (Minutes)	Number of IDIs	Duration (Minutes)	
Northern Senatorial Zone	Soba	Gamagira (F1)		1 (Community)	7	14	1	17	9 th and 19 th
	Zaria	Babandodo (F2)		1 (Facility)	7	19	1	14	10 th
		Angwan Alkali (F12)		-	-	-	-	-	-
Central Senatorial Zone	Igabi	Zango Aya (F3)		1 (Facility)	7	14	1	12	10 th and 13 th
			Turunku (F8)	1 (Facility)	6	21	1	21	9 th
			Rigasa (F10)	-	-	-	-	-	-
	Kaduna South	Barnawa (F4)		1 (Community)	6	7	1	12	12 th and 23 rd
		Kinkinau (F11)		-	-	-	-	-	-
	Chukun	Dande (F5)		1 (Community)	6	31	1	13	12 th and 16 th
Southern Senatorial Zone	Jama'a	Emir's Palace Kafanchan (F6)		1 (Facility)	8	19	1	20	11 th
	Kaura		Kaura (F9)	1 (Facility)	8	21	1	6	11 th
	Kauru	Barwa (F7)		1 (Community)	8	27	1	20	9 th and 20 th
Total	8	9	3	9	63	173	9	135	

3.9.4 Focus Group Discussion (FGD)

A thorough knowledge of the expectations of the community and particularly the women with whom midwives were often involved, was considered essential by the researcher, for any effective behaviour change communication programme for maternal newborn and child health (UNICEF, 2006:40). Therefore, to have the women's perceptions on the behaviour change communication process for maternal, newborn and child health in the facilities, focus group discussions (FGDs) were held with women living in the community within which each health facility existed. FGDs were used because of Amin et al.'s (2008:275) observation that within a short period, FGDs are capable of generating adequate data on issues and exposing the processes influencing outcomes. Polit and Beck (2008:395) suggested that the group size should be 6-12 discussants. According to Debus (2005:13), however, the current trend is for smaller groups of 5 - 7 discussants to allow for greater depth, cohesiveness and meaningful interaction.

Amin et al. (2008:275) stated that qualitative data is valuable when responses flow unhindered in semi-structured discussions where the interview guide is used only as a checklist. A semi-structured discussion guide was developed by the researcher in collaboration with her supervisor. Debus (2005:24) advised that a well thought out and constructed guide makes discussions fruitful. The content of the discussion guide was based on Nigeria's behaviour change communication framework for reproductive health (F.M.O.H, WHO., et al., 2005), the programme communication plan for maternal, newborn and child health (F.M.O.H, 2009), and the interpersonal communication and counselling (IPCC) model used as adjunct to some training programmes by the Federal Ministry of Health in Nigeria (F.M.O.H, 2005a; F.M.O.H, PATHS, et al., 2005). The focus group discussion guide contained questions arranged under the following sub-headings: health facilities and their services, the women's perception of midwives and the quality of their services, their

experience of behaviour change communication practices of midwives, effect of the behaviour change communication, and the women's concept of friendly services and friendly midwives [see Annexure 1(d)]. The semi-structured discussion guide was reviewed by the validation group but no additions were made to the instrument. Because of the low literacy level of women in Kaduna State (NPC & ICF Macro, 2009:334), and to have rich data that would satisfy the purpose of the study, the validation group advised that the FGDs should be conducted in the Hausa language which is the predominantly spoken local language in northern Nigeria. The researcher's use of Hausa language is not fluent. Therefore, after due consultation, a seasoned Hausa journalist working with one of the media outfits in the state volunteered to assist with the translation of the instrument from English to Hausa. A married Hausa female mass communicator was also approached to serve as a research assistant for the FGDs. After the woman gave verbal consent indicating her interest to serve as a research assistant with the FGDs, the researcher educated her on the objectives of the study, the essence of the FGDs, how to gain the women's confidence, the number of women expected per group, how to obtain consent from the women, how to remunerate them afterwards, transcription in the language of discussion, and translation of the Hausa texts to English language. Her wages were also negotiated. By the end of the one-day orientation, the lady gave her consent in writing.

The FGD guide was then translated into Hausa by the journalist. The research assistant worked with the journalist over a two-week period before the commencement of fieldwork. This was to enable her to familiarize herself with the tool, and master the art of interviewing the local women in their settings. In addition, one of the validation group members confirmed the accuracy of the translation of the guide from English to Hausa. The Hausa version of the tool [see Annexure 1(e)] was used for all the nine FGDs. Four of the FGDs were conducted

with women in their home settings and five with women from the health facilities (see Table 3:5 on page 110). This was intended to have a balanced result that ensured that both users and non-users of health facilities were interviewed. Women involved in the FGDs were married women within the childbearing ages (15-49 years), who were actual or potential users of the health facilities for themselves or for their under-five year old children. Community or facility entry was investigated by both the researcher and the research assistant. To avoid bias or mass response if selection had been influenced largely by a significant person, the researcher sought counsel from the officer in charge of each facility on the best way to have an unbiased mix of women. Therefore, entry approach varied from place to place. For community entry at Gamagira, it was suggested at the PHC facility that the community leader be consulted. Although he was not present, he was contacted by telephone and he directed that approval be given for the discussion. For Barnawa, in the urban setting, and Dande, a rural setting, the women were approached freely and brought together. At Barwa, the community health extension worker (CHEW) assisted in securing the consent of the women's husbands but the CHEW was not part of the discussion, so that the women could speak freely. For discussions held at the facility, once approval was secured, the research assistant approached the women personally and, when the desired number was reached, they were removed to carefully selected and comfortable venues, away from the midwives and facility staff. This, as recommended by Polit and Beck (2008:395), was to minimize the possible influence of the environment and personnel on the responsiveness of the women.

At both the home and facility settings, informed consent was duly obtained from each of the women, after the purpose of the study, their expected roles, and the fact that they could withdraw from the discussion without any fear of recrimination had been clearly explained. According to Emanuel, Wendler, Killen, and Grady (2004:931,935), culturally and

linguistically suitable methods should be employed to obtain consent and where written consent is not possible, consent could be tape recorded or documented in writing. Since the majority of the women could neither read nor write, the content of the information sheet and the consent form were presented to them verbally in Hausa. Each woman gave her consent verbally and provided her first and last names as indication of her consent. The names were then written on each woman's form by the research assistant. Consent was also obtained to have each discussion recorded electronically.

The mean group size for the FGDs was 7 women, and on the average the duration of the FGDs was 19.2 minutes (see Table 3:5 on page 110). Adequate group dynamics to stimulate discussions were employed. Prompts or probes were used where necessary to enhance responsiveness. As advised by the validation group members, the researcher wore long dresses with arms and hair acceptably covered. The researcher and research assistants sat on the floor with the women where necessary. All the women who participated at home or in the facilities were paid a token after the discussion though they were not told about it before the discussion. It was a small token, but, because they were not expecting it, they all appreciated it.

The administration of the personal data questionnaire, collection of facility data, conduct of the IDIs and the FGDs were all undertaken in each facility / community on the day the facility was visited, except, at Gamagira (F1) and Barwa (F7), where the participants were not available at the first visit, and at Zango-Aya (F3) where the participant was too busy to attend to the researcher. Appointments were therefore fixed for favourable dates with the midwives for the IDIs, collection of their facility data, and administration of their personal data questionnaire. The FGDs were, however, conducted by the research assistant in the

community or facility on the day of the first visit because the FGDs were independent of the participants and because of the financial implication of bringing the research assistant back to the community at a later date. The data collection lasted from Monday 9th to Friday 23rd November 2009 as in Table 3:5 on page 110.

3.9.5 The Search Conference

The action part of the diagnostic phase was in the form of a search conference. A three-day search conference was organized to appraise the findings from the data collected from the women, the facilities and the participants. The conference was also used for the participants to suggest strategies for bridging any identified gap(s), in the next phase of the study. Search conference has been described as a suitable tool for this type of activity in the action research approach (O'Brien, 2001:9). A typical search conference made up of both plenary and group sessions, is held on a "social island", where participants are separated from their daily routines for about three to four days and occasionally for five days (O'Brien, 2001:10), to attend to the issues of interest.

Invitation letters: Three weeks before the conference, invitation letters [see Annexure 1(f)] were sent to each participant through the Director of Primary Health Care (DPHC) in the Ministry for Local Government, for those in the primary health care facilities; and through the Director of Nursing Services (DNS) in the Ministry of Health, for midwives in the rural hospitals. Direct short messages (SMS) were sent to each participant two weeks before the conference. The validation group members were also invited.

Date and Venue: The Kaduna State School of Midwifery was approved for free use by the government, for all the interactive sessions held throughout the project. The search conference was held on 27th – 29th January 2010 at the Kaduna State School of Midwifery, Tudun Wada, Kaduna (see Table 3:6 on page 116).

Table 3:6 Time-Table for the Search Conference (First Interactive Session)

FACILITATION OF BEHAVIOUR CHANGE COMMUNICATION PROCESS FOR MATERNAL, NEWBORN AND CHILD HEALTH AT PRIMARY HEALTH CARE LEVEL OF MIDWIFERY PRACTICE IN KADUNA STATE

TIME-TABLE: First Interactive Session 27th – 29th January 2010 Held at the State School of Midwifery, Kaduna

DAY	9a.m – 10:30a.m	10:30a.m. – 12:30p.m	12:30p.m. – 1:30p.m	1:30p.m. – 3:30p.m.	3:30p.m – 4p.m.
Wednesday 27 th	Arrival & Registration	<ul style="list-style-type: none"> • Introductions • Review of Project Objectives • Overview of Methodology • Expectations during First Interactive Session 	LUNCH / PRAYER BREAK	<ul style="list-style-type: none"> • Discussion of Findings from <ul style="list-style-type: none"> ○ FGDs ○ IDIs ○ Participants' Questionnaire ○ Facility Data • 1st Group Session 	Plan for Thursday
Thursday 28 th	Group Reports	Development of Plan for Phase Two of the Project		Development of Plan for Phase Two of the Project	Plan for Friday
Friday 29 th	SMALL GROUP / COMMITTEE ACTIVITIES <ul style="list-style-type: none"> • Capacity Building Programme • Messages • Checklist • Etc 			DEPARTURE	

Time-Table / Registration: A time-table of activities (see Table 3:6 on page 116) during the conference was prepared. During the programme, the order of events was slightly modified as in the summary of attendance (see Table 3:7 on page 118). Activities lasted from 9 a.m. – 4 p.m. on the first two days, and from 9 a.m. – 1:30 p.m. on the third day as it was Friday and Muslims’ special prayer day. One hour lunch / prayer break was observed from 12:30 – 1:30 p.m. daily. Participants were registered on arrival. Their names, ranks, institutions, contact addresses, telephone numbers, and e-mail addresses were captured on *particulars of participants’ data sheet* [see Annexure 1(g)], so as to enhance subsequent contacts in the course of the project. The facility and participant codes were confidential and known by the researcher only. An attendance register [see Annexure 1(h)] was maintained throughout the search conference and signed by participants during each activity for record purposes.

Conference materials: Conference materials were given to every registered participant including the validation group members and observers. Each pack consisted of: a plastic file jacket, a copy of each of the overview, FGD matrix and IDI matrix containing excerpts from the FGDs and the IDIs, a summary of the facility data, a summary of participant personal data, a pen, a pencil, an eraser, a sharpener, a ruler, plain and ruled sheets of paper. Other materials used during the conference were: a laptop, a projector, a printer, a digital and a manual audio recorder, flip charts and a flip chart stand, and assorted coloured markers.

Table 3:7 Summary of Attendance at the Search Conference (First Interactive Session)

FACILITATION OF BEHAVIOUR CHANGE COMMUNICATION PROCESS FOR MATERNAL, NEWBORN AND CHILD HEALTH AT PRIMARY HEALTH CARE LEVEL OF MIDWIFERY PRACTICE IN KADUNA STATE

ATTENDANCE SUMMARY: First Interactive Session 27th – 29th January 2010 Held at the State School of Midwifery, Kaduna

S/N	Category	Number Recruited / Expected	Number Registered	Day 1			Day 2			Day 3			
				Introduction	Review of FGDs & Facility Data	Group Session	Review of Personal Data & IDIs	Group Session	Group Work	Group Work	Group Presentation	Departure	
				Number Present at Activity									
1.	Participants (Midwives)	22	15	15	15	15	15	15	15	15	15	Departure	
2.	Representatives of the Kaduna State Ministry of Health's Quality Assurance Unit	3	2	1	2	2	-	2	-	1	-		
3.	Housewife	1	1	-	-	1	1	1	1	1	1		
4.	Validation Group Members	3	3	1	1	1	3	3	1	-	-		
5.	Researcher	1	1	1	1	1	1	1	1	1	1		
	Total =	30	22	18	19	20	20	22	18	18	17		

Human resources at the conference were the participants, researcher and the validation group members (O'Brien, 2001:10).

Attendance: A total of 22 persons were registered for the conference. This was made up of 15 participants representing 68.18% of the recruited 22 participants, 2 representatives of the State Ministry of Health's quality assurance unit (observers), 1 housewife, 3 validation group members, and the researcher as in Table 3:7 on page 118.

Day 1 of the Search Conference: The day's activities started with opening prayers followed by individual introductions. The importance of partnership and professional equality in relationship between the researcher and the participants was reiterated. An overview of the project [see Annexure 1(i)] was presented by the researcher. The participants expressed their expectations from the interactive session and suggested some rules to guide everyone, for example that phones should be on silent. Participants' welfare matters (accommodation and transport) were discussed, activities on the time-table explained, and questions answered before the review sessions. Review of the FGDs and facility data session was facilitated by the researcher. The content of the FGD matrix and the facility data were read through together. All facility and participants' codes remained confidential and known only to the researcher. For the group sessions, the participants suggested that three groups were adequate and members in each group should be mixed, not from the same facility. The participants therefore took numbers from 1 to 3. All the 1s, 2s, and 3s formed groups 1, 2, and 3 respectively (see Table 3:8 below).

Table 3:8: Composition of Participants' Groups during the Search Conference

Group 1	Group 2	Group 3
F71 (PHC-Rural)	F11 (PHC-Rural)	F23 (PHC-Urban Slum)
F45 (PHC-Urban)	F51 (PHC-Rural)	F32 (PHC-Rural)
F41 (PHC-Urban)	F81 (Rural Hospital-Rural)	F84 (Rural Hospital-Rural)
F21 (PHC-Urban Slum)	F42 (PHC-Urban)	F91 (Rural Hospital-Rural)
F82 (Rural Hospital-Rural)	F46 (PHC-Urban)	F44 (PHC-Urban)
Total = 5	Total = 5	Total = 5

In their various groups, participants were to identify the strengths and weaknesses of the participants with respect to behaviour change communication for maternal, newborn and child health, and to suggest appropriate strategies to attend to the weaknesses. Participants were reminded of the ethical principles in the overview [see Annexure 1(i)] and the agreed rules. They were encouraged to see the strengths and weaknesses as belonging to all and not to condemn any facility or midwife and that none should be seen as better than others. The participants had problems executing the tasks and organizing their ideas. It was then decided to suspend the group activities until the researcher provided a worksheet the following day (Day 2 of the conference). Activities for day two were discussed and the first day closed.

Day 2 of the Search Conference: The day started with the outstanding review of the personal data and the IDIs. The contents of the documents were read together before the participants went into their respective groups.

The worksheet: The worksheet [see Annexure 1(j)] designed by the researcher was in form of a template with the items from the FGD and IDI matrices, personal data, and facility data already in the table. It had empty columns for the midwives to insert the strengths, weaknesses, strategies, and the training / support required. It also had two additional columns - the plan and decision columns - for the training manual development committee to work with later. The worksheet was explained to the participants by the researcher and they were able to execute the tasks. The rest of the day comprised group work, using the worksheet. The day ended with an agreement to conclude group work and present the group reports early on the third day.

Day 3 of the Search Conference: Group work was rounded up on the third day. A summary of the activities and observations in each group was presented by a group member to the entire participants.

Development of Plan for Phase Two of the Project: Participants in their groups had suggested among other things, that BCC capacity building workshops and meeting with government officials to present some of the suggested strategies be organized. They also wanted to know about action plans mentioned in objectives 4 and 6 while presenting the overview. The date, duration, time, materials, and invitation letters for the proposed capacity building workshop were discussed together by all. For the date, the participants wanted the workshop within the shortest time but they were informed the programme for the workshop would have to be prepared to meet their needs and expectations and could not be completed earlier than four weeks. Some of the participants suggested the end of February while the majority preferred first week of March because of some scheduled end of month activities at the various local governments. Seven participants wanted the duration to be three days, five wanted four days, while three abstained. The majority did not want more than three days, because this would result in a backlog of clients and they would be overworked the week after the workshop. Three of the participants wanted it on Monday – Wednesday while eleven wanted Wednesday – Friday because of their clinic days. Considering the fact that phase two would not be mostly group work unlike the search conference, but would entail knowledge and skills acquisition, all the participants agreed that daily activities should span through 9 a.m. – 5 p.m. and there should be two break periods – tea and lunch/prayer breaks.

The participants also suggested that their letters of invitation should follow the same despatch routes, that is, through the Director of Primary Health Care and the Director of Nursing. On the issue of the continued involvement of participants who could not attend the search conference, the participants agreed that those with genuine reasons for being absent should be allowed to participate but anyone who was absent from the capacity building workshop should not be allowed to continue. To save cost on materials, it was agreed that all the

writing materials should be preserved till the next phase when new materials would be added. To satisfy the request of the participants for a model action plan, a table [see Annexure 1(k)] was created and a copy given to each facility for those interested to think about before the capacity building workshop when an issue of action plan was attended to.

Committee Activities: A committee of three was constituted by the participants to work on the decisions agreed on at the search conference. It consisted of the researcher, one of the validation group members, and one of the participants (F21). The committee was to design the capacity building workshop in line with the expectations of the participants. The committee met only briefly to decide the *modus operandi* for the group.

Evaluation of the Search conference: An evaluation form [see Annexure 1(l)] was used to document the impression of the participants about the search conference in respect of the introduction, review sessions, group work, time management, duration of the conference, conference materials, achievement of study objectives one and two (diagnostic phase), refreshment, venue, and transportation fee, as well as their general comments.

3.9.5.1 Data Collection During The Search Conference: As suggested by Cano (2009:4), data record sheets used during the conference included the particulars of participants form [see Annexure 1(g)], attendance register [see Annexure 1(h)], the worksheets [see Annexure 1(j)] and the conference evaluation form [see Annexure 1(l)].

3.10 The Intervention Phase

The intervention phase was the second of the three phases of the study and built on the decisions taken in the diagnostic phase.

3.10.1 Development of the Capacity Building Manual

The participants chose the areas of interest they wanted to be covered at a capacity building workshop at the search conference which the committee that was set up would work on. These were utilized by the researcher to source relevant materials to design a capacity building workshop to meet the specific needs of the participants and their clients. Related materials were found scattered in some of the Federal Ministry of Health's training manuals for health professionals in Nigeria. For example, the training manuals on life saving skills (F.M.O.H, PATHS, et al., 2005) and family planning (F.M.O.H, 2005a) contained sections on interpersonal communication and counselling (IPCC); and the national clinical service protocol (F.M.O.H, USAID, & COMPASS, 2006) contained some health education messages. More materials were derived from many other resources in public domain. Permission [see Annexure 4(d)] was obtained to use relevant portions of the interpersonal communication and counselling training manual from the David and Lucile Packard Foundation et al. (2006a). The IPCC content was similar to the Federal Ministry of Health's IPCC model but the manual had additional sections related to friendly service and behaviour change. The focus of the David and Lucile Packard Foundation et al.'s (2006a) training manual was youth reproductive health, hence the need to adapt relevant sections to maternal, newborn and child health.

Members of the committee met on 11th and 12th February 2010. Annexure 2(a) is the report of the two-day committee meetings. The development of the capacity building manual [see Annexure 2(b)] was completed in five weeks. The head of the safe motherhood branch, Federal Ministry of Health, requested to see a copy of the manual and expressed her satisfaction with it, particularly with the section on *marketing of maternal, newborn and child health services using client-centred and customer service approaches*, and she described it as

what was really needed in the country. A copy of the manual [see Annexure 2(b)] was also forwarded to the researcher's supervisor for the School of Nursing, University of KwaZulu-Natal, to also see.

3.10.2 Development of the Pre- and Post-Test Questionnaire

Apart from the capacity building manual [see Annexure 2(b)], the committee also developed the pre- and post-test questionnaire [see Annexure 2(c)], and the marking scheme [see Annexure 2(d)]. Some test items were generated from the developed training manual and forty were selected for use as the pre- and post-test items. The marking scheme was also prepared along with the test items [see Annexure 2(c) and 2(d)].

3.10.3 Development of the Observation Checklist for the Assessment of Midwife-Client Interaction

To assess the interaction between the midwife and the client in the behaviour change communication process, there was the need to identify clearly the events involved (criteria), and to state the acceptable standards (Donabedian, 1981:409). This was to guide the participants, researcher, and other users of the checklist (Mesquita et al., 2010:147). McNiff (2009:11) reported that such criteria are usually stated in behavioural terms and drawn up in form of checklists. The resources used in developing the capacity building manual and Nigeria's IPCC model discussed on page 73 in chapter two (F.M.O.H, 2009; F.M.O.H, WHO., et al., 2005), specified what the health workers should know and do with respect to interpersonal communication and counselling. Since the focus of this study was the process of behaviour change communication, these documents and the views expressed by participants during the diagnostic phase of the project, were used to develop a checklist of criteria for the midwife-client interaction during the behaviour change communication

process. Items on the checklist were organized under interpersonal communication (sender, messages, channel, and receiver), counselling, and documentation [see Annexure 2(e)].

The observation checklist prepared by the researcher was reviewed by the committee of three. Adjustments to the instrument included: making it suitable for self assessment by participants; under *Messages* – “Regular (repeated at more than one visit)” was deleted because observation would be per encounter and probably not with the same patient as implied by the phrase; under *Receiver* – this section was adjusted to 1. Requested for information, responded to / asked questions freely (comfortable / relaxed) and 2. Attentive; letters of all acronyms were highlighted; and “Observer” was changed to “Assessor” to accommodate self assessment by the participants [see Annexure 2(e)]. In its final form, the checklist could be used for self or peer assessment, or by an independent assessor. It could also be used to assess five sessions of midwife-client interactions, so that the participant’s performance could be compared, and the volume of papers would be minimized [see Annexure 2(e)].

3.10.4 The Capacity Building Workshop

Action research is emergent, responsive and solves practical problems (Holter & Schwartz-Barcott, 1993:300; McNiff, 2009:6). The three-day capacity building workshop (the intervention) decided on at the search conference was scheduled for 3rd – 5th March 2010 (see Table 3:9 on page 126). The capacity building workshop was to attend to the identified gaps (weaknesses) in knowledge, attitude, skills and practices related to behaviour change communication process in the midwives’ respective workplaces. This workshop was to answer research questions three, four and five of this study.

Table 3:9 Time-Table for the Capacity Building Workshop (Second Interactive Session)

**Facilitation Of Behaviour Change Communication Process For Maternal, Newborn And Child Health At Primary Health Care
Level Of Midwifery Practice In Kaduna State**

Time-Table: Capacity Building Workshop 3rd – 5th March 2010 Held at the State School of Midwifery, Kaduna

Date	8:30-9:00 am	9:30-10:30 am	10:30 am	11 am -12:30 pm	12:30-1:30 pm	1:30-2:30	2:30-3:30 pm	3:30-4:30 pm	4:30-5:00 pm
Wednesday 3rd March 2010	<ul style="list-style-type: none"> Registration Pre-Test (30 minutes) <p align="center">Validation Group Member</p>	<p>Overview & Introduction to Behaviour Change Process (60 minutes)</p> <p align="center">Researcher</p>	BREAK (30 minutes)	<p>Introduction to Integrated Maternal, Newborn and Child Health (IMNCH) & Review of Primary Health Care (PHC) (90 minutes)</p> <p align="center">F21 - Participant</p>	<p>Marketing of MNCH Services Using Client-Centred and Customer Service Approaches (60 minutes)</p> <p align="center">Researcher</p>	LUNCH / PRAYER BREAK (60 minutes)	<p>Review of Communication and Interpersonal Communication / Counseling (IPCC) Skills & Discussion of the Checklist (120 minutes)</p> <p align="center">Researcher</p>		<p>Group Work (IPC Process using the Checklist) (30 minutes)</p> <p align="center">Validation Group Member / Researcher</p>
Thursday 4th March 2010	<p align="center">Counseling & Individual demonstration (90 minutes)</p> <p align="center">Validation Group Member</p>			<p align="center">Review of the Use of Information, Education & Communication (IEC) Materials & Individual demonstration (150 minutes)</p> <p align="center">Researcher</p>			<p align="center">Community Mobilization (60 minutes)</p> <p align="center">F21 - Participant</p>		<p align="center">Review of Core MNCH Messages - Value Clarification (60 minutes)</p> <p align="center">Researcher</p>
Friday 5th March 2010	<p>Group Presentations (30 minutes)</p>	<p>Challenges of Rural Midwifery Practice / Networking (Special Interactive Session) (90 minutes)</p>	<ul style="list-style-type: none"> Post Test Programme Evaluation Discussion of Next Stage <p>(90 minutes) Validation Group Member / Researcher</p>		<p>LUNCH / DEPARTURE</p>				

Invitation: The letters of invitation [see Annexure 2(f)] to the capacity building workshop were distributed as was done for the search conference, and direct short messages (SMS) were also sent to each participant and the validation group members.

Date and Venue: The workshop was held on 3rd – 5th March 2010 at the Kaduna State School of Midwifery, Tudun Wada, Kaduna.

Time-Table / Registration: As on the time-table (see Table 3:9 on page 126), activities lasted from 8:30 a.m. – 5p.m. on the first two days, and from 8:30 a.m. – 2:30 p.m. on the third day. A thirty minute tea break and one hour lunch / prayer break was observed from 1:30 – 2:30 p.m. daily. The participants were registered on arrival. Names, ranks, institutions, contact addresses, telephone numbers, and e-mail addresses captured on the particulars of participants' data sheet [see Annexure 1(g)] during the search conference were reviewed, and updated where necessary. An attendance register [see Annexure 2(g)] was maintained during the workshop and signed by participants during each activity, for record purposes.

Workshop Materials: The participants had the workshop materials added to the packs they collected during the search conference. The capacity building workshop materials consisted of the training manual, the checklist, cue cards, the diagrammatic representation of the three delivery modes, the action plan template, some plain and ruled sheets of paper. A laptop, a projector, a printer, a digital and a manual audio recorder, flip charts and a flip chart stand, and assorted coloured markers were also used during the workshop. Some information, education, and communication (IEC) materials and job aids collected from the Ministry of Health were also distributed to participants in the course of the workshop.

Human resources at the workshop included the participants, the researcher, the validation group members, stakeholders from the Ministry for Local Government and the Ministry of Health (O'Brien, 2001:10).

Attendance: Seventeen (77.27%) of the recruited twenty-two midwives registered for the workshop. Also present at the workshop were the three representatives of the Kaduna State Ministry of Health's quality assurance unit (observers), one housewife, three validation group members, and the researcher (see Table 3:10 on page 129). There were five guests at the special interactive session. These included the Director of Primary Health Care, the Director of Nursing and an Assistant Director of Nursing, as well as the Principal and Vice Principal of the Kaduna State School of Midwifery.

Mode of Delivery of the Workshop: Progressive professional learning activities according to McNiff (2009:5), assume that professionals can learn independently and they only require a supportive milieu within which to exercise themselves and create new knowledge. That the purpose of the study was *facilitative* was kept in view all through the different phases of the project. Contrary to the traditional approach to training, where there is limited learner involvement, the intervention phase of this project was built on the model of learning where practitioners were stimulated and assisted to discover more productive ways of doing their work (McNiff, 2009:16). The professional development (capacity building) package was implemented by the researcher with active participation by the participants. This learner-oriented approach was based on the assumption that the participants, being professionals, only required a supporter, partner and critical friend, with whom to work and answer their queries instead of an instructor who was totally independent (McNiff, 2009:13). One of the validation group members was in charge of the secretariat and facilitated one of the plenary sessions. Two sessions were facilitated by one of the participants, and the researcher facilitated the remaining sessions as indicated in Table 3:9 on page 126. Questions were entertained and attended to by discussion at the end of each plenary session. The participants retained their groups as at the search conference. In their groups, participants exchanged roles as client and midwives and used the observation checklist for assessment.

Table 3:10 Summary of Attendance at the Capacity Building Workshop (Second Interactive Session)

Attendance Summary: Capacity Building Workshop 3rd – 5th March 2010 Held at the State School of Midwifery, Kaduna

S/N	Category	Number on Register	Day 1						Day 2					Day 3			
			Registration and Pre-test	Overview & Introduction to BC Process	Introduction to IMNCH & Review of PHC	Marketing of MNCH Services Using Client Centred / Customer Service Approach	Review of Communication / IPCC Skills & Discussion of the Checklist	Group work IPCC Process Using the Checklist	Counselling & Individual Demonstration	Use of IEC Materials & Individual Demonstration	Community Mobilization	Values Clarification and review of Core MNCH Messages	Group Work IPCC Process Using the Checklist	Post-test & Preparation for Individual Teaching	Challenges of Rural Midwifery Practice / Networking (Special Interactive Session)	Individual Teaching	Group Evaluation & Individual Assessment
			Number Present at Activity														
1.	Participants (Midwives)	17	14	16	16	16	16	16	16	16	17	17	17	16	16	16	16
2.	MOH Quality Assurance Unit	3	*	3	3	3	*	*	*	*	*	*	*	1	1	*	3
3.	Housewife	1	*	*	*	*	*	*	*	1	1	1	1	1	1	1	1
4.	Validation Team Members	3	1	1	1	1	1	1	1	2	1	1	1	1	3	1	1
5.	Research Assistant	1	*	*	*	*	*	*	*	1	1	1	1	1	1	1	1
6.	Guests for Special Interactive Session	5	*	*	*	*	*	*	*	*	*	*	*	2	5	*	*
7.	Researcher	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Total =		31	16	21	21	21	18	18	18	21	21	21	21	23	28	20	23

Group activities were facilitated by the researcher and the midwife-educator in the validation group. As part of the workshop, a special interactive session was held by participants with top government officials from the Primary Health Care Department of the Ministry for Local Government, and the Nursing Division of the Ministry of Health, Kaduna State. The Zonal Officer, Nursing and Midwifery Council, Kaduna was also invited but could not attend the session owing to other official engagement. Interesting stress relieving video clips were shown during break. All the sessions at the workshop and the special interactive session were tape-recorded with the consent of all participants and those present at the special interactive session.

3.10.4.1 Data Collection during the Intervention Phase: Data were collected during the phase using the pre- and post-test questionnaire [see Annexure 2(c)] and the observation checklist [see Annexure 2(e)]. Records were also captured using various data sheets (Cano, 2009:4) such as the particulars of participants' registration form [see Annexure (1g)], attendance register [see Annexure 2(g)], the workshop evaluation form [see Annexure 2(i)], and individual assessment form [see Annexure 2(h)].

The Pre- and Post-Test: To assess the immediate effect of the intervention on the knowledge of participants, pre- and post-tests were carried out, using the same set of forty test items [see Annexure 2(c)]. At the beginning of the workshop, before exposure to any content of the training manual, the participants were exposed to the pre-test. At the end of the workshop the test was repeated for every participant except the participant who served as a member of the committee and facilitated two sessions during the workshop.

Observation Checklist for the Assessment of Midwife-Client Interaction: After the checklist was reviewed and discussed, it was used in the groups for practical demonstrations and peer assessment. To take a baseline reading, titles of some core messages for maternal, newborn

and child health in the training manual were typed, cut out, folded and each participant allowed to pick one. Each participant then prepared the topic for presentation to the whole class, representing a group of women at her clinic. The observation checklist was then used to assess the interaction.

Individual Assessment Form: Each participant filled in an individual assessment form to document the gains of each individual participant at the workshop. Information requested on the open-ended form included: most important things I have learned; the skills or abilities I have developed; what I would like to improve; what I will start doing now; and what I would like to see change in midwifery practice and education in Kaduna State, and in Nigeria [see Annexure 2(h)].

The Workshop Evaluation Form: The workshop evaluation form was used to capture the views of the midwives about the various activities during the workshop and achievement of project Objectives 3, 4, and 5 - intervention phase [see Annexure 2(i)]. A copy of the form was completed by each of the three groups.

3.11 The Monitoring Phase

It is required in action research that the change in practice, or whatever was being done differently, must be monitored (McNiff, 2009:6). After the capacity building workshop, there was the need to see how things worked out in the practice areas with the participants. This was in line with the sixth objective of the study. Two of the seventeen midwives who participated in the capacity building workshop could not continue with the study (see Table 3:4 on page 105). F21 was too busy officially and F32 joined the National Midwife Service Scheme (MSS) in Kano State outside the study setting. Therefore only 15 (68.18%) of the initial 22 participants recruited participated in the monitoring phase (see Table 3:4 on page 105). The participants' weekly schedule of activities was collected by the researcher to guide

the days of visit. Monthly visits were paid by the researcher to the participants at their workplaces. Days of visits were not made known to the midwives. The researcher and the participants participated in the monitoring exercise, discussing the plan of action developed by the midwives and using the observation checklist.

3.11.1 Action Plan

During the capacity building workshop, participants from each facility developed practicable action plans to enhance their implementation of the gains of the workshop in their facilities. The plans were simple and originated from the participants. They contained statements of the objectives, activities to be carried out, and evaluation. Some also contained the time frame and budget - financial and human [see Annexure 1(k)]. The action plans were discussed during each visit.

3.11.2 The Observation Checklist

At the workshop, each participant was given a copy of the checklist which could be used for five assessments. During the monthly visits, additional copies of the checklist were given to the participants where the previous ones had been used up. Participants' questions about the checklist were answered.

3.11.3 Simulated Patient

Process quality evaluation methods according to Amin et al. (2008:32) include: use of clinical vignettes, simulated patients and observation techniques. According to Mesquita et al. (2010:147), if a simulated patient is to be used, she should have specific counselling needs. At the third (last) visit, the same simulated patient was engaged to assess all the participants at their respective workplaces using the observation checklist [see Annexure 2(e)]. To

develop the patient's case story, essay or vignette, the title of the forty-two core messages for maternal, newborn and child health in the training manual were typed, cut out, folded and someone picked three topics. The researcher developed the stories and prepared a client record booklet for each case. The validation group member who served on the committee crosschecked the stories. A married, Kaduna State woman in her thirties, fluent in both English and Hausa languages, was recruited as a research assistant and to present as the client. Her consent was duly obtained in writing. She was adequately prepared for the three cases by the researcher, and a pilot was also conducted on a midwife to eliminate any ambiguity, and to ascertain the suitability of the research assistant for the task. Findings were discussed with the validation group member.

To choose the one to be used, the researcher, the validation group member and the research assistant met and discussed the selected cases in the light of the Kaduna State context. The three cases were: case one – Drugs in Pregnancy; case two – Warmth for Newborn; case three – Feed Children with Energy-Rich and Nutrient-Dense Complementary Foods from 6 Months, while Continuing Breastfeeding up to 24 Months. The researcher informed the group that she would have chosen *antenatal clinic attendance*, but because of the randomization she did not want to alter the process. Only one case was required for uniform assessment. It was noted that provision of warmth for a newborn was not a problem in the north because of the weather and availability of cheap second hand warm clothing. Breastfeeding up to 24 months was also not a major problem because it was part of the culture and religion. The group agreed on *drugs in pregnancy* for the selected case for discussion [see Annexure 3(a)] because of the prevailing problem of drug abuse and buying of drugs from doubtful sources. Practice of this case was repeated again on the Friday before the commencement of the final monitoring and evaluation visits on Monday 21st June 2010. Participants were not informed

of the time and nature of the visit. During the presentation, participants were assessed by the researcher, using the observation checklist. At the end of each exercise, the client was asked to comment about the participant and the participant also responded. Observations were discussed by the researcher and the participant, and the discussions were described as rewarding by the participants.

3.11.4 Repeat Post-Test

Without prior notification, during the last monitoring visit to each facility, the knowledge of the midwives was reassessed, using the pre- and post-test questionnaire.

3.11.5 Evaluation of Midwives' Workplace Experiences Implementing their Action Plans Post-Intervention

A data capture form - evaluation of workplace experiences post-intervention [see Annexure 3(b)] was created. It was to find out how the following helped the midwives in implementing their action plans and meeting their expectations with respect to behaviour change communication in their workplaces: the checklist; the training manual; the messages; the monthly visits; the facility – supervisors, colleagues, other professionals; the facility – structures, drugs and supplies; the clients; and the community. There was provision for other comments (requests, recommendations, and so forth) on the form.

3.12 Debriefing (Reflection):

In line with the recommendations of Trochim (2006:1-3) and Polit and Beck (2008:196, 539-540), there was the need to provide opportunity for all participants in the project to confirm the researcher's reports and results of the study. All through the various phases, participants had to review the activities preceding the current phase. At the end of the monitoring (the

third) phase, there was the need for them to come together again to review the report of the monitoring phase and confirm the reports of the whole study. The last interactive session was therefore organized for debriefing purposes. Invitation letters were sent out as for the previous two sessions [see Annexure 3(c)]. Fourteen, representing 93.33% of the participating fifteen midwives were present at the debriefing. The only absent participant (F62) had called earlier, explaining that she had to stand in for her supervisor, who was away. Also present at the session was one of the validation group members and the research assistant who conducted the FGDs. The research assistant who played the role of the simulated patient and the other validation group members were away on official assignments. A written apology via an e-mail was received from the safe motherhood official in the Federal Ministry of Health.

The debriefing was held on 29th July 2010 at the Kaduna State School of Midwifery. Copies of the monthly reports of the monitoring exercise, the evaluation of the action plans, the results of the repeat post-test and interaction with the simulated patient were given to each participant. Only participants from a particular facility had access to the report of that facility while the pre- and post-test scores and those from the use of the checklist were given to all. During the session the facility and participant codes that had been kept confidential hitherto were presented to each participant sealed, and they were advised to keep them confidential as they were given only so that they could locate themselves and their facilities in the report and be able to react appropriately. All the reports were reviewed one after the other and the participants' comments taken individually (for the scores) and facility by facility (for the monthly report and the action plans). Observations were treated with utmost confidentiality. Participants who had contrary observations documented them in writing. All the midwives signed and returned signed copies of the reports to the researcher. A general discussion

session was held and opinions of the participants on changes to be made were taken. At the end of the session (unexpectedly) there was a spontaneous delivery of speeches by the participants and the researcher responded.

Appreciation: At the end of the debriefing, letters of appreciation were written to the Ministry of Health, Ministry for Local Government, the School of Midwifery, and the validation group members, thanking them for their cooperation.

The activities during the diagnostic, intervention and monitoring phases of this study are summarized in Figure 3:4 on page 137.

Results: Presented in Chapter Four and Discussed in Chapter Five

Phase (Cycle) Three of the Study – The Monitoring Phase:

- **Planning** – Review of action plans and agreement on pattern of supervisory visits
- **Action** – (three months)
 - Implementation of **action plans**
 - **Hands-on practice** of gains of workshop using: the training manual / core messages, observation checklist, networking and innovative behaviour skills
 - Monthly **supportive visit** / interaction with midwives (study objective 6)
- **Feedback** –
 - Review of monitoring phase (**repeat post-test, second IPC skills assessment, assessment of extent of helpfulness** of reminders, clients, facility human and material resources using a questionnaire)
 - Review of all the phases and all the reports through a one-day **debriefing session**

Phase (Cycle) Two of the Study – The Intervention Phase:

- **Planning** (through committee activity including representative of midwives) – Development of the **training manual** and **test items / observation checklist** in line with midwives' recommendations in phase one, and the planning of the 3-day capacity building programme.
- **Action** (a three day training workshop) –
 - Three day **training** programme (study objective 3)
 - Development of **action plans** to facilitate BCC activities at midwives' work places (study objective 4)
 - Establishment of a **support network** through **interactive session** between midwives and government officials representing their employers (study objective 5)
- **Feedback** – Review of activities in phase two and objectives 3,4 & 5 (administration of **pre- and post-tests**, first interpersonal communication (**IPC**) **skills assessment** using the observation checklist, **individual assessment** using open ended questionnaire, and **workshop evaluation** using evaluation form)

Phase (Cycle) One of the Study – The Diagnostic Phase:

- **Planning** – Twenty-two midwives recruited. Data collected from midwives (nine in-depth interviews and 22 personal data questionnaires); and from women (nine focus group discussions). Information collected about midwives' facilities (9 facility data forms)
- **Action** (through a 3-day search conference) – **Appraisal** of behaviour change communication practices of midwives looking at the data and **identification** of:
 - The weaknesses and strengths (study objective 1)
 - Appropriate mechanisms to address gaps (study objective 2)
- **Feedback** – Review of search conference and objectives 1 & 2 using **workshop evaluation** form

Background / Motivation

- Unacceptably high MNC morbidity and mortality rates related (among others) to consumers' lack of access to correct helpful information to assist in appropriate decision making about their health and promote utilization of facilities for timely interventions.
- Repeated complaints about poor attitude of health care providers including midwives.

Figure 3:4 Outline of phases of the study described in chapter three, utilizing Kurt Lewin's cycle of *planning, action, and feedback* in each phase of *action research* with each succeeding phase building on the previous phase (Lewin, 1948:205)

3.13 Academic Rigor

Academic rigor describes the efforts of the researcher to ensure that the research procedure and findings are believable, acceptable, and useable by the academic and relevant professional communities, as well as other interested members of the wider society.

3.13.1 Trustworthiness (Validity and Reliability of Qualitative Data)

Trustworthiness ascertains the value of qualitative data (Polit & Beck, 2008:196). Qualitative data collected at various stages of this study included data from the in-depth interviews, from focus group discussions, and from the data recording sheets at the search conference, capacity building workshop, and the feedback from the monitoring visits. Trochim (2006:1-3) and Polit and Beck (2008:196, 539-540) agreed that Guba and Lincoln's (1985) criteria for judging the soundness or trustworthiness of qualitative research as an alternative to more traditional quantitative-oriented criteria (validity and reliability) are helpful. These criteria include: credibility, transferability, dependability, confirmability, and authenticity.

3.13.1.1 Credibility – This involves establishing that the results of qualitative research are true and accurately interpreted by the researcher and believable from the perspective of the participants in the research (Polit & Beck, 2008:539-540; Trochim, 2006:1-3). Cohen and Crabtree (2006:3684-3703), stated that credibility may be established through prolonged engagement, persistent observation, triangulation, peer debriefing, and member checks. These, according to Cohen and Crabtree (2006:3684-3703), facilitate openness and ensure that phenomena of interest are accessed and observed. Interaction in the case of this research project between the researcher and the participants spanned through nine continuous months. Rapport and trust were developed between both parties so much that favourable or unfavourable issues were freely discussed without any fear or uneasiness. Multiple data sources and collection methods were used at different phases of the study. Furthermore, data

collected at each phase were reviewed and discussed by the participants, validation group members and the researcher. This reviewing was also necessitated by the fact that action research approach was used for the study and findings from one phase formed the basis for planning and action in the succeeding phase. The participants, members of the validation group, and the researcher had opportunity at the search conference, capacity building workshop, monitoring visits and the final interactive session to verify the records and results, and indicate their observations for discussion and correction where necessary.

3.13.1.2 Transferability –This refers to the degree to which the results of qualitative research can be generalized or transferred to, or be applicable in, other contexts or settings (Polit & Beck, 2008:539-540; Trochim, 2006:1-3). Miles and Huberman (1994:279) suggested that generalization from sample to population may not be very useful in qualitative research and identified two other levels of generalization which included analytic (theory-connected) generalization, and case-to-case generalization. According to Cohen and Crabtree (2006:3684-3703) transferability is achieved through *thick* (detailed) *description*. To enhance transferability, the details of every step taken to arrive at findings in this study, are presented in chapters three and chapter four. Furthermore, Miles and Huberman (1994:279) stressed that the theoretical connection of a study beyond its immediate context gives it more strength and enhances transferability. The adaptation of Michie et al.'s (2005) theoretical domains, the Federal Ministry of Health's behaviour change communication (BCC) strategy and interpersonal communication and counselling (IPCC) model, and the David and Lucile Packard Foundation et al.'s (2006b) IPCC training approach in the study, provided a theoretical network of connection.

3.13.1.3 Dependability – This has to do with consistency, which emphasizes the need for the researcher to account for any unstable circumstances within which the project was executed and how these changes influenced the manner in which the researcher progressed through the work (Polit & Beck, 2008:539-540; Trochim, 2006:1-3). To track changes and enhance accountability, a detailed daily diary of events during the fieldwork was maintained by the researcher and voice recording of every session was undertaken as back-up. Observations were presented to the participants and available validation group member(s) for their views at each session before any changes were effected in the process by the researcher. The major changes during the study had to do with the delay in resumption of some participants, and withdrawal or transfer of a number of participants (see Table 3:4 on page 105). At the diagnostic phase the issue of allowing those not present to continue at subsequent phases was raised. The participants decided that those absent from the search conference (diagnostic phase) for genuine reasons, should be allowed to continue, but anyone absent from the capacity building workshop (intervention phase), even if present at the diagnostic phase, should not be allowed to join again. Similarly, the issue of transferred participants was discussed and only the participant transferred outside Kaduna State was not followed up at the monitoring phase. Since all other transfers were done within the original local government area of the participants they were encouraged to develop an action plan for their new locations, and continue their BCC activities in the new facility. This encouraged the participants and discouraged the idea of allowing the gains of a professional development programme to be compartmentalized, as though not transferable to other settings. These changes have been explained in detail in Table 3:4 on page 105.

3.13.1.4 Confirmability - This refers to objectivity and the degree to which the results could be confirmed or substantiated by others in terms of accuracy, relevance, or meaning (Polit & Beck, 2008:539-540; Trochim, 2006:1-3). This could be established through *audit trail*

which, according to Cohen and Crabtree (2006:3684-3703), could be undertaken personally by the researcher through a very clear explanation of the various steps involved all through the different phases of the study. To achieve confirmability in this study, all results were discussed together with participants at each phase of the study. The personal data, facility data, FGD and IDI matrices with direct excerpts from the transcribed texts were the core of activities at the search conference and all the participants interacted with the results. The results of the pre- and post-tests, and evaluation at the capacity building workshop were revealed to the participants and reviewed together. Similarly, they had the opportunity to go through the reports about their activities during the three months' monitoring exercise. The reports were discussed, they made their comments on copies of the report, signed and returned them to the researcher. Only Barnawa had one contrary observation and an addition. These were indicated on the report, discussed and given to the researcher for correction.

3.13.1.5 Authenticity –According to Polit and Beck (2008:540), *authenticity* was an addition by Guba and Lincoln to their previous four criteria (Lincoln & Guba, 1985). Polit and Beck (2008:540) described authenticity as the extent to which the researcher clearly presents the findings with all the associated emotions and realities, portraying the real lives of the participants. Presented in the chapter on data analysis, in this report, are some direct verbal and non-verbal expressions of participants to provide a fair description of the experiences of the participants.

The trustworthiness of this study was increased by detailed, well explained processes involved in the interpretation of the data through meaningful interaction of the researcher with available pertinent literature (Cano, 2009:4).

3.13.2 Validity and Reliability of Quantitative Data

According to Webb (1989:405), control or comparison groups are not required in action research. The author, however, emphasized that the process of change in the professionals' knowledge, attitude, skills, and practices needed to be analyzed within the same group (Webb, 1989:405). The main quantitative data collected in this study were the participants' personal data (using a structured questionnaire), the facility data (data form), and the reaction of the midwives to the capacity building through the pre- and post-tests (40 test items). The questionnaire consisted of closed- and open- ended items. The questionnaire items were related to participants personal data, education and workplaces and were reviewed by the validation group, piloted on three midwives working in two primary health care centres and a rural hospital. This was done to ascertain the correctness of the instruments, and remove any ambiguity before they were used by the researcher. The checklist for the post-intervention assessment and subsequent monitoring was developed by the researcher, reviewed by the committee and finalized early during the intervention stage by the participants, validation group and researcher working together.

3.13.2.1 Attrition, which could be a threat to the validity of this study, as identified by Lie (2009:3), was borne in mind and prevented as much as possible within the context of the study design. This was done by the researcher's recruiting interested participants directly and not employing the usual nomination approach for engaging participants for staff development programmes (Bradley, Lynam, Dwyer, & Wambwa, 1998). Similarly, a sense of ownership of the project by all was encouraged, through active participation and professional co-learning. The contact periods (dates and duration) were determined by the participants and kept as short as agreed on by all. Other threats like reactive effects, researcher effects and Hawthorne effects were taken care of by ensuring that ethical considerations, as well as the

sense of professional responsibility and accountability, were promoted and sustained throughout the duration of the project.

3.13.2.2 Triangulation - The process of comparing and justifying data from one source to another is known as triangulation (Cano, 2009:4; IDEAS for Action Research, 2003b:7; Polit & Beck, 2008:196). To increase the reliability of this study, multiple data sources were used at every phase of the study. Data from the diary and field notes, in-depth interviews, focus group discussions, participants' personal data questionnaire, pre- and post-intervention tests, and monitoring records were compared in interpreting results in this study. Documentations and reports were double checked (Cano, 2009:4) at the debriefing session.

3.14 Data Analysis

The procedures employed in analyzing both the qualitative and quantitative data are presented below.

3.14.1 Qualitative Data

Data analysis in qualitative studies is an on-going and repeated activity at every stage. As recommended by Bradley et al. (2007:1), data analysis commenced early at data collection and went on throughout the study. According to Polit & Beck (2008:517), qualitative studies that are not the conventional ethnography, phenomenology, or grounded theory, but are descriptive, require simple content analysis. The qualitative data in this study was basically descriptive, therefore, the content analysis procedure employed to analyse the qualitative data was as follows:

3.14.1.1 Transcription - All audio recordings of in-depth interviews, interactive sessions with government officials at the capacity building workshop, and interactions during the

monitoring visits were transcribed personally by the researcher, as recommended by Creswell et al. (2008:104). The focus group discussions were transcribed by the research assistant, who moderated the discussions. She transcribed the audio recordings in the original language of the discussions (Hausa) and translated the Hausa transcripts to English. Both the Hausa transcripts and their English translations were confirmed by one of the validation group members and a staff member of one of the Federal Government parastatals in Kaduna, who also assisted in typing the Hausa texts. Transcripts and translations were compared with the audio recordings during the confirmation exercises.

3.14.1.2 Reading for overall understanding - All transcripts were read through over and over again by the researcher to gain an initial understanding of the content before coding (Bradley et al., 2007:2; Creswell et al., 2008:104).

3.14.1.3 Colour Coding - According to Miles and Huberman (1994:58), it is preferable to create a “start list” of codes before data collection. These are called *a priori* codes and derived from the literature review, looking at pertinent empirical studies and theoretical frameworks (Creswell et al., 2008:107). Michie et al’s (2005) set of theoretical constructs and constructs from the F.M.O.H’s (2005a) interpersonal communication and counselling (IPCC) model formed the researcher’s “start list” (Creswell et al., 2008:107; Miles & Huberman, 1994:58). The words, phrases and sentences related to these constructs were identified in the texts and assigned colours to highlight them in each of the IDI and FGD texts as many times as they occurred. Information provided by the FGD discussants or IDI informants that were not directly relevant to the current study were omitted (Colorado State University, 2009). The same colour was assigned to concepts, paragraphs or statements that were similar in the transcripts.

3.14.1.4 Establishing themes - Themes were derived from the words, phrases and sentences related to the research questions that emanated from the transcripts, and provided clear

perception of the behaviour change communication process (Bradley et al., 2007:5). As indicated by Creswell et al. (2008:109), the researcher, having used *a priori* coding, proceeded to use the twelve (12) theoretical domains by Michie et al. (2005) as the preset categories. These are: knowledge, skills, social/professional role and identity, beliefs about capabilities, beliefs about consequences, motivation and goals, memory, attention, and decision process, environmental context and resources, social influences, emotion, behavioural regulation, and the nature of the behaviour. The texts were searched for the coded themes and arranged under the appropriate categories.

3.14.1.5 Generating results - Data matrices or templates (Amin et al., 2008:275) were created manually. Highlighted words, phrases or sentences from each in-depth interview and focus group discussion were retrieved and arranged within the matrices for cross analysis, participant by participant, and group by group. This made similarities and differences between key informants and focus groups obvious, easy to identify, and explain (Creswell et al., 2008:108).

3.14.1.6 Analysis of the Observation Checklist - Each item on the checklist was examined to see if it was observed at the first and second assessments in each participant's presentation, and across the participants. Observation notes, assessor and client's remarks were also examined and compared with the audio recordings.

3.14.1.7 Presentation of results - The raw data in the IDI and FGD matrices were presented to the participants at the search conference. These served as the working material from which the participants found out the strengths and weaknesses of midwives with respect to the behaviour change communication process for maternal, newborn and child health in the facilities. Interpretation and decisions about the data were undertaken together at the diagnostic phase (search conference). The exercise was fundamental to the development of

the capacity building programme (intervention). Findings at the FGDs, IDIs, and from using the observation checklist, are presented in chapter four of this dissertation.

3.14.2 Quantitative Data

The quantitative data generated in this study came from the participants' personal data questionnaire, the facility data sheet, and the pre- and post-tests scores. The readings on the observation checklist were also assigned values (1 = observed, and 0 = not observed). Data from all these data sources were analyzed using the SPSS 15.0 for Windows. Results were presented to participants at various phases of the study, using tables, graphs, statistical summaries, such as frequencies, percentages, minimum and maximum values, the median, Spearman's correlation coefficient, Friedman's test, and Wilcoxon's signed ranks test. The quantitative data were processed following the steps outlined below:

3.14.2.1 Editing - All the questionnaires / data sheets were examined at point of collection for completeness. This was to ensure usability and to avoid wastage.

3.14.2.2 Coding - Open ended responses in the questionnaires / data sheets were coded in readiness for data entry.

3.14.2.3 Data entry - Participants' responses to each item on the questionnaire (raw data) were entered into the computer personally by the researcher, using the SPSS 15.0 for Windows.

3.14.2.4 Sorting - All the hard copies of the instruments were sorted and grouped according to type and facility, to facilitate retrieval when necessary.

3.14.2.5 Generating results - Although literature recommends the use of *decision trees* for choosing appropriate statistical tests (Burns & Grove, 2009:465-468), the researcher also consulted and worked closely with one of the Faculty of Health Sciences statisticians who assisted the researcher with the correct choice of appropriate tests and interpretation of

findings. Statistical commands for analysis were utilized to produce frequencies and percentages, descriptive statistics, cross-tabulations, and test statistics – Wilcoxon, Friedman and Spearman’s correlation coefficient. These analyses were to provide a description of the participants, the facilities, and the pre- and post-intervention observations.

3.14.2.6 Presentation of results - Results were presented at the various sessions using simple frequency and percentage tables, descriptive statistics, and charts. The charts were created by the researcher, using the Microsoft Office Excel 2007.

3.14.3 Data Management

While the study was going on, data in papers, audio tapes, compact discs (CDs) and flash drives were sorted and stored away for safety and confidentiality, in a room accessible to the researcher alone. As soon as possible, all data in papers and recorders were transferred to a laptop. Data in electronic forms in computers were protected, using a password known to the researcher alone. On completion of the study all tools for data collection will be stored away with the researcher’s supervisor for five years in line with the university’s policy and will be properly discarded in an incinerator thereafter.

3.15 Ethical Considerations

The nature of the project and the action research approach adopted were made clear to everyone involved in the project from the beginning, as recommended by O’Brien (2001:12). Ethical clearance to undertake the study was obtained from the Humanities and Social Sciences Ethics Committee of the University of KwaZulu-Natal, South Africa [see Annexure 4(a)]. Written permission to carry out the study in Kaduna State among the midwives was secured from the Honourable Commissioner for Health, Kaduna State, through the Director of Nursing Services [see Annexure 4(b)] and from the Honourable Commissioner for Local

Government, through the Director of Primary Health Care, Ministry for Local Government, Kaduna State, Nigeria [see Annexure 4(c)]. The medical directors of the selected rural hospitals and all the chairmen of the seven selected local government areas were duly notified by the Ministry of Health and Ministry for Local Government respectively. Similarly, permission to use the State School of Midwifery facilities as venue for all the meetings was sought in writing from the Principal, although the permission was granted verbally. The Principal also informed verbally that the Ministry of Health directed that the facilities be made available at no financial cost to the researcher as it was part of the state's support for the project.

The informed consent of everyone who was involved in the study was duly obtained. Each person's information sheet contained essential information about the study, his / her expected roles, benefits, and the right to withdraw at any stage of the study without any fear of recrimination. See the sample information sheets and consent forms for the different groups: validation group members [Annexure 5(e)], IDI key informants [Annexure 5(a)], the participants [Annexure 5(b)], the women [Annexure 5(f)], the research assistant for the FGDs [Annexure 5(c)], and the research assistant for simulated patient [Annexure 5(d)].

The safe motherhood branch of the Federal Ministry of Health (responsible for maternal, newborn and child health policies in the country) was informed about the study from the onset of the study. The Nursing and Midwifery Council of Nigeria, the regulatory body for nurses and midwives' training in Nigeria, was also duly informed about the project through its zonal office in Kaduna. Most of the materials used in this study were in the public domain, and have been acknowledged appropriately in the body of the work and in the references. Similarly, most of the resources used in developing the capacity building manual were in

public domain. The Federal Ministry of Health materials are open for professional development programmes in Nigeria. Permission was also sought by the researcher from the Programme Officer, to use David and Lucile Packard Foundation et al.'s (2006) *Interpersonal Communication And Counseling (IPC/C) Skills Training Manual For Health Care Providers*. The permission was granted to use the material freely via an e-mail [see Annexure 4(d)].

Because of the expectations and active involvement of participants at every phase of the study (Oettle & Law, 2005:2) the rights of all the participants, group members, clients, and the researcher were consciously considered, repeated at every meeting, and respected all through the project. The study was strictly guided by the following general principles prescribed by McBride and Schostak (2009:3-4):

- *Principle of confidentiality* - No participant or facility identity was required on all the data collection tools. Where codes were used, they were inserted by the researcher after the instrument had been collected from participants. Although participants interacted richly with data and results at various phases of the study, their personal or facility codes were not disclosed to them. Only at the last interactive session (debriefing session), was each participant given her facility and personal code, sealed. This was to allow them to locate themselves and their facility in the reports before confirming the contents of the report. The researcher ensured that no one had privileged access to any information or data storage device on this study except the researcher.
- *Principle of openness* – Openness is fundamental to the success of action research because of the required dynamic involvement of key players. Everyone was encouraged to be open and all the expressed opinions were treated with respect and confidentiality.

This principle was part of the rules agreed upon at the first meeting and it was upheld throughout the project.

- *Principle of empowerment* - Everybody involved in this project had an equal right to be informed, and to engage in any decision directly affecting him / her, to facilitate and sustain change. The Director of Nursing Services and the Director of Primary Health Care were regularly briefed about the direction of the project and the implication for practice in the facilities under their offices. All mails to participants were despatched through the directors' offices. The directors were both involved in the special interactive session held during the capacity building workshop; and the report of the session was prepared and given to them as requested. Each participant contributed to discussions leading to decisions about date, duration, content, refreshment and so forth at the various sessions. The action plans developed by participants for their facilities were left at what they felt they could handle and were not influenced by the researcher.
- *Principle of freedom* - Every participant enjoyed the right to say 'no' to any request, the right of reply, and the right to have a voice in any aspect of the affairs of the research which affected him / her. This was obvious during discussions preceding arrival at dates and format of subsequent meetings. Every hand raised to register an opinion was recognized at every session.
- *Negotiation of access* – The researcher formally requested colleagues and others if they would participate in the study either as participants, validation group members, or research assistants and if they were willing to give up time for the various activities in which they were involved, during the period of the study. No validation group member, participant, or research assistant was coerced to be involved in the study. Those who wanted to withdraw were not persuaded otherwise.

- *Negotiation of accounts* - The researcher ensured that the reports of the various sessions held by everyone involved in the study, during the various meetings were correct. Where indicated, formats designed together were used to prepare the reports. As advised by O'Brien (2001:12), opportunities were provided for participants and validation group members to contribute at various stages of the work and the participants corroborated all the reports at the various contact sessions.
- *Negotiation of boundaries* – At the first meeting (the search conference), rules to guide interactions between persons involved in the study, and to guide interactions during the sessions, were determined by the participants. These rules were repeated at subsequent meetings and upheld throughout the project. They guided interactive sessions and afforded every participant and validation group member due respect and protection from utilizing divergent opinions against one another.

3.16 Conclusion

This chapter presented a description of the research design – the study approach, setting, population and sample, data collection at the different phases of the study, analysis of the qualitative and quantitative data, the academic rigor and ethical considerations. The chapter provided the essential platform for the understanding and appreciation of the findings presented in the next chapter on data analysis.

CHAPTER FOUR PRESENTATION OF RESULTS

4.1 Introduction

This chapter presents the results of the analysis of the data collected during the various phases of the project. The results are presented in the form of narratives, tables, descriptive statistical summaries, and charts. The narratives include some of the direct verbal and non-verbal expressions of the participants, according to the authenticity criterion of trustworthiness, described on page 141. The phases of the study were in line with the order of the research objectives and questions, hence the results have been organized and presented according to the phases.

4.2 Phase One - The Diagnostic Phase

The diagnostic phase of the project aimed at achieving research objectives one and two. Objective one was to assess the strengths and weaknesses of midwives in relation to behaviour change communication process at the primary health care level in Kaduna State. The second objective was to work in partnership with midwives to identify appropriate strategies / mechanisms for promoting behaviour change communication process at the primary health care level in Kaduna State. Data was collected using a self-administered personal data questionnaire [Annexure 1(a)], focus group discussion (FGD) guide [Annexure 1(d)], in-depth interview (IDI) guide [Annexure 1(c)], and facility data form [Annexure 1(b)]. The 22 midwives recruited as participants for the study, from 9 facilities selected from 8 local government areas, across the three senatorial zones of Kaduna State, filled in the personal data questionnaire. One participant from each of the 9 facilities was a key informant for the IDI (see Table 3:5 on page 110). There were 9 FGD groups consisting of women from the facilities and the communities (see Table 3:5 on page 110). Information about each of the 9

selected facilities was collected using a facility data form [see Annexure 1(b)]. Figure 3:4 on page 137 summarizes the phases of the study and data collection at each phase of the study.

4.2.1 Description of Recruited Participants

The 22 midwives who gave their consent to be part of the study represented 66.7% of the 33 qualified midwives / nurse midwives in all the nine facilities at the time of the recruitment exercise (see Table 3:3 on page 104). Of these, 13(59.09%) came from the central zone, 4(18.18%) from the northern zone and 5(22.72%) from the southern zone. Eleven (50%) were from the rural setting, 6(27.27%) were from the urban setting, while 5(22.72%) came from the urban slum setting (see Figure 4:1 below).

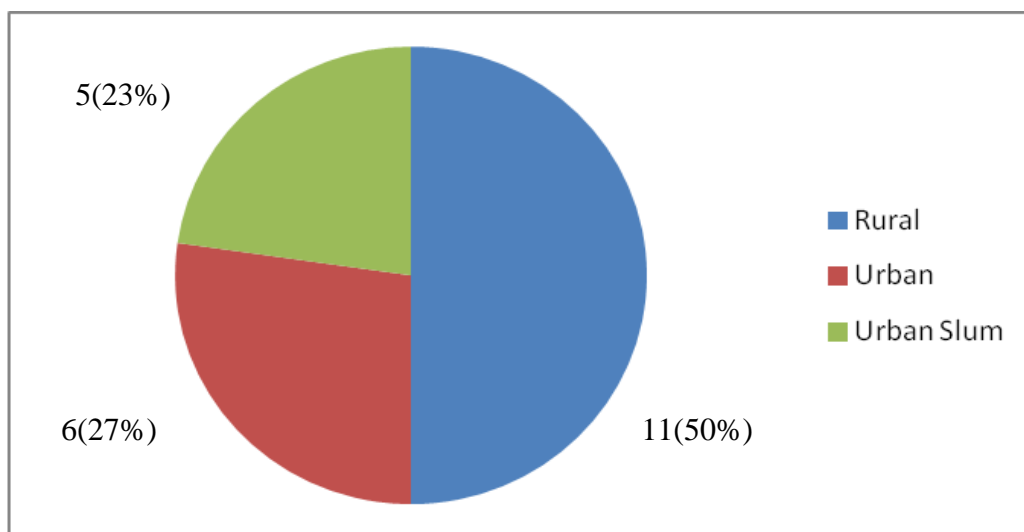


Figure 4:1 Number of participants per setting

4.2.1.1 Personal Characteristics - Two of the participants were about 30 years (9.09%), 5 (22.72%) were aged 31-40 years, 13 (59.09%) 41-50 years, and another 2 (9.09%) were over 50 years. Almost two-thirds [14(63.63%)] of the participants were married, 2(9.09%) were single while the remaining 6(27.27%) were widowed. The majority of the participants [16(72.72%)] were of Kaduna State origin while the remaining 6(27.27%) came from other

states of Nigeria. About two-thirds of the participants were Christians [14(63.63%)] while 8(36.36%) were Muslims (see Table 4:1 below).

Table 4:1: Participants’ Religion, Age, Marital Status, and State of Origin by Setting

Variable	Description	Rural Setting	Urban Setting	Urban Slum Setting	Total
Participant's Religion	Christianity	8(36.36%)	4(18.18%)	2(9.09%)	14(63.63%)
	Islam	3(13.63%)	2(9.09%)	3(13.63%)	8(36.36%)
	Total	11(50.00%)	6(27.27%)	5(22.72%)	22(100%)
Age of participants in years	≤ 30	1(4.54%)	1(4.54%)	-	2(9.09%)
	31- 40	3(13.63%)	-	2(9.09%)	5(22.72%)
	41 -50	6(27.27%)	4(18.18%)	3(13.63%)	13(59.09%)
	> 50	1(4.54%)	1(4.54%)	-	2(9.09%)
	Total	11(50.00%)	6(27.27%)	5(22.72%)	22(100%)
Participant's marital status	Married	8(36.36%)	3(13.63%)	3(13.63%)	14(63.63%)
	Single	1(4.54%)	1(4.54%)	-	2(9.09%)
	Widowed	2(9.09%)	2(9.09%)	2(9.09%)	6(27.27%)
	Total	11(50.00%)	6(27.27%)	5(22.72%)	22(100%)
Participant's state of origin	Abia	-	1(4.54%)	-	1(4.54%)
	Benue	1(4.54%)	-	-	1(4.54%)
	Imo	-	1(4.54%)	-	1(4.54%)
	Kaduna	8(36.36%)	3(13.63%)	5(22.72%)	16(72.72%)
	Kwara	1(4.54%)	-	-	1(4.54%)
	Ogun	1(4.54%)	-	-	1(4.54%)
	Oyo	-	1(4.54%)	-	1(4.54%)
	Total	11(50.00%)	6(27.27%)	5(22.72%)	22(100%)

4.2.1.2 *Educational and Professional Qualification* - The highest educational qualification possessed by the majority of the participants [16(72.72%)] was the West African School Certificate (WASC) or its equivalent General Certificate of Education (GCE) / Senior Secondary School Certificate (SSSC). Two (9.09%) had Higher National Diploma (HND) in Public Health Nursing (PHN), and 2 (9.09%) had Teachers' Grade II Certificate. In addition, one (4.54%) had Secondary School G4 (uncompleted secondary education), and 1(4.54%) had Primary Seven. Professionally, 6(27.27%) had only the midwifery qualification, about half [12(54.54%)] were dually qualified, having nursing and midwifery qualifications, 1(4.54%) had nursing, midwifery and public health nursing qualifications, while the rest [3(13.63%)] had the community health officer (CHO) qualification in addition to nursing, midwifery and public health nursing (see Figure 4:2 below). Eighteen (81.81%) of the participants went through the three-year basic midwifery training, while the other 4(18.18%) had the 18 months post-basic midwifery programme after their general nursing training.

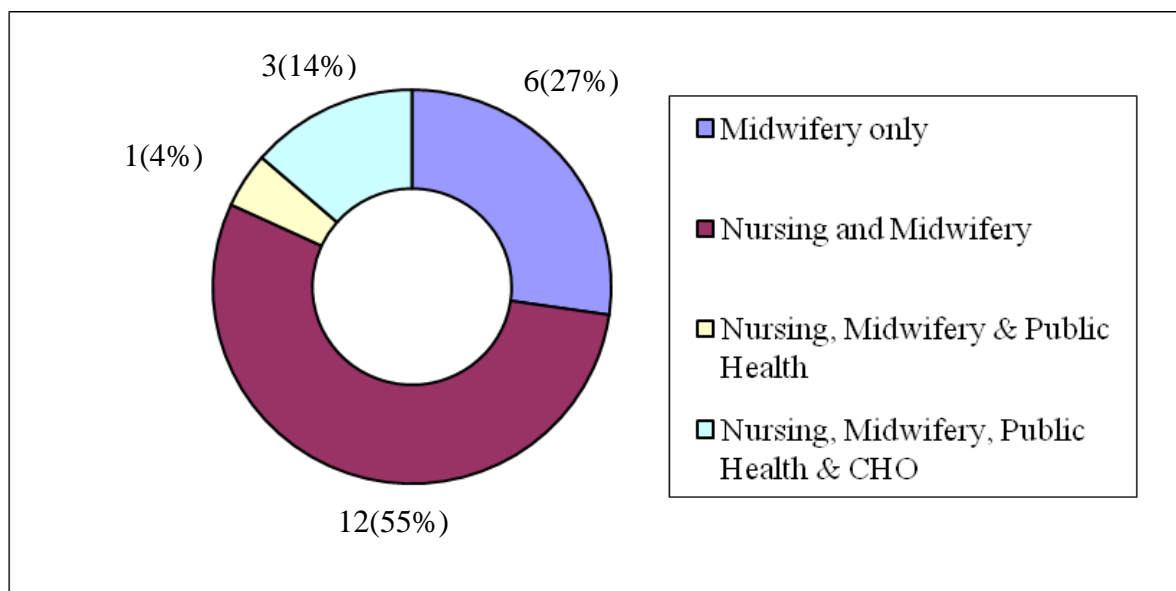


Figure 4:2 Participants' professional qualifications

Six (27.27%) of the participants had not taken part in any professional development programme since qualifying, while 7(31.81%) had participated once, 5(22.72%) had been involved in two, 3(13.63%) in three, and only 1(1.54%) had been involved in four. The various programmes were: family planning - FP [13(59.09%)], life saving skills - LSS [5(22.72%)], integrated management of childhood illnesses - IMCI [7(31.81%)], post-abortion care - PAC [2(9.09%)], HIV counselling / testing and prevention of mother to child transmission – PMTCT – [1(4.54%)], training of traditional birth attendants - TBAs [1(4.54%)], and part-time Bachelor of Nursing Science degree in progress [1(4.54%)].

4.2.1.3 Participants' Experience - Five (22.72%) of the participants had ten or fewer number of years experience as a midwife, 8(36.36%) had 11-20 years, another 8(36.36%) had 21-30 years, and only 1(4.54%) had more than 30 years experience as a midwife (see Table 4:2 on page 157). In terms of experience as a midwife at the primary health care (PHC) / rural hospital level, more than half [13(59.09%)] of the participants had fewer than or had had ten years experience, 4(18.18%) had 11-20 years and 5 (22.72%) had 21-30 years, while none had more than 30 years experience at the primary / rural level of midwifery practice (see Table 4:2 on page 157). The frequency of visit of the participants' supervisors varied. Some indicated that they were visited daily [4(18.18%)], some weekly [4(18.18%)], others monthly [6(27.27%)] or occasionally [8(36.36%)] - see Table 4:2 on page 157. More than two thirds [15(68.18%)] of the participants would remain in their present jobs if given another job offer (see Table 4:2 on page 157). Many of the participants in this category said this decision was because they were almost retiring from service and others wondered what else they could do apart from midwifery. Seven (31.81%), however, would leave their present job for a better offer, though they would still be practising midwifery (see Table 4:2 on page 157).

Table 4:2 Participants' Years of Experience, Supervision, and Intention to Stay on Job, by Setting

Variable	Description	Rural Setting	Urban Setting	Urban Slum Setting	Total
Years of Experience as a Midwife	≤ 10	3(13.63%)	2(9.09%)	-	5(22.72%)
	11 - 20	5(22.72%)	-	3(13.63%)	8(36.36%)
	21 - 30	3(13.63%)	3(13.63%)	2(9.09%)	8(36.36%)
	> 30	-	1(4.54%)	-	1(4.54%)
	Total	11(50.00%)	6(27.27%)	5(22.72%)	22(100%)
Years of Experience as a Midwife at PHC/Rural Hospital Level	≤ 10	8(36.36%)	4(18.18%)	1(4.54%)	13(59.09%)
	11 - 20	2(9.09%)	-	2(9.09%)	4(18.18%)
	21 - 30	1(4.54%)	2(9.09%)	2(9.09%)	5(22.72%)
	Total	11(50.00%)	6(27.27%)	5(22.72%)	22(100%)
Frequency of Supervisor's visit to midwife	Daily	2(9.09%)	1(4.54%)	1(4.54%)	4(18.18%)
	Monthly	2(9.09%)	3(13.63%)	1(%)	6(27.27%)
	Occasionally	6(27.27%)	2(9.09%)	-	8(36.36%)
	Weekly	1(4.54%)	-	3(13.63%)	4(18.18%)
	Total	11(50.00%)	6(27.27%)	5(22.72%)	22(100%)
Whether, if participant has a choice, she would leave or remain on the job	Midwife would leave present job	2(9.09%)	5(22.72%)	-	7(31.81%)
	Midwife would remain on the job	9(40.90%)	1(4.54%)	5(22.72%)	15(68.18%)

4.2.2 Strengths and Weaknesses of Midwives With Respect To Behaviour Change Communication (BCC) at the Facilities

To achieve the first objective of the study, a 3-day search conference (see page 115) was held and participants reviewed the IDI matrix, the FGD matrix, the facility data and the participants' personal data. From these databases, the participants identified strengths and weaknesses with respect to BCC for maternal, newborn and child health (MNCH) in the facilities, using the worksheets [Annexure 1(j)]. The strengths (findings that support BCC activities of midwives in the facility) and weaknesses (findings that militate against BCC activities of midwives in the facility) identified from the different data sources by the participants are organized below using Michie et al.'s (2005) theoretical domains (the conceptual framework). Under each domain, the findings are presented first, followed by the strengths and weaknesses as identified by the participants. **MF** represents the in-depth interview key informant in the facility; **WF** represents the women in FGD group, whether community or facility based group.

4.2.2.1 Knowledge of BCC for Mother, Newborn and Child Health (MNCH) - Constructs considered under this domain are knowledge of BCC for MNCH and rationale for BCC for MNCH. This domain covered what the participants understood by behaviour change communication dealing with maternal, newborn and child health and the participants' awareness of any government initiatives to promote BCC for MNCH. For example: provisions of the national behaviour change communication strategy for promoting MNCH by providers, or the Kaduna State's obstetric and perinatal records for caring for women from pregnancy through puerperium. The state's record booklet contains some elements of education for MNCH to encourage health promotion by providers, though the details were not specified.

Findings – Some of the participants interviewed during the IDI had no idea of what BCC for MNCH meant, and some asked if it was the same as the health talks at antenatal clinic. One, however, explained it in terms of improving the behaviour of the care providers to enable them to provide more friendly services:

...health workers are being informed on the way that they should be more friendly with the clients, ... change their attitude...not to be harsh ... (so that) the client can be free to say what she wants to say and what she wants to do (MF2 – PHC urban slum).

and another saw it as:

... a process to change the behaviour of people, in a certain community or certain belief, in terms of health of either the mother or the child (MF6, PHC urban slum).

Most of the participants interviewed were not aware of the behaviour change communication framework for maternal, newborn and child health. One said she glanced at but did not go through it. None of the participants interviewed in the rural hospitals had seen or used the Kaduna State obstetrics and perinatal records booklet.

No we don't have it here. You know in this rural place, it's not everything we get (MF 8 - rural hospital)

Participants in four of the primary health care centres, however, had seen the Kaduna State obstetrics and perinatal records booklet but it was used in only three of the centres. Where used, the booklets were only used to book (register) new pregnant clients but follow up cards were used for subsequent visits, instead of the relevant follow-up pages of the booklet. Where neither the booklet nor card was available, participants used notebooks (of ruled sheets) or loose ruled sheets of papers for client records, so they had no access to the few client education elements in the obstetric and perinatal record booklet. Only one of the participants attended a workshop on the use of the perinatal record booklet. She said, however, copies were not supplied to her facility, so it was not being used. Some of the facilities, however, had the partograph (the labour monitoring component of the booklet). Informal conversation with one of the maternal and child health coordinators in Kaduna State revealed that the

booklet had been introduced by the state's development partners to about seven (7) local government areas (LGAs) in the state a couple of years earlier. The LGAs were expected to continue to produce copies for their facilities, while the state was expected to cover the remaining sixteen (16) LGAs, and the trained midwives were to pass on the training to their colleagues. The coordinator regretted that there seemed to be no continuity since the development partners concluded the project.

Strengths – Sincerity of those who had no idea, suggested a need or willingness to know; understanding that BCC for MNCH affects both providers and consumers.

Weaknesses – Lack of awareness of BCC for MNCH; limiting BCC for MNCH to health talks at antenatal clinics; lack of access to the state's obstetric and perinatal record booklet; using the booklet for booking only (see Figure 4:3 on page 181).

4.2.2.2 Interpersonal Skills to Execute BCC for MNCH in Facilities - Constructs examined in this domain included competence for interpersonal communication (establishment of rapport, verbal communication skills, non-verbal communication skills, messages, client participation, and feedback), and midwife-client (women) relationship. This domain covered the participants' perceived ability to execute BCC for MNCH to the required standard using the skills standard of the Federal Ministry of Health's interpersonal communication and counselling (IPCC).

Findings – Some of the participants believed they had the required skills for health education and counselling. One confessed she did not know the new methods. None of the participants, however, was aware of the required standards for interpersonal communication for MNCH. Messages midwives discussed with the women had to do with care after delivery, care of the baby, how to prevent complications, how to seek appropriate care if a complication occurred, and family planning. During the FGDs, however, the women (WF) provided more

information on their experiences with midwives. According to the women, what midwives discussed with them included: personal, environmental and food hygiene; care of children; early antenatal booking; drug abuse; family planning; exclusive breast feeding; safe delivery; prevention of early marriage; to seek care early for a sick child or mother when in danger; and postnatal care. Some women said they were satisfied with the information provided by midwives, while others said they wanted more information on how to avoid complications, type of foods and drugs to avoid in pregnancy, AIDS, child care and upbringing, postnatal care, and birth preparedness. Similarly they wanted to know more about midwives in facilities and they wanted midwives to help talk to their husbands.

Like AIDS, we (women) would like them (midwives) to educate us more, it would give us more knowledge on those aspects. We would also know how to protect ourselves (WF3 rural – facility).

... to explain more about the midwives' roles (WF5, Rural – Community).

... we would like to know more about pregnancy and child upbringing (WF4 urban – community).

They (midwives) should tell us what and what to buy for example when we come to antenatal they give us a list of things to buy for the unborn baby... when we are at home, we will hand it over to our husbands so that they (husbands) will now see for themselves why we are at the hospital ...so this type of help is very good (WF9, rural – facility).

(stooping down close to the research assistant) We (women) want you (midwives) to advise our husbands on our health matters. They should be giving us money for the hospital where we will be taken care of, so that we and the baby will be healthier. There was a time when I was pregnant, the foetus lay incorrectly, I could not sleep at all, I only used one side of my body. I spent many days in pain. I went to the hospital twice, I was asked to bring money whenever I'm coming. Since I could not afford to, so I had to endure and stayed at home with the pain until I was through (WF7, rural – community).

The women also wanted to be educated about the care given to a sick person.

Let the health workers be enlightening or informing us of what is wrong with us (WF1, rural – community).

We will want the health workers whenever we bring a patient to let us know any drugs they prescribe to the patient. They will just be giving us drugs and after the ill person

has recovered they will send us home without us knowing the kind of ailment that individual suffered from (WF5, rural – community).

The women said that midwives greeted them, spoke to them cheerfully, politely and in a lively and understandable manner using the vernacular.

They (midwives) start by greeting, that is welcoming us, how do you feel, how is the baby in you, that's all; they don't have any other work apart from that (WF6, urban slum – facility).

... create fun time making us sing and dance or even exercise to make blood flow all over the body. After the fun, (the midwives) start things (routine ANC) (WF1, rural – community).

Sometimes midwives, however, talked harshly and unacceptably to the women.

... it is good for them (midwives) to try and talk to us in a polite way, that will make you feel better and happy ... when ... they become harsh to you, it will do nothing more than worsen the situation (WF7, rural – community).

Women here are predominantly Hausa so they (midwives) communicate in Hausa. Non-Hausa speaking women depend on other women to tell them what is said because if they ask the midwives they will not explain (WF4, urban – community).

... no attention ... neglecting you, making you feel like waste ... for delivery sometimes they (midwives) neglect you saying all bad things, like why didn't you come earlier. Sometime ... not even accept you (WF2, urban slum – facility).

Some midwives asked the women if they had questions.

After all their advice on antenatal they (midwives) do ask us whether anybody has questions to ask and whenever there is, they do answer us politely (WF8, rural – facility).

Some midwives appreciate it when clients participate actively.

They (midwives) do reply that they really appreciate the way we came to the hospital ... answer us nicely so that those (women) that are refusing to come should be motivated (WF5, rural – community).

They appreciate if after the health talks we ask questions, when we show we understand their response they feel happy (WF6, urban slum – facility).

Some women, however, did not know that they could ask questions, or ask questions about their concerns that were not related to the topic discussed for the day.

I didn't know I could ask when it is not what we were taught (WF3, rural – facility).

When the women asked questions or expressed opinions different from midwives', midwives reacted in different ways. According to the women,

Some (midwives) do answer you very well, sometimes they (midwives) ignore our questions saying that they are unimportant questions, but sometimes they feel very happy when you ask them and they answer you nicely and correctly. Some of the health workers hate interruption; they always want to finish their saying before you ask any question you want to ask. Then they will answer you according to their knowledge (WF2, urban slum – facility).

We feel happy with the ways they respond or answer our questions. More especially the experienced midwives are not like the new ones, you know all those young girls of nowadays, they will answer your question anyhow, disrespectful way. Since she (midwife) is not even married, but for the married ones it is the opposite side (WF9, rural – facility).

When there is differing opinion, they will listen to what we have to say, and then they will advise us more on the issue ... Explain everything very well (WF4, urban – community).

Strength – Perceived ability to give health talks and counsel mothers.

Weaknesses – Participants' lack of knowledge of the required standards for interpersonal communication and counselling (IPCC), some women's lack of knowledge of who the midwife in the facility is and her roles; lack of partner involvement making women ask that their spouses be talked to; limited variety of issues covered by midwives; ignoring clients' questions and seeing clients as interrupting; talking disrespectfully / harshly or neglecting those who did not understand the language of communication (see Figure 4:3 on page 181).

4.2.2.3 Professional Role and Identity with BCC for MNCH - Constructs looked at in this domain are professional identity / role and professional boundaries. Under this domain is the participants' perceived purpose of BCC for MNCH, how it is related to their work, and who else should be involved.

Findings – The participants said that the BCC guidelines or the Kaduna State obstetric and perinatal records were very important, and could be useful in improving obstetric care in the country. Where the booklet was being used for booking (registering) pregnant women, it was

said that the materials could provide useful information about the clients to enable the users to know the clients' problems, and how to help them. The participants believed that where such guidelines were available, the midwives could improve their attitude and practice, and as such, the guidelines should determine what midwives do with respect to BCC for MNCH. They also recognized BCC for MNCH as being in line with their work as midwives. The participants did not see BCC for MNCH as the exclusive responsibility of midwives. They believed other health care providers like the nurses, doctors and community health extension workers (CHEWs) should be involved. One of them said that the midwives cannot do everything. The major source of health messages on maternal and child health, common to all the women in the FGD groups, is the nurses and midwives in the facilities. Some said they also listened to the radio or watched the television sometimes, while one woman mentioned her mother, and another mentioned health workers in her women's meetings. The only source of information on health matters for many, however, is the health facilities even where they have radio and television.

Truly, this (the health facility) is our only way; end of discussion (WF8, rural – facility).

Some preferred the facility because, unlike the electronic media, the midwives in the facilities could clarify issues of interest.

But we all here prefer the awareness from the hospital because if there is any place or question you need to ask, then you can go ahead and ask and they will give you an answer (WF5, rural - community).

Strength – Appreciation of the BCC for MNCH guidelines as relevant to midwifery and to determine what midwives do.

Weakness – Women's near total reliance on health workers in facility alone for health information, despite MNCH messages promoted through the mass media in the state, and the fact that some have access to electronic media but do not use them (see Figure 4:3 on page 181).

4.2.2.4 *Beliefs about Capabilities* - Constructs examined under this domain are control of BCC for MNCH in facilities, optimism/pessimism, professional confidence, and self-esteem. Presented under this domain, therefore, is the ease or difficulty with which BCC for MNCH is executed in the facilities and the participants' perceived ability to continue up to the required standard under existing circumstances.

Findings – Most of the participants interviewed felt what they were currently doing in the form of health education (health talks), is difficult.

Sometimes it is difficult (MF1, PHC rural).

Ha! It's not easy. It's not easy (shakes head). *That's the thing* (MF6, PHC urban slum).

It's difficult oh! (MF7, PHC rural).

Is not easy but we (midwives) *are trying to convince them* (clients). *At the end of the day we will win them* (MF8, rural hospital).

A few of the participants, however, felt confident, comfortable and quite equipped for what they were presently doing.

I am very confident because it will help them (clients). *If they* (clients) *will accept, you must be confident in doing it. If ... not ...* (you) *cannot convince them ... it's difficult but ... be trying* (MF3, PHC rural).

I am confident within myself so that they will know that I am superior. Because, if I am just saying hen (stammering), *even they* (clients), *won't take me seriously* (MF8, rural hospital).

The participants said that repeating what they were saying, asking women if they had questions and, continuing to try, would solve the problem. None of them, however, confessed having the capability to maintain a required standard of BCC for MNCH in the facility. To some, that would depend on the authority in charge of the facility.

Strength – Confidence and sense of capability to deliver health talks and counsel clients; expression of the desire to continue in spite of difficulties

Weaknesses – Uncertainty of adequacy of capabilities to desired standards; health talks / counselling very difficult for the participants; some lacked confidence in giving health talks, counselling, or facing clients; some showed feeling of being superior to client (Figure 4:3 on page 181).

4.2.2.5 *Beliefs about Consequences* - Constructs such as outcome expectancies, appraisal, and characteristics of outcome expectancies – physical, social, emotional, and perceived risk /threat were considered under this domain. This domain covered what could happen if BCC for MNCH is or is not carried out, the worth of BCC in terms of doing or not doing it and the consequences.

Findings – The participants believed that BCC was good for the health of both the mother and child and could reduce maternal and child mortality. The participants expected some positive changes in the knowledge, attitude and behaviour of the clients even if not total.

They (clients) will have the knowledge ... understand what is good for them (clients) ... avoid some of the dangers (MF1, PHC rural).

At least to some extent we have a good percentage of change of behaviour in our community... can't be 100% ...that's the truth ... It makes you (midwives) to at least do your work effectively; you would enjoy the work (MF6, PHC urban slum).

There will be much improvement, even the women will know ... the proper care, the way they can handle something before they even come to the hospital (MF7, PHC rural).

On the part of the women, they make use of what they learn from midwives. They said that it influenced their knowledge, drug compliance, and health seeking behaviour in respect of their sick children.

... if they didn't tell us we would never know ...some of the things I didn't know before (WF3, rural – facility).

... the moment a child is ill we do not hesitate but take him to the hospital (WF1, rural – community)

We benefit a lot. When a child is sick we are given drugs and advice on how to use them (WF7, rural – community)

Some of the women use what they learn selectively, some according to their resources, and some with the assistance of their spouses or others. Where the messages appeared to be beyond what the women could do, they adapted the messages to suit their purposes.

... back home we (women) used to try and make use of what they (midwives) say we should do...we do take the important ones more (WF2, urban slum – facility).

Anything they say to us when we come back home we will meet our husbands and inform them, more especially if we are given a prescription, to buy drugs that will make our children healthier (WF7, rural – community).

When they say you should eat this or that and you think these things are expensive and you can't afford them, you go for the cheaper ones like vegetables, beans, and so forth, I think we can all afford these... (WF1, rural – community).

According to the participants, the cost of doing BCC for MNCH is cheaper than that of not doing it. To them it is better to do BCC for MNCH than not to.

The not doing it would cause more problems because they (clients) wouldn't know what to do; but when they know it will reduce much work for us (midwives) (MF7, PHC rural).

What the participants thought would happen if BCC were not done was grave, including deaths of mothers and children.

... they (clients) are ignorant of everything, so dangers; ... most of them will have problems.... most of their children will die ... even ... the women (MF1, PHC rural).

... consequences will be so much, ... dangerous to the women and children ... (MF2, PHC urban slum).

...would have been worst ... if we don't do it how can they know what is good and bad? They won't know ... (MF3, PHC rural).

Ha! There is a lot of things oh! ... doing it is helping, us (midwives) ... even the patients ... it helps them a lot (MF8, rural hospital).

About how participants feel if BCC is not done, they said they felt it was not good and made them feel they had not achieved anything.

Ah! It's not good. It's better to tell them. If I tell them (clients) the truth, and they refuse, To! (an Hausa expression of surrender) God knows I've already told them the truth (MF1, PHC rural).

Ha! At the end of the day honestly, once you finish the day's work you feel you have not achieved something (MF6, PHC urban slum).

They, however, feel good and satisfied when the clients are educated.

Feel good doing it because they (clients) ... are accepting it (MF9, rural hospital).

If I'm able to change a behaviour, even one a day I always feel happy (MF6, PHC urban slum).

I will feel somehow (excited) because the women are enlightened and enlighten others when they get home (MF8, rural hospital).

These feelings, according to the participants, indicate that doing BCC for MNCH is advantageous.

Strength – The belief that doing BCC for MNCH would bring good change, cost less than consequences of not doing it, and that not doing it would cause problems making things worse; feeling happy if BCC was done and bad if not.

Weakness - Talking without considering clients' background and interest led to women's selective compliance (see Figure 4:3 on page 181).

4.2.2.6 Motivation and Goals - Constructs considered in this domain are intention, goals (autonomous, controlled), goal priority, intrinsic motivation, and commitment. Presented here are findings on the extent to which participants wanted to do BCC for MNCH and what encouraged them to do it.

Findings - Most of the participants interviewed said they were eager and happy to do BCC for MNCH, seeing it as their profession and because they want others to have the knowledge. Others were not so eager to do it for fear of the culture and religion of the people and because some of the women might not comply. The participants, however, still did it because they would suffer for not doing it.

Hen! We (midwives) still tell them (clients) because if we don't tell them, in fact we (midwife) will be facing the problem (MF4, PHC urban)

Too many patients, an emergency, and booking (registering new pregnancies) could interfere with the health talks. As much as possible, however, some of the participants arranged for the health talks to be given routinely even if not in details or for the required length of time. Health talks as a routine and part of the procedures women go through, especially at the antenatal clinic, encourages BCC for MNCH. To the participants BCC for MNCH did not conflict with other maternal and / or child guidelines they knew of. Participants were only paid their salaries. Their encouragement came from their belief in God as their rewarder, from women's freedom to discuss with them, from women's improved knowledge, and from positive changes in the community which could be credited to them.

... it's reward from God, Ko?(isn't it? in Hausa) ... I'm doing it because of God (MF1 PHC Rural)

... it's only God will help us even, not matter of salary (MF5, PHC rural)

...Really I feel I am satisfied with it especially after counselling a woman and she asks me so many questions, and we discuss, she is free, she comes to me anytime she wishes, I feel the joy (MF2, PHC urban slum)

... it's (helping the community to change) among our nursing rules and regulation ... it's our pride ... to do something may be in one of the villages or community where you are working, and you are able to change their attitude at least ... they will say malama (madam in Hausa) this came, this is what is happening ... it's like a credit ... (MF3, PHC rural)

... we gain from patients' questions by learning new things and having the opportunity to further enlighten them (MF8, rural hospital)

Strength - Eagerness; seeing BCC for MNCH as a professional responsibility covered by salary; fear of God as a rewarder.

Weaknesses - Giving health talks or persevering for midwives' own safety and not their clients' interest; fear of religion and culture (see Figure 4:3 on page 181)

4.2.2.7 *Memory, Attention and Decision Processes* - Constructs considered here are memory, attention, and decision making. This domain covered the frequency of using BCC for MNCH by participants in the facility, what prompted or reminded them to do BCC for MNCH, and what could make them decide otherwise.

Findings - The interviewed participants said that health talks were given routinely though the frequency varied from one facility to the other. Health talks were given daily in some facilities and once or twice weekly in others, at antenatal clinics. This was corroborated by the women in their groups.

...they (midwives) will give us all their advices before they start antenatal procedures (WF3, rural – facility).

Advice is given when we are at the hospital ... especially to those that are pregnant (WF9, rural facility).

Apart from being a routine, the participants said they remembered to give health talks for various reasons, which included the need for it, and their having something to say. The women also said that midwives talk to them:

... when we are sick and we go to the hospital, then they (midwives) will start advising us on all these things, but not just like that - i.e. not routinely (WF5, rural – community).

According to the participants, however, they may be discouraged and decide not to do it if results of doing it are not visible.

When some (clients) don't want to hear ... after you talk, talk, talk, talk, and they refuse, you say Hun! Why am I bothering myself? Let me forget about them (clients). (MF6, PHC urban slum).

Strength – Health talks were given in the facilities.

Weakness – BCC for MNCH in some facilities is done only when clients are sick; midwives may decide not to when clients appear unyielding (see Figure 4:3 on page 181).

4.2.2.8 *Environmental Context and Resources* - Constructs examined are available resources, environmental stressors, and knowledge of the task environment. Presented under this domain is the availability of resources and how the resources in the facility support or hinder BCC for MNCH; as well as the influence of time and other tasks on implementing BCC for MNCH.

Findings - According to the interviewed participants, shortage of staff, inadequate accommodation - small space for ANC clinic, lack of conveniences, lack of privacy and safety, plus inter-professional issues, hindered BCC for MNCH. The participants said further that, competing tasks and time constraints could also affect BCC for MNCH in a facility, because when midwives were too busy or had to spend a long time with a particular client, then they saw BCC for MNCH as time consuming, or it had to be suspended for competing tasks.

(Took a deep breath) Well, it's only taking time ... the time you spend, you continue to attend to one person and tell them individually, because it's during booking that we always do that ... we interview individually ... we interact with them (MF4, PHC urban).

If you don't have many staff, definitely it is time consuming ... sometimes you may spend more than an hour with a patient, you can't condemn that patient you have to take time, follow this, follow that .. it prevents you from doing other things; and to some of the patients (those waiting to be attended to) it's as if you neglected them (MF6, PHC urban slum).

The women in the FGDs also acknowledged some of the constraints:

The way we (staff and clients) do things here are somehow different. Patients used to be many for the health workers, for example look at the midwives of this morning. The patients are many and the midwives have been working since early... The issue of poor salary ... is also an additional problem related to their (midwives) job. It would be better if government should increase their salaries because you can see they will be working from morning till night. Whenever you bring a sick person they are always here to attend to you (WF9, rural – facility).

Some facilities had posters and the one in the urban setting had promotional materials and information leaflets from some companies. One facility had posters but put them behind the door for lack of space and the participant explained:

That's why it's good for us to have our own separate place (MF8, rural hospital).

A participant said:

We don't have anything. I only use my initiative to tell them the most important things I know (MF5, PHC rural).

In addition to the views of the key informants, the participants, in their personal data form, provided information on the challenges they faced that could interfere with BCC for MNCH in their facilities. Of the 22 participants, 17 (77.27 %) mentioned staff related challenges which included lack of / or inadequate qualified or technical staff; lack of motivation and encouragement; poor conditions of service; and no visiting doctors (to see complicated cases). Fourteen (63.63%) of them identified system related factors such as inadequate space; no privacy; transportation problems causing poor referral system; lack of water supply; no generator; lack of basic amenities (light, toilet, bathroom, water, the patients use bush); very close to a major highway, and the failing free drug programme. Another challenge mentioned by 13 (59.09%) of the participants was the lack of equipment, while 2(9.09%) mentioned lack of / or insufficient free drugs; and no insecticide treated nets for antenatal mothers. The facility data also confirmed constraints identified by the participants, such as the gross shortage of staff and distance of referral facilities.

Strengths – Adequacy of space and posters in some of the facilities.

Weaknesses – Time constraints; staff shortage; lack of privacy; lack of toilets and bathrooms in some facilities; lack of job aids; poor personnel remuneration; lack of free maternal and child drug programmes in some facilities; poor referral system (see Figure 4:3 on page 181).

4.2.2.9 Social Influences - Constructs looked at include social support that is, personal / professional / organizational support, intra / interpersonal support, society / community support; learning and modelling; supervision; and inter-group conflict. This domain covered

the extent to which peers, managers, other professional groups, patients, and relatives supported or hindered BCC for MNCH in the facility; and whether or not the participants would benefit from modelling of BCC for MNCH to improve their skills.

Findings - MF3 (PHC rural) enjoyed the support of the health committee and together they trained traditional birth attendants with whom she worked hand in hand and sometimes attended workshops on MNCH. The other key informants did not enjoy such social support.

I'm the only one; sometimes I use my own money to buy items to motivate the women (MF5, – PHC rural).

A participant said that:

It depends on where you find yourself ... the type of community ... the type of religion, or ... certain behaviours ... (MF6, PHC urban slum).

Many of the participants interviewed associated the difficulties they had with BCC for MNCH with the clients. This, according to the participants, is because of the socio-cultural background of the clients, poverty, and the low level of education. Some participants felt that some women did not listen to or comply with what they were told while others saw them as being difficult to convince.

... if you explain to them ... tell them the truth about health ... like bringing their babies for immunization ... sometimes they will refuse ... sometimes they will not even listen. To!(To! is an expression indicating helplessness in Hausa). Sometimes, they will hear but to practise is the problem (MF1, – PHC rural).

... they may say they are charmed (bewitched) ... (MF6, PHC urban slum)

... they don't even take you seriously ... because you are not from their community, ... not part and parcel of them ... (MF7, PHC rural)

... some ... don't understand quickly (MF9, rural hospital)

Similarly, 13 (59.09%) of the 22 participants in their questionnaires indicated the client-related challenges they faced that could hinder their BCC for MNCH activities as - ignorance (gravida 11 refusing family planning, they prefer home delivery); difficult to be convinced; lack of education; poverty (not all drugs are free); refusal of community members to take

women to a referral facility when necessary. Eight (36.36%) of them identified other social challenges as lack of support from the community; unnecessary threats from members of the community (when midwives go for home visits); religion / cultural barriers; traditional beliefs; language barriers and the presence of a lot of private clinics in the urban area. Furthermore, most of the women in the FGD groups, particularly those in the urban slum and rural areas confirmed their failure to utilize the facilities for delivery. Some attended the antenatal clinics and delivered at home while some neither attended the antenatal clinic nor delivered at the facility. According to them they use the facilities mostly for their children and sick women.

We use the clinic for antenatal and general check up (WF1, rural – community).

... only come for antenatal ...have never delivered here... (WF3, rural – facility)

...we have never delivered in the hospital (WF6, urban slum – facility).

Their reason is basically because home delivery is traditional.

*This is an old way of giving birth from the beginning; women don't go to hospital to give birth. ... Not like in the city, where you see a pregnant woman who is not sick taken to the hospital to give birth. We give birth at home. ... Whenever you see a woman give birth at hospital, it means she is sick at the time. When you are sick they will take you to the hospital and collect drugs and bring you back home so they will go and call the local midwife (TBA) for you, for the delivery (the women laughed) and in response to the probe on what if there was a serious case they said *We go to the hospital* (WF7, rural – community).*

The women, however, reported being tired of the TBAs and desired good midwives.

These midwives (professional midwives) that you are talking of, it is good for government to look for a good one and bring to our hospital because we used to get tired of these old women (TBAs) that do nothing more than to bath your baby. As you know they are old and illiterate but the midwives in the cities (professional midwives) know how to educate you ... since they (TBAs) are illiterate they don't know what to do or to say about health (WF7, rural –community).

The majority of the women do not deliver in the facilities, however, women in all the groups reported that they enjoyed the health talks and felt happy and great when listening to midwives. They believed the midwives and appreciated their efforts.

We do believe very well, all they are saying, because we know what they are saying is true (WF5, rural community).

We believe them. For example when your blood pressure is high then they will send you to a bigger hospital so that they will check you very well there and give you drugs. Sometimes it is not because they don't know or cannot handle it, no, but they have to send the patient to an advanced hospital so that they will use instruments that they may not have here. They are really trying their best for us (WF6, urban slum – facility)

The participants desired to watch others do BCC for MNCH because they believed others would learn and gain from it.

Ah! We will like oh! Because every day you learn (MF4, PHC urban)

I believe I will gain more (MF9, rural hospital).

Strength – Desire to learn more; women are tired of TBAs and want professional midwives.

Weakness – Lack of social support and threats from community; participants' poor understanding of clients' behaviour and of clients' reaction to their BCC for MNCH activities; women's lack of awareness of the presence of a professional midwife in the community and request for a "good" one; poverty; poor educational level; language, religion and cultural barriers; presence of private clinics, chemists (drug vendors) and TBAs (see Figure 4:3 on page 181).

4.2.2.10 Emotion - Constructs considered under this domain are positive and negative affect, stress, anticipated regret, fear, burn-out, cognitive overload / tiredness, threat, anxiety / depression. Under this domain is the emotion evoked by BCC for MNCH and how midwives' emotions influence BCC for MNCH.

Findings - Behaviour change communication for maternal, newborn and child health evoked pleasant emotions in the participants, especially when clients complied with the counsel and experienced positive changes. To one of the participants it was a time for a humanitarian job. Emotional factors do not hinder most of the participants. The participants felt that as

professionals, emotional factors should be controlled and not allowed to hinder. A participant who was not happy with the way a crisis in her workplace was handled by her supervisor concluded

So sometimes I feel bad doing it; true! ... Unless someone clears the existing crisis (MF7, PHC rural).

According to the women in the focus discussion groups, delay in booking or in coming to the hospital when in labour, and non-compliance to instructions irritate midwives.

Mostly they (midwives) talk harshly only to those women who do not want to go to antenatal. You know, some women do go while some don't go until their pregnancy is 7, 8, or even 9 months so this kind of behaviour normally irritates them (midwives) and makes them (midwives) talk to them (women who attend late) in an annoying way. They (midwives) tell us to come to the clinic once the pregnancy is 2 or 3 months old, to enable them to detect any arising problem (WF7, rural – community)

According to the women, midwives seemed to be more emotional when women were in labour.

Why is it that some midwives whenever they are on duty like there is a woman in labour, they are always not friendly or even insulting the woman knowing full well how she (woman in labour) is feeling? (WF2, urban slum – facility)

The women also tried to explain why some midwives may not be able to control their emotions.

Sometimes the problem or reason for their behaviour is because of lack of enough salary. It is only God that will pay them for their good doing; no matter the amount of money they are paid (WF2, urban slum – facility).

Rather than face the outburst of an annoyed midwife some of the women concluded

... it is better for you to buy your drugs at the chemist (local drug store, often illegal) or to take anything (WF7, rural – community)

Strength – Some participants try to control their emotions and prevent it from affecting BCC for MNCH.

Weakness – Unmanaged emotion influences BCC for MNCH negatively, and keeps women away (see Figure 4:3 on page 181).

4.2.2.11 *Behavioural Regulation* - Constructs examined under this domain include target setting, implementation intention, action planning, feedback, barriers and facilitators. This domain contains preparatory steps needed for BCC for MNCH and the ways in which tasks were executed that promote BCC for MNCH activities in the facility.

Findings - The participants believed no preparation was needed for BCC in the facility. Almost all of them do not prepare before giving their health talks since they have been doing it before and they do not document whatever is done.

I will just tell them (MF1, PHC rural).

I don't prepare. When I come I just do it, I don't record and I don't repeat (MF3, PHC rural).

You don't need to prepare... it's a routine ... except when you are new (MF4, PHC urban).

One, however, felt there was need to prepare so that one would not be angry when a client offended you or be stranded when a client asked a question.

... first of all ... yourself, ...and what you are going to face with the patient, ... because some patients will say some words that will be hurting to you but you should be prepared to be patient with them and take it, don't be angry... you have to read because after your lecture she may ask you questions and if you are not prepared you will be stranded (MF6, PHC urban slum).

One still refers to her midwifery textbook occasionally.

Sometimes I go back to my Margaret Myles and I read the most important things to teach, and I tell them about it (MF9, rural hospital).

Strength – Preparation by some participants

Weakness – Lack of target and plan for BCC for MNCH by the majority (see Figure 4:3 on page 181).

4.2.2.12 *Nature of the Behaviours* - Constructs looked at under this domain included routine / past behaviour, representation of tasks, and stages of change. This domain covered what is

currently being done in the facility and what needed to be done differently in the facility to make BCC for MNCH effective in the facility.

Findings -Most of the participants said what they were currently doing was mainly giving health talks to pregnant women and occasional counselling on demand or when deemed necessary. They saw the health talks as part of BCC for MNCH. Health talks were usually given routinely, to the women together as a group. To improve the present behaviour and implement BCC for MNCH to the required standard in the facilities, some of the participants wanted a bigger and better place with adequate privacy. Many needed posters, one wanted a fulfilment of the promise to distribute insecticide treated nets to motivate pregnant women and nursing mothers, and another wanted funds to set up a nutrition demonstration unit. Another participant suggested that women be motivated with stipends because of poverty and the time women have to spend, and one wanted the PHC committee revived. One of the participants requested a uniform manual or protocol to guide BCC for MNCH activities in all the health facilities:

In future could you produce something standard so that all health facilities will be using in common, so that the treatment will harmonize, and everybody will have a book, balanced, the information sound and accurate on different levels? (MF2, PHC urban slum).

To know if BCC for MNCH is taking place in a facility, the participants said that they would need to be supervised and the monitoring and evaluation (M and E) data reviewed.

Through your (researcher) supervision; if you supervise us, and at least through the M and E, and through our records, you will be able to know definitely if it is taking effect or not. (MF6, PHC urban slum).

Most of the participants could not respond to how long they felt it would take for desired changes to take place. Some of them laughed, some kept silent but one said:

To! (an expression indicating helplessness) You see, I cannot answer this question it should be directed to the supervisor (MF8, rural hospital).

They all, however, believed that if changes were effected they had the wherewithal to maintain the changes.

Strengths: Participants recognised that the effectiveness of BCC was observable and measurable; they believed that BCC for MNCH should be implemented and would be maintained once started in their facilities.

Weaknesses: Current behaviour (health talks) was only a part of the BCC for MNCH strategy at the health system level; participants felt that only the supervisors were capable of initiating changes in the facilities (see Figure 4:3 on page 181).

4.2.2.13 *Friendly Service* - Constructs considered here were characteristics, outcomes, and optimism / pessimism. This section addressed the nature and feasibility of friendly service and friendly midwives in view of the service oriented component of the BCC strategic approach at the health system level. The service oriented strategic approach included improving the image of the service providers for increased client confidence and providing opportunities for integrated service approach (F.M.O.H, WHO., et al., 2005:64).

The women's description of friendly service during the FGDs included:

client education –

...teaching after delivery... (WF1, rural – community); ... after I have explained the reason of my coming, she will take her time to explain to me politely and nicely (WF4, urban – community); ... after we have given birth and brought the baby to the hospital, they will check the baby very well. Then they will tell us how to take care of children, and our husband so that they will not be going to see other women ... (WF6, PHC urban slum – facility).

good reception –

She welcomes you with cheerfulness and happiness (WF5, rural – community); ...the helpful way they attend to people (WF3, rural – facility); ... petting you, then you will start feeling well (WF4, urban – community); ...when you come as a sick person and you meet them ... when they start their joke, you will feel better ... always in a good mood (WF3, rural – facility); ... patience and love, whatever sickness you may have ... they are not supposed to run away from you (WF9, rural – facility).

prompt care –

... the way they take care of people that are sick ... some will see you quickly ... (WF8, rural – facility).

personality of the particular professional –

It depends on the midwives' behaviour. If you are lucky to find one who is friendly that is how she is going to behave to you ... (WF2, urban slum – facility).

Other elements of friendly service identified by the women during the FGDs included: free drugs, a doctor in the facility, and equipment to manage complicated cases. The women explained that where services are not friendly, women would refuse care for themselves and their children.

That is the main reason why if the health workers go to some people's houses they (women) are refusing (not allowing) their children to be immunized (during the immunization campaign days) (WF9, rural – facility).

The women believed that if a midwife fears God, irrespective of whether or not conditions of service are favourable, she would be friendly.

In the same vein, 17 (81.81%) of the participants indicated that a friendly service depends on personal attributes of the midwife, and good interpersonal relationship skills. These included: the midwives' good behaviour and attitude to clients, tolerance, patience, politeness, smiles, listening skills, friendliness, punctuality, empathy, ability to talk with clients freely, cheerfulness, hospitality and understanding, welcoming clients warmly, and rendering assistance where necessary. Other characteristics of friendly service mentioned by the participants were: good midwifery practice [5(22.72%)] that is, maintaining confidentiality and possessing obstetric skills that make her perform better than the chemists or local drug vendors; system factors [5(22.72%)] such as a good environment, free or subsidized drugs, and the availability of equipment for effective service; and continuing education [1(4.54%)] constantly to improve quality of service rendered. Like the women, the participants were optimistic that friendly service was possible and would promote the utilization of the facility.

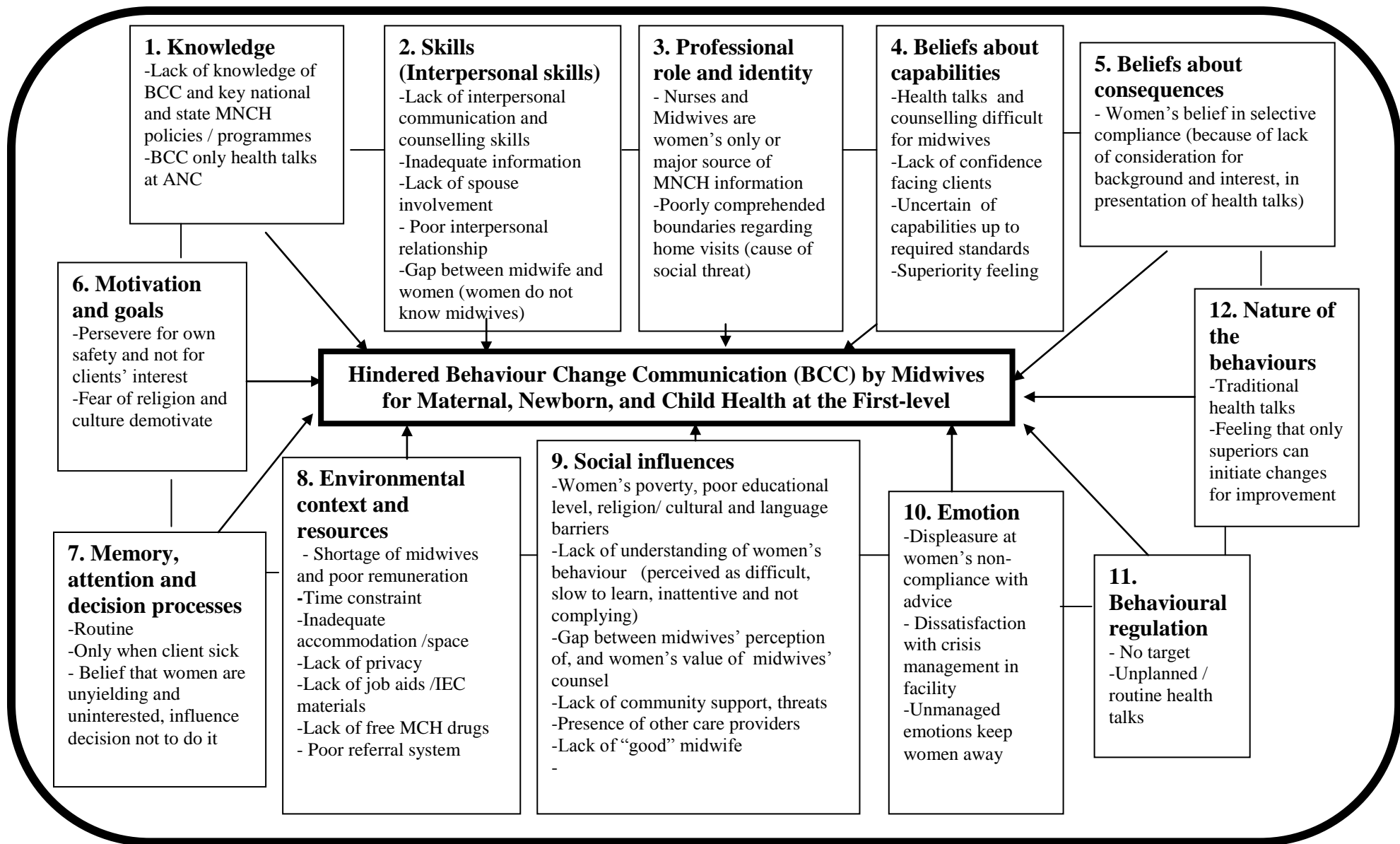


Figure 4:3 Summary of the Weaknesses (hindrances to BCC for MNCH) identified at the Diagnostic Phase using the twelve domains in Michie et al's (2005) *Integrative Framework for Studying the Implementation of Evidence Based Practice*

4.2.3 Strategies and Mechanisms to Attend to the Identified Weaknesses With Respect to BCC at the Facilities

During the search conference and while still using the worksheets [Annexure 1(j)], the participants prescribed strategies to attend to the weaknesses (gaps) they identified. The participants proffered many solutions many of which were repeated across the domains and had to be organized, and summarized under, community involvement, greater government commitment, as well as personal and professional development of midwives (see Figure 4:4 on page 186).

4.2.3.1 Community Involvement - The participants suggested that there should be increased community awareness and mobilization. The facilities should improve on home visits and follow up, and conduct outreach programmes. They felt there should be the formation of functional village health committees to support the facilities / midwives in enlightening the community about various health matters, available services, different categories of workers, the role of the midwife, and the importance of hospital delivery. The committee would also encourage utilization of facilities and assist with proper training of TBAs for supportive roles only. They said that the community should also partner with the government on poverty alleviation and women empowerment programmes.

4.2.3.2 Greater Government Commitment - To bridge the gaps, the participants coveted the support of the government. They suggested more commitment on the part of the government in the areas of provision of adequate human resources, provision of material resources, and increased advocacy for BCC for MNCH.

Provision of Adequate Human Resources: The participants said that to ensure availability of skilled attendants on all shifts (24 hours), the government should employ and deploy more

midwives to the rural areas, posting midwives who were of Kaduna State origin to their communities of origin. Other midwives who were not from the state, according to the participants, should be allowed to work for a certain period of time before transfer to rural areas, and the rural posting should be limited, not endless. To reduce internal and external migration, the participants suggested that the government should encourage midwives (especially those below 30 years of age) to stay, by considering the interest of these midwives and improving their welfare packages, such as their rural posting allowance and their salary. Similarly, that the government should provide accommodation for midwives, and, in collaboration with other support groups, should ensure the safety and security of midwives within the community. Those at higher risk of occupational hazards because of an inadequate work environment should be taken care of. To enhance the performance of the health personnel, the participants suggested that the government should always organize workshops on new ideas and regularly release midwives for continuing education programmes, to update their knowledge and skills. They said that more midwives should be trained on the basic midwifery programme. According to the participants, the supervisors should be trained and supervision should be more frequent and supportive. They also suggested monthly staff meetings and research at the facilities and that the findings of such studies should be utilized. The participants also wanted even distribution of tertiary institutions to enable them to access current information on health matters.

Provision of Material Resources: The participants wanted the government to provide proper accommodation for the facilities lacking adequate structures, such as toilets, bathrooms, examination / counselling rooms for pregnant women, and family planning units. The government should also provide and ensure that all utilities in the communities and the facilities were functional, for example, electricity, water, ambulance / motorcycles services

and so forth. Furthermore, the government should ensure the availability of equipment and sufficient drugs; and provide more educational materials TV, radio, video player, posters and so forth in all facilities to facilitate the health talks. The participants also wanted the government to provide more government hospitals to bring referral facilities closer to the clients.

Increased advocacy for BCC for MNCH: The participants suggested that a training workshop / seminar on BCC for MNCH should be organized and all staff should be encouraged to attend. Similarly, copies of the obstetric and perinatal record booklet should be made available in all the facilities for quality care and continuity of care because most facilities used notebooks or loose sheets for client records. Afterwards, facilities should be visited to monitor if BCC for MNCH was taking place.

4.2.3.3 Personal and Professional Development of Midwives – The participants indicated the need to market their services, improve on their interpersonal relationships, client education and counselling, and to develop personally and professionally as narrated below.

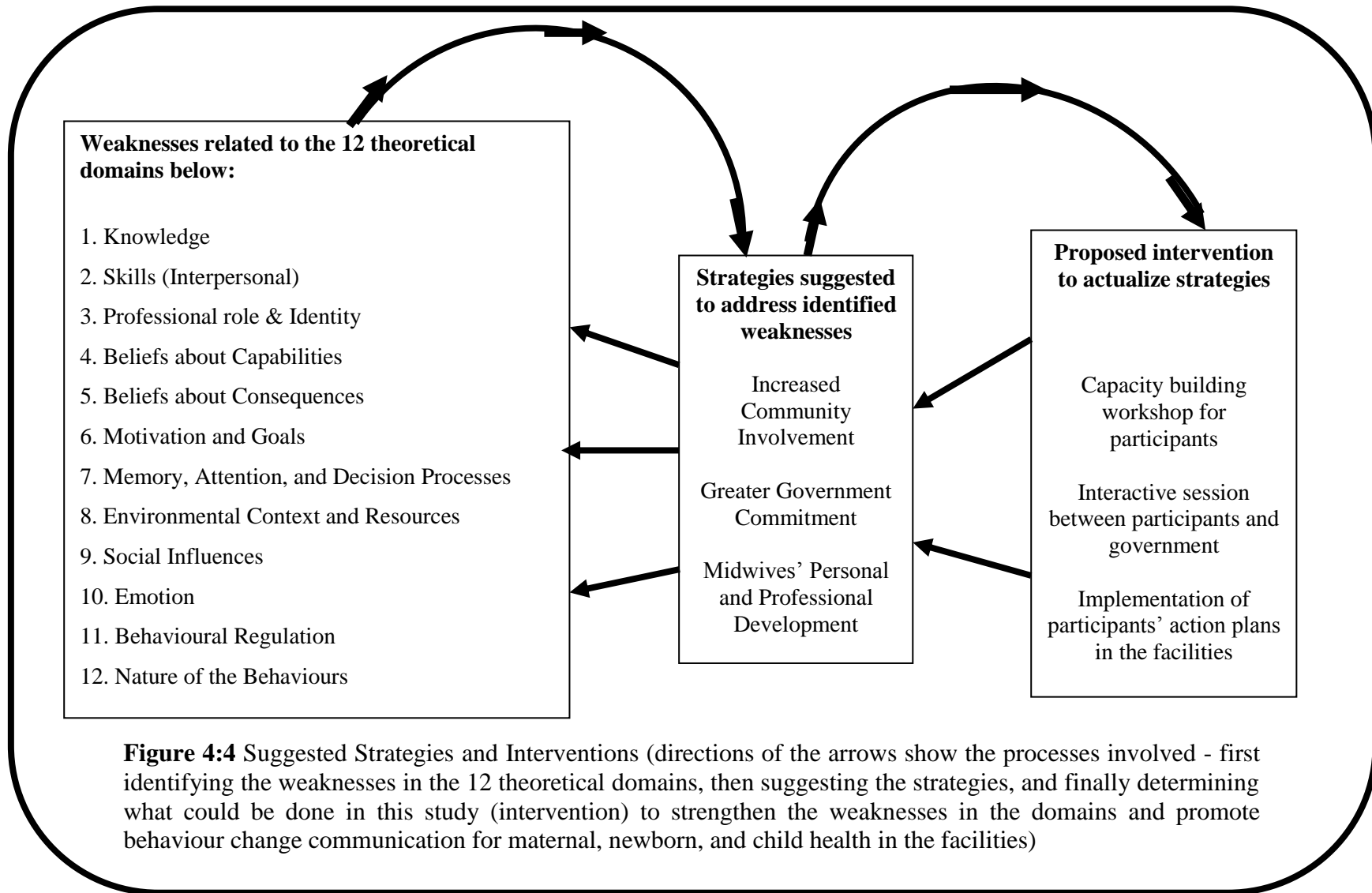
Marketing of Services: Participants indicated that they needed to create awareness of services available at the facilities and on the need for hospital delivery, during women's visits to the ANC clinic. Participants needed to educate clients on the availability of a skilled midwife and encourage them during ANC even if they were late in booking.

Improvement on Interpersonal Relationship: To improve their interpersonal relationship with their clients and the community, the participants identified the following that must be done: proper introduction of themselves to their clients; living within or close to the community to have close contact with the people; learning the people's language; learning how to talk with the clients and improve their attitudes towards them; let clients see that the midwives are doing the best possible under prevailing circumstances; show no discrimination between

clients; believe in themselves, and feel free to talk with their clients; and always try to be friendly despite unfavourable situations.

Improvement in Client Education and Counselling: The participants recommended that midwives should be more committed to client education and that the method employed for health talks should be improved in terms of: preparation and documentation, use of IEC materials, variety of topics - relevant to the needs and interest of the clients, use of appropriate language of interaction, and respect for clients' views and questions.

Midwives' Personal and Professional Development: The participants suggested that there should be a set standard, and midwives should be trained through workshops on BCC for MNCH to acquire more knowledge, and improve their skills, so that the clients were not misled. They said that midwives should conduct research and utilize the findings. They indicated that midwives should really know their role, practice it daily, and be experienced. Furthermore, they noted that midwives should consistently give their clients the best, through hard work, the fear of God, and self motivation. They suggested that at staff meetings, midwives should be reminded of the importance of interpersonal relationship and behaviour change communication to the clients' utilization of facilities. Towards providing quality care on a daily basis, they said that midwives should prepare a schedule of duties daily or draw up a work plan and execute it; midwives should be time conscious and not delay clients; midwives should be at their best whether or not they expected supervisors; midwives and other cadres should work in collaboration; and midwives should stop teaching cleaners their duty. According to them, midwives also had a part to play in ameliorating the shortage of drugs and supplies, by liaising with the government regularly for provision of commodities; making requests for equipment and needed items; making prompt monthly returns and requisition for drugs and supplies; and proper utilization of drugs and available resources.



4.2.4 Evaluation of the Search Conference

Fifteen participants representing 68.18% of the 22 recruited, 2 representatives of the Kaduna State Ministry of Health's quality assurance unit (observers), 1 housewife, 3 validation group members, and the researcher were at the search conference (see Table 3:7 on page 118). An evaluation form [Annexure 1(l)] was used to document the impression of the participants about the search conference. The responses of the participants are presented in Table 4:3 on page 188. The extent of the participants' involvement at the conference was extensive. All the sessions were interactive, and apart from the break times, there were 6 hours (360 minutes) available on each of the first two days and 3½ hours (210 minutes) on the third day for the various activities. Participants spent 49.94%, 73.61% and 85.71% of the available time on days one, two and three respectively, for group activities (Figure 4:5 below).

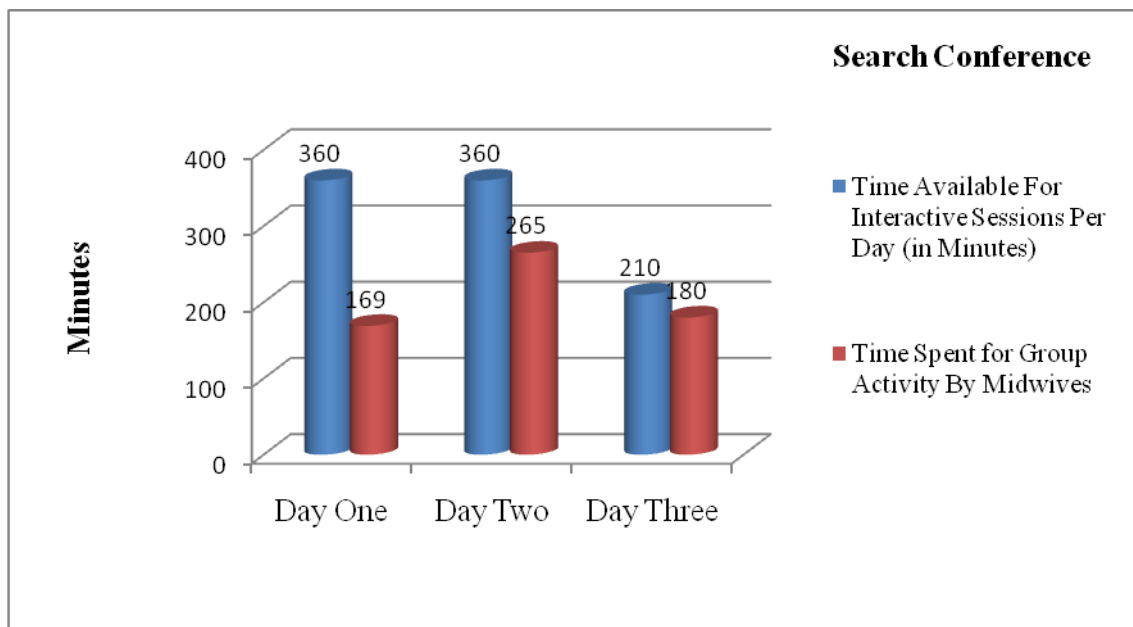


Figure 4:5 Extent of participants' involvement at the search conference

Table 4:3 Group Evaluation of the First Interactive Session (Search Conference)

Activity	Responses		
	Group 1	Group 2	Group 3
Introduction	The introduction of the programme was perfect	An eye opener	The introduction was well understood; it helped us to know exactly why we are here for the workshop.
Review Sessions	The reviewed sessions were okay	Satisfactory and well understood	Papers were well organized step by step but not everything was discussed deeply.
Group Work	Fairly Good	Encouraging. We enjoyed ourselves. It's good working in groups.	All contributed and highly cooperative, will want same group members to be maintained at the next workshop.
Time management	Okay	Short. Strictly to the time	Kept to time, but time was too small for bulky work.
Duration of the Workshop	Okay	Adequate	Duration is okay
Workshop Materials	Very Good	Adequate, useful and helpful for references.	Materials were well provided for workshop, very educative.
Achievement of Project Objectives 1 and 2	Average	We were able to develop strategies, able to assess the strength and weaknesses. We were able to work in partnership.	Gained more knowledge on midwives' roles
Refreshment	Excellent	Satisfactory and enjoyable with the package	Excellent, the foods were always delicious and balanced.
Venue	Conducive	Okay	Venue was also okay and comfortable for learning (quiet)
Transportation Fee	Very Good	Satisfactory and encouraging	Very okay
General Comments	The workshop was very interactive, educative, and inspiring. We are motivated to improve in our services. We look forward to be trained on better ways to deliver services.	It was good to attend a workshop that was related to our field of work which will help the society. Government should always organize this for their employees by emulating this. The researcher was nice, simple, eloquent and hardworking, a woman of integrity and up to the task. We say thank you.	Despite the economic meltdown everything pertaining to the workshop was excellently provided. We were all very grateful.

4.3 Phase Two - The Intervention Phase

Three objectives of the study were attended to at this phase of the research. The first was to support midwives in developing the capacity for behaviour change communication at their respective workplaces, in line with the appropriate strategies / mechanisms identified. The next was to support midwives in developing plans of action to facilitate the behaviour change communication process for maternal, newborn and child health at their respective workplaces; and finally to establish a support network with the midwives to facilitate behaviour change communication process for maternal, newborn and child health at the primary health care level in Kaduna State. A capacity building training programme and an interactive session between participants and their employers (government) were suggested at the search conference, as a useful intervention to achieve their suggested strategies against the weaknesses identified (see Figure 4:4 on page 186). The committee set up during the search conference designed the capacity building programme as in the time-table (see Table 3:9 on page 126). The committee's report [see Annexure 2(a)] presents the procedure followed by the committee to design the capacity building workshop incorporating the interactive session between the participants and government representatives. Data collection during the intervention phase is outlined in Figure 3:4 on page 137. The report of the 3-day capacity building programme and the session with the government officials follows.

4.3.1 The Capacity building Workshop for Behaviour Change Communication

Seventeen (77.27%) of the 22 midwives recruited to participate in the study (see Table 3:4 on page 105) registered for the workshop. Also present at the workshop were the 3 representatives of the Kaduna State Ministry of Health's quality assurance unit (observers), 1 housewife, 3 validation group members, and the researcher (see Table 3:10 on page 129). Attendance of participants at the various activities was high with not more than one

participant absent at any given time (see Figure 4:6 below). One of the participants who had a baby a week before the programme started, was absent on the first day and the participant who served on the committee was absent on official business from some of the sessions on the second day.

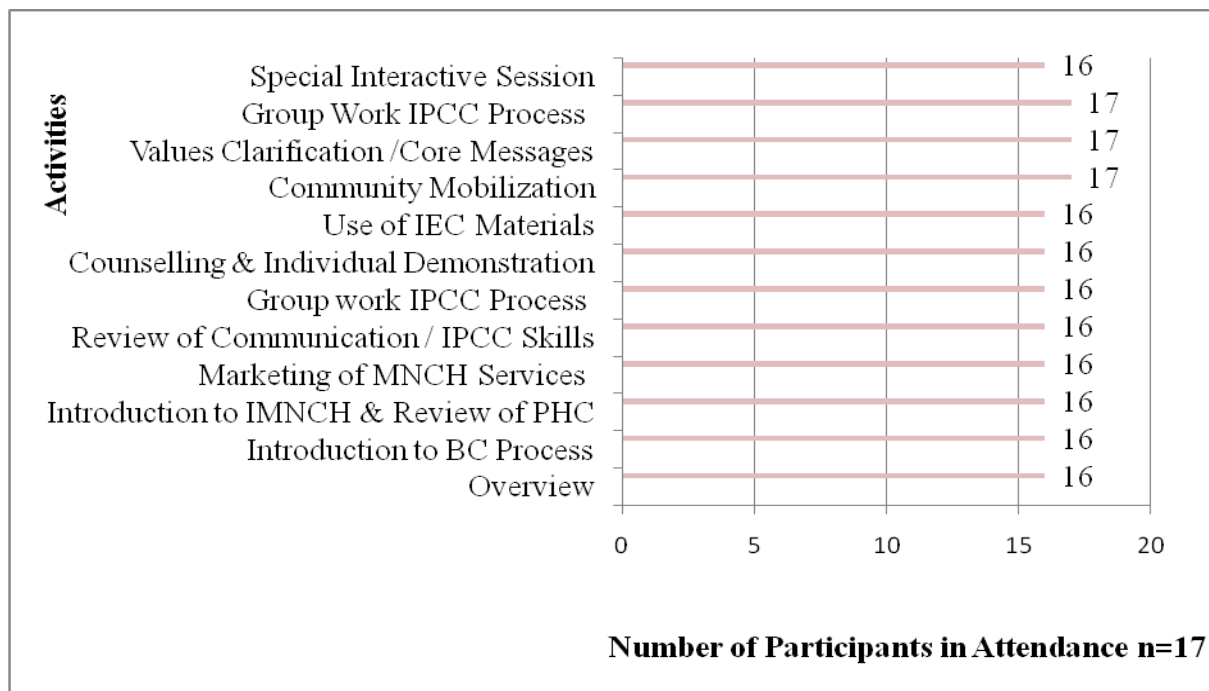


Figure 4:6 Attendances of participants at the capacity building programme activities

The midwife-educator in the validation group was in charge of the secretariat and facilitated one of the plenary sessions (see Table 3:9 on page 126). Two plenary sessions were facilitated by the participant (F21) who also served on the committee (see Table 3:9 on page 126), and the researcher facilitated the remaining plenary sessions (see Table 3:9 on page 126). The methodology was participatory. Questions were entertained and attended to during and at the end of each plenary session. One of the sessions facilitated by the participant, however, witnessed each of the participants reading and explaining a portion of the text. Participants were provided opportunities for individual demonstrations as indicated in Table 3:9 on page 126. The participants retained their groups as at the search conference. In their

groups, participants exchanged roles as clients and midwives, and used the observation checklist for peer assessment. Group activities were facilitated by the researcher and the midwife-educator in the validation group. Energizers (exercises) were performed occasionally, and interesting stress-relieving video clips were shown during break time.

The learning activities engaged in during the workshop and the actual time spent for each (in minutes) are summarized in Figure 4:7 on page 192. These include: introduction to behaviour change (BC) process (54 minutes), introduction to integrated maternal, newborn and child health and review of primary health care (98 minutes), marketing of MNCH services using client-centred / customer service approach (76 minutes), review of communication / IPCC skills and discussion of the checklist (90 minutes), group work IPCC process using the checklist (30 minutes), counselling and individual demonstration (138 minutes), use of information, education and communication (IEC) materials and individual demonstration (116 minutes), community mobilization (54 minutes), values clarification and review of core MNCH messages (53 minutes), and group work on the IPCC process, using the checklist (30 minutes). The participants were provided with IEC materials collected from the State Ministry of Health for their various facilities.

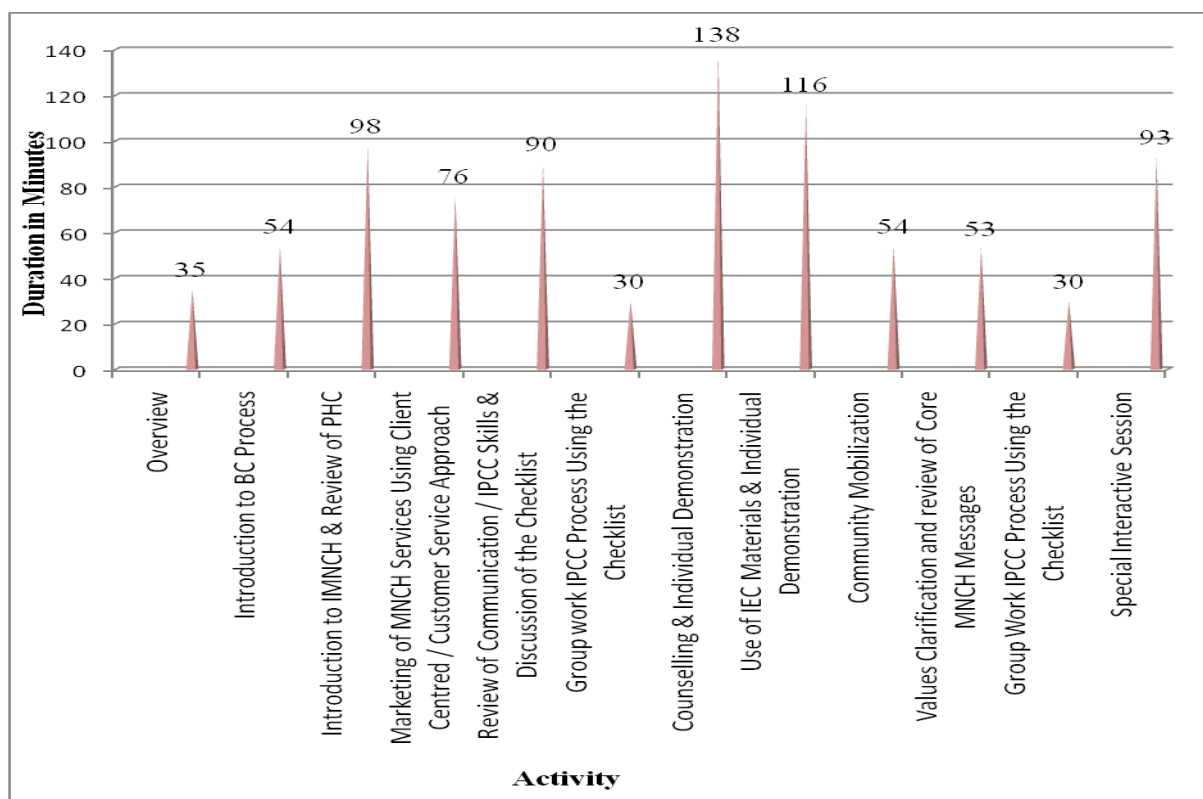


Figure 4:7 Duration of activities during the capacity building workshop

4.3.1.1 Results of the Pre- and Post-Tests - A 40-item questionnaire [Annexure 2(c)] was used for pre- and post- intervention assessment of participants' knowledge. Among the 15 participants who took part in all the tests and assessments, the minimum and maximum scores at the pre-test were 5 and 24, while at the post-test they were 15 and 35 respectively (see Figure 4:8 on page 193). The median scores were 12 at the pre-test and 27 at the post-test. Twelve (80%) participants scored less than 20 at the pre-test while only 4 (26.7%) scored below 20 marks at the post-test (see Figure 4:8 on page 193). Friedman's Test indicated that the difference between the pre and post tests was statistically significant; the asymptotic significance was .000. F21, the participant who served on the committee did not participate in the exercise.

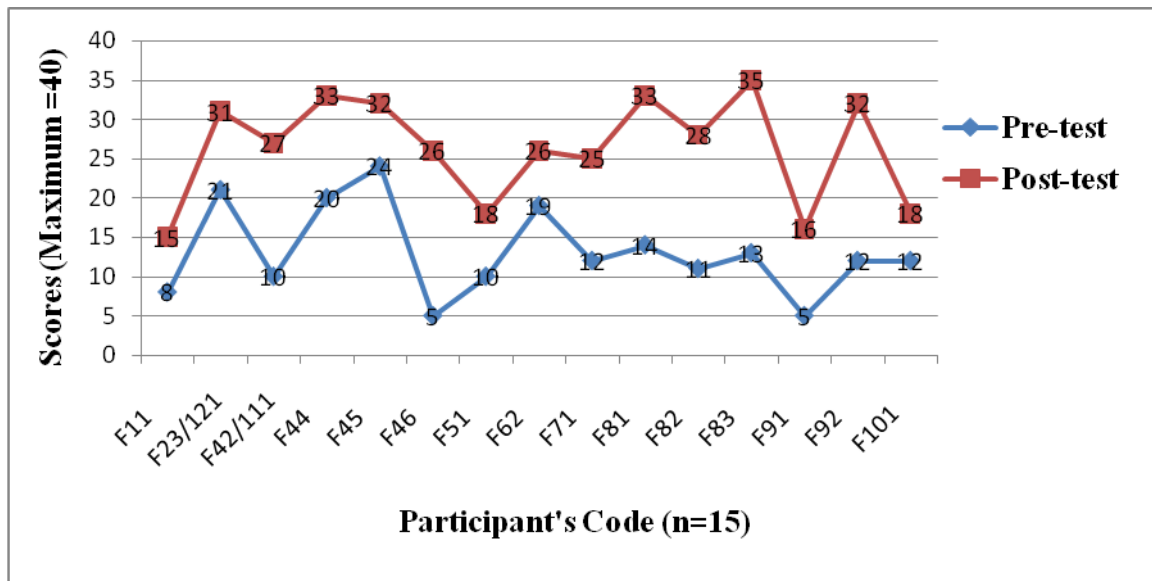


Figure 4:8 Capacity building pre- and post-test scores

4.3.1.2 Results of the First Assessment Using the Observation Checklist - All the participants indicated that they were not aware of the standard for interpersonal communication and no pre-intervention IPCC skills assessment was taken. The participants practiced the IPCC skills in their groups using the observation checklist. On the last day of the workshop, however, each participant presented a message to the entire class and the interaction was assessed using the observation checklist [Annexure 2(e)]. Observations were documented as baseline before participants went back to practise at their facilities. Each participant picked a topic from a pool of short, core messages, selected from the training manual by the researcher, and the participants had time to go through the basic information provided on each message in the manual before presenting her message to the class. They were encouraged to feel free to use their preferred language and the IEC materials, and be guided by the criteria in the checklist. Each participant presented, and the class reviewed the session after they had all presented.

The minimum duration of the interactions was 84 seconds (1 minute 24 seconds), the maximum duration was 225 seconds (3 minutes 45 seconds) and the median was 200 seconds

(3 minutes 20 seconds). The overall maximum obtainable score using the checklist, was 23. The minimum score obtained by the participants was 5, and the maximum score obtained was 21, and each participant's overall score is as shown in Figure 4:9 below.

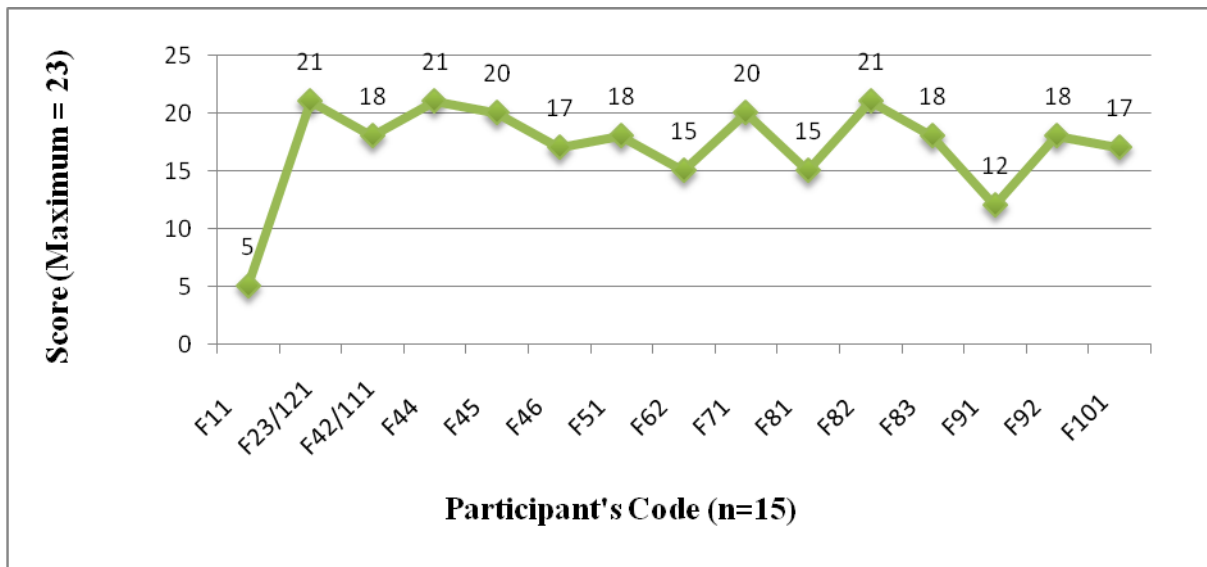


Figure 4:9 First interpersonal communication skills assessment scores

For the purpose of specific skills / item analysis, criteria on the observation checklist were analysed under reception, midwife's verbal communication skills, midwife's non-verbal communication skills, the messages, client participation and feedback. Item analysis revealed that during the *reception*, all the participants welcomed their clients well, they all maintained acceptable equal levels with their clients in language, but 4 (26.7%) did not introduce themselves to their clients. For the *verbal communication* 2(13.3%) were not clear and 2(13.3%) were not patient. Three (20%) did not encourage the behaviour of interest, 11 (73.3) did not show repeating or reflecting skills, while 7 (46.7%) did not keep their verbal expressions simple or free from medical terminologies. As for the *non-verbal skills*, 2(13.3) participants were not relaxed and 2(13.3%) were not open. One participant in particular was not confident, she could not maintain eye contact and she was visibly uncomfortable.

With respect to the *messages* presented by the participants, 2(13.3%) were not appropriate for the audience described by the participants, 3(20%) were not correct, and 4(26.7%) should not be done by the clients. Some of the participants were not able to discuss the topics they picked. The participant who picked the topic “Rest, sleep and exercise in pregnancy” could not talk about it. Similarly, another participant picked “Personal hygiene after episiotomy” but personally changed it to “Health” and was presenting WHO’s definition of health. She was asked to go back to what she picked because, as midwives, all were expected to be able to talk about all the topics in the manual and she could refer to the manual if she wanted. Her explanation of the sitz bath was wrong and the whole class became rowdy with arguments.

During presentation by 5(33.3%) of the participants, the *client participation* was inadequate because the audience could not ask questions, and during presentations by 2(13.7%) of the participants, the audience was particularly inattentive / rowdy. The analysis of the *feedback* revealed that 3(20%) of the participants did not allow the clients to respond or ask questions, 6(40%) did not answer the clients’ questions, the audience did not express satisfaction with 10(66.7%) of the sessions, and 9(60%) of the participants did not assure their clients of their availability and readiness to assist always. Summaries of the participants’ scores in each category of skills are presented in Table 4:26 on page 245. As for the channel / medium, the environment was the venue of the workshop and considered favourable for all the participants. None of the participants made reference to electronic / print media or any community support related to their topics, and only 1 (6.25%) made use of IEC material in her presentation using a role play and a doll baby in teaching “Home management of malaria infection”. None of the participants documented the interaction. Spearman’s correlation coefficient showed no significant relationship between the participants’ post-test scores and

their overall interpersonal communication (IPC) skills scores at the first assessment (see Table 4:4 below).

Table 4:4 Correlations – Post-Test and First IPC Assessment

			Post-test Score	First IPC Assessment
Spearman's rho	Post-test Score	Correlation Coefficient	1.000	.501
		Sig. (2-tailed)	.	.057
		N	15	15
	First IPC Assessment	Correlation Coefficient	.501	1.000
Sig. (2-tailed)		.057	.	
N		15	15	

4.3.2 Development of Action Plans

The plans of action developed by the participants during the capacity building workshop were simple and originated from the participants, to enhance their implementation of the gains of the workshop in their facilities [Annexure 1(k)]. A copy of the action plan for each facility was given to the researcher to guide discussion and support during the monitoring phase. Results of the participants' implementation of their action plans as monitored monthly by the researcher, and the achievements made in each facility are presented under the monitoring phase in this chapter.

4.3.3 Establishment of Support Network

Incorporated into the capacity building training workshop period, was the suggested special interactive session between participants and top government officials from the Primary Health Care Department of the Ministry for Local Government, and the Nursing Division of the Ministry of Health, Kaduna State. There were five guests at the special interactive session. These included the Director of Primary Health Care, the Director of Nursing and an

Assistant Director of Nursing, as well as the Principal and the Vice Principal of Kaduna State School of Midwifery. The session which was captioned Challenges of Rural Midwifery Practice / Networking was held on the last day of the workshop (see Table 3:9 on page 126) and lasted 93 minutes (see Figure 4:7 on page 192). The report of the special session [see Annexure 3(d)] was requested by the two directors. This report was prepared by the researcher and forwarded to them for necessary action. Key issues discussed during the session were those related to the welfare of the participants and the conditions of the health facilities [Annexure 3(d)].

4.3.3.1 Support Network - In response to the plea of the participants to ensure that the capacity building workshop was replicated by the local and state governments, the Director of Nursing Services (DNS) appreciated the need to build capacity of other personnel in the state for BCC for MNCH, and pledged to support the participants in stepping down (training others or transferring acquired knowledge, attitudes, and skills) the workshop at their facilities. He reiterated his plan to make the participants resource persons and models for interpersonal communication (IPC) in the state. He added that any facility or person intending to step down any training would be adequately supported and motivated by the government in every possible way. The proposal must, however, be detailed and relevant, and the beneficiaries of such step down workshop would be as recognized as the original participants. The participants were educated on the operations of the non-governmental organizations (NGOs) in support of MNCH in the state, and about the fact that not all the LGAs were usually covered and various NGOs had various project sites in the state. They were also informed about the upcoming national campaign on distribution of insecticide treated nets.

The participants were provided with contacts of agencies that could assist them with family planning commodities and insecticide treated nets at affordable rates; for example the Society for Family Health (SFH) and the Planned Parenthood Federation of Nigeria (PPFN). They were connected with the State's Health Promotion and Education (HP&E) Unit. There the participants learned that IEC materials were usually produced by the state government and the development partners, but distributed through the LGAs in response to demands by facilities or providers. Though given some materials, participants were advised to contact HP&E units of their LGAs regularly for assistance with IEC materials and other job aids.

The directors gave the participants their contact addresses –physical, e-mail, and telephone - and the participants gave theirs in return as requested so that they could be contacted to serve as resource persons in future. The participants were encouraged by the directors to contact them anytime, as they were often not aware of some of the happenings in the field brought up by the participants. If informed, they promised to use the various forums of meeting with the supervisors to encourage them to ensure support for the gains of the workshop in the facilities. The participants were also briefed on the new initiatives in the Ministry of Health to ensure equitable technical development of midwives in the state so as to correct the imbalance in recommendation and sponsorship for continuing education. The issue of improper placement of dually qualified midwives (nurse-midwives), raised by the participants, was already being handled at the ministry and dually qualified participants who were not properly placed on appointment were advised by the DNS to apply, and he promised that their cases would be given due consideration.

4.3.3.2 Plan for the Monitoring Phase

To facilitate the monitoring process, the participants provided the researcher with their clinic schedules. Participants were given copies of the checklist for further practice. They were

encouraged to maintain a link with the researcher and informed that they would be visited at least once a month without detailed information of the exact date. They were equally informed that their action plans and checklists would be reviewed, and that some sessions between the participants and their clients would be observed.

4.3.4 Individual Participant's Experiences at the Intervention Phase

Evaluation of the individual participants' experiences at the intervention phase was done using an assessment form, asking participants about the most important things they learned, the skills or abilities developed, what they would like to improve, what they would start doing, and what they would like to see changed in midwifery practice and education in Kaduna State and Nigeria.

4.3.4.1 Most Important Things Learned - The participants' responses were grouped under three sub-headings: midwife related, interpersonal communication and counselling (IPCC) related, and client's behaviour and rights related. The midwife related things learned included being empathetic, being a role model, changing their own behaviour, and discharging duties with the fear of God (see Table 4:5 on page 200). The Interpersonal Communication and Counselling (IPCC) related issues indicated included how to communicate freely and openly, how to listen and allow clients express themselves, to be polite, the proper way to give health talks and counsel clients, and to provide privacy for clients (see Table 4:5 on page 200). Concerning Client's behaviour and rights related issues, the participants learnt about individual differences, that behaviour change is a process that takes time and varies from one person to another. They also learned about clients' rights and how to respect clients' values (see Table 4:5 on page 200).

Table 4: 5 Most Important Things Participants Said They Learned at the Workshop

	Most Important Things I have learned	Freqs
Midwife Related	a. Empathize with clients and attend to them the way you want people to attend to you	3
	b. To be a role model to the community members	1
	c. Change attitude / behaviour to clients for the better in the interest of clients and not be harsh to them	5
	d. One cannot effect change when she has not changed personally	1
	e. Some things I thought I knew how to do through this workshop I know I still have to improve	1
	f. Discharge duties with the fear of God	1
	Total Responses =	12
Interpersonal communication and counselling	a. How to communicate freely and openly with clients	3
	b. Have listening ears for clients and give chance to my client to tell me all she has got in mind	2
	c. To be polite	2
	d. How to interact	1
	e. Proper health talks - choice of topic, how to give health talks in the proper way	2
	f. Proper counselling method / skills	3
	g. Provision of privacy	1
	Total Responses =	14
Client's Behaviour and Rights	a. Individual difference in terms of views, decision making process, and behaviour, accepting clients as they are, knowing that all clients cannot change at the same time	2
	b. Behaviour change is a process and not rapid	1
	c. Patient's rights	1
	d. Respect client's values	1
	Total Responses =	5

(n=16 Multiple responses allowed)

4.3.4.2 *The Skills / Abilities Developed* - The skills or abilities the participants indicated they had developed were summarized under planning / time management, marketing, midwife's perception of herself and her client, and interpersonal communication and counselling. The Interpersonal Communication and Counselling skills reportedly developed included

introducing self to the client, courage to face the client, proper counselling and health talks, as well as proper use of IEC materials (see Table 4:6 below).

Table 4: 6 Skills /Abilities Participants Indicated They Developed at the Workshop

	The Skills or Abilities I have Developed	Freqs
Planning / Time Management	a. Give a lot of time to my clients	2
	b. Proper organization	1
	c. Give a lot of time to my staff	1
	Total Responses =	4
Marketing	a. How to market our services rightly	1
		Total Responses =
Related to Participant's Perception of Herself / Client	a. To be a good midwife, counsellor and a mother	1
	b. To see people as unique and different individuals and not to treat them as one (patient)	3
	c. Understanding client well before taking decision on treatment	1
	d. How to be more friendly with my client / clinic staff	2
	Total Responses =	7
Interpersonal communication and counselling related	a. Introducing myself to the client	1
	b. Courage to face my client face to face	1
	c. Proper counselling	6
	d. Health talks	4
	e. Proper Use of IEC Materials	7
	Total Responses =	19

(n=16 Multiple responses allowed)

4.3.4.3 What the Participants Would Like To Improve - The participants' responses were organized under three sub-headings – interpersonal communication and counselling (IPCC), practice, and self-development. Concerning IPCC, the participants wanted to improve in the areas of verbal communication and counselling, helping clients to open up, self introduction, and the use of IEC materials (see Table 4:7 on page 202). In relation to Practice, areas mentioned by the participants for improvement were attending to clients always, even if they came late, tolerating clients, their relatives and colleagues, commitment to work despite discouragements, and maintaining confidentiality (see Table 4:7 on page 202). Towards self

development the midwives desired to improve in the areas of reading and attending seminars and workshops (see Table 4:7 below).

Table 4: 7 What the Participants Would Like to Improve

	What I Would Like To Improve	Freqs
Interpersonal Communication and Counselling	a. My verbal communication skills	2
	b. Counselling	2
	c. Helping clients open up to me	1
	d. Use of IEC materials	1
	e. Form the habit of always introducing myself	1
	Total Responses =	7
Practice	a. At all times to attend to my clients / patients patiently without being in a hurry, no matter how late they come to me	1
	b. Interpersonal relationship with clients, community, colleagues, and other clinic staff, utilizing the skills acquired to be friendly and tolerate clients and colleagues	4
	c. To be hardworking and face work properly irrespective of any friction and discouragement	2
	d. Maintain confidentiality properly	1
	e. Assist clients in every situation and give them more time	2
	f. Develop other skills that will help in delivery of service to clients	2
	Total Responses =	12
Self Development	a. Read more to improve my knowledge	1
	b. Attend seminars and workshops. More training should be carried out	3
	Total Responses =	4

(n=16 Multiple responses allowed)

4.3.4.4 What the Participants Would Start Doing After The Workshop - The participants said that they would implement what they learnt, take good care of their clients by relating to them at the clients' level. In addition, the participants indicated that they would step down the training, creating awareness on BCC in their facility (see Table 4:8 on page 203).

Table 4: 8 What the Participants Would Start Doing After the Workshop

	What I Will Start Doing Now	Freqs
Implement what was learnt	a. Implement what I learnt	3
	b. Initiate change by being a role model and coordinating activities	2
	c. Involving males in maternal care	1
	d. Try to counsel	1
	e. Preparing my health talks before the actual time to deliver the talks / Improve on health / Have a book to document health talks in the facility	3
	f. Community mobilization and advertising services to outreach communities	1
	Total Responses =	11
Care of Clients	a. Improve interpersonal relationship with clients / Give clients warm welcome	2
	b. Taking good care of my clients / Use skills developed here to improve client care services / face work squarely	4
	c. Go down to their level and see myself on the same level with them, relating to them in the way they would understand	1
	Total Responses =	7
Step down the training (train others)	a. First step down the training	6
	b. Create awareness on BCC	1
	c. Advise the gatemen and others on how to welcome patients well to our facility	1
	Total Responses =	8

(n=16 Multiple responses allowed)

4.3.4.5 *Changes Participants would Like to see in Midwifery Practice and Education in Kaduna State* - The participants' responses were grouped under midwifery practice, midwifery education, and government / management related issues. In the area of midwifery practice in the state, the participants would like to see more effort put into BCC for MNCH , great improvement in the behaviour of nurses and midwives in the state, as well as acceptance and appreciation of midwives by the community (see Table 4:9 on page 204). Concerning training, participants would like midwives to attend refresher courses, and to see BCC incorporated into the curriculum for training nurses and midwives (see Table 4:9 on page 204). They desired, among other things, that the state government and employers of midwives would ensure adequate staff and equipment in the facilities, review salary of

midwives upwards and place midwives with dual qualifications properly on the salary scale (see Table 4:9 below).

Table 4:9 What Participants Would Like to See Change in Midwifery Practice and Education in Kaduna State

	What I Would Like To See Change In Midwifery Practice And Education In Kaduna State	Freqs
Midwifery Practice	a. Change BCC for MNCH and put more effort in practising it	1
	b. Midwife should always be polite to patients no matter their socio-economic status	1
	c. Changes in the behaviours, negative image and information about nurses and midwives in Kaduna State and midwives in labour ward	6
	d. Develop confidence and trust in, and acceptance of midwives by the community	1
	e. Good interpersonal communication and counselling	1
	Total Responses =	10
Government /Management Related	a. Improve productivity	1
	b. Provision of technical staff	3
	c. Provision of adequate equipment	3
	d. Proper placement of midwives with dual or more qualifications	2
	e. Differentiate between nurses / midwives and other health workers	3
	f. Kaduna State should review their midwives' salary	1
	g. Kaduna State should stop appointing unskilled workers as head of clinics both at state and local government levels / Midwives should be given real chance to practice without hindrances from others - CHEWs	3
	h. Government should not show favouritism to the indigenes in posting of staff to rural areas	1
	i. Kaduna State government should look at the certificates and review the licence of every health worker	1
	Total Responses =	18
Midwifery Training	a. Midwives should seek to go for, and be encouraged / sponsored to participate in workshops, seminars, refresher courses, all necessary trainings and further studies	5
	b. Incorporate BCC in curriculum	1
	Total Responses =	6

(n=16 Multiple responses allowed)

4.3.4.6 *What the Participants would Like to See in Midwifery Practice and Education in Nigeria* - The responses of the participants were sorted under the following sub-headings: midwifery practice, administrative issues, community issues, and issues related to training.

Changes the participants wanted in the area of midwifery practice were that all midwives improved their behaviour, to erase the bad image midwives had in the country, and that midwives constantly practise the professional skills acquired during their training (see Table 4:10 below). They desired that the quality of life of the members of the community be improved to reduce morbidity and mortality, and that the people should see midwives as partners (see Table 4:10 below).

Table 4: 10 What Participants Would Like to See Change in Midwifery Practice and Education in Nigeria

	What I Would Like To See Change In Midwifery Practice And Education Nigeria	Freqs
Midwifery Practice	a. Midwives should try their best to erase the bad names given them by improving their relationships with clients	2
	b. Constantly practising the ideal professional skills learnt in school	2
	c. Improve the quality of services by health workers	3
	Total Responses =	7
Administrative Issues	a. Consider those that work in state and local government levels because they buy from the same market with federal staff and improve their salary to give job satisfaction	3
	b. The politicians should help the Ministry of Health to improve our services by providing our needs	2
	c. Elevate the level at which nurses are employed to encourage good performance	2
	d. Midwives with basic midwifery training should be posted to rural areas in line with their preparation for community practice	1
	e. Review the licence of every health worker	1
	Total Responses =	9
Community	a. Improvement in the quality of health and reduction in maternal death throughout the country	1
	b. General populace should see midwives as partners in progress and have confidence in them, instead of the current dislike for midwives.	1
	Total Responses =	2
Training	a. Federal government should upgrade the midwifery certificate and recognize it as an educational qualification and not only professional	4
	b. Look into the slow progress of courses run by the national open university for nurses	1
	c. Encourage and organize workshops / seminars and refresher courses for midwives to upgrade their knowledge	3
	d. Sponsor midwives for further education relating to midwifery	1
	Total Responses =	9

(n=16 Multiple responses allowed)

4.3.5 Group Evaluation of the Intervention Phase

The participants in their groups, evaluated the workshop. Their evaluation and comments are presented in Table 4:11 below.

Table 4: 11 Group Evaluation of the Capacity Building Workshop

Activity	Responses		
	Group 1	Group 2	Group 3
Introduction	The introduction is perfect	The introductory aspect was short, precise and satisfactory	We are highly satisfied with the introduction
Review Sessions	The review sessions were interesting, educative and mind warming	It is educative and more knowledge was acquired	Well understood and educative
Group Work	Well coordinated, though there were one or two mistakes which were instantly corrected	Understandable and cooperatively done	Well organized and understanding each other
Time management	The coordinator is a good time manager. Very punctual and time conscious	It's okay. Well managed	Time well kept
Duration of the Workshop	The duration of the workshop is suitable since we were able to cover all workshop content	The duration was fine, qualitative and well organized and packaged	It was all right
Workshop Materials	Money and time were really spent to give us quality materials which will assist us even in future	Adequate and reliable	It's ok
Achievement of Project Objectives 3,4, and 5	The objectives were achieved	Well achieved, adopted and will be carried out in the field	The goals and objectives have been achieved
Refreshment	In fact we are all satisfied with the feeding and God will replenish the source of income. Amen	Satisfactory. Mouth watering. Well garnished and nutritive.	Highly satisfactory and recommendable
Venue	We appreciate the hospitality of the leaders of the venue. It is o.k.	Conducive and well ventilated. Quiet for learning	It's ok
Transportation Fee	We are grateful	Excellent and satisfactory	Highly regarded and appreciable
General Comments	We thank God and the coordinator generally for the workshop. We look forward to seeing all that was promised to be improved by our leaders and we promise to work hard to improve our BCC and IEC skills. We also look forward for more of this type of educative workshops.	The researcher has tried day and night to package a knowledgeable, educative and informative programme. God bless and you will be rewarded by getting your doctorate degree. More grease to your elbow. The food was <i>waooh sh sh</i> mouth watering. Thank you. Remain blessed.	We appreciate you ma for all your efforts, time, energy and so on. More grease to your elbow ma. God will also replenish your effort. More blessings.

4.4 Phase Three - Monitoring Phase

This phase of the study aimed at achieving objective six, which was to monitor the implementation of the midwives' developed action plans for behaviour change communication. Fifteen, representing 68.18 % of the 22 recruited participants, and 88.23% of the 17 participants who took part in the capacity building workshop, continued through to the end of the three months of monitoring (see Table 3:4 on page 105). The 2(11.77%) who could not continue were F21 who was officially busy and F32 who was posted to Kano (another state in Northern Nigeria), outside the study setting, to participate in the national Midwives' Service Scheme (MSS). During the monitoring phase, the participants were visited monthly to see how they were implementing their various action plans and how they were using the checklist to guide their IPCC. The visits also provided support to the participants where necessary. The reports of the monthly visits, and participants' implementation of their action plans, are presented in the following section.

4.4.1 Report of Monthly Visits to Facility 1 PHC / Rural Setting (Participant F11)

First Month 14th April 2010 The participant saw herself as slow in learning and pleaded with the researcher to bear with those of them who were slow. She was using the checklist and the checklist was reviewed again together with the researcher. She was worried because she had not received her March salary, and had just received alert of the payment on her phone. She wanted to go to the bank which was in another community, but she was very busy. She said she observed lots of changes which according to her included the improved way she talked with clients. The clients saw this, and were concentrating more; when asked questions they answered, if they were not taught they insisted that they should be taught. She created a palpation room (room used for examining pregnant women) from the store to provide privacy for the women to open up. She also decongested the labour room by removing many of the

things there to another section of the facility where the other store items were kept. She, however, complained about the lack of benches for the women, hence they stood up for their clinic.

Second Month 13th May 2010 The participant was the only one on duty. She was met consulting and wanted to finish before attending to antenatal care (ANC) clients. There were over 60 ANC clients waiting, only 9 had space to sit on 2 benches and a stool while the others sat on the floor. The women were complaining that they might not leave till 6 pm. The researcher assisted with blood pressure and weight checks (the attendant used to help with the blood pressure and weight but was busy with the cards). The participant was already tired from consulting and attending to the children. The women insisted on having health talks before palpation (witnessed by researcher). The participant had prepared to talk on drugs but because there was not enough time, clients were many and insisting on health talks, she decided to talk briefly on hygiene. The researcher had a chat with the women on what they wanted in the clinic, and suggested to the participant that she could take a photograph of the situation and make a case for help.

Third Month 25th June 2010 The participant was the only one on duty. The clients (mostly women and children) were angry about waiting so long. The participant was very busy consulting – mostly sick children, about 40; she had seen 19 already (no ANC clinic). A woman was also in labour. The participant was tired, very slow, and not cheerful. When asked if the research evaluation would be possible, she said she would leave the clients, as if surrendering or fed up. One of the women (addressing the researcher, assuming she was from the government) requested that more staff be sent to the unit to relieve the one working so that clients would no longer be delayed. The women, however, said they had no problem with

the participant. According to the participant, the free drugs from the Local Government also contributed to the increased attendance.

4.4.1.1 Review of Action Plan Facility 1 PHC / Rural Setting – The participant planned to improve the family planning services; improve antenatal care, advising on hospital delivery and maintaining correct records; improve routine immunization; increase outreach services through home visits and involving community in MNCH programmes; and encourage change in the behaviour of health personnel. Table 4:12 below summarizes what the participant was able to achieve at the facility in three months, as well as what she could not achieve.

Table 4:12 Summary of What the Participant (F11) Was Able and Not Able to Achieve

Facility code	What the participant was able to achieve	What the participant could not achieve
F1	<ul style="list-style-type: none"> • Improvement in IPC skills • Encouraged hospital delivery • Improved interest of women in health talks • Improved antenatal care with women coming from distant communities • Vaccines available, immunization days were observed and documented in record books • Created a palpation room to provide privacy • Decongested the labour room to make it more conducive • Met with the community once • Shared what she learnt at workshop with her supervisor twice. The supervisor told the researcher that the participant reorganized the place to create space for her clients 	<ul style="list-style-type: none"> • Could not follow prepared schedule of health talks because of heavy workload • No family planning services (participant was not a trained provider) • No home visits • No community MNCH activity • Most of the women still delivered at home and those with complications were referred

4.4.2 Report of Monthly Visits to Facility 4 PHC / Urban Setting (Participants F42, F44, F45, and F46)

First Month 8th April 2010 One of the four participants in the facility (F42) was counselling a client on prevention of mother to child transmission (PMTCT) of HIV / AIDS on the arrival of the researcher. There was good midwife-client interaction and topics covered included breastfeeding and drug education. Drugs, MAMA kit and insecticide treated net were given to the client free. One of the participants (F44) was not present as she was said to be on the afternoon shift. Her colleagues (F42 and F46), however, said she participated in planning a step down workshop with the others. She was also involved in peer assessment using the checklist. It was, however, difficult getting through to her on the phone. F45 was away attending a workshop. Her absence was said to be one of the reasons for suspending activities towards the proposed step down training at the facility level.

F46 was seen attending to a client with threatened abortion. She gave a report of the health talks earlier in the morning. The researcher saw the IEC materials – prepared chart, real objects and so forth, and the topic was Malaria. She said that the health talks delivered by the participants were better than before the workshop. The use of IEC materials that day was initially discouraged by the supervisor (a CHEW) who was later impressed, seeing how it all went. Furthermore, she said the clients were no more in a hurry and were much happier now. The participant (F46) said that she had no problem, she was relating well with her clients. According to her, the clients came back for assistance because the participants were friendly. There were days when she closed late because she had to attend to a particular client. Her attention was, however, drawn to the fact that she did not introduce the researcher to her client in respect of the client's right to privacy and information about what affects her.

Second Month 21st May 2010 and 28th May 2010 The researcher found on 21st May 2010 when she visited that F42 had been transferred to Kinkinau, another primary health care facility in the same Local Government Area. F46 was busy with a difficult delivery when the researcher visited. The client was HIV positive and very grateful and happy that it was this particular participant that was on duty. The participant said that the woman saw her one day during one of her ANC visits and the participant noticed that she was positive (she saw the result on client's card) but yet to be informed, counselled or placed on the treatment regimen. She then referred the client for PMTCT care in the facility. The researcher noticed poor observance of universal precautions by the participant and attendants involved in the delivery, and drew their attention to it. The participant-client interaction was, however, generally very good and the client was extremely happy and grateful.

F44 was visited on 28th May 2010. The participant was observed providing information to a couple on immunization of their baby, and assisting a man and his three sons who came for treatment although the man could not find their appointment cards for easy tracing of the case cards, – the participant showed good midwife-client interactions. The participant informed the researcher that they had not received salary for 3 months. On her experiences after the workshop, reviewing the content of the checklist together with the researcher, the participant said she has tried to improve relationship with her patients – she gave more time, and explained to them about delays. She would tell clients to give her a little time and she would then be back to attend to them. She remarked that counselling was not difficult when initiated by the client. She confessed that it was not all her clients she asked if they were satisfied, or told them to come if they had need to. She was grateful for being reminded about documentation, and showing her where and how to document on the client's card; she promised to start doing that. She, however, said it had not been easy because sometimes

while trying to help patients, she still had some problems. She cited an instance where a client's father was insulting her but she just kept quiet and walked away when she remembered the capacity building workshop. She said that the lack of referral forms during afternoon and night shifts affects record keeping. Similarly, drugs from government were not usually enough. She indicated that they would like to have a certificate of participation in the project, but was informed that the issuing of certificates depended on the researcher's school's approval.

F45 was also seen on 28th May 2010 on the afternoon shift. On changes observed since the workshop, she said that the behaviour of the staff (participants and others) had changed positively. She said the participants talked to the staff about friendly service, and she had to personally intervene in some instances, especially with respect to attending to clients after the time fixed to stop issuing cards to clients. She said good interaction with her clients made her feel like a nurse, patients were happy and kept thanking her. Many clients came looking for her because of the way they were treated or were referred to another facility. She taught those on the same shift with her about IPCC, and used the checklist to assess her own practice occasionally. She said that the staff sometimes had problems with drugs. She would be happy if given a certificate for participating in the workshop. She also engaged the researcher in extensive discussion on the Open University, midwifery practice and poor remuneration of midwives by local governments.

Third Month 21st June 2010 F44 was disappointed about the poor record keeping in the facility, and promised that something would be done about it. She saw the whole project as challenging, unlike other workshops which ended once they were finished. F45 laboured with F44 to get facility data and lamented the poor record keeping; she promised that things would change because now they would see to it. According to F45, record keeping was not on their

schedule but she considered it embarrassing to discover the scantiness of the records, and intended to meet with the officer in charge and make amends. She described the whole project as wonderful. F46 was on afternoon duty. She described the project as:

Fine, making me pick myself up again. I find myself picking up books to read, I need to do something, I am thinking of going to look for any course to further my experience, I'm just hungry for more development - F46

4.4.2.1 Review of Action Plan Facility 4 PHC / Urban Setting – The participants planned to improve family planning services, increase awareness on the disadvantages and dangers of home delivery, and improve child welfare clinic attendance through health talks, home visits and advocacy. They also planned to improve provider-client interpersonal relationship and build IPCC skills of personnel in the facility by organizing a 3-5 days training workshop / seminar for the members of staff. Table 4:13 below summarizes what the participants were or were not able to achieve within the three months of monitoring.

Table 4:13 Summary of What the Participants (F42, F44, F45, and F46) Were Able or Not Able to Achieve

Facility code	What the participants were able to achieve	What the participants could not achieve
F4	<ul style="list-style-type: none"> • Improved provider-client interaction • Improved health talks • Improved clients' interest in health talks with patients commenting that things had improved and that they had learned more things • Clients freely asked for assistance • Closed late for sake of clients in need • Coped with 'insulting' clients • Awareness on IPCC created with health workers on same shift with participants • Discouraged sending clients away after card issuing time had elapsed • Worked on advocacy issue through the schedule officer in facility i.e. the second person in charge who is a CHEW. 	<ul style="list-style-type: none"> • Could not implement planned step down workshop due to time constraint • Participants did not participate in routine home visits in facility • Advocacy meeting between participants and community heads was not possible because it was the duty of the CHEW (the second person in charge) who meets regularly with the community

4.4.3 Report of Monthly Visits to Facility 5 PHC / Rural Setting (Participant F51)

First Month 12th April 2010 The first visit was on a general clinic day not for antenatal care (ANC). The participant had used the checklist only once, immediately after the capacity building workshop (the checklist was seen by the researcher). Both the participant and the researcher went through the checklist together. There was no documentation, the participant promised to get a notebook. The participant observed that the women followed her use of the posters during health talks and asked questions. She said that the community wanted her to be in the community 24 hours of the day. The chief was informed of the need for accommodation for her if she were to be in the community 24 hours a day. According to the participant, she was formerly using a room in the clinic as residence but she was embarrassed by hoodlums one night and she had to stop using the place. The community was already making arrangements for her accommodation.

The participant met the Head of Health at the Local Government but could not get insecticide treated nets (ITNs) for the women, because of the proposed national mass campaign and distribution of ITNs. The women were worried, having completed immunization, completed ANC and delivered, but, had received no net as promised. The participant was encouraged by the researcher to find new ways to motivate the women. The review of the action plan revealed that family planning had not started as there was no commodity, because the cost of commodities at the Local Government was the same as at the market, and it would be too high for the community. The participant had not checked the Society for Family Health or Planned Parenthood Federation of Nigeria (PPFN) for affordable commodities, as advised by guests at the special interactive session held during the capacity building workshop.

She had written a letter for a community meeting. There was no other midwife in the facility for her to train, but she had made a request for one. There was no freezer for the vaccines but she applied. She reported that the chairman had asked her to request for a generator, adding that the BCC workshop had made her understand many things midwives were supposed to do (referring to making contact with the Local Government).

Second Month 11th May 2010: It was ANC clinic day and the researcher arrived at 8:50 a.m. The general ANC clinic was over already, the participant said they usually started at 7 or 7:30 a.m. She said she had more than 10 women and she gave them the routine drugs. According to her, the women asked questions and she made the health talks lively using the IEC materials from the workshop and those collected from the Local Government. Some women came to ask questions privately. The women were still requesting for nets; the Local Government assured the participant that the facility would be covered during the net campaign. She had two meetings immediately after the researcher's April visit; first with the chief then with the sub-chiefs. Other community meetings were held thereafter, and the community members contributed to extend the facility to include a toilet and the labour room. They would request the Local Government to roof it for them when they got to the roofing stage. The researcher met the chief who gave her ₦200 (US \$1.3) for transport.

The participant said she had bought the notebook for documentation of ANC clinic attendance, but she was yet to use it. She did not have the checklist with her; she said the materials were at home where she was reading them. Some women came later for ANC or child immunization after others had left and the participant said she would attend to them. The researcher encouraged the women to invite the participant to their secular meetings

where she could enlighten them more on MNCH matters, and one of them said a female doctor in town had told them that before.

Third Month 21st June 2010: It was a general clinic day. The work on the extension of the facility was yet to commence, but some of the building materials required had been purchased. The participant was not happy that the Local Government did not include her among those participating in the on-going immunization and net distribution exercise. She was therefore encouraged by the researcher. She had collected registers from the Local Government for documentation, though she had yet to transfer the records from the note books. No new midwife was posted to the facility. The participant attended to labour cases if called upon, and to unregistered pregnant women who came to deliver at the facility. She complained that the work was too much – The routine immunization, ANC clinic, and the monthly monitoring and evaluation reports sent to the Federal Ministry of Health.

4.4.3.1 Review of Action Plan Facility 5 PHC / Rural Setting – The participant planned to provide family planning services and maintain proper records; improve antenatal care and advise the clients on hospital delivery; improve on routine immunization; increase outreach services through home visits and the involvement of the community in MNCH programmes; and train colleagues on IPCC. As shown in Table 4:14 on page 217, the participant was able to achieve some of the things she planned for, while she could not achieve others within the three months of monitoring.

Table 4:14 Summary of What the Participant (F51) Was Able or Not Able to Achieve

Facility code	What the participant was able to achieve	What the participant could not achieve
F5	<ul style="list-style-type: none"> • Women participate actively during health talks • Commenced family planning services • Active community involvement • Home visits • Liaised with the Local Government for the needs of the facility • Held four sessions to enlighten supporting staff on good provider-client relationship • Collected registers from LGA to improve record keeping 	<ul style="list-style-type: none"> • No midwife to train • No insecticide treated nets to give women as promised • No residential accommodation for 24 hour service to encourage facility delivery after normal closing hours • Poor family planning records – mere list of names, no individual client record.

4.4.4 Report of Monthly Visits to Facility 6 PHC / Urban Slum Setting (Participant F62)

First Month 7th April 2010 It was the ANC clinic day and the participant was very busy with clients in the palpation room, and was also teaching two students [Junior Community Health Extension Workers (JCHEW)] from a non-governmental institution. She was alone doing the palpation – heavy workload, clients were in a hurry and annoyed about the delay if a client stayed for a long time inside the palpation room. The researcher used the checklist to observe the midwife-client interactions. There was good greeting and welcome of clients, but the participant needed to improve her finishing, as clients kept asking for clarification or had to be called back for more instructions or direction. She was advised to introduce strangers (e.g. the researcher) to clients and seek the client’s consent for others to be present while being palpated (examined). She was not using the checklist. She said she could not assess herself

because she would not know if she was right or wrong. The researcher went over the items one by one with her and encouraged her to use the checklist, or involve her colleagues in peer assessment. She was very grateful for the visit but very tired from the heavy workload.

Second Month 17th May 2010 A booking day and there were student nurses from the State School of Nursing. The clinic was now supplied with charts, posters and job aids. The participant was busy but happy attending to the clients. Two women came for booking after the clinic had closed. They were well received and attended to. The participant confessed that she read the materials but was still not using the checklist. The changes she observed since the workshop included clients' pleasant reaction to the good relationship, and that when some clients came and the participant was not around they went away, and came back when she was present because they preferred her. She said she was happy and free so that clients could open up to her.

Third Month 26th June 2010 The participant was very busy and the researcher, using the checklist, observed the participant's health talks. The clients were satisfied with the health talks and there was good feedback session. The participant was not using IEC materials though there were some in the facility. The members of staff were using the perinatal obstetric record book in the facility for booking.

4.4.4.1 Review of Action Plan Facility 6 PHC / Urban Slum Setting – The participant's action plan aimed at improving family planning attendance by advising women who came for postnatal clinic to go for family planning; promoting positive change in the behaviour of health personnel by training senior and junior members of staff and students; improving interpersonal relationship between midwives and clients by using posters and welcoming

questions from clients; and acquiring more knowledge on BCC through further training. What the participant was able to achieve and what she could not achieve in three months are presented in Table 4:15 below.

Table 4:15 Summary of What the Participant (F61) Was Able or Not Able to Achieve

Facility code	What the participant was able to achieve	What the participant could not achieve
F6	<ul style="list-style-type: none"> • Improved provider-client relationship • Attended to clients who came late after clinic was over • Family planning services were available and women were encouraged to utilize the services • Taught staff and students working directly with her twice since the workshop and had observed some improvement 	<ul style="list-style-type: none"> • No structured staff training because no salary was paid to the staff for 3 months, so there was no money for training. • No other workshop on BCC attended by participant • Participant was not using the posters during health talks

4.4.5 Report of Monthly Visits to Facility 7 PHC / Rural Setting (Participant F71)

First Month 14th April 2010 The researcher arrived at the facility at 8:40 a.m. The clinic doors were opened but there was no member of staff and the researcher called F71 who promised to come soon. By 8:55 a.m. some patients had arrived and were advised to wait for the participant. The participant came by 9:15 a.m. and explained that she had been delayed because one of the passengers had issues to settle with the driver. She said that the experience since the workshop had been good. According to the participant, the majority of the clients understood the talk, and believed they were receiving something good. The community people also agreed. The checklist had been given to her colleague, and the participant could not lay hands on it for the researcher to see. The participant said she did not know she could assess herself. The researcher went through a copy of the checklist with the participant. The

participant said that she had no problem. Delivery in the facility by women in labour was, however, still poor. The participant had a meeting the previous Friday with the village health committee. She said the chief was preventing others from participating actively. They discussed the plan together, and the committee members requested the participant to give them time. The participant also informed them that she had training the year before (2009) and she was asked to train TBAs which the committee approved. The participant said she went on home visits.

Second Month 13th May 2010 The researcher arrived at the facility at 8:40 am. There was one CHEW, no patient and no participant. The researcher was told that the participant had been posted from a neighbouring facility because of a problem with the person in charge who was a CHEW, and the participant was having a problem again with the attendant. The attendant had been there for about 20 years and was preferred to the participant by the community. As the attendant was posted to the next health centre two months before, the clients relocated there. According to the CHEW, the attendant attended to clients even in the isolated rural areas; sometimes the people used a vehicle to fetch her. The CHEW concluded that if not for the problem the participant had had in her former place, the participant was supposed to remain in her former place because it was a bigger facility and there were many clients there. The participant called the researcher later in the day and told the researcher not to think she was not doing her best for the people.

Third Month 25th June 2010 The researcher went around 12:30 pm. The participant was met at the unit, and there were two sick children on admission for observation. The participant expressed a misconception that the researcher thought she was not working and had almost concluded that the researcher would not come again. The action plan was reviewed for the first time together. The pattern of utilization of services was up to date on the displayed wall

charts, though below 20% of the set targets. The village health committee had met twice for marketing of services. A home visit was done occasionally by the participant, because a weekly visit was not possible as the participant attended to clients in other facilities too. Family planning services were provided though only to a few clients, because most of the women were not interested. The participant said that she was improving though the researcher might not appreciate it. The researcher encouraged her and assured her that she was appreciated.

4.4.5.1 Review of Action Plan Facility 7 PHC / Rural Setting – The participant planned to ensure a functional village health committee by visiting the village head and the community, to let them know about the low coverage, and the availability of maternal and child health services in the facility. She planned to improve utilization of services by creating awareness about available services during home and outreach visits. What the participant was able to achieve in three months is presented in Table 4:16 below.

Table 4:16 Summary of What the Participant (F71) Was Able or Not Able to Achieve

Facility code	What the participant was able to achieve	What the participant could not achieve
F7	<ul style="list-style-type: none"> • Visited the village chief • Village health committee met twice since workshop and the committee hoped to involve neighbouring communities • Participant requests the CHEW to go on home visits though not regularly 	<ul style="list-style-type: none"> • No evidence of good relationship between participant and community • Family planning services commenced were not continued because according to the participant, most of the women were not interested, and the interested few were ashamed that their husbands might not allow them to come. This may lead to separation in marriage if talked about.

4.4.6 Report of Monthly Visits to Facility 8 Rural Hospital / Rural Setting (Participants F81, F82, and F83)

First Month 14th April 2010 The place the hospital gave the participants for improved MNCH services was locked up. The participants were using one very small room for delivery and still using the old site for ANC health talks. According to the participants, what had changed since the workshop included:

The way we interact with the clients is more coordinated. Before, we just talked but now we select topic before we talk. Before, there was more repetition, that had now stopped. We introduced ourselves, gave the Hausa meaning of our names, and the clients were happy to hear our names (Facility 8 - rural hospital).

They asked questions. Anyone who says something about the topic before starting will be the first to be attended to even if she came last (that is, motivation for clients' active participation). Clients asked questions after talk although some did not like to (Facility 8 - rural hospital).

Too many arrive for ANC. Palpation continues till 2 p.m. Before the programme, we had our own policy to stop card issue at a particular time but since at the workshop we were told not to send women away midwives suffer more (having to attend to so many clients). The patients appreciate it and even when midwives are tired the clients start begging (Facility 8 - rural hospital).

The participants said they were doing well, the work to them was more interesting, they used IEC materials and when demonstrating with the body, the women followed the moves. The participants document the talks. There was very good use of their checklists but only at the clinic, so they were advised that the checklist could also be used in the ward or for any interaction. They were given one checklist per person again. The participants preferred peer assessment to self assessment. Describing their experiences with the clients further, they said that sometimes the clients did some things to annoy them, but, they were praying to be able to manage the situation always. They had trained three of their colleagues who also assisted them in marking the checklist. They said before the workshop, they thought they knew how to give health talks to the clients, but after the workshop, they realized that they did not. The participants used their manuals. If something was forgotten, it could be checked, and if the

decision was wrong, it could be corrected. The participants suggested that rural postings should be made attractive by raising the allowance from ₦3,000 (US \$19.6) to at least ₦10,000 (US \$65.4) per month. They said that in a particular state in the North West geopolitical zone of the country, it was a punishment to work in town as rural posting was preferred because of the better condition of service in the rural areas.

Second Month 13th May 2010 The researcher observed a noisy and very busy clinic. It was only F82 who was around and she was very busy. She said all was well with the three participants and that they were still using their checklists.

Third Month 25th June 2010 There was a delivery in progress on the researcher's arrival. The researcher observed that the instruments used were not wholly immersed in solution for sterilization, the handles were uncovered. The attention of the participants was drawn to this. The water problem raised during the special interactive session was still unresolved. The participants had moved to a new place and the required equipment had been released to them – a very good place, adequate and the participants were very happy. They informed the researcher that the release of the new place to them by their supervisor did not come easy. Though they told their supervisor since they came back from the workshop and he allocated a place to them, he did not release it till the accreditation team from the Nursing and Midwifery Council of Nigeria came and expressed dissatisfaction with the previous condition. The five midwives in the facility were assigned to the section to provide maternal and child care from the antenatal period, through delivery to the postnatal period. One of the participants (F82) was appointed to be in charge (I/C) of the new maternity section. The midwives in the facility were to have a meeting to plan how to run the new maternity section. They informed that the I/C would be in Kaduna the following week for IEC materials and perinatal record booklets

because the midwives were using loose sheets of paper as client's records book (the researcher saw the sheets of paper used for the woman in labour).

Two of the participants wanted to be posted back to town for marital and health reasons. The participants wanted certificate of participation in the project and the researcher explained that the certification depended on the approval of the researcher's school. Three new clients came for ANC (not a clinic day); the participants told the researcher that they would attend to them as they were told during the workshop not to send them back. They had been attending to clients who came on non-clinic days. They organized a step down training for some of their colleagues, and said that their copies of the training manuals were still with some of their colleagues.

4.4.6.1 Review of Action Plan Facility 8 Rural Hospital / Rural Setting – The participants planned to encourage women to deliver in the hospital by giving health talks on risks associated with deliveries at home, informing all the women during ANC clinic that delivery in the hospital was free, and establishing good interpersonal relationships during the antenatal period. They also planned to increase family planning activities by including family planning in the health talks, informing all the women that delivered in the hospital about family planning, and encouraging male involvement in maternal care. Table 4:17 on page 225 presents a summary of what the midwives were able to achieve and what they could not achieve within the three months' monitoring period.

Table 4:17 Summary of What the Participants (F81, F82, and F83) Were Able or Not Able to Achieve

Facility code	What the Participants Were Able To Achieve	What the Participants Could Not Achieve
F8	<ul style="list-style-type: none"> • A more suitable section of the facility was created for maternity services • Improved provider-client relationship - clients and their relatives voluntarily came for counselling, even on non-clinic days. • Proper preparation and presentation of health talks • Active client participation in health talks • Stopped sending women away after card issuing time had elapsed • Attended to ANC clients who came on non-ANC clinic days • Increased ANC attendance • Documentation of activities • Worked on coping with ‘annoying’ patients • Trained three of their colleagues • Family planning services available and promoted • Presented a successful talk on male involvement and everyone laughed that day • The participants went on home visits (house to house) with student midwives who were attending for community experience. 	<ul style="list-style-type: none"> • Could not have a programme on male involvement with the men as most of the men complain about not having time.

4.4.7 Report of Monthly Visits to Facility 9 Rural Hospital / Rural Setting (Participants F91 and F92)

First Month 7th April 2010 The antenatal clinic was over before the researcher got there. F91 told the researcher that what had changed since the workshop included the way the participants taught the clients, with confidence (no more fear) and encouraging clients to respond. Furthermore, she said since they were told to liaise with the Local Government Area, she did so and had an encouraging reception. The Local Government supplied IEC materials including a giant immunization flip chart. She was given two cupboards – the hospital laboratory took one of them because of lack of space in the ANC clinic. She was also given bibs and bonnets for the babies, and asked to come back anytime. She also reported that there was increased marketing of services, especially immunization, encouraging clients to use what government has provided so that they do not waste supplies. The midwives were respected, so that if the women came once they would come again. She added that the infant welfare clinic attendance had also increased because women were encouraged to tell other women who delivered at home to bring their babies.

The participant (F91) requested further clarification on the checklist. The researcher spent time teaching her and her colleague who could assist with peer assessment. The International Centre for AIDS Care and Treatment Programs (ICAP) office in Kafanchan had been burnt, so the issue of setting up a place in the hospital for prevention of mother to child transmission of HIV/AIDS (PMTCT), that was raised at the special interactive session (though discussed with the Medical Director), could not be pursued. F92 worked on the ward and had changed shifts with someone, so she was not available for the researcher to see on the day of the visit.

Second Month 19th May 2010 The participants were not around when the researcher got to the facility. F91 went to see the ophthalmologist at Kafanchan, for possible surgery the next week. Her colleagues informed the researcher that the ANC clients were responding and happy, with attendance increasing since F91 was posted to the clinic, and because of the free drugs.

Third Month 22nd June 2010 F91 was sick and was visited by the researcher at home. F92 was seen for the first time post-workshop. She was excited with the review using the simulated patient, and she was given a copy of the perinatal record booklet.

4.4.7.1 Review of Action Plan Facility 9 Rural Hospital / Rural Setting – The participants' plan aimed at encouraging antenatal clinic attendance, creating awareness on available services, encouraging utilization of family planning services, promoting immunization of pregnant women and newborn babies as and when due, and promoting hospital delivery. They intended achieving these aims through health talks, home visits, being friendly and assuring the women of the midwives' presence with them in labour. The participants' achievements and what they could not achieve in the three months of monitoring, are summarized in Table 4:18 on page 228.

Table 4:18 Summary of What the Participants (F91 and F92) Were Able or Not Able to Achieve

Facility code	What the participants were able to achieve	What the participants could not achieve
F9	<ul style="list-style-type: none"> • Good interpersonal relationships • Confidence in talking to clients; no longer afraid • Improved health talks and client participation • Marketed available services and encouraged those who delivered at home to bring their babies for immunization • Liaised with the Local Government and obtained help 	<ul style="list-style-type: none"> • Could not set up a separate unit for PMTCT • No home visits

4.4.8 Report of Monthly Visits to Facility 10 Rural Hospital / Rural Setting (Participant F101)

First Month 14th April 2010 The participant was on maternity leave but gave the training materials to those in the ANC clinic. The midwife who took over was not present at the time of the visit, so no direct results were recorded.

Second Month May 2010 The participant had not resumed from her maternity leave so the facility was not visited.

Third Month 24th June 2010 The facility (F10) is a new one, and the participant was posted to the facility just before the search conference, from F8 where she was recruited for the study. By the time of this third visit, the participant had been recalled from her maternity leave by her employer since the beginning of June. There was no light and no security in the facility so only two shifts were in operation, and the afternoon shift ended at 6 p.m. According to the

participant, the in-patients went home and returned the following day to continue their treatment, because if they were referred to a referral facility to continue the care, they would not go. The participant works in the women and children's ward, but goes to the ANC clinic for the health talks, and returns to her ward for her duties. She had taught the midwives in the clinic about interpersonal communication and counselling (IPCC), using the workshop materials. She developed an action plan for the facility (seen by the researcher pasted on the ANC clinic wall). The action plan was reviewed together by the researcher and the participant. The participant was met at the ANC clinic by the researcher on arrival, and the researcher was taken to the ward. There were two sick children in the ward. The mother of the convulsing child was impressed with the intervention by the participant and the child's mother was very grateful. The participant informed the researcher that since the workshop the midwives in the facility now allowed time for questions and answers; and anyone who was able to summarize the topic covered that day, would be the first to be attended to in order to encourage client participation.

There was poor record keeping at the ANC clinic, but there were delivery records in the labour room. There was no money for family planning commodities for the midwives in the clinic to commence family planning services, however, the Medical Director promised to look into it. The midwife in charge of the ANC clinic and family planning (one of the participant's trainees), informed the researcher that she had lost about 20-25 clients who had expressed interest in family planning, some of whom were 'critical cases' who should have been attended to, that is, of very high parity (number of children), having 7 – 11 live children. She said she went to facilities that she hoped could assist but was only given pamphlets on family planning. She said she might have to buy the commodities, and sell them to the clients at the Planned Parenthood Federation of Nigeria (PPFN) rate.

4.4.8.1 *Review of Action Plan Facility 10 Rural Hospital / Rural Setting* – The participant’s plan was to improve women’s attendance at ANC clinic through community orientation and health talks; to educate women on hospital delivery; to include family planning among services provided in the facility; to acquire knowledge on BCC by attending workshops / training on BCC; and to promote change in staff behaviour towards clients by organizing workshops / training on BCC. Table 4:19 below presents what the participant was able to do within the period of the monitoring exercise.

Table 4:19 Summary of What the Participant (F101) Was Able or Not Able to Achieve

Facility code	What the participant was able to achieve	What the participant could not achieve
F10	<ul style="list-style-type: none"> • Community awareness outreach by community volunteers was organized by the facility and done twice before her maternity leave. • During health talks, the importance of ANC was usually stressed • Trained ANC clinic staff on IPCC and emphasized the importance of friendly service for utilization of facilities by clients • Good feedback during health talks • Hospital delivery was improving because of the free drugs. Clients were given whatever was available and advised to buy the rest. 	<ul style="list-style-type: none"> • No family planning services (lack of funds for commodities) • Participant had not attended any other training on BCC since the capacity building workshop because there was none

4.4.9 Report of Monthly Visits to Facility 11 PHC / Urban Setting (Participant F42 / F111)

Second Month 20th May 2010 The participant was transferred from F4 four weeks before as the officer in charge (I/C) of this facility. It is a big comprehensive health centre, well equipped, understaffed of skilled personnel, but has many unskilled personnel. The participant sits with the other staff, works with them, and uses her office only when necessary. According to her, the patients were always interested and amazed as if they had never heard health talks before. They asked questions, and when enlightened, they were happy. Staff had not been paid salary – permanent staff 3 months and casual staff 11 months. The participant takes three vehicles to get to work daily. She was still missing her former facility and cried when she was posted out. She missed being called Sister X instead of In-Charge here. She wished to drop In-Charge for Sister X to bridge the gap between her and the clients. The researcher encouraged her and congratulated her on her new position as In-Charge. The researcher also encouraged her to make an assessment of the workplace and the community and develop an action plan for her new facility. Furthermore, as a team leader, she could build the capacity of the staff and help them to develop good values.

Third Month 24th June 2010 The action plan was reviewed together. The participant had taught the staff the basics of IPCC and friendly service, made ten copies of the checklist and given them to the staff to guide them. She told the researcher that the attendance was increasing, because they had an outreach to create awareness about the restoration of services following her resumption. They provided 24 hour service with a CHEW and JCHEW on night duty.

4.4.9.1 Review of Action Plan Facility 11 PHC / Urban Setting – The participant planned to improve skills of the staff for BCC by organizing training workshops / seminars; to improve

hospital deliveries by creating awareness about the disadvantages and dangers of home delivery; to improve provider-client interpersonal relationship through staff meetings and reminding staff of importance of good interpersonal relationship; to improve family planning services in the facility by providing services and informing all postnatal mothers of available services; and to improve infant welfare services through home visits and health talks at ANC clinic. Outlined in Table 4:20 below is what the participant was able to achieve or not able to achieve in her new facility.

Table 4:20 Summary of What the Participant (F42 / F111) Was Able or Not Able to Achieve

Facility code	What the participant was able to achieve	What the participant could not achieve
F11	<ul style="list-style-type: none"> • Good interpersonal relationship with staff and clients • Improved health talks and planned topics • Clients were interested in health talks and gave feedback • ANC clinic attendance improved • Taught the staff the basics of IPCC and friendly service using the checklist • Family planning services commenced and were available everyday – commodities bought by participant and sold at approved affordable rates • Mapped out strategy for weekly home visits by senior CHEWs and JCHEWs to encourage utilization 	<ul style="list-style-type: none"> • No workshop yet because no salary and need to obtain permission from LG • New in facility but subsequent staff meetings were scheduled for every 2 months • No home visit yet; staff busy with routine immunization campaign

4.4.10 Report of Monthly Visits to Facility 12 PHC / Urban Slum Setting (Participant F23 / F121)

First Month 9th April 2010 The researcher discovered that F23 had been transferred from F2 to Alfadarai, a new PHC facility in the same Local Government Area. The two midwives posted there were willing to work but there were no resources - no equipment, no furniture, and so forth; only the two midwives (participant and another). The participant's earlier efforts to see significant community members were unsuccessful so she requested the researcher to accompany the midwives on a repeat visit. The researcher observed a willing community, the youth leader already had plans and the community was planning to contribute money for benches, doors, two security men for day and night watches, and expressed hope that work would start by Monday (visit was on a Friday). Children were seen around the facility, telling the team with excitement that they had a hospital now. There was great awareness of facility in the community. The researcher called the Maternal and Child Health (MCH) Coordinator for the Local Government Area (LGA), who requested a letter to the LGA in support of requests for human and material resources. The letter was written in collaboration with the midwives and personally delivered by the researcher for necessary action.

Second Month 14th May 2010 Alfadarai could not take off as the LGA could not provide the requirements. The participant was therefore transferred to Angwan Alkali (F12) in the same LGA, to replace the former midwife who was rejected by the community, and to promote utilization of the facility. The participant was happy. She had developed an action plan for the facility before the researcher's visit. She once saw a staff member giving health talks with her back to the clients; she corrected her, and taught her using the checklist and other materials. The participant and the staff had some outreach activities to mobilize the community, and the clients had started making use of the facility. She was expecting an

increase in attendance soon. She had only one delivery since she had resumed three weeks before. As the only midwife in the facility she did not go on night shift. The researcher briefed the MCH Coordinator for the LGA again and the coordinator promised to do something about Alfadarai because of the dense population and the willingness of the community, and to get more staff for the participant who is currently the only midwife at F12.

Third Month 23rd June 2010 The researcher arrived at a very busy clinic. The participant was still the only midwife. The other supporting staff had gone for an immunization programme. The researcher assisted the participant with sorting of the cards and setting up of an intravenous line for a very sick child. The participant had two deliveries since she had resumed, there had been none in the facility before she came. She was encouraged to present her requests to the LGA with the support of the community health committee, backed up with facts of the situation, and encouraged not to give up (she seemed to have lost confidence in having a solution from the LGA). The attendance was increasing; however, the participant was not happy when she compared the attendance with that at F2 where she was working initially. According to the participant, when she arrived, she observed that the members of staff were not reporting for work, they came at 10 a.m. sometimes, and would leave before 12 midday, they would not wear uniform, and they were harsh to the clients. The facility was maintaining both the Free Maternal and Child Health (FMCH) drugs programme and the Sustainable Drug Supply Scheme (SDSS). The community was adequately educated about the SDSS at the launching of the scheme by those who brought the drugs, because unlike the FMCH drugs, the SDSS drugs were not free, and the people would have to pay for them at the facility.

4.4.10.1 *Review of Action Plan Facility 12 PHC / Urban Slum Setting* – The participant’s plan included, encouraging change in the behaviour of staff with respect to BCC for MNCH; promoting punctuality of staff; and improving mothers’ access to adequate resources and information. Table 4:21 below summarizes what the participant was able to do in the new facility before the end of the monitoring period.

Table 4:21 Summary of What the Participant (F23 / F121) Was Able or Not Able to Achieve

Facility code	What the participant was able to achieve	What the participant could not achieve
F12	<ul style="list-style-type: none"> • Had community outreach to promote utilization of facility • Stepped down training for facility staff in the 1st and 2nd week of arrival at facility, using materials from the capacity building workshop. • Participant used IEC materials to teach. • Good feedback was observed during health talks; the health talks were lively and clients asked questions • Friendly environment • Attendance register maintained leading to punctuality and termination of truancy among staff • Wearing of uniform by staff • Efficient management of FMCH and SDSS drugs and supplies 	<ul style="list-style-type: none"> • 24 hours service was not possible as participant was the only skilled attendant in facility • No use of name tags

4.4.11 *Evaluation at the End of the Monitoring Phase*

At the end of the monitoring exercise, the post-test was repeated to assess the participants’ knowledge and a simulated client was engaged for the researcher to be able to observe

midwife-client interaction, using the observation checklist [Annexure 2(e)]. To evaluate the participants' workplace experiences post-intervention, the helpfulness of the training manual, checklist, facility resources, the clients, and the community to the participants was determined, using Annexure 3(b). The results of the repeat post-test, assessment of participants' IPC skills using the observation checklist, and the workplace experiences evaluation, are presented in the following texts, tables and charts.

4.4.11.1 The Repeat Post-Test - Analysis of the repeat post-test showed the minimum score as 10, the maximum 40, and the median score was 26 as presented in Table 4:22 below. A statistical comparison of the the pre-, post- and repeat post-tests suggested a significant difference in the midwives' knowledge. Using the Friedman's non-parametric test, the Chi-Square was 19.9966 and the two-tailed asymptotic significance was .000 at 2 degree of freedom as shown in Table 4:22 below.

Table 4:22 Comparison of the Pre-, Post- and Repeat Post-Test Scores

Statistics	Pre-Test Scores	Post-Test Scores	Repeat Post-Test Scores (after 3 months)	Remarks
Minimum	5	15	10	
Maximum	24	35	40	
Median	12	27	26	
Chi-Square	19.9966			Friedman Test (Significant at the 0.05 level)
Degree of freedom	2			
Asymptotic Significance (2-tailed)	.000			

Eleven (73.3%) of the participants had scores more than or equal to 20. F11 and F51, however, consistently had scores below 20 at the pre-, post- and repeat post-test, although their repeat post-test scores were higher than their scores at the pre-test (see Figure 4:10 below).

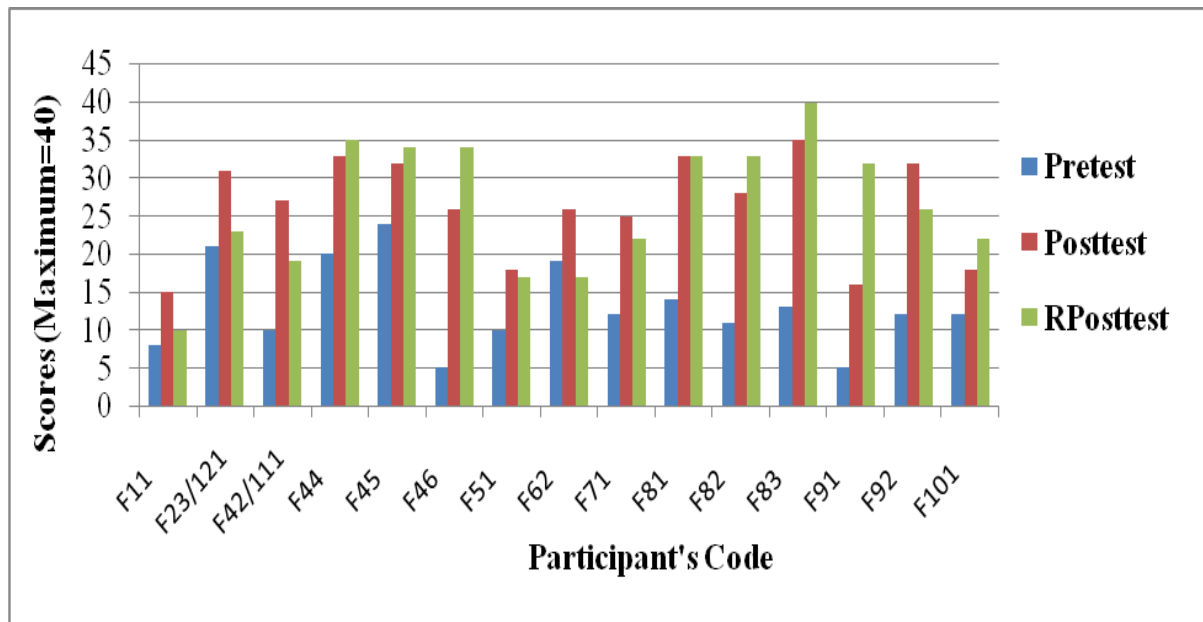


Figure 4:10 Participants' pre-, post- and repeat post-test scores

Table 4:23 on page 238 show that both F11 and F51 had not been involved in any maternal, newborn and child health (MNCH) related continuing education programme in their 19 (F11) or 27 (F51) years of practice as midwives. Eight (55.3%) of the participants at the repeat post-test, gained more, or sustained the increase gained at the post-test, 6(40%) scored less than their post-test scores but more than they scored at the pre-test, while 1(6.7%) - F62, a nurse/midwife who had earlier participated in three MNCH related continuing education programmes, as shown in Table 4:23 on page 238, had a repeat post-test score less than her pre-test score.

Table 4:23 Participants' Code, Continuing Education, Experience, and Tests / IPC Scores

Participant Code	Continuing Education Programme Attended					Total Number of Continuing Education Indicated	Years of Experience Post Qualification as a Midwife	Years of Experience as a Midwife at PHC/Rural Hospital Level	Pre-Test Score	Post-Test Score	Repeat Post-Test Score	First Interpersonal Communication Skills Assessment Score	Second Interpersonal Communication Skills Assessment Score
	Family Planning	Emergency Obstetric Care (LSS)	Integrated Management of Childhood Illnesses (IMCI)	Post-Abortion Care –PAC	Bachelor of Nursing Science (BNSc) in Progress								
F11	-	-	-	-	-	0	19	2	8	15	10*	5	18
F23/121	Y	-	Y	-	-	2	14	14	21	31	23*	21	21
F42/111	-	Y	-	-	-	1	21	2	10	27	19*	18	23
F44	-	Y	Y	Y	-	3	23	23	20	33	35+	21	22
F45	-	-	-	-	Y	1	4	2	24	32	34+	20	23
F46	Y	-	-	-	-	1	22	2	5	26	34+	17	23
F51	-	-	-	-	-	0	27	8	10	18	17*	18	21
F62	Y	Y	Y	-	-	3	20	20	19	26	17**	15	19
F71	Y	-	Y	-	-	2	25	21	12	25	22*	20	12***
F81	-	-	-	-	-	0	4	3	14	33	33+	15	22
F82	Y	-	-	-	-	1	15	5	11	28	33+	21	22
F83	-	-	-	-	-	0	6	3	13	35	40+	18	22
F91	Y	-	-	-	-	1	30	8	5	16	32+	12	19
F92	Y	-	-	-	-	1	20	20	12	32	26*	18	18
F101	-	-	-	-	-	0	12	5	12	18	22+	17	17
Total	7	3	4	1	1								

Y Yes

+ Gained more or sustained increase at Post-Test (8(55.3%))

* Less than Post-Test but more than Pre-Test (6(40%))

** Less than Pre- and Post-Test (1(6.7%))

*** Less than First Interpersonal Communication Skills Assessment Score (1(6.7%))

4.4.11.2 *The Second Assessment Using the Observation Checklist* - The researcher allowed each participant and the simulated client [see Annexure 3(a)] to interact while she observed the participant's interpersonal communication skills, using the same checklist [see Annexure 2(e)] that was used for the first assessment at the capacity building workshop. After each interaction, the simulated client's comment was taken and the participant allowed to respond. The second assessment scores of 11(73.3%) of the participants increased while 3(20%) maintained same scores and only one had the second score lower than the first as in Figure 4:11 below.

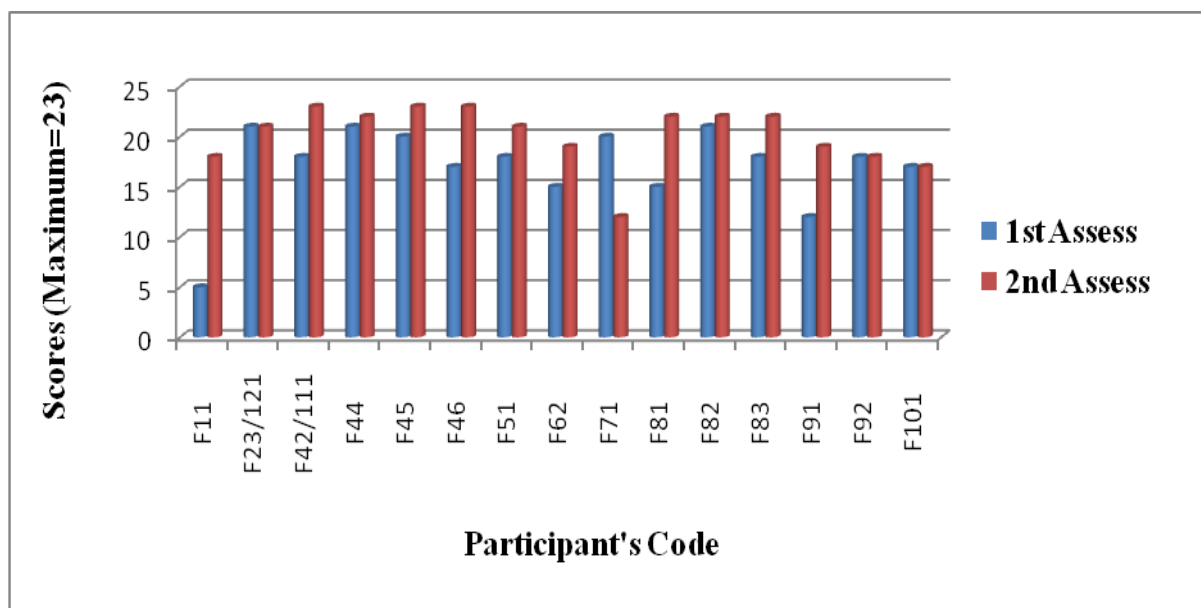


Figure 4:11 First and second interpersonal communication (IPC) skills assessment scores

The minimum duration of the interactions during the second round of assessments was 162 seconds (2 minutes 42 seconds), the maximum duration was 452 seconds (7 minutes 32 seconds) and the median was 236 seconds (3 minutes 56 seconds) as shown in Table 4:24 on page 240. The minimum overall IPC score was 12, the maximum was 23, and the median score was 21 as in Table 4:24 on page 240.

Comparison of the duration of interactions during the first and second assessments, using the Wilcoxon Signed Ranks Test, revealed the Z - statistics as -2.841. The two-tailed asymptotic significance was .004, suggesting a significant difference in the duration of interactions as shown in Table 4:24 below. Similarly, comparing the participants' overall IPC scores at the first and second assessments, the Wilcoxon Signed Ranks Test Z - statistics was -2.200 and the two-tailed asymptotic significance was .028, suggesting a significant difference between the participants overall IPC scores at the first and second assessments as shown in Table 4:24 below.

Table 4:24 Comparison of the Duration and Overall Interpersonal Communication (IPC) Skills Scores in First and Second Assessments Using the Observation Checklist

Variable	Statistics	First Assessment	Second Assessment	Remarks
Duration of Interaction	Minimum	84	162	
	Maximum	225	452	
	Median	200	236	
	Z - Statistics	-2.841 (Based on negative ranks)		Wilcoxon Signed Ranks Test (Significant at the 0.05 level)
	Asymptotic Significance (2-tailed)	.004		
<hr/>				
Overall IPC Scores (Maximum Obtainable Score is 23)	Minimum	5	12	
	Maximum	21	23	
	Median	18	21	
	Z - Statistics	-2.200 (Based on negative ranks)		Wilcoxon Signed Ranks Test (Significant at the 0.05 level)
	Asymptotic Significance (2-tailed)	.028		

For the purpose of specific skills / item analysis, criteria on the observation checklist were analysed as at the first assessment, under reception, midwife's verbal communication skills,

midwife's non-verbal communication skills, the messages, client participation, and feedback. The findings are described as follows and summarized in Table 4:26 on page 245.

Reception: All the participants welcomed the client and related with the client at the same level in terms of language, pace and position. F23/121 interacted with the client in the local language (Hausa). Only 9(60%) participants remembered to introduce themselves to the client. The participants' reception scores are summarized in Table 4:26 on page 245. The Z – Statistics on Wilcoxon Signed Ranks Test (based on positive ranks) for reception at the first and second assessments was -1.000, with a two-tailed asymptotic significance of .317. The result did not suggest any significant difference in the participants' reception skills during the first and second assessments as in Table 4:26 on page 245.

Midwife's verbal communication skills: All the participants were clear, audible, and kept the communication simple for the client to follow easily. F81 had a very good acknowledgement of the client's responses. Six (40%) either interrupted the client at a point or asked a number of questions in succession before allowing the client to respond. F71 was not patient enough to go through the client's note or get to know the client or what the client was saying. She asked the client what to do with the case note and after their discussion she told the client to go back to where the drugs were prescribed for her. During the review, the client expressed dissatisfaction with the participant for telling her to go back to where she got the drugs, and the participant argued with the client that she thought the client said it was a doctor that prescribed the drugs that was why she asked her to go back. Summary of the participants' scores on verbal communication variables are presented in Table 4:26 on page 245. On the Wilcoxon Signed Ranks Test, the Z - Statistic was -2.311 and the asymptotic significance was .021 as presented in Table 4:26 on page 245, suggesting a difference in the midwives' verbal communication skills at the first and second assessments.

Midwife's non-verbal communication skills: Only F71 was not relaxed. Without reading it, she held out the case note given to her by the client, and with a questioning look and case note stretched out she asked the client, what the client wanted her to do with the case note. The client repeated her story and why she was there, and then the participant realized she was a simulated client and continued. Wilcoxon Signed Ranks Test result based on negative ranks revealed the Z – Statistic as $-.736$ and the two-tailed asymptotic significance as $.461$. This did not suggest any significant difference between the participants' first and second non-verbal skills assessment scores as presented in Table 4:26 on page 245.

Message(s) presented by the midwife: All the participants examined the drugs. Some examined the client's note and confirmed her information while others collected the note and did nothing about it. Concerning the advice on the use of the drugs, most of the participants mentioned the dangers of buying drugs from chemists (drug vendors) and encouraged the utilization of the facility for antenatal care. Some of the interactions, however, were worthy of special note. Participant F44 returned the drugs to the client and encouraged her to continue the vitamin B Complex tablet because she was very sure of that but said she was not sure of the other drug and could not tell the client to continue. F82 demonstrated good knowledge of her client's details, held back the drugs cheerfully explaining why, and she promised alternative drugs after examination. It was a constructive interaction despite the participant's occupationally induced hearing defect. F83 also had a very good interaction with the client. She examined the client and told her she had a right to know her drug details, gave feedback on the findings from the physical examination in line with the facts in client's case note. She held back the drugs with explanation, prescribed alternatives, and documented the interaction. F92 looked at the drugs and could not identify the drugs but said the drugs were good but the client should not use them, she should keep them, and go for antenatal care. During the review, the client said she was not satisfied with the counsel given by F92

because it was contradictory. The participant told the client that the drugs were good but that the client should not take them, while the client said she could take them later since the participant said they were good. F101 recognized the vitamin B Complex tablets, but described the unknown drug as either Digoxin or Vitamin C; she, however, discouraged the client from using them. F42/111 examined the drugs, withheld them, told the client to go and collect her card (not identifying with the perinatal record booklet used as client's case note), and said that the client should come back with her card to be reviewed by the participant. F23/121 spoke in Hausa language. She examined the drugs and case notes, withheld the client's drugs cheerfully and with explanation, and prescribed other drugs. There was, however, no indication of any significant difference in the participants' first and second assessment scores on the message criterion as the Z -Statistic on the Wilcoxon's test was -.183 and the two-tailed asymptotic significance level was .855 as shown in Table 4:26 on page 245.

Client participation: Although it was the client who initially requested for advice, her comfort and attentiveness during the interaction was observed using the stated criteria on the checklist. The Z - statistic result based on negative ranks using Wilcoxon non-parametric test was -2.070 while the asymptotic significance was .038, suggesting a significant difference in the first and second assessment scores of the participants with respect to client participation as in Table 4:26 on page 245.

The Feedback: Only 6 (40%) of the participants remembered to assure their client of their availability and readiness to assist always. F46 repeated and reflected on client's responses very well and her assurance of continued assistance to client was also very helpful. The review, at the end of each interaction, provided the participant, the client and the researcher the opportunity to clear any misconceptions and verify the records. The client, however,

maintained that she was not satisfied with 5(33.3%) of the participants. Reasons for dissatisfaction in most cases were related to incorrect message; encouragement to use one of the drugs when the participant was not sure of the expiry date or whether or not it was a fake drug; or the advice to go back to where she obtained the drug when the client came to the participant thinking she could help. The Z – statistic was -2.818 and the asymptotic significance was .005 indicating that the difference between the participants’ feedback skills at the first and second assessments was significant as shown in Table 4:26 on page 245.

The Channel / Medium of Communication: None of the participants made reference to any other source of similar information they were providing to the client, to reinforce their advice and further encourage compliance. All of them, however, provided a conducive environment for the interaction.

Documentation: Only 7 (46.7%) of the participants documented the interaction.

Spearman’s Correlation Coefficient between the repeat post-test and second IPC skills assessment scores at three months was .559 indicating a weak but significant linear relationship between the knowledge and IPC skills of the participants as presented in Table 4:25 below.

Table 4:25 Correlations – Repeat Post- Test and Second IPC Skills Assessment

			Post-test Score (repeated after 3 months)	Second IPC Assessment
Spearman's rho	Post-test Score (repeated after 3 months)	Correlation Coefficient Sig. (2-tailed) N	1.000 . 15	.559(*) .030 15
	Second IPC Assessment	Correlation Coefficient Sig. (2-tailed) N	.559(*) .030 15	1.000 . 15

* Correlation is significant at the 0.05 level (2-tailed)

Table 4: 26 Item Analysis of Interpersonal Communication (IPC) Skills - First and Second Assessments Using the Observation Checklist

Variables	1st Assessment Scores	2nd Assessment Scores	Z- Statistics Asymptotic Significance (2-tailed)**
Reception: Midwife welcomed client to clinic, introduced herself and maintained same level with the client (language, pace, position) (Maximum Score 3)	4(26.7%) scored 2; 11(73.3%) scored 3	6(40%) scored 2; 9(60%) scored 3	Based on positive ranks Z -1.000 Asymp. Sig. .317
Midwife's Verbal Communication Skills using the C-L-E-A-R and the KISS Model: Midwife was C lear and audible, L istened, was patient and did not interrupt, E ncouraged client on desired behaviour, A cknowledged client's responses, R epeated / R elected on what said, and K ept It Simple and S ensible (KISS); the client did not say she did not understand or could not hear frequently (Maximum Score 6)	1(6.7%) scored zero; 1(6.7%) scored 2; 2(13.3%) scored 3; 4(26.7%) scored 4; 6(40%) scored 5; 1(6.7%) scored 6	1(6.7%) scored 2; 2(13.3%) scored 4; 4(26.7%) scored 5; 8(53.3%) scored 6	Based on negative ranks Z -2.311 Asymp. Sig. .021**
Midwife's Non-verbal Communication Skills using the R-O-L-E-S Model: Midwife was R elaxed (not hurriedly conducted, not anxious), O pened up and approachable, L eaned forward tolerably, E ye Contact was maintained tolerably, she S at squarely (and S miled tolerably) (Maximum Score 5)	1 (6.7%) scored zero; 2(13.3%) scored 4; 12(80%) scored 5	1(6.7%) scored 3; 14(93.3%) Scored 5	Based on negative ranks Z -.736 Asymp. Sig. .461
Message(s) Presented by the Midwife: Appropriate for client / group, C orrect (In line with developed messages), S hould / C ould be done / adopted by client (Maximum Score 3)	1(6.7%) scored zero; 1(6.7%) scored 1; 3(20%) scored 2; 10(66.7%) scored 3	2(13.3%) scored 1; 3(20%) scored 2; 10(66.7%) scored 3	Based on negative ranks Z -.183 Asymp. Sig. .855
Client Participation: Requested for information, responded to and/or asked questions freely (comfortable / relaxed), A ttentive (Maximum Score 2)	2(13.3%) scored zero; 3(20%) scored 1; 10(66.7%) scored 2	15(100%) scored 2	Based on negative ranks Z -2.070 Asymp. Sig. .038**
Feedback: Midwife allowed client(s) to respond/ask questions. Answered client's question(s). Client(s) expressed satisfaction / understanding, and Midwife Assured client(s) of readiness to assist always (Maximum Score 4)	3(20%) scored zero; 2(13.3%) scored 1; 5(33.3%) each scored 2 and 3 respectively	1(6.7%) Scored 1; 5(33.3%) scored 2; 3(20%) scored 3; 6(40%) scored 4	Based on negative ranks Z -2.818 Asymp. Sig. .005**

** Wilcoxon Signed Ranks Test (Significant at the **0.05** level)

4.4.12 Evaluation of Participants' Workplace Experiences Post-Intervention

The helpfulness of various resources to the participants in the implementation of their action plans and practice of what they learnt at the capacity building workshop was assessed using Annexure 3(b) - the post-intervention evaluation form. The resources examined were the observation checklist, the training manual, the compiled core messages included in the training manual, the researcher's monthly visits, the facility – supervisor, colleagues and other professionals, the facility – structures, drugs and supplies, and so forth, – the clients, and the community. Only the community was considered by 2 (13.3%) of the participants as not being helpful. All the other resources were either helpful or very helpful. The checklist, the training manual, the compiled messages, and the monthly visits were very helpful to 9 (60%) – 11 (77.33%) of the participants, while other resources – the personnel, facility structures, drugs, the clients, and the community were very helpful to 3 (20%) – 8 (53.33%) of them as shown in Figure 4:12 below.

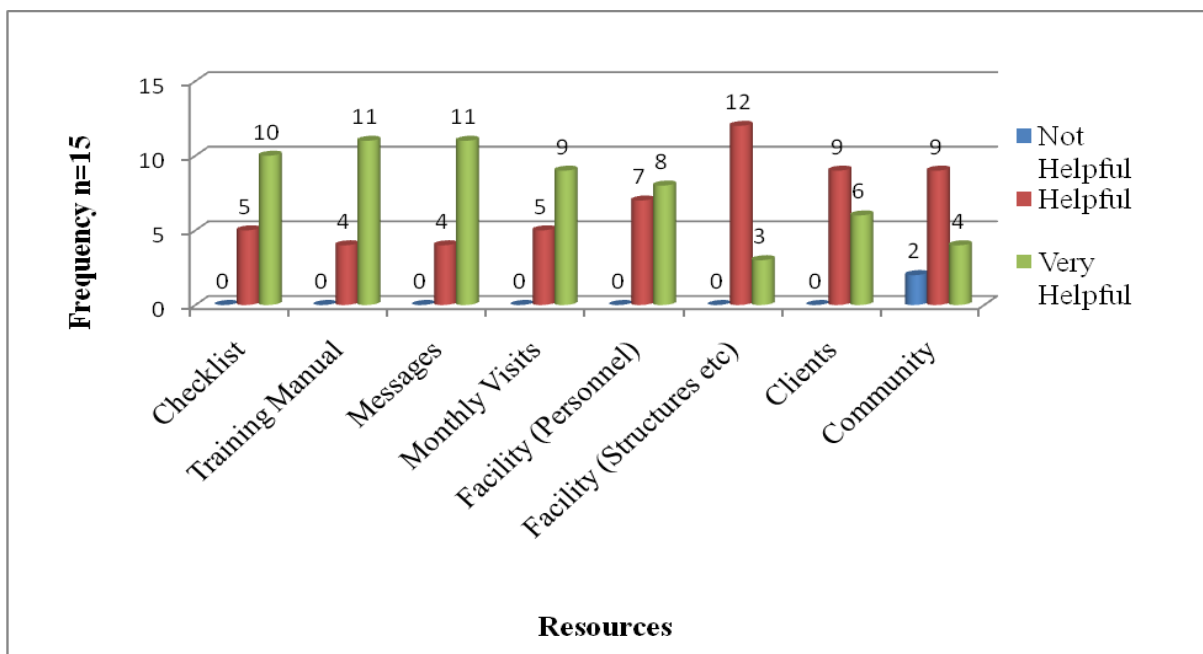


Figure 4:12 Helpfulness of resources to participants at work post-intervention

All the participants at the rural hospitals [6(100%)] and 4(44.4%) of those at the primary health care facilities, found the checklist very helpful, while the remaining participants indicated the tool was helpful as shown in Table 4:27 below. The training manual and the compiled messages were very helpful to all the participants in the urban setting [4(100%)] and 6 (66.7%) of those in the rural setting as in Table 4:27 below. More participants in the primary health care facilities than those at the rural hospitals, indicated that the training manual [8(88.9%)], the messages [7(77.8%)], and the monthly visits [7(77.8%)] were very helpful to them, as is presented in Table 4:27 below.

Table 4:27 Helpfulness of the Checklist, Training Manual, Messages and Monthly Visits Post-Intervention by Type of facility and Type of Setting

The Resources	Type of Facility			Type of setting within which facility is located			
	Primary Health Care Centre (%)	Rural Hospital (%)	Total (%)	Rural Setting (%)	Urban Setting (%)	Urban Slum Setting (%)	Total (%)
The Checklist							
• Not Helpful	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
• Helpful	5(55.6)	0(0.0)	5(33.3)	2(22.2)	2(50)	1(50)	5(33.3)
• Very Helpful	4(44.4)	6(100)	10(66.7)	7(77.8)	2(50)	1(50)	10(66.7)
Total	9(100)	6(100)	15(100)	9(100)	4(100)	2(100)	15(100)
The Training Manual							
• Not Helpful	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
• Helpful	1(11.1)	3(50)	4(26.7)	3(33.3)	0(0.0)	1(50)	4(26.7)
• Very Helpful	8(88.9)	3(50)	11(73.3)	6(66.7)	4(100)	1(50)	11(73.3)
Total	9(100)	6(100)	15(100)	9(100)	4(100)	2(100)	15(100)
The Messages							
• Not Helpful	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
• Helpful	2(22.2)	2(33.3)	4(26.7)	3(33.3)	0(0.0)	1(50)	4(26.7)
• Very Helpful	7(77.8)	4(66.7)	11(73.3)	6(66.7)	4(100)	1(50)	11(73.3)
Total	9(100)	6(100)	15(100)	9(100)	4(100)	2(100)	15(100)
The Monthly Visits							
• Not Helpful	0(0.0)	1(16.7)	1 (6.7)*	1(11.1)	0(0.0)	0(0.0)	1(6.7)
• Helpful	2(22.2)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
• Very Helpful	7(77.8)	3(50)	5(33.3)	4(44.4)	0(0.0)	1(50)	5(33.3)
Total	9(100)	2(33.3)	9(60)	4(44.4)	4(100)	1(50)	9(60)
		6(100)	15(100)	9(100)	4(100)	2(100)	15(100)

* F92 was not met during the two previous visits so she left the space blank

The extent of helpfulness of the facility, the clients, and the community to the participants is presented in Table 4:28 below. The facility staff was considered to be very helpful by 66.7% of participants in the PHC facilities and 75% of those in the urban setting, compared with 33.3% of those in the rural hospitals and 44.4% of those in the rural setting (see Table 4:28 below). The majority of the participants across the facility types and settings did not consider the facility structures, drugs and supplies, and the communities very helpful as is presented in Table 4:28 below.

Table 4:28 Helpfulness of the Facility Personnel, Facility Structures / Drugs etc, Clients and the Community Post-Intervention by Type of Facility and Type of Setting

The Resources	Type of Facility			Type of setting within which facility is located			
	Primary Health Care Centre	Rural Hospital	Total	Rural Setting	Urban Setting	Urban Slum Setting	Total
The Facility – Supervisor, Colleagues, other professionals							
• Not Helpful	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
• Helpful	3(33.3)	4(66.7)	7(46.7)	5(55.6)	1(25)	1(50)	7(46.7)
• Very Helpful	6(66.7)	2(33.3)	8(53.3)	4(44.4)	3(75)	1(50)	8(53.3)
Total	9(100)	6(100)	15(100)	9(100)	4(100)	2(100)	15(100)
The Facility – Structures, Drugs and Supplies etc							
• Not Helpful	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
• Helpful	7(77.8)	5(83.3)	12(80)	7(77.8)	3(75)	2(100)	12(80)
• Very Helpful	2(22.2)	1(16.7)	3(20)	2(22.2)	1(25)	0(0.0)	3(20)
Total	9(100)	6(100)	15(100)	9(100)	4(100)	2(100)	15(100)
The clients							
• Not Helpful	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)
• Helpful	4(44.4)	5(83.3)	9(60)	6(66.7)	2(50)	1(50)	9(60)
• Very Helpful	5(55.6)	1(16.7)	6(40)	3(33.3)	2(50)	1(50)	6(40)
Total	9(100)	6(100)	15(100)	9(100)	4(100)	2(100)	15(100)
The Community							
• Not Helpful	1(11.1)	1(16.7)	2(13.3)	2(22.2)	0(0.0)	0(0.0)	2(13.3)
• Helpful	5(55.6)	4(66.6)	9(60)	5(55.6)	3(75)	1(50)	9(60)
• Very Helpful	3(33.3)	1(16.7)	4(26.7)	2(22.2)	1(25)	1(50)	4(26.7)
Total	9(100)	6(100)	15(100)	9(100)	4(100)	2(100)	15(100)

Some of the participants provided reasons for indicating a resource as very helpful, helpful or not helpful. The *observation checklist* guided the participants in their daily care of their clients and helped them to make adjustments where necessary. It also encouraged some of the participants to maintain records of their activities as summarized in Table 4:29 below.

Table 4:29 Participants’ Reasons for Indicating that the Checklist was Helpful or Very Helpful

Resource	Helpful [5(33.3%)]	Very Helpful [10(66.7%)]
The Checklist	<ul style="list-style-type: none"> • Serves as guideline to what I want to and have to do (F44). From there I check everything (F11) • When we find ourselves on duty together we do assess each other through the checklist which is also helpful to detect any errors (F46) 	<ul style="list-style-type: none"> • It encourages us in our daily activities (F23/121) • It has helped all of us to improve our communication (F42/111) I always go back to it to know and correct my areas of mistake (F45) It has helped me to know areas to improve (F71) It helps me to know where am wrong and to make amendments (F83) • Formerly we did not take data of client attendance but through the checklist we do it now (because of the documentation) (F81) ... we now keep records (F82) • It gives me a step-by-step guide in teaching the client (F91). The checklist assisted in attending to my client; it was my director (F92) • It helps a lot about our attitude towards the patient (F101)

The *training manual* served as a reminder and reference material to some of the participants. Some were able to use it to train their colleagues and it restored the desire to read again as shown in Table 4:30 below.

Table 4:30 Participants’ Reasons for Indicating that the Training Manual was Helpful or Very Helpful

Resource	Helpful [4(26.7%)]	Very Helpful [11(73.3%)]
The Training Manual	It serves as a reminder (F91). I read it always especially to remind myself (F83)	<ul style="list-style-type: none"> • It helps me to remember and practice appropriately (F23/121). It serves as a guide to remind me of what I really need to do (F44). I always go back to it to know and correct my areas of mistake (F45) • The training made me improve in picking up my books to read at times (F46) • Has changed my behaviour communication with my clients (F51). It helps me to know much about my clients, it also helps me personally to improve in my services (F71) The manual was also used for attending to my client (F92) • We were able to do a step down to others with it and we find a lot of topics to discuss in it (F81)

The *core messages* were considered as direct, specific and understandable by the participants. The messages, according to them, were an improvement on what they knew before and covered a wide variety of health issues. Table 4:31 on page 251, presents more of the participants’ reasons.

Table 4:31 Participants’ Reasons for Indicating that the Messages were Helpful or Very Helpful

Resource	Helpful [4(26.7%)]	Very Helpful [11(73.3%)]
The Messages	<ul style="list-style-type: none"> • They are direct and easily understood (F23/121) • The messages cover a lot and there are suggested improvements (F101) 	<ul style="list-style-type: none"> • The messages are well understood (F42/111). The messages are specific (F44) • It is improved, compared with what we had before (F45) • Passing the messages down to my colleagues and clients made me improve in my BCC (F46) • We now use it as health messages (F83) The messages are reference materials for me (F81)The messages are used as reminders (F92)

The participants saw the *monthly visits* by the researcher as important and useful. It encouraged them and made them accountable and hard working. It also provided them an opportunity to follow on, as indicated in Table 4:32 below.

Table 4:32 Participants’ Reasons for Indicating that the Monthly Visits were Helpful or Very Helpful

Resource	Helpful [5(33.3%)]	Very Helpful [9(60%)]
The Monthly Visits	<ul style="list-style-type: none"> • I am impressed by her visits (F51) The visits are very important (F82) • It has put me right in areas where I was not able to follow and they encouraged me. It made us do the right thing (F81) • It helps us to keep up with the pace (F83) 	<ul style="list-style-type: none"> • I am advised on what to do any time I am visited (F11) • It boosts our morale and makes us work very hard (F23/121). It encourages me (F91). • It makes us liable (F42/111). It helps me to maintain my record or data and to be always up to date (F71). It keeps me up and trying to see if I practise what I learned (F44). When I remember that I’ll be visited, it keeps me alert on improving myself and be ready (F45). It helps me to sit up and be very mindful of my work (F46)

The participants found their *supervisors, colleagues and other professionals* in the facilities helpful or very helpful when the personnel supported or encouraged them and accepted their suggestions. Where they initially met resistance, participants said this eased off and they were able to maintain cordial relationships. Some of their colleagues assisted them with their assessments using the observation checklist as outlined in Table 4:33 below.

Table 4:33 Participants’ Reasons for Indicating that their Supervisors, Colleagues and Other Professionals were Helpful or Very Helpful

Resource	Helpful [7(46.7%)]	Very Helpful [8(53.3%)]
The Facility - Supervisor, Colleagues, other professionals	<ul style="list-style-type: none"> • The relationship has been cordial (F44) They supported, encouraged me and accepted my suggestions and my contributions (F92) • They are happy with the BCC now (F82) Formerly the supervisor had been a problem but now he was able to create privacy and a unit for maternity, according to the facilitator’s advice. Our colleagues and the other professionals have been helpful (F81) by assisting with the checklist and other things (F83) 	<ul style="list-style-type: none"> • They are very happy with the programme (F42/111) They have been very helpful especially in standing for us on duty as to help us sit together to carry out our assignments pertaining to this work (F45) • The difference is clear. Our attitude to our clients, our mode of dressing and how we relate to our other colleagues or other professionals have been quite helpful in encouraging other staff to change (F46) • They are very helpful to me in carrying out my services (F71) They support me in management of the client (F91) They attend to the clients very well (F101)

The *facility structures, drugs and supplies* were also helpful or very helpful towards the achievement of the participants’ goals although they desired improvements in some cases. Availability of free drugs or the government’s acceptance of sale of affordable drugs by the health workers were particularly of note, because they encouraged clients’ utilization of the facilities and compliance to advice. Similarly, creation of a more suitable work space and provision of equipment were helpful in some of the facilities as reported in Table 4:34 below.

Table 4:34 Participants’ Reasons for Indicating that the Facility Structures, Drugs and Supplies were Helpful or Very Helpful

Resource	Helpful [12(80%)]	Very Helpful [3(20%)]
The Facility – Structures, Drugs and Supplies	<ul style="list-style-type: none"> • Government does not provide drugs as the facility is not part of those providing Free Maternal Newborn Child Health (FMCH) but we are allowed to sell drugs to clients at affordable rates with minimal profit (F51) • No free drugs (F42/111) • Improvement of drugs and equipment but need for more improvement (F44) The facility has now changed so that we have some equipment and also some free drugs for our clients. (F46) The structures and supply are adequate but the clients buy a few (F82) Most women get free drugs (F83) Free drugs encourages more clients into the facility as we have drugs to supply (F23/121) Some of the drugs we give to the clients are free so it encourages them to come (F92) There are free drugs (F101) • Structures have been sectioned as the facilitator advised and its adequate for practice, drugs supplied before were not supplied this year but everything is moving on as planned (F81) 	<ul style="list-style-type: none"> • Free drugs (F11) • We now get more drugs and supplies (F91)

The participants believed that without *the clients* there would be no work for them. Their clients were helpful or very helpful by the clients' expression of satisfaction with and appreciation of the participants. Furthermore, the clients' improved attendance and invitation of their relations to utilize the facilities were helpful as presented in Table 4:35 below.

Table 4:35 Participants' Reasons for Indicating that the Clients were Helpful or Very Helpful

Resource	Helpful [9(60%)]	Very Helpful [6(40%)]
The clients	<ul style="list-style-type: none"> • The clients are happy since they are treated well (F23/121). The clients, I have realized have been appreciative (F44) • The clients are happy and verbalize well and bring along other relations (F82) They are happy with us and communicate freely (F92) The relationship between me and my clients has been cordial (F46) They pay attention now to the health talks and are active (F83) • Their turn out is encouraging; their response is equally encouraging (F91) The clients are turning up (F101) 	<ul style="list-style-type: none"> • The participant enjoys her work, and heard the clients saying they are now enjoying the services (F71) • The number has increased, they ask questions unlike before and their turnout is encouraging (F81) • Without them there may be no work (F45)

Although some of the participants had some problems with their *communities* and some were not directly involved in community oriented programmes, many of them saw their communities as appreciative, happy, supportive, and utilizing the facilities as presented in Table 4:36 on page 255.

Table 4:36 Participants’ Reasons for Indicating that their Community was Helpful, Very Helpful or Not Helpful

Resource	Helpful [9(60%)]	Very Helpful [4(26.7%)]	Not Helpful [2(13.3%)]
The Community	<ul style="list-style-type: none"> • The community is happy and supporting the facility to develop (F23/121). The head goes to the community; community is supportive (F62) They have been cooperating and have increased their utilization of the facility (F81) The community now is happy with our way of teaching them different principles and more are coming from nearby villages for treatment (F82) The community gave us some volunteers and they are helping us to orientate them (F101) They are appreciative (F91) • The community is not too helpful because the village head is not showing much concern whenever we call for any meeting. But the rest are trying. (F71) • The community is appreciative though we have some problems (F44) Actually without the community there’ll be no patient to attend to, but the problem is that some of them are not grateful at all and we receive a lot of unnecessary threats from them, but are not discouraged (F45) • On Fridays after our night duties we do visit their homes to find out the environment and advise them and also interact with them and exchange views. The other colleagues (CHEWs) also have meetings with them (F46) 	<p>They commend us on what we are doing (F42/111)</p> <p>They now patronize the hospital on daily basis in large numbers (F83)</p>	<p>I have no direct contact with the community, I work in the ward (F92)</p>

Other Comments, Recommendations and Requests by the Participants: The participants had a section on the evaluation form for other comments, requests, recommendations, and so forth. Most of the participants requested prompt action on the part of the government with respect to all the issues raised during the special interactive session they had with the government officials. F81 reiterated the participants' earlier request for certificates of participation. F44 remarked that there was a need for improvement in keeping of records and doing things as they should be done in the facilities. F82 and F83 advocated that the supply of free and sufficient drugs initiated by the government for mothers and children should continue. The suggestions of F46 and F83 were related to further training:

Please expose us to more workshops and seminars to keep us - (F46)

We need more of such workshops. It has really helped us in our BCC with patients. I request that the student midwives should be taught BCC so as to get more children and women attending the clinic - (F83)

F45 and F81 expressed their appreciation for their involvement in the workshop and encounter with the facilitator:

I thank God for being involved in this work. It has helped me a lot in improving my client care / BCC. I also thank God for the initiator / coordinator of this project ... she has done wonderful work by impacting extra knowledge into my life - (F45)

4.5 The Debriefing Session (The Last Interactive Session)

The last interactive session was held on Thursday 29th July 2010 at the usual venue. The forum was to afford participants and validation group members the opportunity to verify the project's records and reports as well as to attend to other interests raised in the course of the deliberations. Fourteen (93.2%) of the fifteen participants who continued to the end of the monitoring phase as in Table 3:4 on page 105 were in attendance. The only absent participant (F62) had earlier sent her apology saying she needed to stand in for her supervisor at the facility on that day. Similarly, two of the validation group members who had earlier promised

to be around could not make it because of official assignments. In addition to the 14 participants, one of the validation group members (the midwife educator), the research assistant who moderated the FGDs, and the researcher were in attendance. Activities during the debriefing session included registration; opening prayers; introduction; review of the report on the action plans and the monthly visits; review of the facility data; review of the entire research process from selection of facility to date; review of results – pre-, post- and repeat post-tests, individual assessment after the capacity building workshop, first and second assessment using the observation checklist, assessment of the helpfulness of resources to the participants in the field; discussion of the way forward; and the closing prayers.

4.5.1 Review of the action plans and reports of the monthly visits

This activity lasted 31 minutes. Only participants in F4 observed that it was not “there were no drugs on odd shifts” (odd shifts meaning afternoon and night shifts), rather it should read that “drugs provided by government were not usually sufficient on odd shifts”. The issue of shortage of staff and training attendants (cleaners) to check blood pressure / check weights of pregnant women (considering the importance of these observations in pregnancy), was discussed. Still maintaining confidentiality, the case of one of the participants to over 60 clients on a clinic day was cited, and the advice to make a case for more staff was also mentioned. One of the participants showing dissatisfaction asked: “To who? Is it Local Government?” - (F23/121), and all the others burst into laughter. The researcher encouraged them, saying, that they should not be discouraged and that it was necessary sometimes to make requests supported with evidence. The participant who spoke earlier explained that when she was at F2, there were times they had 150 patients to only 2 midwives and they were expected to do the observations and the physical examination / palpation. She said they had to train the attendants to assist with the patients and that the clients would allow the attendants,

but would not allow the student midwives who were on posting to the facility, to examine them, unless they were persuaded by the qualified midwives. This was because the majority of clients did not know the difference between skilled and unskilled facility staff, and they saw the students as incompetent and still learning. The researcher reminded the participants about the remark of the Principal School of Midwifery during the special interactive session, that the state was training midwives from the various communities to go back and serve in their communities on completion of their training, and remarked that probably that might help. The participants (almost everyone talking at the same time) said:

They (referring to the newly trained midwives) will not go; they (referring to government) will keep them in the town; they will not post them; what happened to the CHEWs?

The researcher concluded that everyone should think of a solution.

4.5.2 The review of facility data

The exercise lasted 19 minutes and revealed a number of issues that were attended to by the entire group. The researcher told the participants that the second set of facility data collected did not agree with the one collected before. The facility utilization data collected at the diagnostic phase were for August, September, and October 2009. The researcher requested the follow up facility data from October 2009 –June 2010. Unknown to the participants, October 2009 was included again to serve as a control. When the results were reviewed, it was observed that the new October data did not correspond with the previous October data in all the facilities, although they were close in F7. The participants reported that the records department provided the data in the hospitals and in the bigger primary health care facilities. Furthermore, the type of data collected or recorded varied from one facility to the other. For example antenatal clinic attendance per month in some facilities included both old and new cases, while in others, only the new cases were documented. Participants from F8 reported

that midwives had started maintaining records at the new maternity section in addition to those kept by the records department of the facility. Others said they could go back, sort out the data and post a correct one to the researcher from January 2009 to June 2010 to enable her to compare data for the months of interest. At that point one of the participants from F4 responded that the issue was not posting of data, but there were no data in the facilities. In some facilities there were no postnatal records; it is the women who came for the immunization of their babies that were counted as postnatal. After further deliberations, it was finally agreed that data for the following should be provided: antenatal clinic attendance (new cases), antenatal clinic attendance (old cases), immunization, postnatal clinic attendance (where different from immunization), deliveries (in the facility), family planning, and referrals. They decided that the data should start from January 2009 instead of August 2009 and continue through July 2010. The participants said that it would be cheaper and easier to scan and send the data to the researcher's e-mail address which was provided on their information sheets. The researcher assured them that usually it takes time for behavioural changes to become obvious, but that she was interested in the post-intervention data, and that even after the project she would still be collecting the data and requested that the participants keep the agreed format for future use. Between August and October 2010, five facilities (F7, 8, 9, 10 and 11) forwarded their revised facility data while F1, 4, 5, 6 and 12 did not send in any data. For those that sent in data, some of the facilities that were opened in 2010 had no data for 2009.

4.5.3 Review of the entire research process from selection of facility to date

Review of the research process took fourteen minutes. The researcher went through an outline of the research methodology with the participants, step by step up to the present

meeting. She intermittently called for comments from the participants but all agreed with the process as presented.

4.5.4 Review of all the results of evaluation at the different phases of the study

The group spent 58 minutes reviewing the various results. The participants were assisted to read the tables and charts and they were able to locate themselves using their confidential codes. The reviewed results included those of the group evaluation after the search conference; the pre-, post- and repeat post-tests; the individual assessment and the group evaluation after the intervention phase; the first and second assessments using the observation checklist; and the assessment of the helpfulness of resources to the participants in the field. Item analysis of the performance of the participants at the pre-, post- and repeat post-tests revealed that less than half the class correctly answered items 1, 8, and 13 at the pre-, post- and repeat post-tests. Similarly, questions related to the millennium development goals (MDGs), the three delivery modes, and the mortality rates were poorly answered. The participants confessed that they did not like figures (mortality rates) and some of them were learning about the MDGs and the delivery modes for the first time.

Concerning the results of observed provider-client interaction using the observation checklist, the lack of reference to the media or community support by all the participants at the first and second assessments, the poor documentation, and failure to assure the client of continued assistance by some of the participants were acknowledged by the participants. The drug education was reviewed and participants' encouraging the client to continue the recognized Vitamin B Complex without knowing if it was fake or had expired was described as unprofessional by the participants. Some of the participants, however, disagreed with seizing the drugs because the client might think they would be issued to someone else. Some felt

prescribing new drugs and / or destroying the controversial ones in the presence of the client might suffice. The researcher explained the need to understand the people and exhibit the best practice under prevailing circumstances. She, however, said that where a midwife verbalized that “this looks like Digoxin”, and gave it back to the client knowing the implication, if the drug was actually Digoxin, would have been fatal, should the client decide to use the drug. The researcher reminded the participants of the findings from the FGDs which revealed that some of the women had other sources of information like the radio and television. These according to the researcher could be referred to, to buttress the participants’ counsel. She encouraged the participants to read newspapers and listen to radio.

Also reviewed were the results of the helpfulness of resources such as the checklist, training manual, compiled core messages, monthly visits, the facility, the clients and communities, to the participants. Some of the participants said that it was only the person in charge who met with the community, and they were not usually informed or briefed of the proceedings at such meetings. Similarly, staff meetings were seldom held. They said if their supervisor decided against an initiative it was not easy to continue. They suggested that the researcher would exercise some influence. To this the researcher replied and reminding them of the findings from the IDIs where most of them felt they could not make a change. She drew their attention to the fact that they had personally developed their action plans and made some changes, no matter how little. She added that, no matter how little, what the participants achieved in their action plans was what they could do in their own area of operation. The three delivery modes were explained again and the participants appreciated that they were primarily clinic-based personnel while the CHEWs were community-oriented, and that, that was why the study focused mainly on their activities within the facilities. This, however, did not preclude the participants’ involvement in community initiatives. The facility that reported threats from the

community during the IDIs did so again during the monthly visits and in the review of helpfulness of the community. Still maintaining confidentiality, the issue was discussed and the way the home visit was being carried out was identified as the main source of problem. It was agreed that environmental sanitation officers were in charge of routine house to house inspection, while the home visit by nurses and midwives was part of a family-centred approach to client care, and could be very useful for marketing their MNCH services in the community, and not routine sanitary inspection. It was also acknowledged that to be acceptable to the community, the participants must be models because some health facilities were dirty, lacked toilet facilities, and so forth, yet, the staff would take it upon themselves to correct people in the community.

Some of the participants also reported that they had problems with card issuers issuing cards to clients after the scheduled time. Some participants from F4 said the Head of Health in their Local Government Area had also cautioned that clients must not be sent away under any circumstances. The participants said that they had insisted they had to practise what they had learnt, and they did get the clients attended to. The validation group member, who was present, said that where it was not possible to get clients' cards, the participants should still attend to the clients and document everything that had happened in their report. The researcher confirmed that she saw participants attending to women after clinic hours and on non-regular clinic days during the monitoring. She reiterated the provisions of the National Health Act (FGN, 2008) with respect to clients' rights to care anytime.

A summary of the changes, according to the twelve domains of Michie et al.'s (2005) *Integrative Framework for Studying the Implementation of Evidence Based Practice* following the capacity building programme and midwives' implementation of their action plans, documented in this study, is presented in Figure 4:13 on page 263.

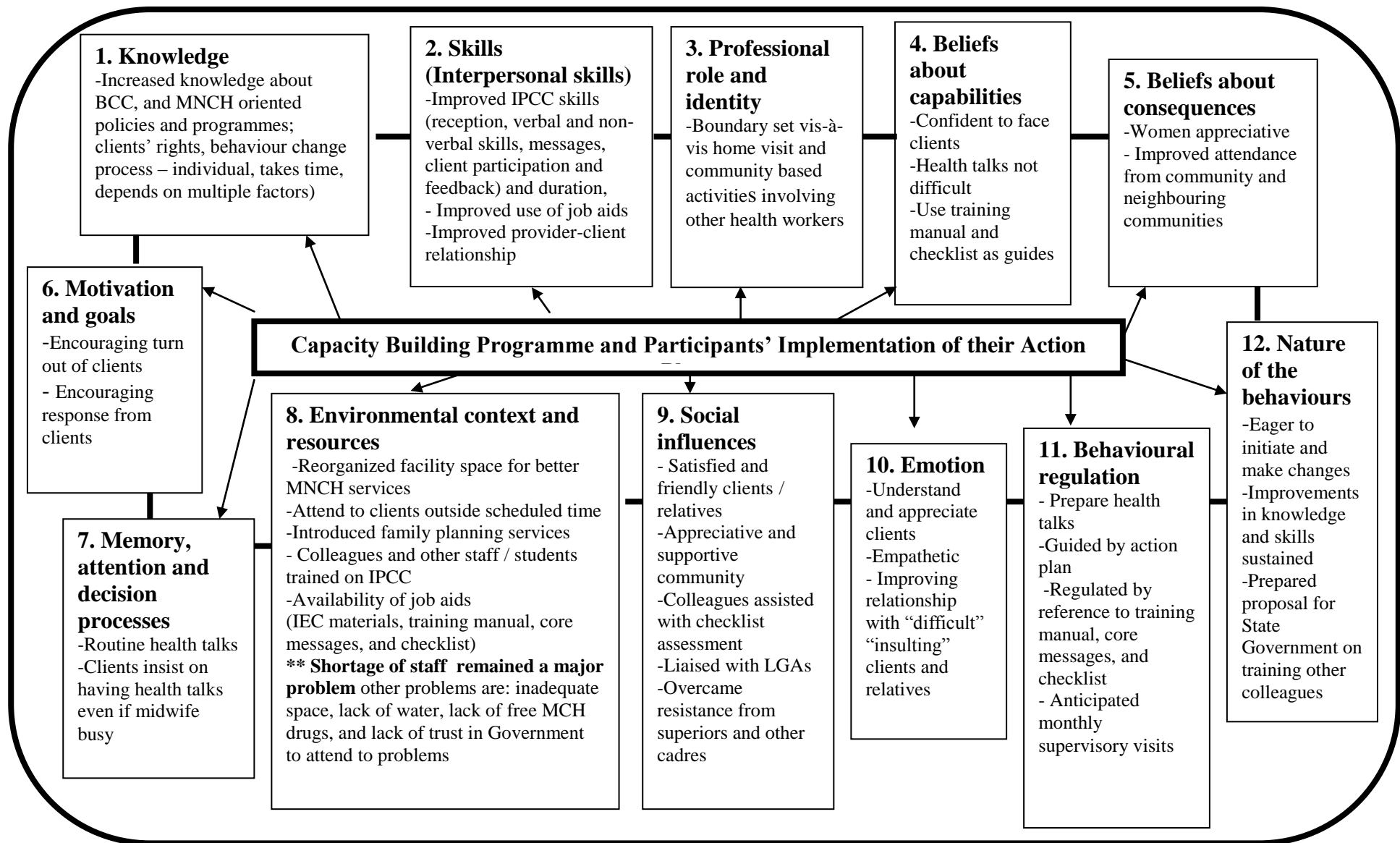


Figure 4:13 Summary of changes in the twelve domains of Michie et al's (2005) *Integrative Framework for Studying the Implementation of Evidence Based Practice* following the capacity building programme and participants' implementation of their action plans

4.5.5 Update on the special interactive session

The researcher informed the participants that she had submitted the report as requested and that the State Ministry of Health was doing something about the issues raised during the special interactive session. F92 reported that she had submitted an application for a correct placement while the other affected participants said they had not. The reason was the slowness of the ministry to respond. The researcher urged them that that was why they should continue and one day what they wanted would be done. The issue of certificates was brought up again and the participants were reassured that the researcher's school would look into it.

4.5.6 The way forward

The discussion on the way forward lasted 21 minutes. Issues discussed included very high failure rates in the council's qualifying examinations for nurses and midwives, which contributed to shortage of midwives; the poor remuneration of nurses and midwives; the need for nurses to be involved in politics so as to be able to influence the education and practice of nurses and midwives in the country; the strategies adopted by other health professionals to obtain the favour of leaders; and the need to bring the reality in the field to the teaching of students in the classrooms.

Conclusion: Some of the participants spoke one after the other appreciating the researcher, the midwife educator in the validation group, the research assistants, their colleagues, and the impact of the project on their lives and practice. One (F71) apologized on behalf of the others for all the mistakes and pledged a better response in future, promising that when the researcher heard about them in future, the reports would be good, and if she visited their facilities, everywhere would be sparkling clean. Closing prayers were offered in the Muslim

and Christian ways to thank God for helping during the past 10 months, for journey mercies and for changes effected in every life and workplace.

4.5.7 Debriefing by the State Ministry of Health

On 1st September 2010, the Director Nursing Services (DNS) invited the participants from the rural hospitals, who participated in the project, for debriefing. Thereafter, he directed the participants to present a proposal with the financial implication of replicating the workshop for other midwives in the state. The participants called, sent e-mails and so forth to request the assistance of the researcher for training materials, and an explanation of how to prepare a budget. They also requested the video clips used as interludes. They co-opted some of their colleagues who participated in the primary health care (PHC) facilities, for the planning and subsequent meetings. The researcher provided the items and support requested. The group coordinator (F81) thanked her for this.

4.6 Conclusion

This chapter presented the results at the various phases of the project and the debriefing sessions. Findings were summarized and presented in narratives, tables, and charts. The implications of these findings will be further discussed in the next chapter.

CHAPTER FIVE

DISCUSSION OF RESULTS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This final chapter of the report discusses the major findings of this study in relation to previous research. It presents the researcher's conclusions and recommendations in the light of the implication of the findings for policymaking, midwifery practice and education as well as for future research. It also explains the limitations of the study.

5.2 Discussion of Results of the Diagnostic Phase (Phase 1)

The participation of the key officials in the Ministry of Health and the Ministry for Local Government from the beginning of the study, and the demonstrated sensitivity of the action research to local preference (IDEAS for Action Research, 2002; O'Brien, 2001:3), was probably responsible for the high level of support enjoyed by the researcher all through the period of the study. Authors advocated active participation of stakeholders including the frontline staff, if behavioural interventions, were to produce satisfactory outcomes (Ajayi et al., 2009; Roberts et al., 1995:iii; Yeshe et al., 2009:397).

5.2.1 Description of Recruited Participants

Sixty-six percent of the 33 qualified midwives in all the nine selected facilities, indicated their interest in the project. This percentage is higher than the 43% of the sixty qualified providers documented by Helitzer et al. (2011:2) in their study. de Negri et al. (2005:38), observed that providers' lack of interest deterred researchers from studying provider-client interactions. The greater percentage, in this study, however, suggests an increasing interest in the need of the participants in this study for professional development, some of whom had not participated in any continuing education programme in decades. That the majority of the participants were of Kaduna State origin was normal, because the study took place in Kaduna

State. This is considered favourable to BCC for MNCH in the state, because the participants should be able to demonstrate a good understanding of the clients' culture and background, and provide culturally relevant services (Mathai, 2008:469). The study revealed that about two-thirds of the participants were Christians; their Muslim colleagues were barely more than a third. Some of the recruited Christian participants worked in areas with predominantly Muslim women, but no Muslim participant worked in the predominantly Christian rural areas. Mill et al. (2007:583), noted that working in unfamiliar terrains generated a sense of insecurity among providers. The occasional religious crisis in the northern part of the country, coupled with the need to be with members of their family was probably why some of the participants, requested transfer away from their locations at the time. It was revealed, however, during the special interactive session, at the second phase of this study, that the Kaduna State Government was recruiting and training midwives from the various communities to go back and serve their respective communities on completion of their programme.

Over three quarters of the participants possessed more than the midwifery qualification. The possession of more than one qualification was also documented about midwives in Africa by the UNFPA (2006b:22). The predominance of participants who had the basic midwifery training at the first level of maternal and child care, and in the rural settings, as observed in this study, probably suggests that, those who did midwifery after general nursing, did so for career progression, rather than for a desire to work with women, to be a midwife. Having a second qualification, was observed by UNFPA (2006b:22), as a factor contributing to the ease of migration of nurse-midwives. Since qualifying, however, some of the participants, including those with only midwifery training, had not participated in any of the MNCH focused professional development programmes in the country or in the state. Studies show

that midwives in isolated areas, were often not involved in staff development programmes (Koblinsky et al., 2006:1383; UNFPA, 2006b:23; UNICEF, 2008:76). Midwives serving in rural or isolated areas required more skills for independent practice, yet, as indicated in the cited studies, they were the ones often left out.

The majority of the participants had been practicing midwifery for three to thirty years and would remain midwives till they retired, or remain midwives even if they changed employment, because they could not think of an alternative to midwifery. This seems to be supportive of the Nigerian government's newly introduced midwives' service scheme, which accommodates retired midwives in its bid to ensure skilled attendants in the rural areas (FGN, FMOH, & NPHCDA, 2009). The commitment and passion of midwives to be with women even under adverse conditions was also documented by UNFPA (2006b:7).

Only 68.18% of the recruited 22 participants attended the search conference. It was, however, not uncommon for researchers to record less than 100% attendance in similar studies. de Negri et al. (2005:35-36) observed that 7(38.9%) of the recruited 18 participants in one of their studies, continued with it. The participants in this study were more keen on participating in the study than withdrawing. They expressed the fear of being excluded from subsequent phases of the project, and of being replaced by government's nominees, indicating the inequality in selection of professionals for continuing education programmes. In line with the participative nature of action research (IDEAS for Action Research, 2002; O'Brien, 2001:3), the participants were engaged in the process of identifying the problem and proffering context-specific solutions. Studies have shown that this made participants feel important, acquire problem solving skills, and feel motivated to be efficient (Boyd & Shaw, 1995:38). Right from the search conference, participants were planning what they would do in their

facilities and about their personal conduct. It has been emphasized, that merely talking to midwives about the need to change their behaviour, was usually not effective, rather they needed a proper understanding of their behaviour, an appreciation of the importance of the desired change, and to personally take steps to effect change because they believed in change (Boyd & Shaw, 1995:20).

5.2.2 Research Question 1 - What are the strengths and weaknesses of midwives in relation to behaviour change communication process, at the primary health care level in Kaduna State?

The conceptual framework adopted for this study, *Integrative Framework for Studying the Implementation of Evidence Based Practice* (Michie et al., 2005), was useful and adequate in identifying the gaps in the BCC activities of midwives at the facilities, as discussed according to the 12 theoretical domains below.

5.2.2.1 Knowledge of BCC for Mother, Newborn and Child Health (MNCH) - Most of the participants sincerely confessed their lack of knowledge of BCC for maternal, newborn and child health (MNCH). Literature revealed that the behaviour change approach is relatively new to the field of MNCH (CHANGE, 2005:20; Middlestadt et al., 2003:2). Many of the participants had never seen the obstetric and perinatal record booklet designed to manage women in pregnancy, labour and puerperium in Kaduna State, so they had no access to the few BCC elements in the obstetric and perinatal record booklet. In the facilities where the booklets were available, they were used only to register new clients and then set aside. The only participant who attended a workshop on the use of the booklet did not have copies supplied to her facility; hence, she was not using it. The participating midwives belonged to

the globally preferred cadre of providers at the first level maternal and child facilities; yet, they did not have adequate up to date information on key national and state programmes for MNCH, to be able to facilitate implementation of such programmes. Boyd and Shaw (1995:38) emphasized the need to expose these providers to the wider state, and national, plans, so that, they could locate themselves within the plans, and function appropriately. NGOs allegedly sponsored the initial production of the booklets, and the LGAs were expected to take over, but this was not the case. It was, however, pleasant to note that three participants, who attempted a definition of BCC for MNCH, saw it as a strategy targeted at the behaviours of both the providers and the consumers of health care.

5.2.2.2 Interpersonal Skills to Execute BCC for MNCH in the Health Facilities - The participants felt that they had the ability to give health talks and counsel mothers effectively, although, none of them was sure of knowing the required standards for interpersonal communication and counselling (IPCC), including those who had participated previously in some in-service training programmes, which had IPCC components as adjuncts. Professionals' lack of essential IPCC skills to communicate appropriate and correct messages that could facilitate behaviour change by consumers is widely reported by researchers (de Negri et al., 2005:7; Roberts et al., 1995:Q23-12; Rowan, 2008:404; Waisbord & Larson, 2005:13; WHO, 2008a:2). The lack of IPCC skills has always been the major gap in midwifery education and training (de Negri et al., 2005:7; Kwast, 1998:133). The previous assumption that midwives could talk to mothers and needed not to be trained (Boyd & Shaw, 1995:31), is currently giving way to greater recognition of the importance of behaviour change communication in MNCH care (ICM, 2002:4-11; WHO et al., 2004:12). UNFPA and ICM, (2006:9) attributed the lack of IPCC skills by professionals, to the disconnection of professionals' pre-service training from the real world in which they practise. Similarly,

according to Mathai (2008:471) short duration of training and less hands-on practical training yielded poor long term results. The failure of the participants who previously had a form of IPCC skills training to recall the required standard, could be because such programmes usually focused more on the programmes' technical components than on the adjunct IPCC component, as documented by Boyd and Shaw (1995:31).

The study also revealed that the participants covered a limited variety of issues, with the messages skewed more towards baby and post partum care. This was in line with Detman et al.'s (2008:291) observation that fewer than two-thirds of providers talked about important topics that have serious implications for maternal and child health during prenatal classes. Similarly, Artieta-Pinedo et al. (2010:194), noted that midwives did not update their information in line with contemporary trends in MNCH care, while Reitmanova and Gustafson (2008:101) observed that client education lacked relevance to clients' socio-cultural needs. The request for standard messages, by one of the participants who had participated in a number of MNCH related programmes, and coordinated MNCH activities for one of the LGAs, was an indication of the participants' lack of access to correct and up to date information to guide their clients. In line with the core competencies expected of professional midwives (ICM, 2002:4-11; N&MCN, 2004:2,3; WHO, 2006a:10,19), it is critical that information provided to clients be correct, culturally relevant, and adequate (Bailey & Jones Cole, 2009:147; CHANGE, 2005:20). Previous studies showed that clients were frustrated by inadequate information (Boscart, 2009:1823; Lamiani & Furey, 2009:272) and desired comprehensive and relevant information to clear their doubts, and enable them take informed decisions (Novick, 2009:233). Similarly, the women in this study mentioned issues about which they wanted more information. It is pertinent to state that, the collection of basic messages for MNCH by UNICEF, the F.M.O.H, and so forth were discovered by the

researcher in the course of this study. These materials could have been distributed to the midwives in the field to use. An informal discussion with UNICEF, by the researcher, revealed that such materials were usually given to the State Government for distribution to facilities. Similar discussion at the State's Health Promotion and Education Unit, revealed that IEC materials were distributed through the LGAs, from where they were given out on demand to health facilities. This distribution channel did not ensure that the expected end users (the midwives) got them.

Vital information sought by some of the women, including those using the facilities for prenatal care, was to know who a midwife is, and what she does. This was probably because most of them delivered at home. They were probably not aware that the midwife at the clinic could also take delivery. Conversely, it could be because only 3(33.3%) of the facilities provided 24 hour service, and most deliveries took place at night when the midwife would not have been at work, leaving behind unskilled attendants or no staff, to mind the other shifts. Hussein et al. (2004:37), also reported that women could not identify skilled attendants, while UNFPA (2006b:7), observed that the mere presence of a midwife in a community created awareness of, and promoted the utilization of, MNCH services. The request by some of the women, that the government should look for a good midwife, like those they knew about in the cities, and post such to the facility in their community, could suggest that, they were indeed unaware of who the midwife in the facility was, and of her roles in the facility.

The women in the study indicated that some midwives welcomed clients cheerfully and politely, and presented their messages in a lively and understandable manner, using the vernacular. Some midwives, however, were described by the women as disrespectful, harsh,

and ignoring or neglecting those who did not understand the language of instruction. Previous studies had also reported that women who did not speak the same language as the provider, women in minority groups, the uneducated, the poor, women in rural areas, and those in the disadvantaged groups, also felt discriminated against (Jensen et al., 2010:34,35; Tsianakas & Liamputtong, 2002:25). Davies and Bath (2001:242,244) observed that such clients doubted the competence of such providers and would not ask them for information.

This study also showed that while some midwives acknowledged their clients' questions and utilization of the facilities, other midwives ignored the clients' questions and considered them as unimportant or interrupting. Some of the women, however, did not know that they could ask questions or ask questions about concerns that were unrelated to the topic discussed for the day. Novick (2009:232) reported that providers' explanations and answers to women's enquiry were inadequate, and sometimes questions were treated as unimportant, making the women feel uncared for. Kriebs and Shannon (2008:266), emphasized the importance of recording favourable and unfavourable discussions and counselling sessions, however, the participants in this study did not document the client education, or individual counselling sessions held with the clients.

5.2.2.3 Professional Role and Identity with BCC for MNCH - The major and sometimes the only source of health messages on maternal and child health, mentioned by the women, was the nurses and midwives in the facilities, and occasionally at women's meetings. This supports previous findings by Devine et al. (2008:108), that midwives and nurses were women's choice for correct and up to date information on MNCH matters. Soltani and Dickinson (2005:636), however, found that, in addition to the health professionals, women obtained most of their information from family members and friends. Family and friends

were not a common alternative in this study as it was only one woman in one of the women's FGD groups who indicated that she got some information from her mother. Novick (2009:233) found out that it was when women could not access information from their provider that they obtained it from friends and relatives. Detman et al. (2008:292) also observed that where midwives failed to consider clients' culture, level of education, and so forth, women were likely to appreciate the counsel of close friends and relatives more than the midwife's.

Some of the women in this study got some information on MNCH from the electronic media, such as, the radio and / or television. Literature also revealed other sources of information on MNCH as being the print and electronic media (Leslie, 2004:155; Seidel, 2005:22; Stanton, 2004:181), including the internet (Larsson, 2009:17). In this study, only the PHC facility in the urban setting reported that companies gave out pamphlets and products for distribution to mothers. These according to Freda (2004:205) usually served as adjuncts to facility-based education. Soltani and Dickinson (2005:636), however, observed that the majority of non-professional mothers in their study did not understand all the information provided in the printed materials. Similarly, Detman et al. (2008:291), explained that brochures or written materials handed out in place of verbal communication, in order to save provider time, may not be remembered or understood by women with poor education. Liu et al. (2006) also found out that women in rural areas, especially in developing countries, had little or no access to print and electronic media. In Nigeria, there is a low literacy level among women aged 15 – 49 years (child bearing age). The national demographic health survey in 2008 revealed that 45.3% of the 33,385 women aged 15-49 years involved in the national survey, could not read at all, and it was worse in the rural settings (58.2% of the 21,451 rural women), than in the urban settings (22.3% of the 11,934 urban women), and worst in the North West zone where

78.1% of the 8,022 women could not read at all (NPC & ICF Macro, 2009:35). Some of the women in this study said that they had television and radio sets, and that they were aware of some MNCH oriented programmes in the media. They, however, said that they seldom listened to or watched them. Only 17.8% of the 8,022 women from the North West zone in the national demographic health survey, reported watching television at least once a week while 47.9% listened to radio at least once a week (NPC & ICF Macro, 2009:37).

The women in this study preferred information from midwives in the facility to the media because the women could clarify issues of interest with the midwives. Researchers have also noted that in view of the incompleteness and inconsistency of information from the alternative sources, women still consulted their provider to have their doubts clarified or to verify the information (Johnson et al., 2010:264; Leslie, 2004:155), hence, the health provider is usually their source of health information on maternal and child health issues (Davies & Bath, 2001:241). The participants in this study appreciated BCC for MNCH as the responsibility of midwives. According to Freda (2004:203), midwives over the years considered client education as one of their priority duties. The participants, however, did not see BCC for MNCH as exclusive responsibility of midwives and said that nurses, doctors and CHEWs should also be involved.

5.2.2.4 Beliefs about Capabilities – A few of the participants verbalized confidence and capability to deliver health talks and counsel their clients the way they were doing it, though they were not sure if their way was up to the desired standards. The majority of the participants, however, confessed that health talks, counselling, and facing clients were very difficult for them. Freda (2004:203) also noted that client education has become more challenging for midwives to do effectively. Nurse-midwives in Haruna et al.'s study

(2010:24), related the difficulties they had working with women on behaviour change, to inadequate pre-service preparation for such tasks, and to the absence of what information they needed for their daily experiences from their textbooks. Haruna et al.'s (2010:24) observation was similar to Detman et al.'s (2008:292) observation, that one of the major reasons why providers failed to educate or assist clients with appropriate behaviours to promote MNCH was their feeling that they did not have sufficient training on such issues. The participants in this study, however, did not relate the difficulties they had with BCC to their training. Many of the participants interviewed associated the difficulties they had with the clients. This to them was because of the socio-cultural background of the clients, their poverty, and the clients' low level of education discussed under 5.2.2.9 *Social Influences* on page 283.

5.2.2.5 *Beliefs about Consequences* - The participants believed that BCC activities in the facilities could produce some positive changes in the knowledge, attitude and behaviour of the clients, and that there would be a reduction in maternal and child deaths. They also believed that, in spite of the difficulties they had, it was better to have BCC for MNCH than not to, because without BCC the clients would not know what and what not to do. The women affirmed that they learned a lot from midwives and made use of what they learned, because it influenced their health seeking behaviour in respect of their sick children and for immunization. Provision of adequate information had been reported to increase pregnant women's knowledge of danger signs in pregnancy (Stanton, 2004:181-182), and their ability to seek appropriate care, and take necessary actions about their health (Kumbani & McInerney, 2002:43). Kalita (2006:14), however, noted that women acted on what they learned if the messages were considered important or advantageous. Similarly, the women in this study used what they learned selectively, according to their resources and if they considered

what they were told as important. This was probably because some of the messages were not planned or related to the women's socio-economic and socio-cultural peculiarities. Schneider (2001:20) observed that women sought help when they were equipped with appropriate information to enable them to gain an understanding of their condition. Detman et al. (2008:293), also observed that women who had pleasant prenatal care, continued to access care for their children too, and utilized preventive health services.

The participants believed that giving the health talks cost less than the consequences of not doing so, which, according to the participants, could worsen the current unacceptably high mortality rates among women and children in the country. Only 8.4% of the 8,022 women from the North West zone in the demographic survey delivered in facilities, and only 6.6% were assisted by nurse/midwives (NPC & ICF Macro, 2009:132,134). Similarly, the majority of the women in this study delivered at home and only used the facilities for delivery when there was a complication. Literature revealed that utilization of health professional at delivery by women, was strongly related to the education they had received at antenatal clinic, about danger signs and the use of skilled attendants (APHRC, 2006:xvii; Stanton, 2004:181-182). Only 28.7% of the women from the North West zone in the national survey, however, had antenatal care (ANC) provided by a doctor or nurse/midwife (NPC & ICF Macro, 2009:126), indicating the limited number of women who have access to the information required to inform appropriate behaviour, including delivery in a facility.

5.2.2.6 Motivation and Goals – Some of the participants gave health talks eagerly, and as a duty for which they were paid, and all of them did not expect or request for additional gratification from the clients for client education. Their encouragement to do so came from their belief in God as their rewarder, and it also came from the women's freedom to discuss

with them, the women's improved knowledge, and from positive changes in the community credited to them. Storey et al. (2009:1403), also noted that older nurses in primary and community service were encouraged by their clients. Too many patients, emergency situations, and booking of new clients occasionally interfered with the participants' health talks. This is in line with previous findings that shortage of staff and heavy workload shortened client education sessions during ANC, and made midwives focus more on services, jeopardizing counselling and provision of information (Couillet et al., 2007:293; Seidel, 2005:21). As much as possible, however, the participants arranged to give the health talks routinely. Dykes' (2005:247) also observed, that midwives delivered client education as a routine under pressure for time, without considering whether or not their clients understood the information. Midwives are known to still try to give their clients the attention, information and support possible, despite the heavy workload and difficulty. (Dykes, 2005:248; Freda, 2004:208).

Another major driving force indicated by most of the participants in this study for educating their clients in spite of all odds, was because of their own safety. This was because if the women were not informed or reminded often, they would not comply, and it would mean more work for the participants, and the participants would suffer. This is because the clients would come in late in labour and probably with complications, and they could come in without bringing the required toiletries, hand gloves, baby's things, and so forth. Whitehead (2001:822) observed that nurses were more traditional health educationalists than health promotionalists. Fear of religion and cultural factors demotivated the participants. This is quite understandable because the behaviour of the clients is rooted in their culture and religion; culture and religion are volatile issues in Nigeria. There are frequent politico-religious crises in different parts of the country and some of the participants worked in

environments where the religion and culture differed significantly from theirs. Authors documented that living and working in a strange community is challenging and poses dangers to midwives, especially in rural settings (Mill et al., 2007:583).

5.2.2.7 Memory, Attention and Decision Processes - Participants said that they always remembered to give health talks because it was a routine during ANC clinic in all the facilities, although the frequency varied. The women also corroborated this in their groups. Antenatal period seems to be a globally accepted suitable time for BCC for MNCH as studies have shown that women need, and are more responsive to, BCC activities in pregnancy (Detman et al., 2008:293; Fraser et al., 2006:920). Furthermore, as indicated in the North West zone's data presented earlier (on page 277), on delivery by skilled attendant and ANC by skilled attendant, antenatal care was the most utilized of the maternal health services compared to childbirth and postpartum care; hence, the suitability of the antenatal period for BCC on MNCH (Bhutta et al., 2009; FGN, 2004:42; Mathai, 2008:469). Apart from being a routine, some of the participants also educated their clients whenever they had something to tell the clients, or whenever the women were sick. The regional consensus on the role of skilled attendants emphasized the importance of health education, including counselling, as part of maternal health services through pregnancy, child birth and the postpartum period (WHO, 2006a:13) and not only during ANC.

5.2.2.8 Environmental Context and Resources - Only 1(4.5%) of the participants felt she had no challenge that could hinder her BCC activities at her workplace. She was the only one who indicated that she went through the workshop on the use of the perinatal record booklet and enjoyed the support of the health committee in the community. de Negri et al. (2005:62) also noted that only 15% of the professionals did not believe they faced any difficulties, the

percentage in their study, however, appeared better than that was recorded in this study. One of the environmental hindrances was lack of appropriate job aids and guidelines. None of the facilities or participants had any copy of the government guidelines or clinical protocols on MNCH BCC core messages. The participants mainly used their initiative to tell the clients what they knew and felt was important. Freda (2004:203) and Haruna et al. (2010:25) observed that lack of appropriate job aids and guidelines militated against client education, and according to Haruna et al. (2010:25), it limited the information provided by providers' to their personal experiences. Development of job aids and other IEC materials is usually part of BCC programmes (Boyd & Shaw, 1995:5; F.M.O.H, WHO., et al., 2005:65; Roberts et al., 1995Q17-2); hence, the strategic approach at the health system level in Nigeria also aimed at developing and producing job aids for health workers (F.M.O.H, WHO., et al., 2005:65). The IEC materials were supposed to be in the training schools and in the field for midwives to use, but they were missing in most of the facilities.

Only one of the facilities in this study had enough space for the women attending antenatal clinic, therefore, inadequate space, lack of privacy, and lack of toilets and bathrooms, were identified by the majority of the participants as interfering with effective client education. The women sat on the floor, in and around the facilities, and loitered around windows while waiting to be attended to, giving them access to conversations between the providers and the clients being attended to inside. Literature showed that external interruptions, lack of privacy, and inappropriate conversation environment (de Negri et al., 2005:62; Jangland et al., 2009:201) interfered with client-provider interactions. According to Dykes (2005:242), women preferred that midwives provide privacy. This is important, particularly when women matters or reproductive health issues are to be discussed, demonstrated or displayed on job aids. Many people, including health care providers, may not be comfortable discussing such

issues when there is a mix of intended and unintended audience. Similarly, in spite of the obvious need for water, toilet, bathroom, and safety in maternity care, a number of the facilities had no such conveniences; hence, the midwife would not be able to talk to the clients about the related hygiene issues, effectively, when they were not available in the facility. The F.M.O.H Nigeria recognized, and clearly expressed, the essential combination of adequate skills and enabling work environment for midwives to be motivated to address the needs of their clients for appropriate information in the rural areas (F.M.O.H, WHO., et al., 2005:5), yet, the majority of the participants operated under unspeakable conditions. Visser and Wismans (2010:404), recognized the importance of a therapeutic and supportive environment to encourage the adoption of desired behaviours by staff and clients, therefore, the reconstruction and refurbishing of the nursing department was part of their communication project.

The shortage of staff was another environmental factor the participants (77.27 % of 22), identified as limiting their effectiveness with respect to client education and counselling because they were usually too busy. In the very busy facilities, women also acknowledged that clients were usually too many for midwives, making them work all day. All the four PHC facilities in the rural areas had only one midwife each, although, one had three newly qualified midwives awaiting MSS posting. According to Koblinsky et al. (2006:1382), ideally, midwives are supposed to work in teams within the health facilities, with a mix of professionals and non-professionals involved in maternity care. Wiegers (2007:425) reported that reducing each midwife's workload led to 20% increase in the time spent for direct client care. In view of the heavy workload, and the amount of time sometimes required to attend to a particular client, the participants saw BCC for MNCH as time-consuming. The waiting clients often complained if a client stayed a long time with the midwife. Time is vital for

effectiveness of communication. CHANGE (2005:20), observed that both clients and providers considered lack of time a major barrier to client education. Similarly, McKellar et al. (2002:26) observed that women indicated that the midwives' workload was a factor responsible for the lack of adequate time for client-education, and made the midwives say a lot within a short time, which might not all be fully understood. Furthermore, Titaley, Hunter, Dibley, and Heywood (2010:1) emphasized that shortage of midwives was a major hindrance to women's utilization of the services of skilled attendants.

Both the participants and the women mentioned poor personnel remuneration as capable of negatively affecting the midwives' performance of their functions. Smith (2000:15S), observed that economic incentives motivated providers to adopt the desired behaviour. It was reported by UNICEF (2008:77) that in Mali, the Ministry of Health encouraged newly graduated doctors to serve in rural areas by offering them training, accommodation, equipment and transport if needed. Similarly, Indonesia supported midwives to establish practice in rural areas through a subsidy scheme (Koblinsky et al., 2006:1383). Nepal, also provided financial incentives for service providers assisting deliveries, either at home or in a health facility, to encourage provision of services (Barker et al., 2007:85). The participants complained consistently about the gross disparity in the remuneration of health workers in the three tiers of the health system, which studies have linked to the internal migration of personnel in the country, and to the shortage of staff at the primary level (Asuquo et al., 2000:69; CRR & WARDC, 2008:48). The MSS scheme seemed to have noted this problem and made provision for better (though not adequate) remuneration of midwives on the scheme.

One of the participants, in a bid to ensure 24 hour service, once resided in the facility, close to the highway, but was disturbed by hoodlums at night. The enabling environment required by midwives, as concluded at the First International Forum of Midwifery in the Community, include adequate housing, provision for their children's education, and provision for their personal security (UNFPA et al., 2006:37); unfortunately this was not the case with the participants in the field. According to the WHO et al. (2004:12), it is understandable when a facility is being developed or the system is being strengthened, and the midwives had to work in sub-optimal environments, but it becomes unacceptable when midwives had to continue under such conditions indefinitely.

Other environmental challenges the participants identified were lack of equipment, and lack of / insufficient free drugs and ITNs for pregnant women. de Negri et al. (2005:62) reported that lack of drugs and clients' lack of funds to purchase drugs militated against compliance with instructions. The introduction of the Free Maternal and Child Health (FMCH) drug programme and the Sustainable Drug Supply Scheme (SDSS) in selected facilities, in Kaduna State, a couple of years ago, was probably responsible for the low percentage of participants (9% of 22) who indicated lack of drugs as a challenge. Some of the participants attributed the favourable response of the clients to marketing of the services available in the facility, and to the assurance given by the participants to the clients that drugs were available. According to de Negri et al. (2005:51), clients cannot effect lifestyle changes or comply with treatment if they cannot access drugs and essential supplies. About three-fifths of women in the North West zone of Nigeria do not access care because of lack of funds for drugs and the lack of drugs in the facility (NPC & ICF Macro, 2009:138). The National Health Act 2008 (FGN, 2008) has adequate provision for strengthening the health system and the PHC in particular, however, it is yet to be implemented.

5.2.2.9 *Social Influences* - Only one participant indicated that her facility enjoyed the support of the community health committee, while some of the other participants reported the lack of social support, as well as some threats from the community. Although midwives worked mainly in facilities in Nigeria, according to the delivery modes (F.M.O.H., 2007:41-42,47-49,82), authors maintain that success in behaviour change is enhanced where partners, spouses and significant members of the community are also empowered to promote MNCH care services (Bradshaw et al., 2008:8; CHANGE, 2005:20; Schooley et al., 2009:9). Boyd and Shaw (1995:8) documented the influence of the community's appreciation of the health care providers, and the financial support for facility needs, in encouraging the care providers. The fear created in the participants by cultural and religious problems and the preference of the CHEWs to work in a facility rather than in the community, militated against effective mobilization of the community for MNCH. Kwast (1998:133), noted that traditional values often hindered midwives from counselling.

The social challenges identified by the participants included the clients' lack of education and ignorance. Some of the participants felt that some women did not listen to, or comply with what they are told, while others saw the women as being difficult to convince. The MotherCare (2000:6) pointed out that desired change in behaviour takes time, and appropriate efforts towards the desired change must be sustained. The providers in de Negri et al.'s (2005:62) study also identified clients' ignorance and poor level of education as hindrances to efficient provider-client interaction. Poverty was another social hindrance identified by the participants. Detman et al. (2008:292), recorded that providers sometimes failed to educate or assist clients because they saw it as a waste of time and energy, believing that clients would not benefit from or make use of the information, or that the clients and / or community lacked the resources to support the desired behaviour. Literature emphasized the

need for midwives to understand the process of behaviour change - that it takes time, and the fact that when the clients appreciate the providers, providers would be able to respond appropriately to their clients' need for information and support (Crafter, 1997; Reitmanova & Gustafson, 2008:101; Roberts et al., 1995:Q14-4).

The women in this study used the facilities mostly for their children and sick women. The women, particularly those in the urban slum and rural areas, confirmed their failure to use, or their underuse of the facilities, particularly for delivery. Some of the women attended the antenatal clinics but still delivered at home, while the others neither attended the antenatal clinic nor delivered at the facility. The reason was that home delivery was their traditional method of delivery. Although some studies showed that most women who had access to skilled attendants preferred them for their maternity care (Koblinsky et al., 2006:1377), CHANGE (2005:6), as observed in this study, also noted that women delivered at home in spite of awareness of availability of quality services.

Similarly, Titaley et al. (2010:1) reported that the preferential use of TBAs, and preference for home delivery by women, in spite of the presence of a professional midwife in the community, was mainly because of the distance, cost of care, and the belief that facility delivery aimed at women who had pregnancy related complications. Some women in this study also reported that women delivered in the facility only when there was a complication; however, none of them gave financial reason for their continued use of TBAs. This was probably because women paid the TBAs in cash and kind, as much as they could afford, while delivery in some of the facilities was free. The women in this study, who were aware of midwives in the city, however, reported being tired of the TBAs because the TBAs could not educate them about MNCH matters, they cared only for the baby, and sometimes arrived late

to separate the cord. This is different from the views of the participants in this study, and the previous reports in several government documents in Nigeria, that women preferred to use TBAs (F.M.O.H & WHO, 1999:1). According to CRR, & WARDC (2008:47), the assumption held by Government and health workers that women preferred TBAs was incorrect. The authors maintained that women utilized the services of TBAs because they were affordable, available 24 hours a day, and because of the TBAs' good interpersonal relationship, but they would rather have their deliveries in the public facilities if the conditions there were different (CRR & WARDC, 2008:47). The women in this study requested good midwives like those in the city to be posted to their community. Literature reported the willingness of women to try new practices to improve their health and that of their babies MNCH (CHANGE, 2005:20).

The women in all the groups reported that they enjoyed the health talks and felt happy and strengthened when listening to the midwives. They believed the midwives and appreciated their efforts. Ratanawongsa et al. (2011:5), observed that while the providers described the clients negatively, as frustrating, because of their non-compliance, the clients appreciated the providers. Kalita (2006:14) also discovered that women welcome information and messages. There is an obvious gap between the participants' opinion that the women were unyielding, and the expressed preference of the women for the professional midwives. According to Ratanawongsa et al. (2011:6), health workers' understanding of their clients' perception, helps them realize how appreciative their clients are of their services and support. The participants desired to learn more, and watch others do BCC for MNCH, because they believed they would learn and gain from it. This was favourable to the research process and differed from previous reports that providers were often not interested (de Negri et al., 2005:38).

The participants also considered the presence of many private clinics in the urban areas, and chemists (drug vendors) everywhere, as a threat. This is not surprising because Rosenfield and Min (2007:202) and the F.M.O.H (2007:3) observed that the majority of the public health facilities are not functioning. Furthermore, the delay in receiving attention (CHANGE, 2005:8; CRR & WARDC, 2008:48), lack of drugs and essential supplies (Baltussen & Ye, 2006:30), lack of equipment and other infrastructure, shortage of staff especially in rural areas, and failure of facilities to provide 24 hour service or to open for long hours (CRR & WARDC, 2008:9; FGN, 2004:41), contributed to the underutilization of facilities by the consumers (FGN, 2004:41; Ozumba & Nwogu-Ikojo, 2008:355).

5.2.2.10 Emotion – The health talks and counselling evoked pleasant emotions in the participants and gave them a sense of achievement, especially when the clients complied with the counsel. The women remarked that their delay in booking or coming to the hospital when in labour, and their non-compliance with instructions, irritated midwives and made them talk harshly. From the women's discussions, midwives seemed to exhibit negative emotions when women were in labour; and some of the women concluded that they would rather seek the assistance of a chemist (drug vendor), or go nowhere, than face the outburst of an annoyed midwife. The participants, however, said that they usually tried to control their unpleasant emotions, and prevent them from affecting BCC for MNCH. One of the participants indicated that the mismanagement of a workplace crisis involving her, grieved her, interfered with her BCC activities, and would remain so, until justice was done.

The reason adduced by researchers as being largely responsible for the negative attitudes of skilled attendants was the lack of an enabling environment required to function optimally (Asuquo et al., 2000:69; CRR & WARDC, 2008:48). Similarly, some of the women said that

poor salary and poor working conditions were responsible for the inability of the midwives to be friendly sometimes; they encouraged midwives to look up to God who alone could reward them. Contrary to the women's counsel, Boyd and Shaw (1995:51), based on their vast experience in the field, and observation that a lot had been done over the years in the field of client-centred evidence-based care, demanded that similar efforts be made to understand and support midwives.

5.2.2.11 Behavioural Regulation - The participants did not plan, and believed they did not need any preparation before giving health talks in the facility, because of their experience. This was contrary to Al-Motlaq et al.'s (2010:476) finding that nurses in remote and isolated areas did not plan their health promotion and education activities because of their heavy workload. Whitehead (2001:822) observed earlier, that nurses were more inclined towards educating clients, than promoting behaviour change for health. Thyrian et al (2006:32) emphasized the need to make client education more than a mere routine. Preparation enables midwives to make messages client-centred (Reed & Jernstedt, 2004:1). The participant who felt there was a need to prepare, however, said it was to avoid being angry when a client annoys her or to avoid being stranded when a question is asked.

5.2.2.12 Nature of the Behaviour – The participants' BCC activity in the facilities was only the routine health talks to pregnant women in groups and the occasional individual counselling, which, as rightly explained by them, was part of BCC for MNCH. According to Yeshe et al. (2009:397), however, BCC focuses on observable and sustainable changes in behaviour, and not, mere creation of awareness. The participants were, however, able to mention some changes needed in their facilities to improve what they were doing, although, they felt it was their supervisor who could initiate such changes. Observing midwives' feeling

of powerlessness, Pettersson et al. (2006:165) emphasized the need for midwives to be more proactive and make a difference in their places of work. Similarly, Knol and van Linge (2009:361,362) expressed the critical need for nurses to develop innovative behaviour. This is critical for BCC for MNCH in Kaduna State, especially in the rural areas.

The participants, though, were willing to maintain whatever change was made to improve their BCC activities, but, midwives are not only to implement changes but should be able to advocate for changes and make a case for improved MNCH services (WHO et al., 2004:12). If midwives are to be innovative, they need the opportunity to participate actively at the various stages of developing the MNCH programmes implemented at their facilities. Unfortunately, according to Martin and Bull (2005:126), they are seldom allowed to do this by their senior colleagues. Likewise, Storey et al. (2009:1404), observed that the flow of information and the way changes and innovations were executed in facilities were usually unfavourable to nurses. The participants wanted to know more about BCC for MNCH. This was positive for the study, because Boyd and Shaw (1995:49) maintained that change in the behaviour of health workers was key to changing the behaviour of pregnant and nursing mothers. The participants believed that if supervised, the effectiveness of BCC in their facility could be observed and measured.

5.2.3 Research Question 2: What strategies / mechanisms can be used by midwives to promote behaviour change communication at the primary health care level in Kaduna State?

In view of the extensive interaction the participants had with the data during the search conference, they were able to identify the problems related to their BCC activities, and they eagerly listed many things to be done to address the gaps. The extent of involvement of the

participants in this study, was identical to that which Boyd and Shaw (1995:32,34), found to be effective in previous projects, where the participants reviewed the baseline data on their performance, and determined the solution (Boyd & Shaw, 1995:32). CHANGE (2005:20), also observed that change in the behaviour of care providers was possible when they were involved at every stage of the programming cycle. The focus of the study was on the participants; their suggested solutions, however, were all encompassing. This was probably because of the detailed problem identification process using the conceptual framework, and the worksheet designed by the researcher. Michie et al. (2005:26) developed the framework in realization of the fact that lack of a theoretical understanding of all that is involved in a required change by health professionals often resulted in the failure in implementing whatever guidelines were prescribed to effect the change. To effect the desired changes, the participants recommended strategies focused on the community, the government, and the participants (professionals).

Similar to the participants' recommendations, was Awa et al.'s observation (2010:189) that it was important to focus on both the workers and their organizations for interventions to produce positive results. Likewise, Kalita (2006:15) pointed out that the gains of behaviour change interventions (BCI), were only sustainable when the social and environmental factors that could militate against it were taken care of. de Negri et al. (2005:62), reported that providers' suggestions on how to improve their performance included reorganization of the clinics, better equipment and facilities, and IPC training. CHANGE (2005:5) recommended an integrated approach whereby behaviour change was addressed on all fronts, including households, community and the health facility. In addition to making the health talks and counselling sessions to aim at behaviour change, the participants considered some of the

social and environmental factors that they could manipulate to support their clients' efforts at behaviour change.

5.3 Discussion of Results of the Intervention Phase (Phase 2)

This phase of the study answered research questions 3, 4, and 5.

5.3.1 Research Question 3: How can the midwives be supported to develop their capacity for behaviour change communication in line with the identified strategies and mechanisms, to facilitate behaviour change communication for maternal, newborn and child health in Kaduna State?

The participants were represented on the committee that planned the capacity building programme and developed the manual for the training component of the programme. The solutions they proffered at the search conference to bridge the identified gaps, and their expectations from the project which they provided at the beginning of the search conference, guided the selection of the content for the capacity building programme. This was in accordance with recommendations from literature that the participants be involved in determining what they thought was feasible and should be included in the curriculum (CHANGE, 2005:19; WHO, 2001:9), and that focus should be on participants' preferences, within approved professional and national standards (Boyd & Shaw, 1995:20). Parry's (2008:193) review of previous studies on development of communication skills of professionals revealed that they were more effective when tailored towards the needs of a specific group. Similarly, researchers have repeatedly emphasized that capacity building programmes must have content, context, and cultural relevance (de Negri et al., 2005:20; Visser & Wysmans, 2010:407; WHO, 2008a:5,9). The national behaviour change

communication strategy was also considered (F.M.O.H, WHO., et al., 2005:65) in designing the training programme. Visser and Wismans' (2010:407) suggested that in-service communication training for professionals should be based on a strong supportive policy on developing professionals' IPCC skills. A special interactive session was incorporated into the capacity building programme as recommended by the participants in order to attend to the issues for greater government commitment. According to UNFPA and ICM, (2006:2), all environmental, social, and personnel issues must be considered in capacity building.

The participative approach adopted in developing the capacity building programme in this study, and in line with evidence from previous projects, is often not the case in normal practice in Nigeria. As documented by the WHO (2008a:9), most of the capacity building programmes are designed by the initiating agency or engaged experts, in alignment with the country's national MNCH policies. The trainers usually used the same centrally developed manual to teach professionals from different parts of the country, yet, Nigeria has cultural diversities, and professionals serve under different tiers of government and private administration, and under varied circumstances. This could create a gap between the professionals' behaviour promoted during such training programmes, and the reality the professional faces in the field after the workshop, and hinder continuity or sustainability.

5.3.1.1 The Capacity building Programme – The high attendance rates recorded among the participants during the various activities of the programme, was probably because of the human focus by the researcher, who treated the participants as colleagues and promoted their sense of identity with the project. The participants, as reported in the evaluation forms, saw the researcher as a role model and were encouraged. This was also reported by the students in Licqurish and Seibold's (2008:487) study, who preferred midwife preceptors who were

attentive, supportive, caring, treated them like human beings, and served as positive role models. Boyd and Shaw (1995:31,32,49) also emphasized that participants must be treated as important, and with respect, as they are expected to treat their clients.

Knowledge - The participants' knowledge increased significantly immediately after the training and remained statistically significant after three months. Harvey et al. (2007), Lamiani and Furey (Lamiani & Furey, 2009:272), and Subramanian et al. (2010:6) also recorded significant improvements in participants' knowledge post-intervention.

Skills - The significant difference between the first and second overall IPC assessment scores suggested a general improvement in the participants' IPC skills. de Negri et al. (2005:36,63) and Helitzer et al. (2011:1) made similar observations, that the communication skills of providers in their intervention groups improved significantly immediately after the training, and the improvements were sustained during subsequent assessments. Further analysis of the IPC skills revealed that there was no statistically significant difference between the first and second assessment scores of the participants on *reception*. Greetings and warm welcome is a rich part of the Nigerian culture; self-introduction to clients, however, was new to the participants. As part of the drive to ensure accountability and promote consumer's rights, wearing of badges indicating providers' names and positions, was advocated in the country by NGOs, professional associations, and regulatory agencies (CRR & WARDC, 2008:67), although, not practised or enforced in many settings. Most of the women in the rural areas cannot read, hence the self-introduction, which also narrows the provider-client gap, was motivated in this study. Where participants introduced themselves, however, they reported that the clients were happy.

Statistical analysis of the participants' first and second *verbal communication skills* scores, suggested a significant improvement. At the first assessment, some of the participants were not clear, patient, did not encourage the clients, did not keep their verbal expressions simple or free from medical terminologies, and the majority of them did not show repeating or reflecting skills. At the second assessment, however, all the participants were clear, audible, and kept the communication simple for the client to follow, though six of the participants either interrupted the client at a point or asked a number of questions in succession before allowing the client to respond. de Negri et al. (2005:63) also recorded that before intervention, providers in their study interrupted the clients but improved post-intervention. Subramanian et al. (2010:4) also reported improvement in their participants' verbal communication skills, post-intervention. Statistical analysis did not suggest any significant difference between the participants' first and second *non-verbal skills assessment scores*. A few of the participants, who could not maintain eye contact, and were not relaxed, open or confident at the first assessment, showed a lot of improvement by the second assessment; they were relaxed and confident. The confidence gained by the participants was most likely related to the repeated practice, and the increased knowledge about what to tell the clients.

There was no statistically significant difference between the first and second assessments of the participants IPC skills in terms of the *messages*. Some of the participants had problems with the correctness of the messages at both assessments, however, only 2 participants scored 1 point out of the 3 obtainable points at the second assessment, and, unlike at the first assessment, none of the participants scored zero or shied away from the topic during the second assessment. Subramanian et al. (2010:4) reported that the information provided by providers post-intervention was correct. There was only one focus for Subramanian et al.'s intervention - non-scalpel vasectomy (Subramanian et al., 2010:4). The participants in this

study, however, had many issues from pregnancy to the care of the child, to assist clients with, depending on the clients' needs. Studies have emphasized the need to retrain midwives to keep abreast of the trends on these various issues (Bradshaw et al., 2008:8; F.M.O.H, WHO., et al., 2005:5). Although the participants were given a set of compiled core messages, there is a need to find a way of regularly updating these core messages, and familiarizing midwives at primary level with contemporary issues in MNCH.

The difference in the extent of *client participation* at the first and second IPC skills assessments was statistically significant. At the first assessment a third of the participants did not allow client participation, and the clients were inattentive. The participants, however, allowed more client participation at the second assessment. This affirms the finding in previous studies that client-education was usually provider-dominated (Boscart, 2009:1823; Lamiani & Furey, 2009:272). Similarly, as recorded in this study, Boscart (2009:1823) observed that practitioners significantly became less authoritative post-intervention. The difference between the participants' *feedback skills* at the first and second assessments was statistically significant with improved, though not total, client satisfaction. The improvement is in line with Griffin et al.'s (2004:595) finding that interventions to alter relationship between provider and clients significantly altered the process of interactions in 74% of the trials (26 of 35). Reasons for dissatisfaction in most cases in this study were related to the message component of the interaction. Similarly, as found by de Negri et al. (2005:49,63) post-intervention, the client was satisfied with welcome, respect, and some of the explanations and actions of the participants. Assuring clients of midwives' availability and readiness to assist always, was uncommon behaviour to the participants, however, six (40%) of the participants remembered to assure the client of their availability and readiness to assist always, at the second assessment. Literature recommends that to acquire and sustain essential

competencies, practice must be repeated and objectively assessed (UNFPA & ICM, 2006:9). Probably with further practice more of the participants would adopt the behaviour and exhibit it regularly.

Only one of the participants made use of IEC materials in her presentation at the first assessment. At the second assessment, however, the participants made reference to community structures but not electronic / print media or any community support to reinforce their advice and further encourage compliance. This is probably because they did not use media themselves or did not consider them relevant to the needs of the client. The participants' use of IEC materials needs further strengthening because only marginal improvement was observed in this study. None of the participants documented the interaction at the first assessment, while seven remembered to do so at the second assessment. Client education and counselling is an important aspect of client care, and Kriebs and Shannon (2008:266) emphasized the importance of recording discussions and counselling sessions held with clients. There is provision in the client record booklet for documentation, yet some of the participants did not document their interactions. Those who remembered to do so were those who used their checklist frequently in the field.

There was statistically significant difference between the duration of midwife-client interaction at the first and second assessments. Subramanian et al. (2010:4) also reported that interaction time increased post-intervention. de Negri et al. (2005:49,63) observed that the clients in their study reported greater satisfaction post-intervention because the trained providers gave them more time; the average visit with the trained physicians lasted five minutes, while the average visit with the untrained physician lasted three minutes (de Negri et al., 2005:47,53). Nurses in Lamiani and Furey's (2009:272) study also gave clients

sufficient time to talk post-intervention. Literature recommends at least 3 minutes per counselling session with each client in simulated situations, to allow professionals to have meaningful discussion, as in real life situations, where they would need to access and assess information from clients and allow feedback from the client (Mesquita et al., 2010:147). The participants in this study spent approximately 4 minutes per client; this appears adequate in the view of the findings in previous studies. The inadequate midwife: client ratio in many facilities, however, poses a threat to satisfactory interaction as reported by the participants at the diagnostic phase of the study. According to UNICEF (2008:76), the number of skilled attendants is related to MNCH outcomes and enhanced where the health worker : population ratio is more than 2.5 : 1,000 inhabitants. As rightly documented by Koblinsky et al. (2006:1379), and observed in this study, the gross staff shortage is worse in the rural areas.

Apart from IPCC skills training, subject matter to equip participants for increased community involvement, and their personal development were included in the training package (see Figure 4:7 on page 192). The participants indicated that they learned new things, developed new skills, intended to improve their practice, and would initiate some changes after the training (Tables 4:5 on page 200 to 4:10 on page 205). This supports previous observations that health workers respond positively to well planned training (de Negri et al., 2005:7; Ratanawongsa et al., 2011:6).

5.3.2 Research Question 4: What plans of action do the midwives need to facilitate the process of behaviour change communication at their respective workplaces?

Literature encourages the development of action plans to guide professionals' new behaviour (Roberts et al., 1995:Q15-6,7), and the trainees in Yeshi, Wangdui, and Holcombe's

(2009:397) BCC programme developed their own plans of action. Findings in this study revealed that no two facilities had the same action plan, indicating the ingenuity of the participants, stimulated by a training with which they could identify (de Negri et al., 2005:20; Visser & Wismans, 2010:407; WHO, 2008a:5,9). It is pertinent to note that the participants, who during the initial survey could not suggest the changes required to support BCC in their facilities, were able to put up action plans for implementation in their facilities by the end of the training. The participants' initial assumption that only their supervisor could initiate changes, gave way to an eagerness to do something in their respective facilities.

Adequately trained professional midwives are expected to be able to advocate for changes and make a case for improved MNCH services (WHO et al., 2004:12). Similarly, according to Pettersson et al. (2006:165) they should also be agents of change; and Knol and van Linge (2009:361,362) emphasized the need for them to be innovative. The participants' action plans contained items related to client education, reorganization of services to enhance client compliance, altering the environment for client comfort, liaising with community and government agencies on various issues to improve their practice and support their BCC activities, and stepping down training to other personnel. The participants in de Negri et al.'s (2005:62), and Visser and Wismans' (2010:404) studies also suggested similar changes in addition to IPC skills to provide client-oriented service.

What is often prepared at the end of workshops is usually a joint communiqué and not individual plans on the way forward in participants own real world. The authors of the integrative framework adopted for this study emphasized the need for a theoretical understanding of the fundamental requirements for the implementation of guidelines (Michie et al., 2005:26). The researcher believes that where planners / trainers failed to involve

participants prior to training, the process of developing a feasible action plan by participants may provide them an opportunity to examine the implication of implementing such guidelines in their facilities, bearing in mind the 12 theoretical domains. WHO (2008b:14-15) reiterated the desire of professionals to have input into what affects them.

5.3.3 Research Question 5: How can the midwives' implementation of their plans be supported?

5.3.3.1 Networking with employers and other agencies - The coming together of the very busy government officials at the special interactive session with the participants was described by the Director of Primary Health Care as a 'miracle'. This may be an indication of their support for the project, having been involved by the researcher from the beginning. The forum, however, revealed a wide gap between employers and their employees. It revealed that the supervisors in the facilities were a weak link between the participants and the government, because some of the issues raised by the participants were unknown to the government officials. Such issues were not usually raised at the regular leaders' meetings. According to Martin and Bull (2005:126) such supervisors sometimes hindered the good initiatives of the younger midwives.

Takase et al. (2008:295) maintained that it is critical for employers to pay attention to the staff. To bridge the gap, the officials and the participants exchanged their contact addresses – physical, e-mail, and telephone and the participants were advised to feel free to inform the officials of happenings in the facilities. This was seen as a reassuring move by the participants, as was documented also by Boyd and Shaw (1995). The session also provided the government officials, the opportunity to pledge their support and encourage the

participants, educate them on the operations of the government and non-governmental organizations (NGOs) in support of MNCH. As observed by Boyd and Shaw (1995:38), this helped the participants' understanding of how they fitted into the bigger plans for MNCH. The participants also got information about how they could benefit from relevant agencies and their LGA headquarters. Networking was documented as an essential skill for professionals by Knol and van Linge (2009:359), and was particularly beneficial to staff in the rural and isolated areas according to the UNFPA and ICM (2006:12).

It appeared, however, that the MOH was more forthcoming; the Director of Nursing Services promised to invite the participants as resource persons to scale up the IPCC training in the state. This was in line with the views expressed earlier, while the MOH selected facilities to participate in the study. The seeming weakness of the PHC Department in the MLG to commit itself, was understandable, because there is still a Local Government (LG) Board involved in the running of the PHC facilities, and each LG also exercised a measure of independence in running its facilities. The management of the PHC facilities was more complex, hence, the conditions in some LGAs were better than others, with some owing workers salary up to 3 months while others did not. This scenario calls for the speedy actualization of the provisions of the National Health Act 2008 which expectedly would bring PHC under an adequately funded and administered development agency (FGN, 2008:10).

5. 4 Discussion of Results of the Monitoring Phase (Phase 3)

Discussed here are the results related to research question 6.

5.4.1 Research Question 6: How are the midwives implementing their plans at their work places?

5.4.1.1 Supportive supervision - During the diagnostic phase, the participants expressed the belief that BCC activities are observable and assessable through supervision and review of data. Yeshe, Wangdui, and Holcombe (2009:397) stated that the outcomes of BCC are observable changes in behaviour. The researcher undertook unscheduled monthly, but, supportive and non-judgmental, supervisory visits to facilities. As documented in literature, and later reported by the participants, the visits helped to attend to any problems, motivate and support the participants (Subramanian et al., 2010; The LINKAGES Project, 2004:54). The unscheduled nature of the visits, however, was to remove bias, and encourage the participants to do the right always.

5.4.1.2 Implementation of the Action Plans – Target setting and development of action plans were encouraged by Roberts et al. (1995:Q15-6,7) and Smith (2000:16S), and demonstrated in Yeshe et al.'s (2009:397) study. The participants in this study exhibited some observable achievements in their *IPCC skills* within the three months of implementing their plans. They were more confident in talking to their clients, and were able to manage allegedly annoying or insulting clients. Their preparation and delivery of health talks and counselling of the clients improved, with impressive feedback during health talks. This affirms the importance of hands-on practice in skills development as observed by UNFPA and ICM's (2006:9) and Licqurish and Seibold (2008:487). This was upheld by The LINKAGES Project (2004:vii) and Mesquita et al. (2010:145) who emphasized that health workers should be provided with

sufficient opportunities for active learning, practice and corrective feedback. Similarly, the participants in Doyle et al.'s (2011:6) study emphasized the importance of teaching communication skills in community-based settings.

There was improvement also, in *promoting MNCH services* and *making them available* on request outside scheduled times. This is in line with the expectation of the BCC service-oriented strategy in the health system, which required that opportunities for integrated services be created, to promote access to services outside the scheduled days and time (F.M.O.H, WHO., et al., 2005:64). The Nigeria DHS 2008 (NPC & ICF Macro, 2009:138), revealed some reasons why women did not access health care (see page 25 in chapter two), pointing out that if they appeared eventually, it would be most unfair to send them back. The illustrations given during the training helped participants to appreciate that fact, and they implemented it in the field, though with some resistance from some staff, especially the card-issuing officers. To make their workplaces friendly, participants did various things; they provided privacy or created more space; ensured that staff were identifiable and observed work hours; maintained good records; ensured access to drugs by clients; and influenced colleagues to support changes among others. Boyd and Shaw (1995:32) and WHO (2001:9), documented that, in addition to benefiting from participatory approaches, adult learners preferred skills that were relevant to their daily activities, and applicable to their context. These observations were reiterated by the participants, and reflected in the contextualization of their plans, which made it easy for them to achieve what they did in three months. As recommended in previous studies, implementation of the action plans stimulated the participants to be innovative (Knol & van Linge, 2009:361,362) and they became agents of change in their facilities (Pettersson et al., 2006:165).

The participants reported, and the researcher observed, *improved clients' interest and active participation* in health talks. The researcher heard comments about improved midwife-client interaction from clients in some of the facilities. Clients and their relatives freely approached participants for assistance and sometimes participants had to close late after attending to clients in need. Preference for a particular midwife (participant) in the facility was documented in a number of instances by the researcher. The possibility of positive results among disadvantaged groups was documented by Willems et al. (2005:145), who observed increased client participation and improvements in health outcomes among women with low educational levels.

The participants through the process of implementing their action plans learned the act of direct *networking*. Enhancing the capacity of midwives to be able to recognize and utilize available legal, environmental, and managerial supports for quality MNCH services was documented in literature as part of capacity building (UNFPA & ICM, 2006:2). Some of the participants worked through their CHEW colleagues to gain the support of their communities, while some worked directly with their community leaders and documented interesting experiences, including mobilization of women to use services, and construction of conveniences in the facility. The participants, including those in the rural hospital under the MOH, liaised with their LGAs and obtained assistance. MacDonagh (2005:4) and UNFPA & ICM (2006:2,12) maintained that networking is supportive, and improves quality of care, especially in remote or rural areas. The participants also found their networking experiences exciting and encouraging, as had been described by Knol and van Linge (2009).

Furthermore by the implementation of their action plans, the participants created *awareness on IPCC and friendly services among colleagues and subordinates*. Similarly, peer assessment thrived where there was more than one midwife in the facility, and the

participants trained their colleagues who had not participated in the training, to serve as their assessors. The LINKAGES Project (2004:53), reported that where midwives practised what they learned and taught others too, it helped them to remember what they had learned. Although de Negri et al. (2005:24) and Lanning (2011:1,3,4) observed that self-assessment was useful for critical self reflection and encouraged improvement, most of the participants in this study preferred peer-evaluation to self-evaluation. Koblinsky et al. (2006:1382), indicated that midwives ideally, should work in teams within the health facilities. Most of the PHC facilities in this study, however, operated the solo-midwife approach discouraged by these authors. This made assessment of some of the participants' IPC skills practice, using the checklist, impossible for those who insisted they could not assess themselves. According to Lanning (2011:1,3,4), assessment by different assessors served various purposes. The World Bank (2007:37) noted that through peer assessment, professionals understood that others had weaknesses similar to theirs, and learned together, strengthening one another. de Negri et al. (2005:24) and Lanning (2011:1,3,4) reported that assessment by the educator or supervisor provided opportunity to demonstrate the proper skill, and assisted trainees with whatever problem they had.

Staff shortage, staff transfers, lack of drugs and supplies, and heavy workload among others, however, were *barriers to the optimum implementation of some of the plans*. Lanning et al. (2011:4) made a similar observation where inadequate resources and heavy workload interfered with communication skills training in the clinical area. The participants in this study did not mention frequent transfer as a problem at the diagnostic phase, but, two of the participants experienced transfer during the three-month period, one of them twice. The lack of provider continuity was identified as an obstacle to efficient provider-client interaction by de Negri et al. (2005:62) and Dykes (2005:247). WHO (2008b:50,51) maintained that

continuity is critical to client-provider relationship because trust, understanding and respect, develop over time. According to the United Nations (2008:5), continuity promotes compliance with advice given, and clients are more satisfied with care. The transferred participants, however, moved to their new PHC facilities without being deterred, probably because two of the transfers were to replace midwives posted out owing to the communities' dissatisfaction and request for a change. The participants prepared new action plans and commenced their implementation before the end of the three month period. This was a positive achievement in this study, indicating that the participants had learned to transfer what they acquired to new settings, and the researcher commended them.

The *checklist, the training manual, the compiled messages, and the monthly visits* were very helpful to the majority of the participants; while other resources such as the personnel, facility structures, drugs, the clients, and the community were noted as very helpful by 3 to 8 of the participants. According to Smith (2000:16S) complementing training with evidence-based guidelines facilitated implementation of the gains of such training. The simplicity of the checklist and the clearly defined behaviour to observe made it easy to use, and according to the participants, it served as a reminder and guide to the care of their clients. To some of the participants, the training manual served as a reminder, reference material, and a tool for training others. The compiled messages were considered direct, specific, understandable, an improvement on what they knew before, and covered a wide variety of health issues. Studies show that where professionals were provided with relevant job aids or guides (Devine et al., 2008:110; The LINKAGES Project, 2004:vii) they were found useful as reminders in improving their interaction with the clients (de Negri et al., 2005:36; Devine et al., 2008:110).

It is pertinent to state, however, that two of the participants did not use their checklist, insisting they could not assess themselves. This finding supports previous studies which proposed self-directed learning strategy for midwives to be in groups, especially those in rural areas (Engels et al., 2003:251; WHO, 2008a:2). WHO's (2008a:25,26) evaluation of the self-directed approach for developing midwives' IPCC skills for MNCH, showed that the midwives still wanted an initial orientation, and brief periodic facilitated training sessions. This means that in spite of the aids and guides, supportive supervisory visits are essential. The participants in this study saw the monthly visits as important and very helpful, because it encouraged them, made them accountable and hard working, and provided them with an opportunity to clarify issues. Similarly, WHO (2008a:26) reported that midwives, especially those working alone in the rural areas, indicated that supportive supervision reinforced their learning and motivated them. Literature is replete with studies that documented the importance of supportive, non-judgmental, and purposeful supervision in strengthening the new knowledge, attitudes, and skills, enhancing implementation in the workplace, and evaluating the strategy (de Negri et al., 2005:24,35-36; Subramanian et al., 2010:5; The LINKAGES Project, 2004:vii).

The participants found their *supervisors, colleagues and other professionals in the facilities* helpful or very helpful where the personnel supported or encouraged them, and accepted their suggestions. The initial resistance to change eased over time, and they were able to maintain cordial relationships. In one of the instances, it took the unplanned intervention of a national team visiting the facility for the supervisor to keep his promise to the participants. As documented by Martin and Bull (2005:126) and Knol and van Linge (2009:362), the participants needed to be supported and empowered by their supervisors to be able to execute their plans. The *facility structures, drugs and supplies* were also helpful or very

helpful towards the achievement of the participants' goals, although they desired improvements in some cases. Availability of free drugs, or the government's acceptance of sale of affordable drugs by the health workers were of particular note. Similarly, creation of a more suitable workspace and provision of equipment were helpful in some of the facilities. According to the UNFPA and ICM (2006:2), an enabling environment is critical to professionals' compliance to guidelines, while de Negri et al. (2005:51) observed that access to drugs and essential supplies was critical to clients' effecting lifestyle changes or complying with treatment.

The implementation of the plans improved the *participants' appreciation of their clients*. Their perception of clients as unyielding and difficult to convince, gave way to positive reports by the end of the three months (see Tables 4:12 on page 209 to 4:21 on page 235). This type of understanding was encouraged by Falcon et al. (2010) and WHO (2008b:47) who observed that only a few health providers have the required skills for client-centred care. Only *the community* was considered by two of the participants as not being helpful to them in implementing their plans, and it was because they had no direct contact with the community on MNCH matters. The design of the strategy for delivery of IMNCH in Nigeria (Figure 2:2 on page 38) provided that midwives work within the health facilities mainly (F.M.O.H., 2007:41-42, 47-49,82). Many of the other participants, however, saw their communities as appreciative, happy, supportive and utilizing the facilities. Where the participants complained that their community threatened them, it was later discovered that it was due to unclear job description, with the participants encroaching on the functions of environmental sanitation officers, during the participants' home visits.

5.5 Discussion of the Report of the Debriefing Session (Reflection)

The debriefing session was required as part of the processes involved in ensuring the trustworthiness of the study (Polit & Beck, 2008:539-540; Trochim, 2006:1-3). The findings from the project were reviewed at the debriefing session and participants were satisfied with the extent of the achievements recorded in most of the facilities. The participants said that they had more work because of their improved interaction with the clients, and attending to pregnant women at all time; but they were happier. Literature indicates that if the evidence from evaluation of a programme was positive, it could be scaled-up from the sample to the population of study (Casey, 2007:580; WHO, 2001:9). The two major issues unresolved as at the debriefing forum, however, were the problems of staff shortage and the lack of confidence by participants in their employers' being sufficiently committed to solving their appointment, placement, posting and remuneration concerns.

5.6 Conclusions from the Study

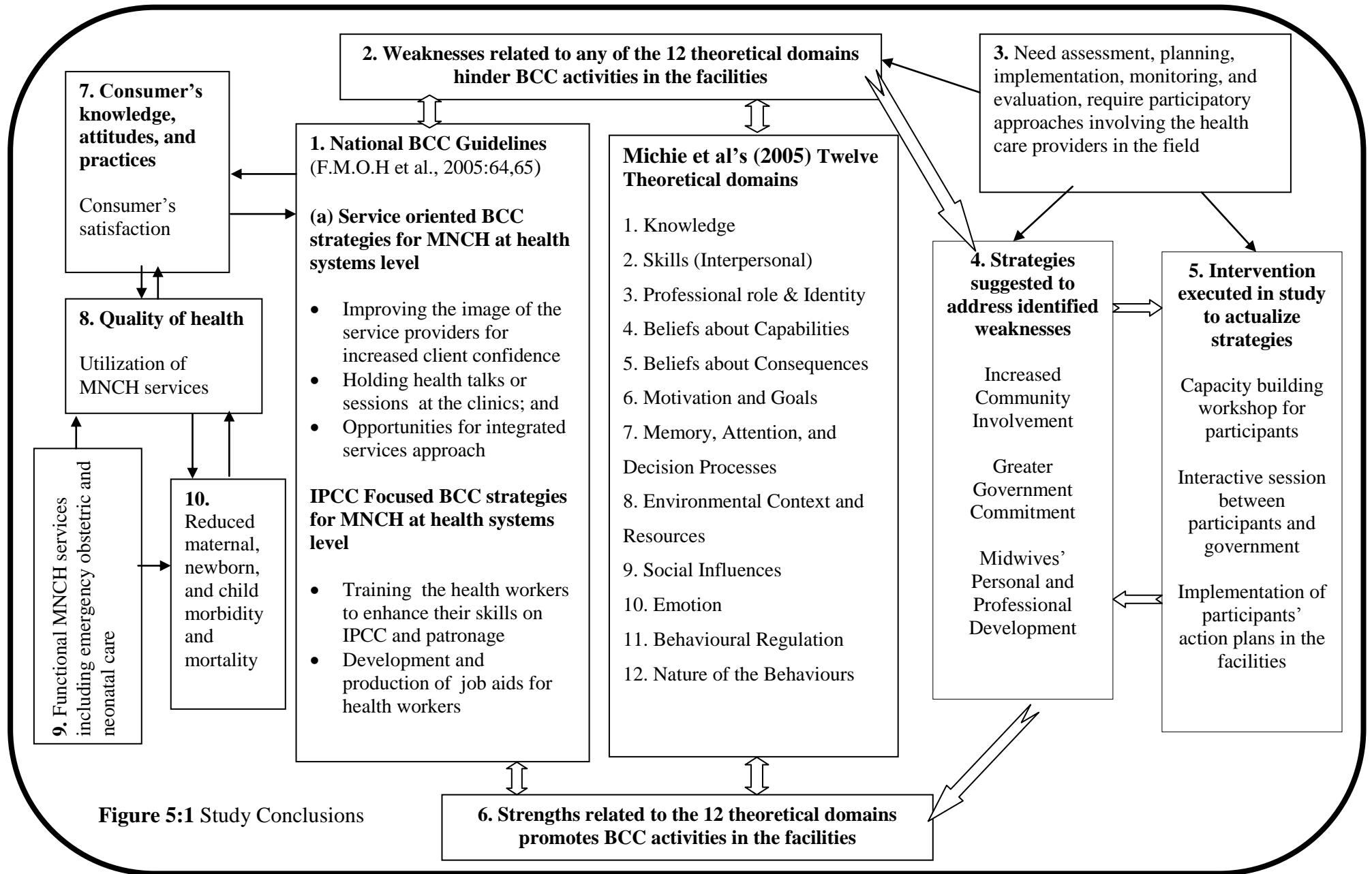
The major conclusions from this study are outlined below.

- There are weaknesses (gaps) in behaviour change communication (BCC) for maternal, newborn and child health (MNCH).
- Weaknesses in BCC activities in the facilities included: the midwives' lack of awareness of the BCC guidelines; lack of IPCC skills; lack of access to correct and up to date messages for MNCH; demotivation by the religious / cultural beliefs and practices of the clients; the poor socio-economic status of the clients; unsupportive work environment with gross shortage of staff, poorly managed inter-professional crisis, excessive workloads, inadequate space, lack of conveniences, lack of job aids, lack of integrated services, and time constraints; unplanned health talks delivered routinely without behaviour change focus; and, a general sense of helplessness of the midwives.
- Midwives are willing to acquire essential IPCC skills and improve their image.
- Active involvement of midwives at every stage of the programming cycle promotes their sense of identity, commitment, and sustains their interest in the desired change.
- The use of a theoretical framework in identifying the weaknesses in BCC, makes identifying the strategies and interventions easy, comprehensive, and relevant.

- Increased government commitment, appropriate mobilization of the community, and the personal and professional development of midwives are essential for BCC for MNCH in the facilities.
- One-off IPCC training approach to developing capacity of midwives for BCC toward promoting MNCH is inadequate; skills must be practiced and repeated to attain competency levels.
- To be successful, a BCC for MNCH capacity building programme must include interpersonal communication and counselling (IPCC) skills training, target setting (action plans), networking, hands-on practice at workplace, use of reminders, and supportive supervision.
- A successful capacity building package produces positive changes in weaknesses in the BCC activities in the facilities.
- Workplace hands-on practice promotes transfer of knowledge, attitude, skills and practices from the participating midwives to their colleagues and others in the facilities.
- An effective capacity building programme eliminates compartmentalization of the gains of professional development, and makes midwives able to transfer acquired knowledge, attitudes, skills and practices to new settings.
- Improved preparation of health talks makes midwives confident, and the consequent improved delivery of the health talks increases client participation and interest, encourages clients' voluntary request for more information and assistance when necessary, and could increase utilization of MNCH services.
- Midwives' attending to clients outside scheduled service hours and days promotes utilization of MNCH services in the facilities.
- Increased confidence in, and appreciation of the midwives, by the clients, encourage clients' utilization of services and mobilization of their spouses, relatives and women from neighbouring communities to utilize the facilities especially for antenatal care and child welfare.
- Much as many women delivered at home, they are willing to explore the services of professional midwives in the facilities.
- Preference of clients for the midwives empowered by BCC capacity building means more work for such midwives, but it also leads to increased job satisfaction and motivation.
- Environmental factors such as shortage of staff, inadequate space, lack of water and other conveniences, lack of free maternal and child drugs, and lack of essential supplies are critical in influencing utilization of facilities by clients.
- Midwives lack trust in the Government to attend to the environmental factors and this poses a serious threat to the midwives' job satisfaction, to BCC for MNCH, and to MNCH services in general.

- The term *health talks* is task-oriented compared to *behaviour change communication* which is more attractive to midwives and makes them readily identify with the need for change in both the provider and the clients, leading to result-oriented *client education*.
- The observed improved midwife-client interaction could improve the image of midwives.

Figure 5:1 on page 311 represents a diagrammatic summary of the study conclusions.



5.7 Recommendations

In view of the findings in this study presented in chapter four and discussed in the light of pertinent literature earlier in this chapter, as well as the conclusions outlined above, the researcher presents the following recommendations for consideration by the relevant agencies of government and the professional bodies.

5.7.1 Recommendation for the National Association of Nigerian Nurses and Midwives (NANNM) Kaduna State Chapter

The workplace environment in most of the facilities was far below that required of a functional system (WHO et al., 2004:14). Some of the participants in this study had been in practice for 17-27 years without attending continuing professional development programmes. The National Association of Nigerian Nurses and Midwives (NANNM), Kaduna State Chapter, could consider improving its networking activities, to provide support for colleagues in the rural areas in advocating for enabling environments, and securing professional development opportunities for them. There is a need for practising midwives in Kaduna State to have a forum at the LGA and State levels, to address issues peculiar to midwives, and to support one another for professional development and quality practice. The association may wish to consider creating such a forum for midwives.

The anxiety of the participants over the possibility of being replaced in the course of the study, and the inequitable nomination of participants for training by employers brought up during the special interactive session with officials, need to be reviewed. It is suggested that the lack of relief staff should no longer be an excuse for exclusion of midwives, they should be actively involved and understand why they do whatever they were requested to do according to introduced guidelines on MNCH, so that, they can be committed to it. The NANNM, State and LGA Chapters could work in collaboration with the Kaduna Zonal

Office of the N&MCN, to ensure that employers organize, and support midwives to participate in professional development programmes relevant to their daily practice regularly.

5.7.2 Recommendation for pre-service training

In view of the worrisome high failure rate at the midwifery qualifying examinations reported by the N&MCN (2007), and again the by the participants in this study, it is recommended that the Kaduna State Government reviews the training of midwives in the State if the State is to overcome the problem of severe shortage of midwives and be close to the ideal skilled attendant : population ratio of 2.5 : 1000 inhabitants (UNICEF, 2008:76).

The participants' lack of awareness of the MDGs and lack of interest in mortality data, call for ingenuity of curriculum implementation committees and the midwife-educators in the schools of midwifery. They should be able to incorporate issues of international, national and local importance into appropriate content areas in the midwifery curriculum. The training schools may consider reviewing their curriculum more regularly, and encouraging students to make presentations on contemporary MNCH issues.

Some of the participants were fearful before the capacity building training workshops. The participants suggested that the reality in the field be made known to student midwives while in school. Midwife educators could consider increasing students' practice on real patients in clinical and community settings. It is suggested that educators should teach students to educate and counsel clients aiming at behaviour change.

If midwives must respect clients' rights, be respectful, empathetic, and exhibit other essential skills for positive interpersonal relationship, they must have experienced these attitudes in the educator-student relationship while in school; where the educators were role models and facilitators, helping students attain their goals. The training schools should encourage a

culture that recognizes student midwives as partners and allows them to make suggestions about their training programme from the planning stage to the evaluation stage.

5.7.3 Recommendation for In- Service Training

The participants, who had participated in other workshops prior to this, remarked that, earlier, everything ended with the workshops. In line with the current trends in organizational and human resource development, it is recommended that, the organizers of professional development programmes for IPCC skills training in Kaduna State should consider incorporating follow-up strategies to monitor the gains of the training and support professionals in the field to attain competency levels in the related skills.

This study supports an organizational development approach which advocates whole-site or on-site training (Bradley et al., 1998), that is, training should take place at professionals' workplace, real life setting. It is recommended that as adult learners, professional midwives could participate from the need identification to implementation, and evaluation of effectiveness of MNCH programmes in their facilities. This does not preclude the use of a national training manual; it could be a guide, and adapted to the local realities in each facility or community.

5.7.4 Recommendation for practice

Job aids were absent from most of the facilities. The clinical protocols and messages were totally missing. This study confirmed previous findings that these materials are useful reminders if they are available. It is therefore recommended that the procedure for disseminating guidelines to the frontline staff (including midwives at first-level MCH care) in Kaduna State should be reviewed to ensure that such material got to the end-users.

Unsupportive behaviour of nurse-leaders in the facilities could have terminated the zeal of the participants if there had been no external intervention. There were no meetings for staff to air their views and contribute to the system. It is recommended that midwives in the State or LGA services be provided with ample opportunities to express their creativity. This may be the only source of strength for some of them in an isolated environment, away from their loved ones.

The study showed that midwives in Kaduna State, especially those in the PHC facilities need to have a clear understanding of the roles of different cadres of workers in the PHC facilities. This would promote teamwork, healthy inter-professional relationship, and eliminate the hostility reportedly experienced from the community when midwives act more as sanitary inspectors (environmental health officers) during home visits.

5.7.5 Recommendation for management

The Government may need to review the staff transfer policies in the State to be seen as fair and transparent, in line with the discussion during the special interactive session. Beyond meeting with supervisors, employers may have to establish an appropriate, direct and more effective link with the midwives to communicate government programmes and attend to the concerns of the midwives. It is further suggested that regular meetings in the facilities should be encouraged, and if possible, the minutes forwarded to the ministries to ensure that information is passed to the grassroots, and that the ministry is adequately informed of happenings in the facilities.

The gross shortage of staff, and the use of unskilled attendants in facilities to cover afternoon and night shifts and take deliveries, distorted the image of the real midwife. The Kaduna

State Government may have to review the remuneration of midwives at the State and LGA levels, including the rural posting allowance, to reflect an understanding and acknowledgement of the challenges faced by midwives in rural areas. Otherwise, the migration of midwives to neighbouring northern states and the federal service, where the conditions of service are better, will continue. Every midwife is critical to the government's goals for improving maternal and infant health, as they have the greatest ability for reducing high infant mortality rate (IMR) and the perinatal health disparities.

Midwives are trained to lead maternal and child care services at the PHC facility level, therefore working under a CHEW, whose primary role is in the community, is a major cause of dissatisfaction among midwives at this level. This is worse where midwives co-exist with CHEWs and a CHEW is the officer in charge of MNCH services. There needs to be a clear job description at the PHC facility level to reduce conflict among the staff. In the same vein, teamwork and facility goals need to be promoted in the State above the struggle to be the In-Charge.

The researcher also pleads for a speedy implementation of the provisions of the National Health Act by the appropriate agencies, particularly with respect to strengthening the PHC facilities. It is also recommended that there be active involvement of the frontline staff, for example the midwives, who are to be affected by, or expected to implement, most of the decisions.

5.7.6 Recommendation for Community-Based BCC

Women expressed dissatisfaction with the services of TBAs and their preference for professional midwives. They also asked for more information about the midwife and her

roles. This is a window of opportunity for BCC at the community level to be intensified further to enlighten the people on what to expect in the facilities with respect to MNCH care, especially when in labour. Mass and local communication media could be used to deliver relevant MNCH core messages, and portray a favourable image of the facilities and of the midwife.

5.7.7 Recommendation for policy makers

When government policies or programmes are not correctly advertised, or effectively implemented, they become counterproductive, for example, the partial distribution of ITNs to motivate pregnant women to utilize the facilities, and the selective implementation of the free maternal and child drugs programme. It is important to inform the public correctly about what is available or what to expect at the facilities, instead of creating the impression that makes people see providers as denying them access to what the government has provided. As much as possible, health should not be politicized.

5.7.8 Recommendation for Research

In view of the abundant evidence in literature, and from this study, that midwives still lacked the IPCC skills required to effectively educate, counsel, and support their clients to adopt behaviours that promote MNCH, there is a need to look at midwives' pre-service IPCC skills training and examine how to improve it. More research could be conducted on best practices and how to incorporate best practices into the basic curriculum for nurse midwives.

Midwives are predominantly health education traditionalists presenting health talks routinely in a task-oriented manner, and not health promotionalists presenting health talks strategically with behaviour change in mind. This study has demonstrated that it is possible to assist midwives through appropriate capacity building strategies, to be health promotionalists at the

first level of maternal and child care. It would be worthwhile to replicate the study at the secondary and tertiary levels of maternal and child care where there is a mix of professionals, to see the prominence of the midwives' role in BCC for MNCH at these levels, in terms of the service oriented components of the BCC strategy.

It is increasingly becoming obvious that the positivist or quantitative study approach alone is not adequate to understand the real world of midwives with respect to the midwife-client relationship. The excitement of the midwives because of their involvement in the study made them call for more research and utilization of findings to inform their practice in the field. It is recommended that more research work in midwifery be participatory, involving frontline practitioners and related to their daily needs. This will stimulate professionals' interest in research and promote evidence-based practice.

In view of the consistently high number of participants maintained throughout the various phases of this study, researchers who are interested in looking at similar areas of study or using the action research approach are encouraged not to be deterred by the fear of not getting through. Researchers should rather demonstrate the interpersonal and technical skills required to drive the process.

Religion and spiritual themes featured several times in the findings in this study. This suggests the important role of religion in midwife:client relationship. It is therefore recommended that in future studies and interventions, religion / spiritual issues should be considered and addressed.

5.7.9 Recommendation for Sustainability of the Gains of the Study

The researcher gave copies of the report of the special interactive session with the government officials to the Director of Primary Health Care (DPHC) and the Director of

Nursing Services (DNS) as they requested, for necessary actions on the issues raised. After the last interactive session of the study (the debriefing session), the participants from the Ministry of Health (rural hospitals) were invited by the DNS to plan how to train other midwives in the State. The researcher's recommendation that the State should not discriminate between the State and LGA participants, but to engage all the participants as a team of resource persons in the State, was considered, and the participants co-opted their colleagues from the PHC facilities (under the Ministry for Local Government) in developing the proposal.

The State Ministry of Health is yet to finalize plans for the training of the other midwives. The researcher maintains a link with all the participants and gets feedback on their BCC activities, periodically. It is recommended that the State Government and LGAs support the participants' zeal for the one-to-one facility-based IPCC skills training of their colleagues and other members of staff, because it seemed to be quite effective where the participants trained their colleagues in this study.

5.8 The Study Limitations

The study took place in Kaduna State, which is one out of the thirty-six states in Nigeria. As a student with limited time to complete the study, and because of the financial constraints, the researcher could not involve more than one state of the federation in the study. This limits the extent to which the findings from the study can be generalized. As a national policy statement, however, the behaviour change communication (BCC) strategy for Nigeria, provides the platform for all health education and communication interventions, by all tiers of government, programme planners, and researchers in the country (Barker et al., 2007:85; UNICEF, 2006:127; WHO, 2008a:5,9,26). This study was based on the BCC strategy for

Nigeria (F.M.O.H, WHO., et al., 2005), although applied only to Kaduna State. The processes involved in the need identification, the intervention development, and the implementation, as well as the monitoring in the field, in this study, have been described in detail, that is *thick description*, as recommended by Cohen and Crabtree (2006:3684-3703). The thick description, would enhance transferability to settings, similar to the first level of maternal and child health care settings in this study, both in Nigeria, and in other countries with similar characteristics.

The researcher recognizes that the sample of participants was small, although it was selected across the three senatorial zones of Kaduna State. The action research approach adopted for the study, however, allowed the utilization of an assortment of research tools for data collection and analysis (Dick, 2009:2; O'Brien, 2001:9) at the three stages of the project, to strengthen the study. Furthermore, the theoretical framework - *Integrative Framework for Studying the Implementation of Evidence Based Practice* (Michie et al., 2005) - guided the study, giving it a theoretical connection. Miles and Huberman (1994:279), maintained that the theoretical connection of a study beyond its immediate context, gives it more strength, and enhances transferability.

5.9 Conclusion

Nigeria has maternal and child mortality rates that are among the highest in the world. The causes of this unpleasant situation are avoidable and preventable. The country believes that an effective BCC strategy could lead to improved consumer knowledge, attitudes, and behaviours that encourage utilization of MNCH services, and consequently lead to reduction of maternal morbidity and mortality (F.M.O.H, WHO., et al., 2005:4). It is acknowledged

that to change the behaviour of the consumers, the behaviour of the providers must be changed (Boyd & Shaw, 1995:49).

Working with midwives through the action research process, the weaknesses and strengths of midwives with respect to BCC for MNCH in their facilities were identified. In addition, appropriate capacity building intervention was implemented, and the participants, working through their action plans, were supported to influence the BCC activities in their facilities.

The diagnostic phase revealed that the participants lacked essential skills for effective BCC activities in their facilities and, importantly, that they were willing to change, and they were supported to work out the path to change for themselves. Observable improvements in the participants' IPCC skills were documented after implementing the developed capacity building package. The attitudes of the participants changed positively and their counselling / delivery of health talks were more purposeful. Furthermore, participants initiated adjustments in service delivery patterns in some of the facilities, while some of the participants recorded major community supports to encourage utilization. Environmental factors, especially shortage of staff, were the major hindrances to participants' full implementation of their plans. The majority of the participants found the checklist, training manual, compiled core messages, and monthly supportive visits very helpful in achieving some of their goals.

Capacity building is more than training and must be context specific to be effective. Whole-site or partial-site training with active involvement of the participants from the need identification to evaluation is required, to stimulate midwives to be innovative agents of change, and to sustain their interest in BCC activities in their facilities, in spite of their workplace challenges. Therefore, organizers of training programmes for midwives need to change their approach from didactic trainer-trainee approach, to one of partnership for MNCH.

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ANNEXURE

Project Title: Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State Nigeria

Aim of project: The study is to appraise and facilitate behaviour change communication for maternal, newborn and child health at the primary health care level of midwifery practice in Kaduna State Nigeria.

Name of researcher: Bridget Omowumi Akin-Otiko

Affiliation: University of KwaZulu-Natal, Durban.

Dear Participant,

You are requested to provide the information required below as part of the project. Kindly, complete the questionnaire to the best of your knowledge. All information will be treated with utmost confidentiality.

B. O. Akin-Otiko

Personal Data:

1. Sex: a. Male b. Female

2. Religion: a. Islam b. Christianity c. Others (Please specify)

3. Age in Years:

4. Marital Status:
 - a. Married
 - b. Single
 - c. Divorced
 - d. Widowed
 - e. Others (specify)

5. Place of Origin: Town L.G.A State

6. Highest Educational Qualification:
 - a. WAEC / GCE / SSC
 - b. First degree (Please specify)
 - c. Second degree (Please specify)
 - d. Others (Please specify)

7. Professional Qualification:
 - a. Midwifery only
 - b. Nursing and Midwifery
 - c. Nursing, Midwifery, Public Health Nursing
 - d. Nursing, Midwifery, Public Health Nursing, CHO
 - e. Others (Please specify)

8. Is your midwifery training (a) Basic (b) Post-basic or (c) Community midwifery?
.....

9. Continuing Education since qualified as a Midwife (can mark more than one option if they apply to you):
- a. Family Planning
 - b. Emergency Obstetric Care (LSS) Specify Type
 - c. Integrated Management of Childhood Illnesses (IMCI)
 - d. Post-Abortion Care (PAC)
 - e. Others (Please specify)

10. Do you live in the same community where you work? a. Yes b. No
- a. If Yes, Why do you live in the community where you work?
-

- b. If No, Why do you not live in the community where you work?
-

Work Experience:

11. Years of Experience as a Midwife:

12. Years of Experience as a Midwife at PHC / Rural Hospital level:

13. Mention five (5) major challenges you face as a midwife at PHC / Rural Hospital level in order of seriousness (to you):

- a.
- b.
- c.
- d.
- e.

14. How can these challenges be addressed?

.....

.....

15. How often does your supervisor visit you?

- a. Daily
- b. Weekly
- c. Monthly
- d. Occasionally
- e. Never

16. Mention some attributes of a friendly service:

.....

.....

17. If you have a choice you would (a) Leave your present job Or (b) Remain on the job

Facility Code **Participant Code**

1. Knowledge
 - a. What is health behaviour change communication for MNCH?
 - b. Are you aware of the behaviour change communication guidelines for maternal, newborn and child health (MNCH)? (prompt: what are they?)
 - c. What do you think about this behaviour change communication for MNCH guidelines?
 - d. What do you think is the effect of using this behaviour change communication for MNCH guidelines?
 - e. Should you be doing behaviour change communication for MNCH? (prompts: why should or should not)
2. Skills
 - a. Do you know how to do behaviour change communication for MNCH?
 - b. How easy or difficult do you find behaviour change communication for MNCH to the required standard? (prompts: IPCC framework)
3. Social / professional role and identity (Self-standards)
 - a. What is the purpose of the behaviour change communication for MNCH guidelines?
 - b. What do you think about those who put these guidelines together?
 - c. Should the guidelines determine what you do?
 - d. Is doing behaviour change communication for MNCH as in the guidelines in line with or against your professional standards / identity? (prompts: moral / ethical issues, limits to autonomy)
 - e. Is this true for the CHEWs, doctors and others who are also involved in behaviour change communication for MNCH?
4. Beliefs about capabilities (Self-efficacy)
 - a. How difficult or easy is it for you to do behaviour change communication for MNCH? (prompt: internal and external capabilities / constraints)
 - b. What problems have you encountered?
 - c. What will help you?
 - d. How confident are you that you can do behaviour change communication for MNCH despite the difficulties?
 - e. How capable are you to maintain behaviour change communication for MNCH in this place?
 - f. How well equipped / comfortable do you feel doing behaviour change communication for MNCH? (prompt: reason for response)
5. Beliefs about consequences (Anticipated outcome / attitude)
 - a. What do you think will happen if you do behaviour change communication for MNCH? (prompt: themselves, patients, colleagues and the organization; positive and negative, short term and long term consequences)
 - b. What are the costs of behaviour change communication for MNCH and what are the costs of the consequences of behaviour change communication for MNCH?
 - c. What do you think will happen if you do not do behaviour change communication for MNCH? (prompts)
 - d. Do the benefits of doing behaviour change communication for MNCH outweigh the costs?
 - e. How will you feel if you do / do not do behaviour change communication for MNCH? (prompts)
 - f. Does what you feel suggest that behaviour change communication for MNCH is a good thing?
6. Motivation and goals (Intention)
 - a. How much do you want to do behaviour change communication for MNCH? How much do you feel you need to do behaviour change communication for MNCH?
 - b. Are there other things you want to do or achieve that might interfere with behaviour change communication for MNCH?
 - c. Does the behaviour change communication for MNCH guidelines conflict with other guidelines? (prompt: specify if any)
 - d. Are there incentives for doing behaviour change communication for MNCH? (Do you feel encouraged to do BCC; What encourages you?)
7. Memory, attention and decision processes
 - a. Is behaviour change communication for MNCH something you do usually?
 - b. Will you think of doing behaviour change communication for MNCH?
 - c. How much attention will you have to pay to behaviour change communication for MNCH?
 - d. Would you remember to do behaviour change communication for MNCH? How do you remember?
 - e. Should you decide not to do behaviour change communication for MNCH, why would you decide not to? (prompt: competing tasks, time constraints)

8. Environmental context and resources
 - a. To what extent do physical or resource factors here facilitate or hinder your doing behaviour change communication for MNCH?
 - b. Are there competing tasks and time constraints to behaviour change communication for MNCH here?
 - c. Are the necessary resources to undertake behaviour change communication for MNCH available to you? (prompt: job aids, resources to support behaviour being promoted, etc)
9. Social influences
 - a. To what extent do social influences facilitate or hinder your doing behaviour change communication for MNCH? (prompts: peers, managers, other professional groups, patients, relatives)
 - b. Will you like to observe others doing behaviour change communication for MNCH (i.e. have role models)?
10. Emotion
 - a. Does doing behaviour change communication for MNCH evoke an emotional response or feeling in you? If so, what type of emotions do you have doing it?
 - b. To what extent do emotional factors facilitate or hinder your behaviour change communication for MNCH?
 - c. How does your emotion affect behaviour change communication for MNCH?
11. Behavioural regulation
 - a. What preparatory steps are needed for behaviour change communication for MNCH here? (prompt: individual and organizational)
 - b. Are there procedures or ways you do your work that encourage behaviour change communication for MNCH?
12. Nature of the behaviours
 - a. What do we need to start doing differently to behaviour change communication for MNCH here (i.e. who needs to do something? what needs to be done? when should it be done? where should it be done? how should it be done? how often should it be done? with whom should it be done?)
 - b. How do we know if behaviour change communication for MNCH is taking place here?
 - c. What are you doing currently?
 - d. Is what you are doing presently different from behaviour change communication for MNCH? Is behaviour change communication for MNCH an existing behaviour that needs to become a habit?
 - e. Can your workplace be used to remind you to engage in behaviour change communication for MNCH? (prompts: layout, reminders, equipment)
 - f. How long will the changes take?
 - g. Are there things in place to maintain the changes for a long time?

Adapted from (Michie et al., 2005)

1. Introduction:

- a. Identify self
- b. Welcome participants
- c. Allow participants to introduce themselves
- d. Explain purpose of discussion
- e. Encourage to be open and assure of confidentiality again
- f. Assure of freedom of speech and respect
- g. Assure of freedom from recrimination again

2. Health facilities and their services

- a. How many health facilities do we have in this community?
- b. What type of services do they provide?
- c. Which of these health facilities do you use?
- d. Why do you use the ones you mentioned?
- e. Why do you not use the ones not used?
- f. What type of services would you like to have in these facilities?

3. The Women's perception of midwives and quality of their services

- a. What categories of workers work in the health facilities?
- b. How would you describe the midwives in the health facilities?
- c. What things do the midwives do?

4. Experience of behaviour change communication (BCC) practices of midwives

- a. Who talks to you or advise you about health matters in the facility? (Prompt: midwife, others)
- b. What things do these midwives tell us? (Prompts: Key household practices in BCC framework for IMNCH- message)?
- c. How do they tell us these things? (prompts: IPCC skills – C-L-E-A-R (Clarity, Listen/Patient/Uninterrupted; Encourage/ Acknowledge; Repeat/Reflect) R-O-L-E-S (Relax; Open-up; Lean forward; Eye contact; Sit squarely/ smile appropriately) G-A-T-H-E-R Greet; Ask about welfare; Tell; Help; Explain; Return/Referral) etc
- d. Do you believe what they tell you?
- e. How do you feel when they are saying these things?
- f. How do they react or respond to your questions or differing opinions?
- g. What else would you want the midwives to do with respect to talking to you about your health or that of your children?

5. Effect of BCC

- a. What do you do with the things the midwives tell you?
- b. How have these things you heard from the midwives helped you in particular? (Prompt: self, children, family)
- c. Do you have other sources from which you hear these things?

6. Women's concept of friendly services / friendly midwives

- a. What are the things that make services friendly?
- b. What would you see in a midwife who is friendly?
- c. How can midwives be friendly? (Prompt: when they have so much work to do, they are poorly paid, things they need to work are not available, clients and their relatives are 'difficult')

7. Conclusion:

- a. Call for questions
- b. Appreciate everyone

1. GABATARWA.
 - a. Gabatar da kai daga mai Bincike
 - b. Maraba da Mahalarta
 - c. Ba Mahalarta dammar gabatar da kan su
 - d. Baiyana makasudin Tattaunawar
 - e. Karfafa gwiwwa domin bada sahihan bayanai da kuma tabbaci na tsare sirri
 - f. Tabbaci na yancin fadar albarkaci baki da kuma girmamawa.
 - g. Tabbacin na bada yancin ba tare da zargi ba.

2. KAYAYYAKIN KIWON LAFIYA DA AYYYUKAN SU.
 - a. Yuraren kiwon lafiya nawa muke dasu a wannan al'uma?
 - b. Wani bukату yuraren kan biya wa al'uma?
 - c. Wane daga cikin yuraren kiwon lafiya ka/ki taba amfani da su?
 - d. Shin me ya hana ka/ki kin amfani da wadanda baka amfani dasu?
 - e. Ko me yasa ba a amfani da waddanda ba'ayi amfani dasu ba?
 - f. Wane irin bukату kake so wdannan kayayyakin su dunga bayar wa?

3. FAHINTAR MATA AKAN UNGUWAR ZOMA DA INGANCI NA AYYUKAN SU.
 - a. Wani rukuni ne na ma'aikata ke aikin kiwon lafiya?
 - b. Ya za ka/ki baiyana Unguwar zoma a harkar kiwon lafiya?
 - c. Wani irin ayyuka Unguwar Zoma keyi?

4. KWAREWAR DA AKE DA ITA WAJAN CANJIN DABI'UN SADARWA GA AYYUKAN UNGUWAR ZOMA.
 - a. Wa yayi Magana da ke Ko ya shawar ceki akan kiwon lafiyar ki?(Unguwar zoma ko sauran su)
 - b. Wani irin abubuwa Unguwar zoma kan fada mana?(mahimman ayyukan gida na BBC da sakon IMNCH)
 - c. Ta wadanne hanyoyi sukan bi wajan baiyana mana wadannan abubuwar? (IPCC skills da sauran su)
 - d. Shin kin amintu da abubuwan da suke fada maki?
 - e. Ya kika ji lokacin da suke sheda maki wadannan abubuwar?
 - f. Ta yaya suka amsa tambayar ki da kuma banbance banbance ra'ayi da ake sashi?
 - g. Me kuma kike ganin ya kamata Unguwar Zoma su baki shawar akan lafiyar ki ko ta yaranki?

5. TASIRIN SADARWA NA CANJIN DABI'U
 - a. Taya kike sarrafa abubuwan da Unguwar Zoma suke gaya miki?
 - b. Tayaya wadannan abubuwan da Unguwar Zoma suka baiyana miki suka tallafa miki, musamman (ke kanki da yaranki da Iyalanki)
 - c. Kinada wasu hanyoyi na samun wadannan bayanai baya da wadannan hanyar?

6. GAMSUWAR MATA MASU JUNA BIYU AKAN KYAKYAWAR TURBA DAGA UNGUWAR ZOMA.
 - a. Wani irin abubuwa ne kan sa ku jin dadin ayyukan Unguwar Zoma?
 - b. Me kike iya fahinta daga Unguwar Zoma mai kyakyawar tarba?
 - c. Ta yaya Unguwar Zoma kan kasan ce masu haba-haba? Promt: lakaci da suke da ayyuka da yawa da karancin Albashi da karancin kayan aiki da rashin fahinta ta fuskar marasa lafiya da dangin su.)

7. RUFUWA
 - a. Niman Tambayoyi
 - b. Godiya ga mahalarta.



SCHOOL OF NURSING UNIVERSITY OF KWAZULU-NATAL, 5TH FLOOR, DESMOND CLARENCE BUILDING, HOWARD CAMPUS, DURBAN, 4041, SOUTH AFRICA

6th January 2010

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Invitation to the First Interactive Session on Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State

I wish to invite you to the first interactive session for participants in the above project which has been scheduled for Wednesday 27th – Friday 29th January 2010 at the Ministry of Health School of Midwifery, Tudun Wada, Kaduna starting at 9 a.m. daily.

The undersigned will be around to receive you on arrival.

Thanks for your continued cooperation.

B. O. Akin-Otiko (Student Number 209506880)
(B.Sc. (Nursing), D.H.A.M., MPH, FWACN)

Local Address:

Nurse Tutors Programme
(Federal Ministry of Health)
Department of Education Technical
C.S.T. PMB 2021
Kaduna Polytechnic
Kaduna
Tel: 0803 7213 522; 0813 9616 248; 0819 1246 675
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Cc:
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FACILITATION OF BEHAVIOUR CHANGE COMMUNICATION PROCESS FOR MATERNAL, NEWBORN AND CHILD HEALTH AT PRIMARY HEALTH CARE LEVEL OF MIDWIFERY PRACTICE IN KADUNA STATE

Particulars of Participants:

S/N	Names	Rank / Position / Designation	Institution / Hospital	Contact Address	Telephone Number(s)	E-mail Address

FACILITATION OF BEHAVIOUR CHANGE COMMUNICATION PROCESS FOR MATERNAL, NEWBORN AND CHILD HEALTH AT PRIMARY HEALTH CARE LEVEL OF MIDWIFERY PRACTICE IN KADUNA STATE

ATTENDANCE REGISTER: First Interactive Session 27th – 29th January 2010 Held at the State School of Midwifery, Kaduna

S/N	Participant's Name	Name of Health Institution	Day 1			Day 2			Day 3			Remarks
			Activity									
			Signature									

PROJECT TITLE:

FACILITATION OF BEHAVIOUR CHANGE COMMUNICATION PROCESS FOR MATERNAL, NEWBORN, AND CHILD HEALTH AT PRIMARY HEALTH CARE LEVEL OF MIDWIFERY PRACTICE IN KADUNA STATE NIGERIA

RESEARCHER:

B. O. AKIN-OTIKO

Purpose of the Research:

The main purpose of the study was to appraise and facilitate behaviour change communication process for maternal, newborn and child health in collaboration with midwives at the primary health care level in Kaduna State Nigeria.

Research Objectives:

1. To assess the strengths and weaknesses of midwives in relation to behaviour change communication process at the primary health care level in Kaduna State.
2. To work in partnership with midwives to identify appropriate strategies / mechanisms for promoting behaviour change communication process at the primary health care level in Kaduna State.
3. To support midwives in developing the capacity for behaviour change communication at their respective workplaces in line with the appropriate strategies / mechanisms identified.
4. To support midwives in developing plans of action to facilitate the behaviour change communication process for maternal, newborn and child health at their respective workplaces.
5. To establish a support network with the midwives to facilitate behaviour change communication process for maternal, newborn and child health at the primary health care level in Kaduna State
6. To monitor the implementation of the midwives' developed action plans for behaviour change communication.

Motivation for the study:

- At almost every gathering of professional nurses and midwives in Nigeria, the attitude of professionals to clients and its implication for the image of the profession and service utilization feature.
- 2007 stakeholders' forum to improve midwifery education and practice for reduction of maternal mortality and morbidity
- Interpersonal relationship skills constitute the heart of quality midwifery practice.
- BCC Framework - "it is crucial that skilled health care providers are continually employed, trained, retrained and supervised to provide comprehensive and factual information and quality RH services that are user-friendly to their clients, families and communities. With adequate skills and operating within an enabling work environment, providers are more motivated to address the needs of their clients and communities, especially in the rural and hard to reach areas" (F.M.O.H, WHO., et al., 2005 pp 5).
- The idea of facilitating the midwife's performance of her behaviour change communication roles within the overall framework for reducing maternal morbidity and mortality in Nigeria was conceived based on the assumption that BCC involves a lot of interpersonal relationship and partnership and if the midwife does this well, the issue of interpersonal relationship would have been significantly addressed.

Research Design – Action Research:

- Action Research
 - Practical way of looking at one's work
 - Assumes that practitioners will gain a deeper insight into their own situations and a greater understanding of their own practice
 - In line with current patterns of professional development
 - Bridges the gap between theory, research and practice
 - Powerful tool for change and improvement at the local level

The approach adopted in this study is one of partnership and collaboration between the researcher and the midwives in a co-learning and professional development process which is expected to ultimately lead to better client care.

The Study Setting: The study will take place in Kaduna State Nigeria.

Population of the Study: Professional midwives registered by the Nursing & Midwifery Council of Nigeria and thus authorized to provide first line care for mothers, newborn and children in the country.

Sample / Sampling Technique:

- Rural hospitals and primary health care facilities where there are registered midwives.
- Stratified according to location (urban / urban slum / rural) and according to type (rural hospital /primary health care centre)
 - Nine facilities providing primary health care services for mothers and children were selected in collaboration with the validation group members
 - A non-probability sampling technique was used
 - Recruitment of participants was voluntary
 - Same set of participants will collaborate with the researcher all through the various stages of the project
 - Interest, commitment and desire for professional development are important for the researcher and participants

Data Collection Techniques and Data Collection Instruments:

- **Fieldnotes**
- **The Diagnostic Stage:**
 - In-depth interview (IDI)
 - Focus group discussion (FGD)
 - Self-administered Questionnaire for Participants' Personal Data / Workplace Experience
- **Intervention Stage:** The findings in the diagnostic stage of this study will be utilized to adapt training (capacity building) to meet the needs of the midwives and their clients. Agreed professional development (capacity building) approach will be implemented collaboratively by the researcher and the midwives
- **Monitoring Stage:** The researcher and the midwives will be involved in the monitoring exercise via a collaboratively established network, using a jointly developed monitoring tool (criteria for midwife-client interaction for Behaviour Change Communication). The instrument will be used to monitor the improvement or change in the process, in accordance with working criteria agreed upon during the intervention stage.

- **Ethical Considerations:**

- The University
- Written permission to carry out the study in Kaduna State among the midwives secured from the Honourable Commissioner for Health, Kaduna State and from The Honourable Commissioner for Local Government, Kaduna State, Nigeria.
- The Federal Ministry of Health overseeing nursing activities in the country is aware.
- Permission to use some instructional material has been sought from appropriate authorities where applicable
- Validation group members and participants have been duly informed about the study and their expected roles, benefits and right to withdraw at any stage without any fear of recrimination. To this end each participant / group member was requested to complete a detailed informed consent form
- This study will be strictly guided by the following general principles prescribed by McBride and Schostak (2009 pp 3-4):
 - Principle of confidentiality
 - Principle of openness
 - Principle of empowerment
 - Principle of freedom
 - Negotiation of access
 - Negotiation of accounts
 - Negotiation of boundaries

As opined by O'Brien (2001 pp 12) this study will provide opportunities for involvement of all participants and decisions made about the direction of the research and the probable outcomes will be collective. There will be equal access to information generated by the process for all participants through the feed-back contacts.

ACTION PLAN TO IMPROVE BCC FOR MNCH

Annexure 1(k)

S/N	Objectives (Purpose, Expected Outcome)	Activity	Time	Budget (Personnel & Financial)	Evaluation (Indicators)

EVALUATION FORM First Interactive Session 27th – 29th January 2010:

S/N	ACTIVITY	COMMENTS
1.	Introduction	
2.	Review Sessions	
3.	Group Work	
4.	Time management	
5.	Duration of the Workshop	
6.	Workshop Materials	
7.	Achievement of Project Objectives 1 & 2 (Diagnostic Phase)	
8.	Feeding	
9.	Venue	
10.	Transportation Fee	

General Comments:

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Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State**Committee Activities:**

A committee of three was constituted by the house to work on the decisions agreed on at the search conference. It consisted of the researcher, one of the validation team members, and one of the participants (F21). The committee was to design the capacity building workshop in line with the expectations of the midwives.

The committee members met immediately after the search conference to agree on the *modus operandi*, date and venue of subsequent meetings. It was obvious from the desire of the midwives for a training workshop within six weeks that the committee had to work round the clock to ensure the expectations of the midwives were met. A 2-day meeting was scheduled for 11th & 12th February, 2010 (2 weeks from the end of the Search Conference). The researcher was to merge the comments of the participants in the worksheets from the three groups and make copies available to the members within one week so that they could go through them before the scheduled meeting. The researcher and the group members were also to source for materials that could be useful to the group. Such materials should be reproduced by the researcher and copies made available other members on or before the scheduled meeting.

Because F21's workplace was closer to the school where the validation team member on the committee worked than to Kaduna the venue of the search conference, the school was chosen as the venue of the meeting. Permission to use the school was obtained in writing from the head of the school.

Committee Meeting 11th -12th February 2010**Day 1 – Thursday, 11th February 2010****Opening** – 9:00 a.m. Opening Prayer**Agenda:** Members decided on the agenda for the 2-day meeting as:

- Examine reports of the last interactive session (search conference)
- Plan Capacity Building Workshop
- Review Checklist

1. Reports of Activities at the Interactive Session held on 27th – 29th January 2010***Participants' suggestions about the next workshop***

- Date – Wednesday 3rd- Friday 5th March, 2010
- Duration 3 days
- Keep and bring writing materials. Committee recommended that the invitation should include that they come along with their previous materials

Attendance

- Good
- Participants' suggested that those with genuine reasons for being absent should be accommodated e.g. one whose daughter had surgery and those who sent apology.

Evaluation

- Generally wonderful
- Points to note while planning capacity building workshop
 - "Small time for bulky work" – Not too loaded time-table
 - "training on better ways to deliver services" – ownership and co-learning to be stressed not a trainer learner relationship
 - "related to field of work" – prepare manual to suit participants' daily workplace experiences

Group Worksheet Discussion

- The committee went through line by line
- Grouped participants' observations and suggested strategies to promote BCC as well as the suggested training and support required
- Identified specific topics / sessions to capture each group of suggestions in the proposed capacity building workshop
 - IMNCH
 - PHC
 - Communication
 - Counselling
 - Use of IEC Materials
 - Community Mobilization
 - Value clarification
 - Challenges of rural midwifery practice (special interactive session with stakeholders) – supervision, too many clients, community threats, materials, drugs, TBAs,
 - Practical demonstrations and discussion

2. Planning of Capacity Building Workshop

Time-table

- Calculated number of hours available on Wednesday, Thursday and Friday for:
 - Contact – plenary and group work
 - Breaks

Resource Persons

- To come from among validation team, participants and researcher as much as possible for continuity and relevance.

Methodology

- Participatory – Participants are adults and professionals
- Include Practical demonstration / Discussion

Assessment

- Pre- and Post- Tests to assess knowledge
- Practice assessment - Checklist for use during workshop (baseline), in practice and at the end of monitoring
- Monitoring of the implementation of the action plans in each facility monthly

Plan For day 2

- Provide relevant materials on all identified topics
- Produce dummy time-table to fix activities in
- Produce attendance sheet for committee members to sign
- Visit one of the participants in one of the facilities in town

Closing

- Members felt a lot had been done for the day
- A member had an engagement
- Meeting ended at 1:17 pm followed by lunch sponsored by the validation team member in the committee
- To reconvene at 9:30 a.m. tomorrow after visit to participant on way from Kaduna to Zaria

How Observations and Suggestions were grouped before identifying Topics

- ***Interpersonal Relationships / Marketing of MNCH Services Using Client-Centred and Customer Service Approaches***
 - *Available facilities*
 - *Encouragement during ANC even if they are late*
 - *Introduction of self*
 - *IPCC – act and skills – good mood, lively, learn to talk, be patient, polite, respect, friendly, control emotions, humility, good rapport*
 - *Experience*
 - *Allow room for questions*
 - *Punctuality*
 - *Marketing - Customer / client care*
 - *Improve provider attitude*
 - *Provider should be free to talk*
 - *Behaviour change among midwives*
 - *Education and counselling – harsh,*
 - *Condition worsened by harshness*
 - *Questioning – ignore, consider client’s question as interruption, disrespectful*
 - *Midwife’s superiority complex - Not a war / no superior inferior-relationship*
 - *Understand clients and their needs – some things taught considered by clients as not important*
 - *Reinforcement / motivation e.g. for right answers*
 - *Harmonize / verify information from other sources like women programmes on radio and TV*
 - *Friendly service is key*
 - *Threats from the community*
 - *Language barrier – local, consideration of small group*
 - *Prefer married / experienced midwives*
- ***Provision of Service***
 - *Use of available facilities*
 - *Better working condition*
 - *Encouragement*
 - *Electricity to maintain drug potency*
 - *Create section on Family planning*
 - *Provide space*
 - *Provide privacy*
 - *Provide educational materials*
 - *Ultra Sound Scanner*
 - *Provision of more equipment*
 - *Best care*
 - *Free medical services*
 - *Inform authority*
 - *Monitoring*
 - *Time management – no wasting, not stay too long*
 - *Punctuality*
 - *Labour room – key place now because many do not deliver in hospital*
 - *24 hours*
 - *Proper accommodation*
 - *Post more midwives to rural*
- ***Availability of Midwife / Employ more midwives***
 - *Schedule of duty*
 - *More midwives for rural*
 - *Documentation – maintain a chart, research and use what is found*
 - *Self encouragement*
 - *Support network*
 - *Job scheduling*
 - *Cover shifts*
 - *Adequate information*

- **Follow-up Visits**
 - *Postpartum mothers*
 - *Encourage utilization even ANC*
 - *Scheduled visits – Health talks, knowledge of midwife and role of midwife*
 -
- **Create Awareness**
 - *Availability of facility and services delivering – ANC, delivery, postnatal, family planning, IWC*
 - *With or without complications*
 - *All talks important*
- **Drugs / Drug Revolving Funds**
 - *Free*
 - *Sustainable Drug Supply System (SDSS) – pay small*
 - *Supply drugs*
 - *Prompt monthly returns and requisition*
 - *Proper utilization of the drugs*
- **Resource Linking**
 - *Request for drugs and liaise with government*
- **Specific Roles**
 - *Discourage teaching cleaners*
- **Village Health Committee**
 - *Awareness of available facility – entry, dialogue, drama / role play*
 - *Promote use of available facility*
 - *Community mobilization*
 - *Ignorance and poverty – promotion of literacy, girl child education and alleviation of poverty*
 - *Categories of workers – midwife’s skills and roles*
 - *Outreaches on what midwives do – ANC, labour, postnatal, mother and child care*
 - *TBAs – training or partnership*
 - *Find out MNCH related programmes on radio and TV for women*
 - *Local transportation for referred cases*
 - *Community involvement*
 - *Behaviour change possible with their cooperation and easier*
 - *Threat*
- **Behaviour Change Communication**
 - *Create awareness*
 - *Organize workshop*
 - *Many have not seen booklet or BCC framework*
 - *Why guidelines put together*
 - *Role of midwives*
 - *Cannot have 100% but there will be improvement*
- **IMNCH Strategy**
 - *Awareness*
- **Messages**
 - *Women believe*
 - *Women want to know more – broaden what women are told*
 - *Compile key messages - common to all, touch on all areas, factual,*
 - *Draw a plan*
 - *Need IEC materials*
 - *Prepare*
 - *Documentation*
 - *Broaden health education*
- **Workshops and Continuing Education**
 - *On IPCC*
 - *BCC*

- Regularly

Additional Input by Committee

- Midwives' burnout and rights to be given consideration
- Encourage Basic Midwifery and career progression in various areas of MNCH
- Present research papers at workshops and conferences
- Hold annual midwives' conference

Day 2 – Friday, 12th February 2010

Opening – 9:58 a.m.

Plan

- Design capacity building workshop
 - Topics
 - Content
 - Allocation of time
 - Time-table
 - Remuneration of resource persons
- Identify and compile core messages
- Review the checklist

Background of participants

- Quick review of the basic midwifery curriculum to see relevant courses already taken by participants
 - Behavioural Science
 - Primary Health Care (PHC)
 - Nutrition
 - Normal Midwifery
 - Community Midwifery
 - Complicated Midwifery
 - Child Health
 - Family Planning
 - Reproductive Health
 - Principles of Management and Teaching

Decided on topics in line with observations and suggestions of participants

- Interpersonal Relationship (IPR) –
 - *Interpersonal communication*
 - *Counselling*
- Create Awareness, Village Health Committee, follow-up
 - *Community Mobilization*
- Behaviour Change Communication
 - *Introduction to Behaviour Change Process*
- IMNCH strategy
 - *Introduction to Integrated Maternal, Newborn and Child Health (IMNCH)*
- Broadening of health education and messages
 - *Review of the Use of Information, Education & Communication (IEC) Materials*
 - *Review of Core MNCH Messages*
 - *Values Clarification*
- Equipment, drugs, manpower, discourage teaching cleaners and TBAs, Free Services, Poverty, Threat in community, supervision, workshop, etc
 - *Challenges of Rural Midwifery Practice (special interactive session - participants and government officials)*

Review of Relevant Training Manuals and Other Materials to Select Appropriate Content

The following materials were examined together and appropriate content to meet participants' expectations were selected together by members of the committee.

- i. F.M.O.H (2005). Family Planning Training for Physicians and Nurses/Midwives - National Training Manual. Abuja, Distributed by COMPASS Project with funding from USAID/Nigeria. This publication was originally produced under the VISION Project.
- ii. F.M.O.H. (2007). Integrated maternal newborn and child health strategy. Abuja, Nigeria, Federal Ministry of Health.
- iii. F.M.O.H, PATHS, et al. (2005). Training Manual on Life Saving Skills for Nurses/Midwives. Abuja, PATHS Nigeria/Federal Ministry of Health, Nigeria.
- iv. F.M.O.H, USAID & COMPASS (2006) *National Clinical Service Protocol for Obstetric and Neonatal Care*, Abuja, Federal Ministry of Health Abuja, Nigeria
- v. F.M.O.H, WHO., PATHS, UNFPA, UNICEF & DFID (2005) *Behaviour Change Communication Strategy for the National Reproductive Health Policy and framework*
- vi. Kaduna State Government (2009). *Obstetric and Perinatal Records*. Kaduna, Kaduna State Government of Nigeria (Accessed on 3rd April 2009).
- vii. the David & Lucile Packard Foundation and Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs (2006). An Interpersonal Communication And Counseling (IPC/C) Skills Training Manual For Health Care Providers - Trainers' Guide, FIRST KLASS, Ku Saurara!
- viii. UNICEF (.....) *Training Manual on Advocacy and Community Mobilization In Support of the Prevention of Mother to Child Transmission of HIV*
- ix. UNICEF Basic Messages - Maternal & Newborn Child Health (MNCH), UNICEF (Accessed 2009).
- x. WHO (2001). information, education and communication - lessons from the past; perspectives for the future, Department of Reproductive Health and Research, World Health Organization, 1211 Geneva 27, Switzerland or via e-mail from: rhrpublications@who.int World Health Organization WHO/RHR/01.22 Distr.: General.
- xi. WHO (2009). *Counselling for maternal and newborn health care : a handbook for building skills Part 2 Counselling*, Department of Making Pregnancy Safer, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.
- xii. WHO (2009). Counselling for maternal and newborn health care : a handbook for building skills Part 3 Topics, Department of Making Pregnancy Safer, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.
- xiii. WHO (2009). Counselling for maternal and newborn health care : a handbook for building skills. Annex 1: Information and Counselling Sheets from the PCPNC Department of Making Pregnancy Safer, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.
- xiv. WHO (2009) Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice Integrated Management of Pregnancy and Childbirth 2nd Edition, Department of Making Pregnancy Safer World Health Organization, Geneva.

Time-Table

The topics were slotted into the dummy table along with the other activities and break times, considering the time required for each.

Remuneration of resource persons

Not more than ₦2000 per person

Review of the Checklist

- To be used for self assessment by participants, peers and any other
- Under “Messages” – delete “Regular (repeated at more than one visit)” because observation is per encounter with probably not same patient; not once after several encounters with same patient.
- Receiver - merge “comfortable” and “responds freely” and adjust all about the receiver
- Feedback – delete “message understood” and sort out with “client happy / satisfied”
- Highlight letters of acronyms
- Change “Observer” to “Assessor” in which case participant could assess herself

Assignments: Tasks were assigned to members as follows:

- Develop assigned topics and get ready for Friday 19th February 2010
 - Validation team member – Counselling with model questions and answers for pre- and post-tests
 - Participant member – IMNCH and PHC, Community mobilization with model questions and answers for pre- and post- tests
 - Researcher – Other topics and compilation of the core messages with model questions and answers for pre- and post- tests.
 - Researcher to provide participant member with more information on PHC per population, IMNCH,
- Researcher to see the Director of Nursing Services and Director of PHC on Monday 22nd February in respect of special interactive session
- Letters of invitation to participants and others to go out latest Friday 19th February and include: date, time and suggestion on materials

Closing

- Achieved quite a lot
- Continue work separately and meet deadlines
- Participant was given a token for transport
- Closed at 1pm being Friday
- Lunch co-sponsored by validation team member and researcher

B. O. Akin-Otiko

CAPACITY BUILDING FOR MIDWIVES

TO

**FACILITATE BEHAVIOUR CHANGE COMMUNICATION PROCESS
(FOR MATERNAL, NEWBORN AND CHILD HEALTH) AT PRIMARY
HEALTH CARE LEVEL OF MIDWIFERY PRACTICE IN
KADUNA STATE NIGERIA**

3RD - 5TH MARCH 2010

HELD AT

STATE SCHOOL OF MIDWIFERY, TUDUN WADA, KADUNA

TABLE OF CONTENT

1. Project Objectives
2. Participants' Expectations
3. House Rules
4. Methods and Materials
5. Introduction to Behaviour Change Communication
6. Introduction to Integrated Maternal, Newborn, and Child Health
7. (IMNCH) and Review of Primary Health Care
8. Marketing of MNCH Services Using Client-Centred and Customer
9. Service Approaches
10. Review of Communication Process and Interpersonal Communication
/ Counselling (IPC/C) Skills
11. Counselling
12. Review of the Use of Information, Education, and Communication
(IEC) Materials
13. Community Mobilization
14. Values Clarification and Review of Core MNCH Messages
15. Messages For Maternal, Newborn, And Child Health

Purpose of the Project

The main purpose of the study was to appraise and facilitate behaviour change communication process for maternal, newborn and child health in collaboration with midwives at the primary health care level in Kaduna State Nigeria.

Research Objectives

1. To assess the strengths and weaknesses of midwives in relation to behaviour change communication process at the primary health care level in Kaduna State.
2. To work in partnership with midwives to identify appropriate strategies / mechanisms for promoting behaviour change communication process at the primary health care level in Kaduna State.
3. To support midwives in developing the capacity for behaviour change communication at their respective workplaces in line with the appropriate strategies / mechanisms identified.
4. To support midwives in developing plans of action to facilitate the behaviour change communication process for maternal, newborn and child health at their respective workplaces.
5. To establish a support network with the midwives to facilitate behaviour change communication process for maternal, newborn and child health at the primary health care level in Kaduna State
6. To monitor the implementation of the midwives' developed action plans for behaviour change communication.

Participants' Expectations from the Project (27th January 2010)

- modification of behaviour with respect to BCC to reduce MNC mortality rates
- erase the negative information about midwives and differentiate between midwives and other health personnel
- improve our BCC skills
- improve interaction when mothers come to the clinic
- provide adequate resources to mothers
- assist members of the community to understand and perform their own responsibilities
- add more knowledge

House Rules (27th January 2010)

- Phones on silent; receive calls outside
- No "chorus" answers indicate willingness to make contributions by raising of hand
- No side talking
- Respect each other's contributions
- Punctuality is vital because each session is unique
- Those who fail to attend the interactive session now may not be able to follow subsequent stages and so should be excluded
- Cleanliness around and within the venue

(29th January 2010)

- If those currently absent have genuine reasons, and can cope after they are put through what has already been done, then they should be allowed since their absence is not their making.

Methods

- Brainstorming
- Lecture
- Discussion
- Demonstration / return demonstration

- Group exercise
- Role play
- Project - Development of Action Plan

Materials

- Flipchart and markers
- Writing board and chalk or markers
- Pamphlets, leaflets, posters, models, method samples, photographs
- Radio, audio cassette, cassette recorder, recorded radio messages (jingles)
- Video cassette, VCR, television

Introduction to Behaviour Change Communication

Time: 45 minutes

Objectives - By the end of this session, participants will be able to:

- define behaviour and health behaviour
- describe the process of behaviour change
- discuss the rationale for behaviour change communication for MNCH
- discuss the role of the midwife in facilitating behaviour change for MNCH

Behaviour

It is a person's response to situation within or outside him / her. It is also described as actions and inactions

Health Behaviour

This refers to any activity undertaken by an individual, regardless of actual or perceived *health status*, for the purpose of promoting, protecting or maintaining *health*, whether or not such behaviour is objectively effective towards that end (WHO, 1998 pp 8).

Behaviour Change Process:

Behaviour change is the focus of communication for health. There are thousands of behaviour change and health behaviour change theories and models. From these theories, some things come out clearly about behaviour change. These include:

- Behaviour change is a process or progression of events, and not an on-the-spot experience
- The order or progression of events in behaviour change process varies from one person to another
- Some people may experience a straight course of change, while most people move in cycles or spiral course through the various stages - 'relapsing' and 'resuming', until they are able to maintain a stable course
- People decide or are motivated to change for various reasons which may not be the same even for members of the same household
- Both personal (internal) and environmental (external) factors motivate people's behaviour and influence the change process
- Positive change in behaviour affects the health status of the people positively

Some Phases in the Behaviour Change Process:

"Not thinking of doing it" – Pre-Knowledge / Pre-contemplation

One is not thinking at all or not thinking seriously about the behaviour of interest e.g.

- A woman who may have heard others mention a safe birth plan, may not see the relevance to her, so she might not have bothered to know more about it or given it a serious consideration.

"Thinking of doing it" – Knowledge / Contemplation

At this stage, one starts to give a serious thought to the behaviour of interest. One seeks more information on the behaviour e.g. the woman

- Understands what a safe birth plan means
- Can recall safe birth plan messages and pregnancy, labour and postnatal danger signs.

“Intends to do it” – Intention / Preparation

At this stage the individual seems satisfied with her findings as she thought of doing it, and now intends to adopt the behaviour e.g. the woman

- Responds favourably to safe birth planning messages
- Discusses safe birth planning with personal network (family and friends)
- Thinks family, friends and community approve of safe birth planning
- Approves of safe birth planning
- Recognizes that safe birth planning can meet a personal need
- Intends to consult a provider
- Intends to practice safe birth planning anytime she is pregnant

“Actually doing it” – Practice / Action

One practices the new behaviour at this stage

- Goes to a provider for information/supplies/service
- Makes arrangements with family, provider, community members

“Continuing to do it” – Maintenance

The individual continues the behaviour and does not easily relapse again.

- Always has a safe birth plan for subsequent births

“Encouraging others to do it” – Advocacy

She encourages others in her social networks to adopt the behaviour.

- Experiences and acknowledges personal benefits of safe birth planning and tells friends and family about it in an effort to get them to plan too.

People decide / are motivated to change for various reasons:

- **Personal convictions based on:**
 - perceived susceptibility to health problem or condition in question
 - perceived seriousness / severity of the problem or condition
 - perceived benefits of taking the particular action
 - perceived barriers associated with taking the action
 - personally or another’s experience
- **Response to social persuasion / pressures** (in the presence or absence of personal convictions)
 - social norms
 - peer pressure
 - pressure / support from family and other social networks
 - government policies and organizational regulations
 - environmental factors – political, economic, legal, technological
- **Ability to perform the behaviour** to desired standards and continue doing it
 - Intellectual ability – cognitive skills, creative / critical thinking, access to required information / facts, knowledge to answer rising questions and doubts (internal and external) i.e. reasoning ability
 - Physical skills – strength, health status etc
 - Social ability – Household decision-making process, gender roles, interpersonal relationship and communication skills
 - Observance of others (modelling)
 - Economic ability – financial strength
 - Emotional / psychological ability – personality, coping apparatus, will, determination, fear, anxiety, belief in own ability
 - Reinforcements

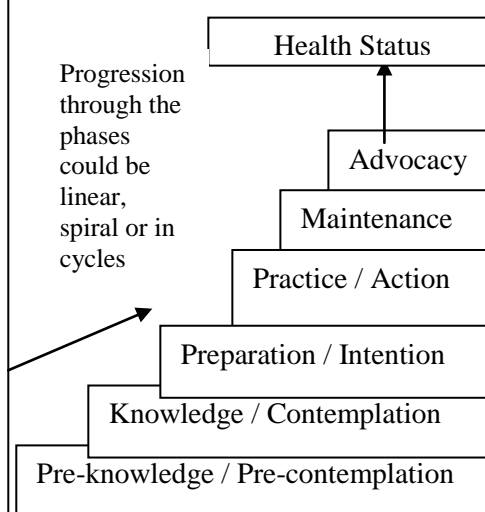


Figure 1: Factors Influencing Behaviour Change Process

Behaviour Change Communication (BCC) is a process whereby individuals, families and communities are provided with relevant resources to influence their knowledge and attitudes; and assisted to gain an understanding of issues pertaining to their health, sufficiently to be able to assume responsibility for, and take, meaningful and deliberate actions to promote their well-being, and maintain healthy lifestyles. It utilizes various communication, teaching and counselling techniques for health promotion.

BCC is also referred to as **Programme Plan**. It is usually adopted as a strategy along with other strategies identified towards achieving a goal. In Nigeria, we have BCC as a component of almost all health projects – HIV/AIDS, Malaria Control, Child Survival, Reproductive Health, Disaster Preparedness, IMNCH etc. Any complete MNCH intervention program must have a BCC component and this has been found to make impact on MNCH.

Axiomatic statements:

- All behaviours (actions and inactions) are health related
- There can be no ultimate control of any disease or health problem whose aetiology is well defined without addressing the associated behavioural patterns involved

Behaviour Change Communication (BCC) / Programme Plan for Nigeria

In recognition of the fact that without a positive change in behaviour, reduction of the unacceptably high maternal mortality rates, and attainment of the MDGs, will remain a mirage, *Behaviour Change Communication (BCC) Strategy for the National Reproductive Health Policy and Framework Nigeria 2005-2008* was developed in 2005.

It was based on the findings of an earlier household survey conducted in the six geo-political zones and other related studies. The BCC framework is currently being revised to include newborn and child related issues and targeted at three levels of intervention - Socio-political level, Health Systems level, and the Community / Individual level. It clearly identifies: The target audience, Key issues / Key Household Practices - KHHP, Problem behaviour, Hindering / Barrier to Ideal Behaviour, Enabling factors / Factors encouraging ideal behaviour, Desired behaviour / Behaviour to promote, Communication objectives, Benefits, Strategies / Activities, Outcome indicators, and the Core messages.

The BCC strategy for MNCH is to:

- promote positive practices among women, in families, and communities
- discourage negative practices among women, in families, and communities
- help to achieve the vision of zero tolerance to maternal, newborn and child mortality in all communities in Nigeria

The Role of the Midwife in Facilitating Behaviour Change for MNCH

Discussion:

- Is there any relationship between the midwife's behaviour and the decision of clients to change or not to change their behaviour?
- What can midwives do to positively impact on clients at different phases of the behaviour change process?

What is done by most health workers in the facility is "health talk" or "giving instructions" to clients and their families, with the expectation that behaviour change is a mechanical / on-the-spot event. When this is not realized the client is labelled "difficult" "ignorant" "lacking understanding" and the provider says "I am tired" "I have tried my best" etc

The midwife needs to realize that people learn new behaviours best:

- when they are learning something they feel is useful,
- when they can put into practice what they are learning, and
- when they receive feedback and are rewarded for doing well.

Most times, modelling is the best way to teach complex behaviours.

- The midwife must examine her values, clarify them and change her own behaviour where necessary to be able to help others change their behaviour. The rule in ethical practice is "do to others what you expect them to do to you"
- In BCC for MNCH the midwife is a facilitator / partner not "the expert"

- As an effective communicator the midwife must identify where her clients are in the behaviour change phases and assist them to make efficient and sustainable progress
- Provide Friendly services that are People-centred, Family centred, and Individualized
- Utilize her Interpersonal communication and Counselling skills efficiently
- Share accurate and relevant BCC Messages for MNCH

Summary:

Behaviour change begins with you and me!

Resource Materials:

Microsoft (2009). Behaviour. Microsoft Encarta Dictionaries 1993-2008 Microsoft Corporation.

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WHO (1998). "Health Promotion Glossary." WHO/HPR/HEP/98.1, 36pgs.

WHO (2001). information, education and communication - lessons from the past; perspectives for the future, Department of Reproductive Health and Research, World Health Organization, 1211 Geneva 27, Switzerland or via e-mail from: rhrpublications@who.int World Health Organization WHO/RHR/01.22 Distr.: General.

Introduction to Integrated Maternal, Newborn, and Child Health (IMNCH) and Review of Primary Health Care

Time: 90 minutes

Objectives - By the end of this session, participants will be able to:

- explain the concept of IMNCH
- discuss the rationale for IMNCH
- enumerate the three delivery modes
- identify interventions within each delivery mode
- discuss the concept of Primary Health Care (PHC)
- describe the structure and operation of a PHC unit

Introduction to Integrated Maternal, Newborn, and Child Health (IMNCH)

About one million Nigerian children die each year before their fifth birthday, representing about 10% of the global total, although Nigeria's population is just 2% of the world's population. Annually an estimated 52,900 Nigerian women die from pregnancy-related complications out of a global total of 529,000 maternal deaths.

A woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 13, although many of these deaths are preventable.

The major causes of maternal death include:

- haemorrhage 23%
- infections 17%
- toxemia / eclampsia 11%
- unsafe abortion 11%
- obstructed labour 11%

- malaria 11%
- anaemia 11%

The major causes of Under-5 mortality are:

- malaria 24%
- pneumonia 20%
- diarrhoea 16%
- measles 6%
- HIV 5%
- Neonatal conditions 26%

Presently, less than 20% of the health offer emergency obstetric care (EOC), and only 36% of the deliveries are attended by skilled birth attendants.

Malnutrition is the underlying cause in more than 50% of these deaths. In addition to this, the rates of underweight (25%) and wasting (9%) are unacceptably high in Nigeria, particularly among very young children (less than 3 years). Newborn deaths account for 26% of the under-5 deaths; about 74% of these occur in the first week of life mainly due to complications during pregnancy and delivery (premature birth, low birth weight, infections, birth asphyxia).

These statistics reflect the close relationship between the well being of the mother and the child, and justifies the need to integrate maternal, newborn and child health.

In the year 2000 at the Millennium Summit held in New York, world leaders pledged to reduce child mortality (Goal 4) and improve maternal health (Goal 5) among other goals set to be achieved by 2015.

Definition of IMNCH

- The integrated maternal, newborn, and child health is a strategy that focuses on care with linkages from home to community to health facility.
- Health policies, programmes and interventions in the fields of maternal, newborn and child health approached together and incorporated into integrated programmes
- It is also a radical way of resource mobilization, coordination, and putting into action a minimum range of effective interventions that have been proven to work for the attainment of MDGs 4 and 5

Delivery Modes for IMNCH

The interventions are packaged in 3 delivery modes:

- Family-oriented / Community-based services
- Population-oriented outreach mobile specialty clinics
- Individually-oriented clinical services (health facility level)

Key Intervention Packages Selected for Each Delivery Mode

Family-oriented / Community-based services

- Family Preventive /WASH Services (Use of ITNs by under 5s & pregnant women , use of safe drinking water, use of sanitary latrine, hand washing with soap, condom use)
- Family Neonatal Care (Clean delivery & cord care, putting to breast within 30 minutes & temperature management, universal extra community-based care of low birth weight infants / referral for very low birth weight)
- Infant and Child Feeding (Exclusive breast feeding 0-6 months, continued breast feeding 6-23 months, adequate & safe complementary feeding from 6 months, supplementary feeding with moderately malnourished children (<2SD)
- Community Management of Illnesses (Oral rehydration therapy, zinc for diarrhoea management, Vitamin A treatment for measles, anti-malaria treatment)

Population-oriented outreach mobile specialty clinics

- Preventive Health Care for Adolescents and Adults (Family planning)
- Preventive Health Care during Pregnancy (Antenatal care, tetanus immunization, de-worming in pregnancy, detection & treatment of asymptomatic bacteriuria, detection & management of syphilis in pregnancy, prevention & treatment of iron deficiency anaemia, IPT for malaria, ITN for pregnant women through ANC)

- HIV/AIDS Prevention and Care (VCCT & treatment with Nevirapine, infant feeding counselling, condom use, Cotrimoxazole prophylaxis for HIV + mothers, Cotrimoxazole prophylaxis for infants of HIV + mothers and mothers with advanced disease)
- Preventive Health Care for Infants and Children (Measles, BCG, TT, OPV, DPT, Pentavalent – DPT-Hib-Hepatitis), Hep B Vaccines; Vitamin A supplementation, ITN for under -5 through NPI

Individually-oriented clinical services (health facility level)

- Clinical Primary Level Skilled Maternal and Neonatal Care (Skilled delivery care, resuscitation of asphyxiated neonates at birth, antenatal steroids for preterm labour, antibiotics for preterm / pre-labour rupture of membranes (P/PROM), detection & management of pre-eclampsia (Mg sulphate), management of neonatal infections at PHC level)
- Management of illness at Primary Clinical Level (Antibiotics for pneumonia, diarrhoea & enteric fever, Vitamin A- treatment for measles, zinc for diarrhea management, oral rehydration therapy for diarrhoea management, Artemisinin-based combination therapy for children & pregnant women, combination therapy for mothers and infants for PMTCT, HIV treatment of mothers and children with ARVs)
- Clinical First Referral Illness Management (Basic emergency obstetric & neonatal care (B-EONC), management of severely sick children (IMCI), clinical management of neonatal jaundice, universal emergency neonatal care (asphyxia, management of serious infections, management of VLBW infants), management of complicated malaria (second-line drug)
- Clinical Second Referral Illness Management (Comprehensive emergency obstetric & neonatal care (C-EONC), other emergency acute care, management of complicated AIDS)

Objectives of IMNCH

The overall objective is to reduce maternal, newborn and child morbidity and mortality in line with Millennium Development Goals 4 and 5.

- Improve access to good quality health services
- Ensure adequate provision of medical and laboratory supplies, drugs, bundled vaccines, reproductive health (RH) commodities, insecticide-treated nets, and the provision and maintenance of basic equipment
- Strengthen the capacity of individuals, families and the community to take necessary MNCH actions at home and to seek appropriate health care promptly
- Improve capacity for organization and management of MNCH services
- Establish a financing mechanism that ensures adequate funding, affordability, equity, and the efficient use of funds from various sources
- Strengthen supervision, monitoring and evaluation systems to assess and report on the progress towards achieving the maternal and child MDGs
- Establish and sustain partnerships to support implementation of IMNCH strategy

Review of Primary Health Care (PHC)

Primary Health care as defined in the Alma Ata Declaration of 1978 is the key to the development of national health policy. “Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally acceptable to individuals and families in the community and through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. It forms an integral part both of the country’s health system of which it is the central function and main focus, and of the overall social and economic development of the community.

It is the first level of contact of the individual, the family and the community within the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process”

10 Service Components of PHC

PHC has 10 Service Components as follows:

1. Maternal and child health care / Family Planning
2. Immunization against major infectious diseases
3. Prevention of locally endemic and epidemic diseases

4. Provision of adequate food and nutrition
5. Provision of safe water and basic sanitation
6. Health Education
7. Provision of essential drugs and supplies
8. Appropriate treatment of common diseases and injuries
9. Provision of mental health
10. Provision of dental health care

The PHC service components implementation is directly monitored and supervised by the management staff of PHC Department of the Local Government. Each LGA has the responsibility of funding and delivering the PHC services to its populace with supports from state and Federal Ministry of Health (See organogram of PHC Department of Local Government Figure 1).

The organogram describes the distribution of services from LGA headquarters to political wards to various health facilities at villages and communities.

At the ward level, minimum health care package was introduced (2007 – 2012) to mobilize political commitment to health service delivery as a requisite for social development.

Structurally, each ward has a ward Development Committee, composed of the following:

- A ward / clan head as patron
- An elected chairman
- Secretary
- Chairmen of village / community development committees
- Headmaster of school
- Senior agricultural extension worker
- Community Development Officer
- Representative of occupational groups (which includes VHW, youth groups, chairmen of patent medicine and store dealers, traditional healers)
- Heads of facilities in the area (O.I.C.S)

Functionally, each ward Development Committee is responsible for the following:

- Identification of health and social needs of the ward and planning solutions
- Mobilization of resources (human and material)
- Supervision, monitoring and evaluation of health activities in the ward
- Mobilization of community participation in health and other health related programmes
- Liaison with government, NGOs, and other partners in the implementation of health programmes
- Forwarding plans from villages and the wards to LGA / PHC

Development Committee and providing feedback

- Supervision and support to TBA / VHW / CHEWs
- Support the establishment of health facilities and overseeing their functions at the ward level.

Similar committees are expected to be formed / function at the village / facility level for closer participation in service delivery.

Resource Materials:

F.M.O.H (.....) Strengthening Primary Health Care at Local Government Level: The Nigerian Experience

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Marketing of MNCH Services Using Client-Centred and Customer Service Approaches

Time: 60 minutes

Objectives - By the end of this session, participants will be able to:

- define marketing
- differentiate between provider-centred and client-centred approaches
- discuss client-centred approach and customer service as marketing strategies for MNCH
- review the rights of the clients
- revise their action plans to be client-centred and customer friendly

Marketing

Marketing is the process by which goods and services are created, valued, and delivered to buyers, users or consumers. The *Ps of Marketing* are: Product, People, Place, Promotion, and Price .

Usually, a preliminary research is carried out to determine potential consumers' wants and needs. The goods and services are thereafter tailored to meet consumers' expectations.

Similarly, strategies are developed to create awareness about, and craving for, the goods or services such that interest of consumers in the product or service is developed and sustained. Manufacturers and providers advertise their goods and services using the mass media, interpersonal relationship skills and promo bonuses.

Because consumers often have alternatives, marketing has grown to professional status requiring training and re-training of practitioners. Services are more challenging to sell and they require more persistent and vigorous efforts to promote than goods.

Quality Maternal, Newborn and Child Care is a *health care service* and must be marketed to attract consumers (clients). The high maternal, newborn and child mortality rates in Nigeria are unacceptable. Nigeria's overall health system performance was ranked 187th among the 191 Member States by the World Health Organization in 2000. The country is second in the whole world in terms of unacceptably high maternal mortality rate. The 2015 MDGs target year is round the corner, yet there is gross under-utilization of available services and preference for unsafe options.

Marketing Quality MNCH services through Client-centred and customer service approaches are the focus of this session.

Nurses and Midwives in Nigeria have been described as the key health care providers, particularly at the grassroots level, for efficient maternal and child care. Most of the activities of the government and her development partners (non-governmental organizations – NGOs) are focused primarily on developing the professional midwives' technical competence (Life Saving Skills (LSS) and Integrated Management of Childhood Illnesses (IMCI). Similarly, government and owners of health institutions are improving quality of their services by renovating or upgrading their facilities, employing more personnel, adhering to clinical protocols, ensuring drug and supplies are available yet client dissatisfaction is grossly reported daily.

Underutilization of health facilities has been linked to provider behaviours. This has grave implication for MNCH. Surveys revealed that many providers are unfriendly, harsh, rude and impatient although a good number are well spoken of particularly in the rural areas.

Replacement of *Provider-centred Approach* with *Client-centred Approach* to service delivery in the health sector, seeks to correct these anomalies. Clients feel comfortable and are willing to pay for services when they feel such services are of good quality and meet their expectations.

Client-centred approach to service delivery:

- considers the client's perceptions and preferences determined through qualitative research
- seeks to meet and / or exceed expectations of the client
- meets the rights of the clients to: access to service, information, choice, confidentiality, and safety
- elements of client-centred approach include (see Figure 1):

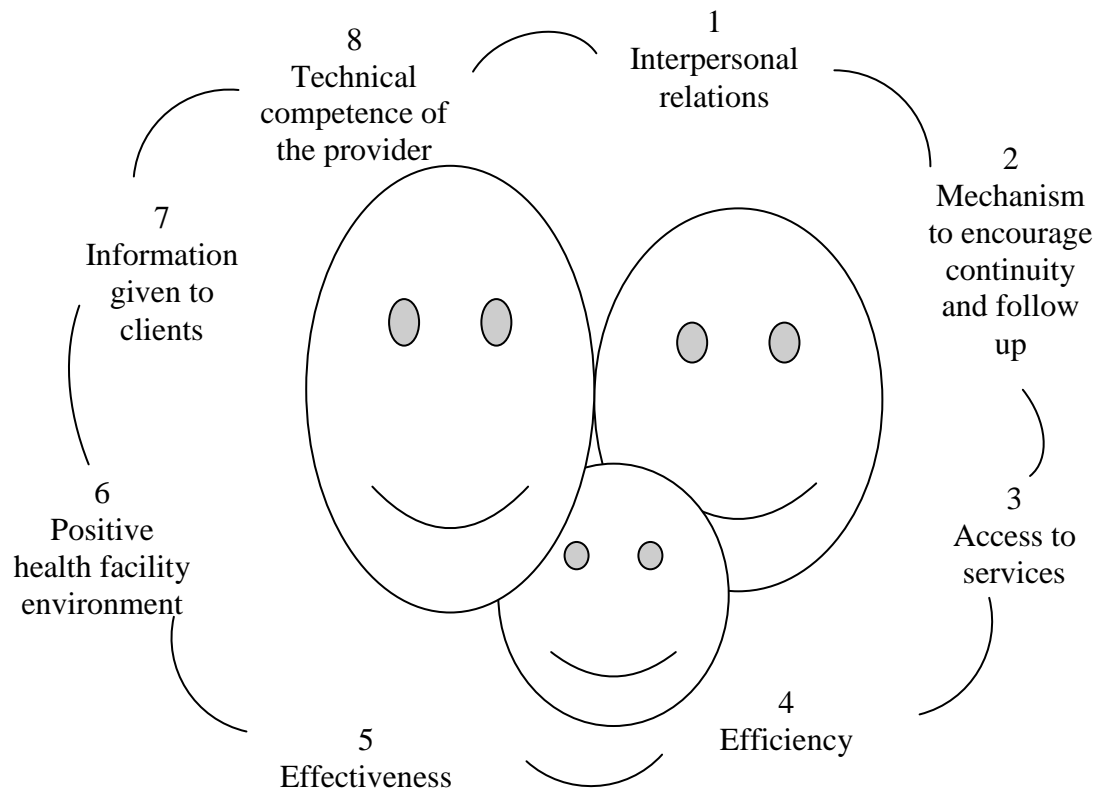


Figure 1: Elements of Client Centred Approach

Quality Maternal Health Services according to WHO involves:

- accessibility, availability and acceptability of services
- technical competence of health care providers
- essential supplies and equipment
- quality of client-provider interaction
- information and counselling for the client
- involvement of clients in decision-making
- comprehensiveness of care and linkages to other reproductive health services
- continuity of care and follow-up
- support to health care providers (APHRC, 2006 pp x; WHO, 1996)

Why improve the Client-Centred Approach? - It is to:

- Increase the number of clients who use services
- Improve the reputation of staff at facility and community levels
- Satisfy the needs and expectations of clients
- Reduce the number of clients who discontinue services
- Produce results within budget limitations
- Provide consistent and uniform information
- Meet desired and needed results not being achieved through former approaches
- Enable the health service system respond to societal needs
- Increase and sustain the viability of centres

What happens when Client-Centred Approach is not employed in service delivery?

- Wastage of resources such as human, equipment, time and supplies
- Decreased job satisfaction and motivation for providers
- Decreased safety for clients and providers
- Decreased satisfaction of clients
- Increased drop out rates and loss of clients resulting in increased defaulter rates

- Fewer new clients
- Poor image of the health facility
- Poor image of the health providers
- Poor compliance with prescribed treatments

Factors that facilitate Client-Centred Approach

- Good Interpersonal Communication and Counselling (IPC/C) Skills
- Availability of Information, Education, and Communication (IEC) materials
- Good technical competence of the provider in the use of IEC materials
- Provision of privacy and confidentiality for the client
- Availability of enough time for client-provider interaction
- Adequate manpower and efficient job distribution

Client-centred and provider-focused approach

While **providers** are more concerned with ensuring technical accuracy, the **clients** are more concerned with issues such as being treated with respect, etc. **Both** sides are required for quality MNCH service.

For the **provider**, adhering to clinical protocols and standards for service delivery, organization, policies and management are paramount. This could **lead to** efficient and effective work environment and positive treatment outcomes for clients and provider.

In client-centred approach, **client** expectations, how client felt he or she was treated, feeling of satisfaction with the treatment, could **lead to** positive client behaviours (treatment compliance, reduced drop out rate, continuation with treatment), client satisfaction, good image of health facility and providers.

Role Play

Mrs. "H" is a 40 year old woman G8 P7 (all alive and all boys). She came to your facility at 34 weeks for booking. She wants a daughter this time around.

- *Discuss the client-provider interaction*
- *Is it Provider Centred or Client Centred Approach?*
- *What are the implications of the approach used?*

Rights of the Client - Every Client Has The Right To:

Information

- Mothers have a right to timely, accurate and appropriate information related to their reproductive health needs such as need for antenatal care, basic components of focused ANC, birth preparedness and emergency readiness
- Mothers have the right to VCT for HIV/AIDS and PMCT and all other information relevant to their well being
- They have right to receive clear information to learn about the availability, benefits, side effects or possible problems associated with health care services and treatment.

Access to Services

- Clients have a right to obtain services regardless of age, sex, colour, tribe, marital status, location or socio economic class
- Mothers have the right of access to services which include those that are not limited or impeded by cost, hours of service, location, physical or social barriers

Informed Choice

- Clients have a right to decide freely whether to use health services and what to use that best meets their needs, goals and life styles
- Mothers have the right to guidance and support based upon access to full understanding of all necessary information for them to make voluntary and informed decision about their healthcare

Safe Services

- Mothers deserve assurance for safe services that are delivered by skilled maternal health providers in accordance with standard guidelines
- They have the right to receive effective services, treatments and care without harm

Privacy and Confidentiality

- Clients have a right to have a private environment during counselling and service delivery
- Mothers' privacy and confidentiality must be maintained at the facility during counselling, physical examination, clinical procedures and in the handling of their personal information and medical records
- Clients have a right to be assured that any personal information divulged will not be shared in public
Therefore for Privacy and Confidentiality, in all contacts with the woman and her partner:
 - Ensure a private place for the examination and counselling
 - Ensure, when discussing sensitive subjects, that you cannot be overheard
 - Make sure you have the woman's consent before discussing with her partner or family
 - Never discuss confidential information about clients with other providers, or outside the health facility
 - Organize the examination area so that, during examination, the woman is protected from the view of other people (curtain, screen, wall)
 - Ensure all records are confidential and kept locked away
 - Limit access to logbooks and registers to responsible providers only

Dignity, Comfort and Expression of Opinion

- Mothers must be treated with respect and their opinion must be considered
- They have the right to be treated with courtesy, enthusiasm, attentiveness and respect
- They have the right to feel comfortable while receiving services
- They have the right to express an opinion about the health services being offered without fear and with confidence that the opinion will be considered valuable.

Continuity of Care

- They have the right to receive appropriate health services, drugs, commodities and supplies for as long as needed
- Mothers have the right to continuity of services and supplies, follow-up and referral necessary to maintain their health

It is pertinent to note that the midwives also have rights as citizens of the country, professionals under obligation to maintain standards, and as employees. However, as a professional and the link between the client and the government / organizational policies, she maintains a balance in favour of her clients always.

Customer Service

- providing assistance to clients in a way that increases their satisfaction with your program or facilities
- is based on the continuous concern for client preferences, both in staff interactions with clients and in design of services
- maintains that facility staffs are accountable to clients, that clients have rights, which staffs need to respect
- service to people in a way that meets their needs, makes them feel they are cared for, and makes them want to recommend the services to family and friends

Customer Service is good when:

- it supplies all the customers' needs
- it "exceeds the needs" – more customers **delight** than customer **satisfaction**
- it constantly and consistently exceeds the customer's expectations
- it is constantly and consistently practiced by all members of staff
- the provider treats the customer as an individual with her special needs and wants, rather than a group with a set of needs and wants.

Improving customer service involves:

- making a commitment to learning what our customers' needs and wants are
- developing action plans and activities that implement customer friendly processes

Principles of commercial marketing should be applied to marketing MNCH services.

Health services need to be provided with distinction. Try to know your customers and recognize their individual needs. Be convinced that you are offering them valuable service. This is key and crucial to good customer service.

It is necessary to be honest in relating with clients. Clients should know the truth about issues that affect or are likely to affect them and their health e.g. free services, state of equipments, available services etc. When the client suspects dishonesty, she feels disappointed and you run the risk of losing the trust secured.

Sometimes, when clients do not receive a particular service consistently they are disappointed and fail to return. In addition, the word gets round and others too (who would otherwise still benefit from the available services) are also discouraged from utilizing the health facility.

Why Add Customer Service to Quality Clinical Services?

- Attracts new clients and generates new demand for services. Health facilities like many businesses rely on word of mouth to bring in new customers or clients give to their friends and family.
- Retains clients who need to return for follow up or other services. This is especially important for those MNCH and continuum of care.
- Reduces per-customer or per-client costs. When providers and staff communicate well with clients, treat them well and provide the high quality services they want, there is rarely a need to redo procedures to please clients.
- Builds a good public image and reputation by word of mouth
- Dispels false morale and performance by working together to fulfil clients' needs and getting positive feedback from clients about the services.

Initiating a Customer Service Approach

Developing a customer service focus is an important and challenging task that requires the participation and commitment of *all staff: this includes receptionists, health staff, accounts clerks and gatekeeper*. They all need to understand that they have an important role in making each client's visit efficient and pleasant and that they must participate. It is essential to incorporate customer service attitudes and skills in all their interactions with clients.

- Introduce staff to the customer service concept. Hold a seminar or meeting on Customer Service.
- Review the anticipated benefits of customer service in terms of both the clinic and the community it serves.
- Encourage staff to think about their own experiences as clients in health facilities and customers of local business so that they can identify good and bad examples of customer service and determine how those experiences have affected where they decide to go for services.
- Take the lead in *modelling* desired customer service behaviour, for example speaking with clients who are waiting to be seen or have just received services to better understand what they need or think of the services. Modelling customer service helps show other staff the kind of respect, friendliness, consideration and attentiveness that you want them also to extend to clients.
- Providers and staff should identify some relatively easy but important guidelines for interactions with all clients that staff will follow. For example, clients will be addressed in a respectful and culturally appropriate manner such as Miss, Mrs. or Mr. instead of 'grandmother', 'the abortion case', or the 'STI case'.
- Providers and staff are encouraged to contribute their suggestions to improving customer service at regular staff meetings. Feedback from clients should be shared at these meetings as well.
- All staff should receive *feedback* on their performance in modelling customer service. This is **not** a punitive process but staff should be recognized for their efforts and encouraged to always look for ways to improve.

Application

Can this be accommodated in your action plan? Discuss

- If the answer is "yes", how?
- If the answer is "no", why?

Table : Comparison Between Provider-centred Attitudes and Client-centred Attitudes

Organization / Service Provider-Centred Attitudes	Client-Centred Attitudes
<ul style="list-style-type: none"> It is considered a privilege for clients to come to the clinic and have trained service providers take care of them 	<ul style="list-style-type: none"> Service providers appreciate the opportunity to provide services to their clients
<ul style="list-style-type: none"> Service providers know what is best for a client 	<ul style="list-style-type: none"> Service providers spend time helping the client choose the most appropriate options to meet their needs. Decision-making is a collaborative process between the provider and the client
<ul style="list-style-type: none"> Service providers are concerned primarily with efficiency and technical competence More effective and also provides a more rewarding working environment; what providers consider to be effective and convenient, often with little attention to or understanding of what is important for their clients. 	<ul style="list-style-type: none"> Service providers understand that though technical competence and efficiency are important, service must be delivered in a clinic that is hospitable, responsive, polite, respectful, and friendly to clients. Realizes that clients want to see that the provider acts in their best interests, equitably and honestly, with knowledge and competence Recognizes that clients are not looking for technical competence alone but for providers who are understanding, respectful and trustworthy
<ul style="list-style-type: none"> Attending to each individual client's needs is too time consuming because it increases the time it takes to provide services 	<ul style="list-style-type: none"> Taking time to listen and meet the client's individual needs saves time, reduces unnecessary return visits, and encourages the client to continue to come to the clinic for services next time It is not a luxury, it is a necessity
<ul style="list-style-type: none"> Clients are exposed to being taken advantage of by corrupt providers Clients are considered as mere targets for disease control programmes 	<ul style="list-style-type: none"> Health care is organized around clients' needs, respectful of their beliefs and sensitive to their particular situation in life Client centred approach encourages transparency, integrity Avoids leaving people at the mercy of unregulated commercialized health care
<ul style="list-style-type: none"> People's needs and expectations are not taken into consideration and the people are not involved so the services are disconnected from the communities they serve i.e. not related to the people and their needs. 	<ul style="list-style-type: none"> Takes into account the socio-cultural context of the families and communities where health problems occur in all efforts to resolve them. Social exclusion is minimized

Conclusion

When you can show concern about what matters to your customer, you are a step closer to acquiring a customer for life.

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WHO (2008). "Primary Health Care Now More Than Ever." The World Health Report 2008: 148 pages.

WHO (2009) Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice Integrated Management of Pregnancy and Childbirth 2nd Edition, Department of Making Pregnancy Safer World Health Organization, Geneva.

WHO (2008). "Primary Health Care Now More Than Ever." The World Health Report 2008: 148 pages.

Review of Communication Process and Interpersonal Communication / Counselling (IPC/C) Skills



Time: 120 minutes

Objectives - By the end of this session, participants will be able to:

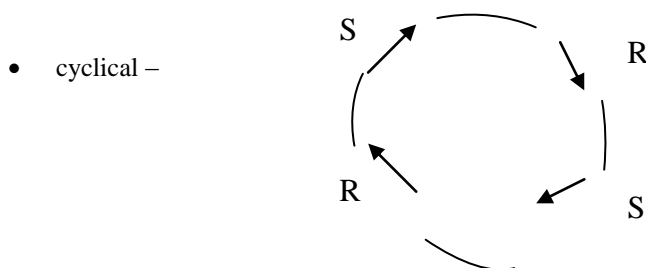
- define communication
- describe the four main types of communication
- discuss the components of effective communication
- utilize the principles of effective communication guided by relevant acronyms
- demonstrate improvement in IPC/C skills
- discuss barriers to effective communication and how to overcome them

A. Review of the Communication Process:

Definition - process of exchanging or sharing information, ideas, feelings, at a given time and place. The process of communication could be:

- one-way – 
- two-way – 

A two-way process whereby a person or group of persons (SENDER) pass a message through a CHANNEL to another person or group of persons (RECEIVER) and get a FEEDBACK that acknowledges the receiver's understanding of the message.



S = Sender R = Receiver

Types of Communication:

Intra-personal Communication – This refers to communication with oneself including justification, rationalization or excuses we make for our actions.

Interpersonal Communication – This is face-to-face / person-to-person sharing of information, ideas and feelings which could be between individuals or in small groups.

Mass Communication – This form of communication involves the exchange of information or messages with a large audience through the mass media whether print, electronic, or local.

Organizational Communication – This refers to communication within a formal group or an organization, and among organizations.

Verbal and Non-Verbal Communication methods could be used separately or together in the process.

Non-verbal Communication – *Body language other than those used to form spoken words or signs are employed in the communication process:*

Some have specific common meanings; some emphasize or make meanings of spoken words clearer; while some mean different things in different cultures. Examples include:

- Facial expressions – frowning, furrowing brow, smiling
- Hand gestures
- Hand shaking
- Hand holding
- Laughing
- Gentle patting / therapeutic touch
- Leg / foot gestures
- Eye gestures – e.g. rolling eyes
- Eye contact
- Body posture / position
- Finger drumming
- Toe /foot tapping
- Folded arms

“ROLES” acronym for non-verbal behaviours to be kept in mind when interacting with clients

- R – **R**elax
- O – **O**pen up and be approachable
- L – **L**isten and **L**ean towards client (as culturally appropriate / acceptable)
- E – make **E**ye contact (as culturally appropriate / acceptable)
- S – **S**it straight and **S**mile (appropriately / acceptably)

Verbal Communication – *Spoken, oral, vocal, voiced, and unwritten:*

The words and tone of voice used in verbal communication have strong influence on the communication process.

- The words must be “**KISS**” :
 - K – Keep
 - I – It
 - S – Simple, plain, easy to understand
 - S - Sensible , rational, calm, polite, right, appropriate
- The volume of words should just be adequate for the situation and need of client
- The tone must be appropriately:
 - Warm and welcoming
 - Interesting showing concern / readiness to assist
- In the Two-way / Cyclical Verbal Communication process, the midwife follows the “**CLEAR**” steps:
 - C – Clear and audible; Clarify their needs i.e. ascertain what she already knows and needs more
 - L – Listen actively and carefully to what they have to say and address the various concerns they may have
 - E – Encourage her to confide in you, praise and accept her as she is
 - A – Acknowledge how she feels / demonstrate that you are listening
 - R – **R**eflect on the process and ask her to **R**epeat the message to reinforce understanding

Verbal and non-verbal behaviours of both the sender and the receiver are important to make the other comfortable, understand and interpret the message correctly. This facilitates attainment of the results desired from the communication process.

Components of an Effective Communication – “MSCREF”

To be effective communication process should be two-way / cyclical, actively involving the following components of communication.

- **M - Message** - The information, idea, feelings sent out or being shared / exchanged i.e. the core Maternal, Newborn and Child Health Messages.
 - The message should be clear, simple, and understandable.
 - It must be relevant to the needs of the woman, her family and their circumstances
 - Importantly, complex, difficult or unfamiliar messages must be simplified and presented at the level of the woman and her family.

- **S – Source or Sender** - The initiator of the communication process who oftentimes is the midwife though the woman initiates the communication process occasionally. When the midwife is the sender:
 - She introduces herself
 - She is not superior to the woman and her family, but they are in a purposeful partnership
 - She sits, talks, interacts with the client and her family at their level
 - She is empathetic. She puts herself in the client’s position and sees from client’s side to gain an understanding of why the client does or views things the way she does
 - The midwife respects the client and her family; appreciating and treating them with deserved dignity
 - She individualizes her expectations by not expecting the same pattern of response or behaviour from all the clients, or expecting all to follow same course / speed of change
 - The midwife understands herself i.e. her own attitude, beliefs, values, pressure of work, home situation and other factors that could interfere with the communication process, and she deliberately takes steps to manage them effectively.
 - Consistently assures woman and her family of her availability and willingness to assist them always

- **C – Channel or medium** - The means or way by which the information, ideas, feelings are shared or given out
 - Talk
 - Electronic media – Radio, Television, etc
 - Print Media – Newspapers, magazines, information leaflets, etc

Communication channels should ensure availability of feedback mechanisms. This is important for reinforcement and for clarifying questions and issues.

The choice of medium must be based on the background of the woman and her family. The social, educational, religious, cultural, economic etc context must be considered in the choice of medium and in the entire communication process, for effectiveness. Where possible, use more than one communication channel to emphasize the information. Channels that require more than one sense and active participation of the clients are very important in promoting and sustaining desired behaviours.

R – Receiver - The one getting / receiving the message from the initiator of the communication process oftentimes the client, her family and relations. Occasionally the midwife is the receiver. When the midwife is the receiver she:

- Listens actively
- Is supportive

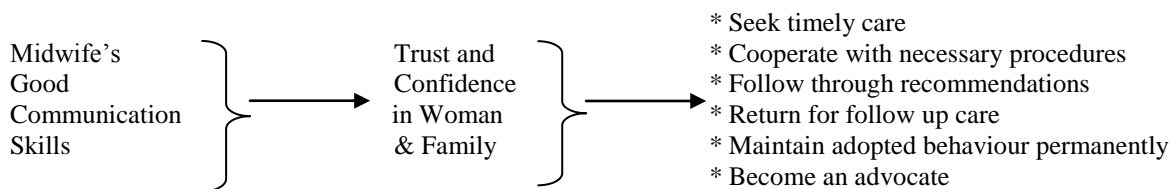
- **E – Effect** – The change in Knowledge, Attitude, Skills and Practice (Behaviour)
 - The appropriate application and utilization of information shared
 - Evidence that message was understood, met the needs of the client and was accepted / adopted
 - The ultimate in purposeful interaction / interpersonal communication for MNCH

- **F – Feedback** - Return of information to clarify or verify understanding
 - The midwife should make sure that the information exchanged in the process is understood by both parties involved
 - Questions asked, summaries, paraphrases, etc must be clear and related to the message and skilfully done to enhance the process towards achieving the goal of the communication
 - The midwife should encourage and repeat the feedback activities regularly and appropriately in the course of the communication

B. Interpersonal Communication and Counselling Skills

Importance of good communication to MNCH

Interpersonal Communication (IPC) is a face-to-face, person-to-person, verbal or non-verbal, exchange of information, feeling or opinion between individuals and requires specific skills to be effective. Interpersonal communication and counselling skills are the heart of midwifery practice and Behaviour Change Communication.



IPC/C Skills

1. **Establishing Rapport** – establishing a good relationship; it is fundamental; image making
 - Be friendly and welcome courteously e.g. greet clients appropriately, show them where to sit
 - Make clients comfortable and relaxed e.g. have comfortable seats, try to sit at the same level
 - Provide a place with few distractions e.g. no telephone, or interruptions from other staff or family members or heavy traffic
 - Ensure and maintain privacy and confidentiality even in small groups
 - Assure of partnership – trust, best interest of all, none superior to the other
2. **Observation** – picking verbal and non-verbal cues or signals
 - direct – what is obviously seen or heard
 - interpretive – making accurate sense of what is seen and / or seen
3. **Active Listening** – paying active / rapt attention
 - Reduce distractions in the immediate environment
 - Make sure everyone is seated comfortably and at the same level
 - Maintain eye contact within culturally acceptable limits
 - Use a warm tone of voice not betraying inward impatience
 - Use gestures and body language such as nodding head and smiling as indicated
 - Use verbal affirmation such as saying 'yes', 'ok', 'I see' 'ah ha' 'Mmmmm'
 - Ask questions related to what the woman and her family have told you to clarify your understanding
 - Repeat back i.e. paraphrase what you heard her say to you to confirm you understanding
 - Summarize key points of the discussion
 - Maintain good group control creatively
4. **Making positive statements** – motivating the client
 - Encouragement – giving supportive feedback indicates to the client that:
 - She is valued and important
 - She can succeed in spite of obstacles when provided with the means to succeed
 - Praise – giving approval or appreciation of what has been said / done indicates to the client that:
 - She is doing the correct thing
 - The correct behaviour is valued and should be continued
 - You care enough to take notice and have indeed taken note
 - Reassurance – comforting or giving client a reason to continue even when she feels inadequate or has failed indicate to the client that:
 - Failure is not limited to her and she can still succeed
 - The midwife actually understands
 - The midwife is a partner indeed
 - The relationship can continue
5. **Efficient Questioning** – inquiring, 'breaking the ice' or wanting more information
 - This should be done in ways that do not make the woman or her family uncomfortable
 - It should be non-judgmental and supportive
 - It should be done efficiently i.e. getting the right response by the most appropriate technique without wasting time and opportunities.

- a. *Open-ended questions*
 - They are recommended for meaningful interpersonal relationship / communication
 - They make many possible answers obtainable
 - They encourage the woman to talk about her situation
 - They explore client's emotions, feelings, beliefs, attitudes, knowledge and specific needs
- b. *Close-ended questions*
 - These are useful when only specific / definite answers are required
- c. *Prompts / Probes*
 - They are useful when more information is required on what client has said and should be asked with appropriate non-judgmental tone of voice
 - These encourage client to open up
- d. *Indirect questions (Recommended when issue is sensitive or may make client uncomfortable)*
 - Cover sensitive subject matters
- e. *Suggestive / Leading questions (Must not be used)*
 - Lead or force the woman or her family into an answer they may not have ordinarily given

6. Paraphrasing or Reflecting content

- Feeds back to the client the essence of what has just been said
- What client has said is shortened and the comments clarified
- Involves midwife using her own words and the important words of the client to check accurate understanding of what the client said

7. Summarizing the information exchanged

- This is similar to paraphrasing except that it is longer and more detailed
- Could be used to
 - begin or end an interview
 - transit to a new topic
 - provide clarity where issues discussed are lengthy and complex
- It goes over what has been shared in a ' nutshell'

8. Reflecting feelings

- The midwife observes and correctly interprets client's feelings
- She helps the client to clarify these feelings and attend to them appropriately

9. Providing accurate and appropriate information

- This skill is vital as many clients rely largely on the midwife for health information
- It is the responsibility of the midwife to access correct information

Barriers to effective communication:

- Language barrier
- Attitudes of the provider
- Previous knowledge of the subject matter by client
- Lack of knowledge of the subject matter by the midwife
- Economic status
 - Timing
 - Physical environment
 - Political constraints
 - Cultural beliefs and values
 - Emotions -Anger, boredom, happiness, frustration, disgust, disinterest, impatience, disapproval

How to Overcome Barriers to effective communication:

- Knowledge of the audience
- Knowledge of the subject matter
- Provision of relevant and credible information
- Avoidance of judgmental behaviour
- Use of simple, clear, and culturally acceptable language the audience understands

Small Group Sessions:

Sometimes midwives find it necessary / convenient to discuss with women in groups for various reasons:

- time
- workload
- topic will benefit many
- general awareness required

At such times, it is necessary to provide for the needs of different groups or categories of women she attends to in her facility so that the needs of every woman / family are satisfied and her services are friendly to such groups. The special group she needs to consider and plan for may include:

Women expecting first babies

- New mothers
- Women abused / living with violence
- HIV positive mothers
- Women with disabilities
- Adolescents etc.

Documentation / Record Keeping:

It is important in spite of the shortage of manpower and workload of the midwife that she documents her interaction with her clients including interpersonal communication and counselling. Such records:

- stimulate discussions and interaction
- remind the midwife of information to be communicated
- serve as reminder of previous communication
- provide information to make communication relevant to client's needs
- are useful in future discussions

Both individual and group sessions should be documented.

Group

1. Topic
2. Attendance
3. Special lessons useful for future planning (e.g. unusual question asked or uncommon household practice / myth revealed)
4. Documentation in clinic record book (e.g. ANC, postnatal, IWC, family planning)
5. Midwife's signature and date of talk or activity

Individual

Issues covered and decisions made should be documented in client's record appropriately (completeness, accuracy, legibility, timeliness, signature etc)

Summary

Positive change in behaviour, improvement in MNCH, and ultimate reduction in maternal, newborn and child morbidity and mortality is the goal of IPC/C for MNCH. Bad communication can mar this vision. Beware!

Activity

Participants work in their small groups:

1. develop hypothetical MNCH related cases
2. work in turns as the midwife / client
3. use the assessment checklist to assess the communication process and the IPCC skills
4. Summarize areas of strengths and weakness
5. Plans to improve weaknesses before next exercise
6. Present summary of activity in small group to the larger group

Resource Materials:

F.M.O.H (2005). Family Planning Training for Physicians and Nurses/Midwives - National Training Manual Abuja, Distributed by COMPASS Project with funding from USAID/Nigeria. This publication was originally produced under the VISION Project.

F.M.O.H, PATHS, et al. (2005). Training Manual on Life Saving Skills for Nurses/Midwives Abuja, PATHS Nigeria/Federal Ministry of Health, Nigeria.

the David & Lucile Packard Foundation and Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs (2006). An Interpersonal Communication And Counseling (IPC/C) Skills Training Manual For Health Care Providers - Trainers' Guide, FIRST KLASS, Ku Saurara!

WHO (2001). information, education and communication - lessons from the past; perspectives for the future, Department of Reproductive Health and Research, World Health Organization, 1211 Geneva 27, Switzerland or via e-mail from: rhrpublications@who.int World Health Organization WHO/RHR/01.22 Distr.: General.

WHO (2009). Counselling For Maternal And Newborn Health Care : a handbook for building skills Part 2 Counselling, Department of Making Pregnancy Safer, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

Counselling

Time: 120 minutes

Objectives – By the end of this session, participants will be able to:

- define counselling
- mention the purposes for counselling
- identify the qualities of a good counsellor
- describe six important steps in counselling
- state the factors that positively influence counselling
- follow the counselling steps in a client – provider interaction

Definition

- Counselling is a face -to-face communication where a provider enables a client to make an informed decision and act on it.
- Counselling is not advising. In advising the provider takes more responsibility for the decision. In counselling the client makes voluntary informed choice or decision.
- Counselling is the process of one person helping another make a decision or solve a problem with an understanding of the facts and emotion involved.

Purposes for Counselling

- To increase patronage of health facilities and utilization of services
- Provide an understanding of available services and assist the client to make informed decision
- Solve problem
- Increase and maintain the level of satisfaction of clients about services received
- Promote acceptance of health services to encourage continuity
- To reduce client's drop out rate
- To help clients develop positive attitudes and maintain good health seeking behaviour

Qualities of a Good Counsellor

- Knowledgeable
- Ensures confidentiality
- Good listener
- Shows interest
- Has self control and tact
- Non-judgmental
- Empathetic
- Honest and acknowledges limitation
- Approachable
- Has ability to create rapport

Factors That Positively Influence Effective Counselling

- Conducive environment, privacy and confidentiality
- Showing concern to the client
- Being flexible and patient
- Accuracy and completeness of information

- Use of appropriate visual aids
- Readiness of the provider to assist the client
- Positive attitudes of client towards the service provider's service
- Technical competence of the provider
- Positive attitude of provider toward the subject of the counselling session

When to Initiate Counselling

- When providing either curative or preventive services
- When client has expressed a need
- When provider has identified the need
- When the timing is convenient to the client

Effective Counselling Consists of Six (6) Steps Described By the Acronym "GATHER"

GREET the client in an open, respectful manner. Give her full attention. Assure the client of confidentiality. Ask the client how you can help, and explain what your facility can offer.

ASK client about herself. Help her talk about her needs. Pay attention to her expressions in words and gestures. Try to put yourself in the client's place. Express your understanding. Find out the client's knowledge, needs and concerns so you can respond helpfully.

TELL – provide specific information on the client's needs in a logical manner. Encourage client to ask questions

HELP client makes an informed choice. Help the client think about what course of action best suits her situation and plans. Encourage the client to express opinions and ask questions. Respond fully and openly. In the end make sure the client has made a clear decision.

EXPLAIN to the client – once the client has made a choice, the provider may possibly use IEC materials to remind client of important discussion points. Encourage questions and answers.

RETURN/REFER/REALITY CHECK

Return visits or referral should be planned. Client needs advice concerning when to return for follow-up or re-supply. This is also a time to do a reality check. Make sure they can apply what they have learned to real life situation.

Group Discussion - Challenging Moments in Counselling for MNCH

Developing awareness of our own particular dislikes blind spots or fears about making counselling mistakes or dealing with unexpected situations can prepare a counsellor to handle difficult moments. Every counsellor deals with inevitable surprises as well as nightmare moments. They are definitely challenging moments. The skill lies in how the counsellor recovers from these situations.

Challenging Moments in Counselling

- Silence
- Client does not stop crying
- Client believes there is no solution to his or her problem
- Counsellor makes a mistake
- Counsellor does not know the answer to the factual question
- Client refuses help
- Client is uncomfortable with the counsellor's gender, age, ethnic group etc.
- Counsellor is uncomfortable with the clients; gender, age, ethnic group etc.
- Counsellor cannot establish good rapport
- Counsellor and client know each other socially
- Client talks continuously and inappropriately
- Client asks personal questions to counsellor
- Counsellor is embarrassed by subject matter

Individual Exercise

Conclusion

Not every counselling session consists of all the six elements (GATHER) or flow in this order. Every counselling situation should be tailored to the client's needs. Clients often talk with counsellors several times before they decide to act. A counsellor should be prepared to see the client as the situation demands.

Resource Materials:

F.M.O.H (2005). Family Planning Training for Physicians and Nurses/Midwives - National Training Manual Abuja, Distributed by COMPASS Project with funding from USAID/Nigeria. This publication was originally produced under the VISION Project.

the David & Lucile Packard Foundation and Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs (2006). An Interpersonal Communication And Counseling (IPC/C) Skills Training Manual For Health Care Providers - Trainers' Guide, FIRST KLASS, Ku Saurara!

Review of the Use of Information, Education, and Communication (IEC) Materials

Time: 150 minutes

Objectives - By the end of this session, participants will be able to:

- explain the term “IEC materials”
- enumerate ten types of IEC materials
- discuss the advantages of using IEC materials to promote MNCH
- demonstrate the use of some IEC materials
- proffer solution(s) to the problem of not using / inappropriate use of IEC materials for MNCH in own facility

Definition:

IEC can be defined as an approach to change or reinforce a set of behaviours in a “target audience” regarding a specific problem in a predefined period of time. It is multidisciplinary and client-centred in its approach, drawing from the fields of diffusion theory, social marketing, behaviour analysis, anthropology, and instructive design. IEC strategies involve planning, implementation, monitoring and evaluation (WHO, 2001p.3)

IEC support materials assist service providers to make learning or counselling session interesting and easier to understand.

The aids are *not* substitutes for skillful face-to-face communication and counselling *but* tools to improve the quality of the sessions, and both provider and client satisfaction. They enhance the understanding and remembrance of the content of the material and subject of interest.

Types of IEC Materials:

Pamphlets, Leaflets, Flipcharts, Real Objects, Models, Posters, Wall Charts, Family Planning Commodities, Photographs, Radio, Audiocassettes, Cassette Recorders, Videocassettes, Video Player and Television

Discussion on Drawing Exercise:

It is often easy to assume that those with whom we interact understand our words and therefore our meaning.

1. Assumed they understood what we said
2. Assumed we were giving clear instructions
3. Assumed the words were enough to help understand what was being communicated.

IEC materials help the service provider communicate more effectively with clients and ensure a greater understanding of the information by the client.

Advantages of Using IEC Materials:

- Attracts the client’s attention
- Triggers discussion
- Helps client bring up questions
- Makes something very small (e.g. germs) big enough to be visible
- Can be used to compare similarities and differences (e.g. types of food)
- Shows steps in doing things (e.g. treatment of ITNs; hand washing)
- Shows changes (e.g. growth of a foetus from conception to delivery)

- Makes complex ideas easier to understand
- Can show things that people cannot see in real life (e.g. position of foetus in uterus)
- Can help when discussing a complicated topic like child survival
- Helps explain sensitive issues, such as condom use; HIV/AIDS
- Helps the clients remember important information / instructions
- Clients can take print materials home as reminders
- Clients can share print materials with husbands and friends
- Provides consistent information to all clients
- Increases client's level of understanding the information provided
- Shows the service provider's interest in the client
- Provides information on side effects and thus help clients cope with minor problems (e.g immunization)
- Helps client to make the best decision for their health needs
- Helps client to understand what to expect from their decision
- Helps client to understand what is happening inside the body e.g. position of foetus; stimulation of lactation

Misuse of IEC materials:

- When the support materials are used as substitutes for interpersonal communication
- When service provider gives support materials to the client before initiating any method
- When the material disrupts the smooth flow of the communication or counselling process
- When inappropriate material is used in motivational or counselling session
- Poor presentation for example when the material is placed too far from the audience, or service provider points to the picture or words which she may not be describing at that time

Process of Designing IEC Print Materials

- Know your audience through research - discussing the issues, questions, and rumours that concern clients and service providers
- Describe the information you want to pass and the key points
- Design the message and the material
- Pre-test the message and the materials with the intended audience
- Revise the materials and if necessary pre-test again until it is acceptable to the intended audience
- Finalize the material by incorporating ideas from the pre-test
- Print and distribute
- Use the materials appropriately

Factors that Ensure Acceptability and Effectiveness of IEC Print Materials

- Words and pictures should be easy to see
- Words and pictures should be easy to understand
- Information should be clear and unambiguous
- Text should be clearly linked to the illustration
- Text should address one theme
- Support materials should be appealing and captivating
- Language should be appropriate for the intended audience
- Message should be relevant, clear, precise, culturally acceptable, credible and timely

Limitations of Using Print IEC Materials

1. No opportunity for discussion unless Clinic Provider reviews with clients
2. Less effective with people who do not read
3. Can be easily lost and sometimes are thrown out without reading
4. Can be expensive to produce
5. The message may not be understood by audience; may need explanation
6. Cannot communicate many written messages
7. Not good for large groups
8. If not well made, pages may tear when flipping over
9. Audience may not remember everything if there is too much information.

Table 1: Advantages, Limitations and Uses of IEC Materials

Types of IEC Material	Advantages	Limitations	Uses
Pamphlets Booklets Leaflets	-Can be given out to large numbers of people -Clients can read at their own speed, as often as they want -Clients can share them with their family and friends. -They are easily produced	-No opportunity for discussion unless Clinic Provider reviews with clients. -Less effective with people who don't read. -Paper is not strong, they are easily lost and sometimes are thrown out without reading -Can be expensive	-For people who can read -To present words and pictures -For detailed information/instruction -To get information to a lot of people -To remind people of what they have been taught.
Posters (usually have one message, a slogan and a picture) Charts (usually have a lot of information) Photographs	-Can be made locally. -Can be used repeatedly. -Can be carried easily. -Can show things that cannot be easily demonstrated on real objects, (e.g. harmful practices - FGC) -Good for many topics.	- The message may not be understood by the audience; may need explanation. -Can be expensive because they are easily destroyed. -Making them require time for pre-testing. -Cannot communicate many written messages (text)	-To reinforce message -Small or large groups. -To be put in places where seen easily. -To promote an idea, event or service. -Can be used in counselling.
Flipcharts Flipbooks (A collection of pictures arranged in order and fastened at top.)	-Can be made locally -Can be made to suit needs of individual groups -Good for maintaining audience interest. -Can be used repeatedly.	-Not good for large groups -If not well made, charts may tear when flipping over. -Audience may not remember everything if there are too many charts.	-For step-by step presentation (e.g. instructions, story) -For small groups or individuals.
Models	-Close to reality; will lead to better understanding -Can be made in a larger form for clearer viewing. -Allows clients to practice a task or skills -Allows use of all senses	-May need skills and materials to make them. -Can be expensive -Can't use with large groups. -Easily damaged -Usually not as good for demonstration as real object or person.	-Giving instructions, demonstration (e.g. preparing oral Rehydration solution). -Good for one-to-one or small groups.

Discussion - Barriers to Using IEC Materials

- Why don't providers use IEC materials?
- How can the problem of not using IEC support materials be overcome?

How to Use IEC Materials

How to Use Posters

There are two kinds of posters: 1. Poster to motivate client 2. Poster to educate

- Display motivation posters in places of high visibility around your health centre, such as waiting rooms, counselling rooms and examination rooms. Think about what the poster is meant to do and who will see it. You also can use posters to stimulate discussion with your client.

- Ask Clients what they see and what it means to them. If correct, reinforce positively her understanding. If incorrect, correct the understanding in a polite and patient way.

How to Use Flipcharts

- Position the flipchart so that everyone can see it.
- Point to the pictures, not the text.
- Face the client or audience (for group talks).
- Move around the room for groups with the flipchart if the whole group cannot see it at one time.
- Try to involve the group.
- Ask the client(s) questions about the drawing to check for accurate understanding.
- If the flipchart has text, use it as guide, but familiarize yourself with the content so that you are not dependent on the text.

How to Use Booklets

Booklets are designed to reinforce or support verbal messages of health workers. If used properly they strengthen the messages you give to clients. The following are suggestions on how to use the booklets:

- Go through each page of the booklet with the client. This will give you a chance to both show and tell about a health problem or practice and answer any questions the client has.
- Point to the pictures, not to the text. This will help the client to remember what the illustrations represent.
- Observe the client's reactions. If your client looks puzzled or worried, encourage her to ask questions or talk about any concerns. Discussion helps establish a good relationship and builds trust between you and the client. A person who has confidence in his or her health worker will often transfer that confidence to the health practice decided on.
- Give the client the booklet. Suggest that she shares it with others, even if the client makes a decision not to adopt the health practice described.

How to Use Cue Cards / Information Cards

The **cue-cards** are designed for provider / Counsellor who are working in the clinic setting or those in the field. The cards are meant to assist provider to remember important information about MNCH issues which will be conveyed to the client so that they can informed choices. **Information cards** are designed to share with the client. They provide information in text and pictures in a concise, one-page format.

- Help client to feel comfortable: Give a warm greeting. Sit together with them for a while before starting a counselling session.
- Show "Information Card" to client: The best way to use information cards is to show it to client during counselling. When showing the card, involve the client as much as possible. People usually give more attention when given the opportunity to be actively involved and a part of a discussion. Try not to read the card. When you point to the card, you have to remember that the focus is still the client. Full eye-contact with client will be more effective in communication. Help them to come up with questions until they understand that they can ask whenever they want to. Let them hold the cards.
- Let the client choose (where options are available) before counselling about it. This will help her to make decision.
- Communicate slowly and clearly: At first, avoid technical terms which will not be understood by the client. Give time to go over all information on the card. You don't have to explain all contents of the card to the client, but make sure that they are exposed to the appropriate information more than one time if necessary.
- Show examples of real objects where applicable e.g. contraceptives. While reading or showing the card also show the real contraceptive method, and let her keep it. This will help her remember better.
- Help her make a decision: Remember (and remind her) that this is her choice. When she asks for suggestions, think about the wish, choice and the social history, medical history and physical examination of the client and let the client information guide you.
- Go over information on the choice: Once the client has made her decision, it is good to go over to how to use the method chosen e.g. infant breastfeeding option for HIV positive mothers. Ask client to repeat by giving explanation to you about the wish, choice and the medical history and physical examination of the client. If they are done, use questions written at the back of the card to help you and your client.
- Talk about the possibility of side effects: Clearly explain to them about the differences between side effects and early symptoms in choices that involve use of contraceptives or treatment methods. Act and think positively. Try not to make your clients over worried without good reason.
- Ask client to come back: Ask client to come back by deciding on the date. Tell her that she can come back earlier if she has questions. Show her that you really care.

How to Use Non-Print Media

- These means can also be used to provide information about MNCH issues and services. Use songs, jingles, plays, puppetry, television or radio programs, videotapes, and traditional dance during presentations to make people aware of MNCH issues and services. Drama could also be used to stimulate thinking about MNCH issues and services.
- As with print materials that are used in a group, non-print media are more effective when they can be seen and heard clearly by everyone in the group.
- To get the most out of non-print media:
 - Use non-print materials in groups. They are usually intended for an audience of more than one.
 - Be familiar with the materials.
 - Ask group members questions about what they have seen and /or heard

Practice Using IEC Materials

Each participant will have an opportunity (three minutes) to practice using IEC material with other two participants role-playing the client(s). The client(s) should provide feedback to the provider.

Counteracting Rumours

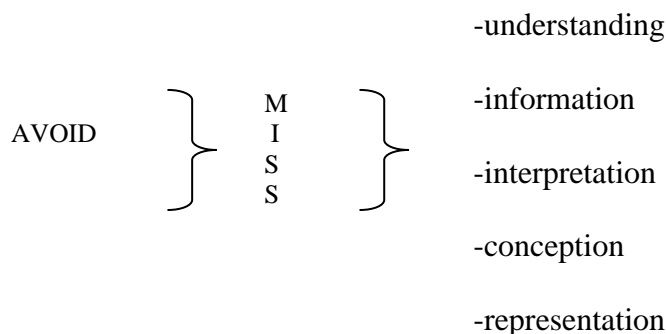
A **rumour** is inaccurate or untrue information that is passed from one person to another and the original source is unknown.

Information becomes distorted and details forgotten during a typical course of conversation. This results in rumours and misconceptions. An important job of service providers is to give correct information, to educate on MNCH issues and services.

Rumours and misconceptions are often the result of trying to make sense out of incomplete or confusing information. People often try to “fill in” or interpret information according to their own knowledge or values.

Possible causes of rumours:

- Inadequate or incorrect information on the provider’s side.
- Inadequate or incorrect information on the client’s side.
- Misinformation, either through intentional or accidental distortion of truth.
- Normal unintended results / side effects that are not adequately explained by the service provider or IEC material
- Cultural and personal values that appear to conflict with the MNCH issues and services being promoted.



- As midwives, we often encounter rumours and misinformation in the course of our work. It is not enough, however to simply tell clients that what they have heard or what they believe is wrong. We must **explain** or **show why** the information they believe is incorrect **in terms they can easily understand**.
- We have to do this **persuasively, politely and with respect for the client’s ideas and perspective**. Remember, we do not want to make clients feel stupid because they heard and perhaps believe some incorrect information. We all have been in their shoes at one point in our lives!

- Once the underlying reasons for a belief are understood, it is easier to find appropriate responses to counter incorrect information.
- A believable source with similar values and backgrounds can help counter rumours. Testimonials are a *great* tool in counteracting rumours.
- Consider the sources, such as *satisfied users* and *community leaders*, who would be valuable in combating rumours and how midwives can use their support.

To counteract rumours effectively, providers need to:

- a) Understand the cause of the rumour
- b) Explain why the rumour is not true and
- c) Provide the accurate information

Summary

IEC materials help both the clients and the providers when used appropriately. Misuse can be damaging. Use IEC materials with due consideration for the audience characteristics.

Resource Materials:

F.M.O.H (2005). Family Planning Training for Physicians and Nurses/Midwives - National Training Manual Abuja, Distributed by COMPASS Project with funding from USAID/Nigeria. This publication was originally produced under the VISION Project.

the David & Lucile Packard Foundation and Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs (2006). An Interpersonal Communication And Counseling (IPC/C) Skills Training Manual For Health Care Providers - Trainers' Guide, FIRST KLASS, Ku Saurara!

WHO (2001). information, education and communication - lessons from the past; perspectives for the future, Department of Reproductive Health and Research, World Health Organization, 1211 Geneva 27, Switzerland or via e-mail from: rhrpublications@who.int World Health Organization WHO/RHR/01.22 Distr.: General

Community Mobilization

Time: 60 minutes

Objectives – By the end of this session, participants will be able to:

- define community and community mobilization
- enumerate the benefits of community mobilization
- explain how community mobilization can improve clinic attendance of women and children for health services
- discuss how to overcome barriers to effective provider-community interaction

Community

A community refers to a social group of people living in a geographical area who have similar interests and needs, a common culture and a shared government.

Interacting with the Community

- The midwife is expected to work together with the community to promote MNCH.
- There are many benefits derivable from meaningful / effective interactions. These include:
 - Increased awareness of services
 - Learning community needs and expectations
 - Providing health messages and information.
 - Dispelling Rumours
 - Obtaining feedback about services
 - Increasing awareness of what the community can expect from providers and the health facility
 - Improving the image of the health provider

Community Mobilization

- Community mobilization involves harnessing community resources to achieve common community vision
- It involves encouraging people at the community level to participate and support development programmes for sustainability
- Community mobilization is essentially dependent on successful advocacy because it will be difficult to get the people except through their leaders
- Community mobilization should be focused, result oriented and cost effective

Benefits of Community Mobilization

- Multiplies resources
- Builds human resources and institutional (NGOs, CBOs, FBOs, etc) capacity
- Provides foundation for ownership and sustainability

How Community Mobilization Improves Clinical Attendance of Women and Children for Health Services

- Create awareness and generate interest on all health services / programmes
- Enhances acceptance of services e.g. Family Planning
- Builds partnerships e.g. with Traditional Birth Attendants (TBAs, Local Midwives)
- Improves and utilizes the resources available e.g. NURTWs
- Improves institutional capacity (NGOs, CBOs, FBOs)
- Engenders ownership
- Enhances sustainability by families and communities

The community assesses the existing situation based on available information, desires a change and finds ways of improving the situation, as well as accepts and adopts the innovations.

Community Members To Be Mobilized

- Men's groups
- Women's groups
- Youth associations
- Cooperative societies
- Opinion leaders
- Religious groups leaders e.g. CAN, FOMWAN, etc

Roles and Responsibilities of Target Groups

- Information sharing
- Mobilization of peers
- Mobilization of resources
- Planning, implementing, evaluating and sustaining programmes

Barriers to Interacting With the Community

Opportunities to interact with community members can be found through using the existing infrastructure such as schools, churches, mosques, cooperatives, women/men/ youth groups, community meetings, market places, water and firewood collection points, outreach services (e.g. Immunization programs), NGO community initiatives, work places etc. Spontaneous social gathering such as weddings, graduations, and funerals also provide an opportunity to impart health messages, correct misinformation, and increase awareness of health services.

Actively seeking out leaders, influential people and opinion makers can assist the provider in gaining access to community members, as well as gaining support for promoting healthy behavior within the community. Examples of these significant community figures might include local government officials and representatives, chiefs, health committee members, group leaders, "unofficial" leaders (opinion makers), TBA's and other traditional healers, religious leaders etc.

Barriers to provider and community interactions

Barriers to interactions can come from both providers and the community. These barriers need to be identified and actions taken to try and reduce or eliminate them.

Possible provider barriers:

- Lack of good client customer focused materials
- Lack of transport and allowances while away from the work site
- Multiple time demands at work and in personal life
- Shortage of facility staff
- Lack of support from management for community outreach activities
- Not knowing how to approach the community or access entry points
- concern that the community will have unrealistic demands for interaction such as providing medicines, treatment, etc
- Lack of experience in talking openly with the community or giving community health talks
- Fear of being confronted with questions or issues that they lack information about or cannot resolve
- Language barriers
- Going outside of the relative “safety” and familiarity of the health facility to provide health information.

Possible community barriers:

- Lack of time
- Life style circumstances
- Cultural or religious beliefs
- Provider’s perceived social status i.e. social gap
- Influence of authority figures (e.g. husbands) or influential leaders
- Gender bias
- Perception of providers as unfriendly, hostile etc
- Not seeing the relevance of proposed health topics or issues to their needs or interests
- Lack of motivation resulting from attitudes such as hopelessness, “nothing will change”, fatalism, etc

Discussion

- How can barriers to provider-community interaction be overcome?
- Consider inclusion of strategies to improve provider-community interaction in action plan

Summary

The midwife is in the community for the people. The people have a right to be involved in what affects them and their health. Community Mobilization is respect for the people’s right and leads to attainment of MNCH goals.

Resource Materials

the David & Lucile Packard Foundation and Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs (2006). An Interpersonal Communication And Counseling (IPC/C) Skills Training Manual For Health Care Providers - Trainers' Guide, FIRST KLASS, Ku Saurara!

UNICEF (.....) Training Manual on Advocacy and Community Mobilization In Support of the Prevention of Mother to Child Transmission of HIV

Values Clarification and Review of Core MNCH Messages

Time: 60 minutes

Objectives - By the end of this session, participants will be able to:

- define perception, values and attitudes
- describe the sources from which values are formed and factors that influence values
- discuss the importance of value clarification to MNCH
- examine and clarify their own values in relation to MNCH messages

Prior Activity:

- At registration for the workshop, participants are given copies of the MNCH core messages and advised to go through at their convenience:
 - Participants are to indicate **agree** (✓) or **disagree** (X) on the MNCH Message Statements

- There is no right or wrong answer to any of them
- They **must** either agree or disagree with each statement; they **must** make a choice

Introduction

People are a complex mix of unique characteristics which include physical characteristics, and emotional characteristics: perceptions, values and attitudes. When trying to communicate there will be many perspectives to the same issue. There is no 'right' or 'wrong' perception. Similar background and level of education do not guarantee that variations in values will not arise.

Perception

- awareness / knowledge gained through the senses
- understanding / illumination

Our perceptions are affected by our age, gender, social class, ethnic background, life experiences, etc. We may think that we see somebody clearly but personal perceptions influence or colour our visions as though we are wearing coloured eyeglasses. As a result, no two people perceive something / somebody exactly the same.

As midwives, it is often difficult to assess quickly what our client's values, attitudes and perceptions are, hence the need for efficient communication. If we do not understand our clients, we risk misleading them, helping them make a decision they don't feel comfortable with, or they are not ready to make or even losing them.

The professional midwife never assumes to know what her client's perspectives and values are about her health situation. She finds out what the client thinks, feels and knows about health conditions in order to provide appropriate, correct and factual information, and / or service that will be beneficial to the client and assist in the uptake and completion of services required

Values

- beliefs that are important to individuals
- social principles and standards held by individuals or groups that influence their daily life activities, decisions and attainment of their goals
- principle, standard or quality regarded as worthwhile or desirable
- things people believe in and attach importance to or those they are against
- they differ among individuals and groups
- Understanding values enables us relate better to other people

Sources from which Values are formed / Factors that Influence Values:

- Heredity – personality traits
- Traditions, Cultural factors
- Media – Television, music, videos, magazines, advertisements, cinemas
- Schools / Education
- Environment / community
- Technology
- Politics / Economy
- Religion
- Friends / peer groups
- Personal experiences / Personal needs
- Age
- Gender etc

It is noteworthy that views held about issues may change from time to time as people are exposed to different people and perspectives, such as when women are exposed to friendly services and BCC activities. It is also important for women and their family members to think and express their opinions about particular issues freely, and to recognize that their opinions may be different from others.

Values clarification

- Sorting out personal values (intrinsic) from the values of others and those of the larger society (extrinsic).

Why clarify values?

- Values are often so deep-rooted that it's possible not to be aware of them until one is confronted with situations that challenge such values.

- No ethical care can be provided by providers who have not objectively examined themselves to gain a good understanding of themselves, because the rule is, 'do unto others as you expect them to do to you'
- Clarifying our own values enables us to relate appropriately with others.
- By understanding their own values, midwives can appreciate and respect the various experiences that shape the values and belief systems of their clients.
- Appreciating our own perception and attitudes towards MNCH issues, helps us recognize that they may differ from our clients' and the expectations of designers of various health programs.

Steps in Values Clarification

- Use of values to guide behaviour
 - Defence of personal values
 - Prioritization of personal values
 - Identification of personal values
-

Attitudes

- a state of mind or a feeling
- views or opinions that are formed by values and beliefs (largely based on our personal values and perceptions)
- mental position individuals take, in relation to the world or society

Group Exercise:

Attitude towards some MNCH Messages (*Opinion Poll*)

- Each MNCH Message statement will be read out
- If participants agree or disagree with the statement when it is read out, they indicate by signs decided by the house.

Summary:

- It is the midwife's responsibility to understand the client's values, attitudes and perceptions as much as possible to facilitate midwife-client interaction and achievement of safe motherhood goals.
- The variation in values and person's choice is a fact of life. No one is wrong or right.
- It is important to respect other people's values because it is crucial in counselling for MNCH, especially sensitive areas such as family planning.
- If clients present with situations, which are difficult to handle because of our values, we should find a skilled provider who can assist the client rather than being judgmental.

Resource Materials:

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Messages for Maternal, Newborn, and Child Health

Health messages should be appropriate to individual needs, gestational age, and related to most prevalent health issues.

Maternal Health Messages

1. Antenatal attendance

- Quality ANC from a friendly midwife encourages better Antenatal care attendance.
- During pregnancy, delivery and after delivery, pregnant women need regular health care
- The Focused AnteNatal Care (FANC) is evidence-based, client-centred, goal-directed care provided by skilled health providers with emphasis on **quality** rather than **frequency** of visits.

The midwife should inform / encourage / advise women to:

- Register for care as soon as pregnant
- Receive regular antenatal care to keep mother and baby strong and healthy
- Attend antenatal clinic at a health facility at least 4 times spread over the three trimesters in pregnancy even if no problem
- Visit the clinic any time in need of help for mother or baby
- Expect the following at the clinic:
 - Checking of your health and the progress of the pregnancy
 - Help in making a birth plan
 - Answers to questions or concerns
 - Treatment for malaria and anaemia
 - Tetanus immunization
 - Advise and counsel on:
 - Breastfeeding
 - Birth spacing after delivery
 - Nutrition
 - HIV counselling and testing
 - Correct and consistent condom use (if indicated)
 - Laboratory tests
 - Other matters related to mother and baby's health
- Obtain care from a skilled birth attendant – a trained doctor, midwife or nurse

The midwife should:

- assure the client that skilled attendants are partners with women and their family
- conduct a risk assessment and also counsel woman accordingly

2. Prevention of Malaria in Pregnancy

- Malaria is endemic in Nigeria and is one of the major causes of maternal deaths
- Fighting malaria is an investment in our future
- Fight malaria – fight poverty
- Inform mothers of the preventive measures which are:
 - Personal protection (wear cloth that do not expose her body to mosquito)
 - Clean environment that does not encourage breeding of mosquitoes. Drain places where water collects, cover water containers or tanks and clear bushes around your house to reduce the number of mosquitoes that transmit malaria
 - Use of door and window nets (ITNs) or mosquito repellent creams
 - Intermittent preventive treatment (IPT)

3. Practice of Intermittent preventive Therapy (IPT) for malaria

Support promotion of IPT for the prevention of malaria in pregnancy

Midwife should inform women that:

- Intermittent Preventive Therapy (IPT):
 - prevents malaria
 - is safe
 - reduces delivery of Low Birth Weight babies and other complications of malaria fever
- They should receive treatment only from the clinic / hospital and follow the instructions given

4. Use of insecticide treated nets (ITNs)

- Midwife should:

- Advise that every member of the family, especially children under 5 years, and pregnant women, be protected from malaria by sleeping under Insecticide Treated Nets (ITN)
- Explain why it is important to use ITNs – Protects against malaria
- Demonstrate how to use ITNs
- Discuss how to get it
- Describe how to re-treat all mosquito nets in the house with long lasting insecticide to kill mosquitoes

5. Sexually Transmitted Infections (STIs)

- These are infections that are transmitted through sexual intercourse e.g. gonorrhoea, syphilis, Chlamydia, HIV / AIDS etc.
- These infections can affect both mother and the foetus.
- Advise partners to use condom correctly in every sexual relation to prevent sexually transmitted infection (STI) or HIV / AIDS if at risk of infection

6. Voluntary Counselling and Testing (VCT)

- This is a process by which an individual undergoes confidential counselling to enable him / her make informed choice about his / her HIV status and take appropriate action.
- Inform mothers that:
 - It is good to know HIV status by doing the test
 - Benefits of pregnant women knowing HIV status include:
 - Being sure of her status, if HIV-positive or HIV-negative
 - If HIV-negative, she can learn how to remain negative
 - If HIV-positive, she can learn how to live positively and care for herself and her infant
 - Revision of her birth and emergency plan to make sure she gives birth in a facility with a skilled attendant
 - She can share HIV test results with partner and encourage him to get tested
 - Special care and treatment to prevent HIV transmission to the infant is available
 - Care, nutrition support, counselling, and follow-up is available for women infected with HIV and HIV-exposed infants
 - Long-term treatment (AntiRetroVirals – ARVs) for women infected with HIV, baby, and family are available in some places
 - It is good to take advantage of available pre- and post-test counselling
 - Mother-to-child transmission of HIV could occur during pregnancy, delivery or breastfeeding
 - Mother and baby can be protected if mother's status is known early
 - Partner should use condom correctly in every sexual relation to prevent sexually transmitted infection (STI) or HIV / AIDS if at risk of infection
 - Prevention of mother-to-child transmission can be achieved by:
 1. use of antiretroviral drugs
 2. elective abdominal delivery (Caesarean section)
 3. infant feeding options

7. Identification of danger signs in pregnancy

- Ensure that the woman, husband and family know the danger signs in pregnancy, which indicate a need to implement the complication plan.
- Inform the woman:
 - that early identification of danger signs and prompt management reduce complications
 - to go to the clinic / hospital for help immediately if any of the following is noticed:
 - ii. vaginal bleeding
 - iii. convulsions / fits / fainting
 - iv. severe headaches with blurred vision
 - v. fever / feeling ill
 - vi. strong abdominal pains
 - vii. fast or difficult breathing
 - viii. swelling of face, hands, legs, feet,
 - ix. foetal movements reduces/stops for days
 - x. labour pains before 37 weeks
 - xi. water breaks and not in labour
 - xii. abnormal weight pattern (excessive or inadequate)
 - xiii. paleness inside the eyelids

8. Signs of Labour

- Ensure that she knows the signs of labour, which indicate a need to contact the skilled provider and enact the birth preparedness plan. These are:
 - xiv. Regular, progressively painful uterine contractions
 - xv. Lower back pain radiating from uterine fundus
 - xvi. Blood stained show / bloody sticky discharge
 - xvii. Breaking of the bag of water (rupture of membranes)

9. Tetanus Toxoid Immunization during pregnancy

All women 15 – 49 years of age should be immunized against tetanus

Every woman aged 15 – 49 years should have 5 vaccinations against tetanus

Give Tetanus Toxoid injection during the antenatal period to pregnant mothers to protect them and their babies against tetanus.

- Explain need for it
- Explain number of doses at least (2 doses) and when having / next dose

10. Birth preparedness and complication readiness

- It is the process of planning for safe delivery and anticipating the actions needed in case of emergencies.
- If a woman is well prepared for normal childbirth and possible complications, she is more likely to receive the skilled and timely care she needs to protect her overall health and possibly save her life and that of her baby
- Preparation and readiness make child birth less burdensome
- Discuss with the mother the elements of birth plan:
 - Skilled Provider - Who to assist in taking the delivery (Midwife / Nurse/ Doctor/ other)
 - assist the woman in making arrangements for a skilled provider to attend the birth;
 - this person should be trained in supporting normal labour / childbirth and managing complication if they arise
 - make sure the woman knows how to contact the skilled provider or health care facility at the appropriate time
 - Place for Delivery - Where to deliver (Preferably in an orthodox health centre/ hospital - name facility)
 - assist the woman in making arrangements for
 - place of birth (whether at the district hospital, health center, community health post) depending on her individual needs, you may need to recommend a specific level of health care facility as the place for delivery, or simply support the woman in giving birth where she chooses
 - where to go during emergencies (Preferably in an orthodox health facility that opens 24 hours and with skilled birth attendants – name facility)
 - Transportation -
 - make sure she knows the available transportation systems within her locality and that she has made specific arrangements for (source of transport and transport fare):
 - transportation to the place of delivery
 - emergency transportation to an appropriate health care facility if danger signs arise
 - Funds - How to raise money for delivery and possible birth in emergencies (Savings, Thrift / Loans, Others)
 - ensure she has personal savings or other funds that she can access when needed to pay for care during normal birth and emergency care if relevant,
 - discuss emergency funds that are available through the family, community and / or health facility
 - Decision-Making
 - ask who makes decisions in the family
 - ask who else can make decisions if that person is not present
 - Support – Who will escort pregnant woman for delivery or emergency (Husband / relation, Friend, Community safe motherhood “link”, other)

- assist the woman in deciding and making arrangements for necessary support, including:
 - companion of her choice to stay with her during labour and childbirth, accompany her to a referral centre if need be
 - someone who will be close by for at least 24 hours after delivery
 - someone to care for her house and children during absence
- Blood Donor – Compatible blood donors who will help if needed
 - ensure that the woman has:
 - identified an appropriate blood donor and that this person will be accessible in case of emergency
 - provided the names of such people
- Items Needed for a Clean Birth and for the Newborn
 - Make sure the woman has gathered necessary items for a clean and safe birth.
 - *for the birth*: perineal pads / cloths, soap, clean bed cloths, placenta receptacle, new unused razor blade, waterproof / plastic cover, cord ties, etc.
 - *for the newborn*: blankets, diapers, clothes, etc
 - *for herself* : what she will wear after delivery
 - Advise her that the items should be kept together for easy retrieval when needed.
- Advise pregnant woman to talk to her family, community and trained health providers to better manage any complications and ensure safety of baby and mother
- **Note**: Items needed depend on the individual requirements of the intended place of birth. Kaduna State Obstetric and Perinatal Records included items like: 2 pairs of gloves, 1 ampoule of Pitocin, 1 bottle of JIK, baby towels, baby clothing, sanitary towels, clean razor, and clean cord tie.

11. Delivery by skilled birth attendants / Danger signs in labour

- For safety of mother and baby, deliveries should be handled by skilled birth attendants. These are trained and qualified midwife / nurse / doctor
- Explain why delivery needs to be with a skilled birth attendant, and preferably at a facility
- Encourage women to deliver in the clinic / hospital
- Inform women that it is preferred that they come to the clinic / hospital once their labour starts, however, if during delivery they are not in the facility and they observe the following they should go to the hospital immediately day or night and should not wait:
 - labour lasts longer than 12 hours
 - cord prolapsed
 - abnormal presentation
 - labour pains (contractions) continue for more than 12 hours
 - Heavy bleeding (soaks more than 2-3 pads in 15 minutes)
 - Placenta not expelled 1 hour after birth of baby
 - Baby is very small
 - Baby breathes with difficulty
 - Baby fits
 - Baby has fever
 - Baby feels cold
 - Baby is bleeding
 - Baby is not able to feed

12. Recognizing dangers signs in the postnatal period

- Early recognition and management of danger signs during post partum period saves lives. Encourage women to:
 - Go to the clinic / hospital as soon as possible if delivered at home for mother and baby to be examined and receive preventive measures
 - Go to the clinic / hospital immediately if any of the following is noticed; explaining why they are danger signs:
 - i. increased / heavy vaginal bleeding
 - ii. fits
 - iii. fast and difficult breathing
 - iv. severe headaches with blurred vision
 - v. fever
 - vi. bad smelling vaginal discharge
 - vii. swollen, red or tender breasts and nipples

- viii. increased pain in the perineum
- ix. infection in the area of wound (redness, swelling, pain, or pus in wound site)
- x. problems urinating, or leaking
- Attend routine postnatal clinic at 6 weeks to receive a post-natal check up after delivery for necessary medical advice to ensure mother and baby are healthy

13. Family planning practice (FP)

- Family planning is the first pillar of safe motherhood
- If not breastfeeding exclusively, woman can become pregnant within weeks of delivery
- Waiting to become pregnant at least 24 months after birth can lead to health benefits for the mother and baby
- Spacing births allows the mother to recover physically and emotionally before she gets pregnant again, and faces the demands of pregnancy, birth and breastfeeding.
- Fewer children in a family mean more resources for each child, and more time for the parents to dedicate to each child.
- Delaying having children can give people the opportunity to complete education or further studies.
- Family planning can also help couple to enjoy sex more because they are not concerned about getting pregnant.
- STIs including HIV AIDS can also be prevented with correct and consistent use of condoms.
- Younger women (adolescents) can delay pregnancy until their bodies are mature and they are ready in terms of their life course.
- Older women (over 35) can prevent unwanted pregnancies that are often risky for their health, and can lead to complications for both mothers and infants.
- Family planning reduces the risk of mothers and children dying from too soon, too frequent, too many, and too late pregnancies
- Inform women about:
 - services that are available for women and men including counselling
 - availability and readiness of providers to answer their questions and attend to their concerns about family planning
 - how to access commodities
- Advise to see the health provider or talk to the family planning provider about choosing a family planning method which best meets couple's needs

14. Male involvement in maternal care:

Rationale for Male Involvement and Participation

- The need to promote the observance of human rights and to enforce equity
- A man should be socially and economically responsible for his nuclear family
- Men have specific Reproductive Health needs information and services; these include knowledge in family planning such as use of male contraceptive methods and devices, and screening services for good health
- Involvement of men to increase contraceptive prevalence and acceptance
- Prevention of HIV / AIDS and other STIs
- The need to prevent gender-related violence
- Increased male support (economical, social and health) to spouse / partner Improve espousal communication
- Male involvement ensures improvement in maternal healthcare and the wellbeing of the family.
- Male involvement in birth preparedness / complication readiness / family planning / child care etc can help reduce 'delays' in decision-making
- Husbands are key decision makers in maternal and newborn care-seeking behaviour.
- They should understand the needs, risks and danger signs of pregnancy, child birth and postpartum periods to support the women.
- The role of men as husbands, fathers and partners in providing the required support is defined by the interplay of cultural aspects of pregnancy, child birth and postpartum care.

The midwife should:

- Create awareness on need to involve men in maternal health
- Make services men-friendly
- Include men in family planning
- Encourage women to feel free to invite or come to the facility with their partners

Encourage the men as follows:

- Make sure that your wife obtains antenatal services at a health facility at least four times during her pregnancy. The care will keep her and the baby strong and healthy

- Help your wife have a safe and healthy pregnancy. Ensure that she sleeps under ITNs to protect her against malaria
- Know the warning signs of pregnancy. Take your wife to a health facility as soon as any danger sign is noticed
- Plan with your wife for a safe birth by talking to your family, community and service provider about a safe birth plan
- Ensure your wife goes for a post-natal check up after delivery to promote her health and that of the baby and to receive necessary medical advice when appropriate
- Encourage your wife to breastfeed the baby for the first six months of life to promote the health of the baby and the mother. This also helps to prevent unplanned pregnancy
- Be a wise man, protect your baby from HIV infection, go for VCT with your pregnant wife / partner
- Help your wife to have a safe and healthy pregnancy. Ensure she gets enough rest by assisting her with domestic work

15. Utilization of health services

- Establish good relationship with client and family to promote utilization
- Assure client and family of continued support of health facility and staff
- Emphasize the available services and that the personnel are always ready to assist
- Explain procedures nicely and clearly
- Encourage facility based delivery as the best option for mother and baby
- Encourage women to go to health facilities early when they or their children are ill to prevent complications

16. Harmful traditional practices

- Every society has harmful, harmless and helpful practices
- Make use of helpful practices that promote MNCH
- After delivery, avoid harmful traditional practices such as sitting or bathing in very hot water, eating food with excess potash, insertion of corrosive substances in the vagina and Female Genital Cutting
- Strongly discourage women against harmful practices that have negative consequences.
 - Do not use local medicines to hasten labour
 - Do not wait for waters to stop before going to the clinic / hospital
 - Do not insert any substances into vagina during labour or delivery
 - Do not push on the abdomen during labour or delivery
 - Do not pull on the cord to deliver the placenta
 - Do not put ashes, cow dung, close-up, or other substances on umbilical cord / cord stump

17. Nutrition

- Advise client on adequate nutritious diet (proteins, carbohydrates, fats, vitamins and micro-nutrients) from locally available sources e.g. cereals, beans, meat, fish, eggs, milk, orange or yellow fruits and green leafy vegetables
- Inform that eating nutritious foods during pregnancy helps build strength for labour and delivery and keeps mother and baby strong and healthy
- Advise to drink plenty of clean and safe water
- Dispel myths and taboos about useful and nutritionally healthy food items

18. Rest, Sleep and Exercise:

- Emphasize the need for adequate rest and exercise during pregnancy
- Advise to:
 - Rest as much as she can; have more rest during the day than before
 - Avoid lifting / carrying heavy objects
 - Avoid hard physical labour
 - Avoid emotionally stressful situations

19. Social habits / lifestyle (smoking, cola nut):

- Discourage smoking, alcohol consumption and harmful substances which may interfere with the utilization of useful nutrients, foetal growth and development
- Counsel on stopping smoking and alcohol and drug abuse

20. Personal hygiene:

- Advise on personal hygiene
- Encourage to:

- Have bath at least once a day
- Pay particular attention to the hidden areas like the perineum, vulva, under the armpit, under the breast etc
- Wash perineum after faecal excretion
- Change pad after delivery, at least 4 to 6 hourly or when soaked to avoid it carrying germs
- Wash / dispose the pads appropriately

21. Hand Washing

- Explain to mothers that:
 - Correct hand washing with soap at critical times can reduce diarrhoea by 47%
 - Hand washing with soap or ash and hygiene are important to fight against polio
 - Hand washing with soap is critical at birth for safe delivery to avoid infection
 - To stay healthy we need to wash our hands regularly with soap or ash
- Advise to:
 - Wash hand with soap to effectively prevent the spread of diseases
 - Wash hands with soap after visiting the toilet, before handling food and after changing baby's napkins

22. Environmental sanitation:

- Advise on environmental hygiene
- Encourage to keep environment clean in and out

23. Drugs in Pregnancy:

- Educate women on the dangers of drugs in pregnancy
- Advise to:
 - Avoid use of drugs not prescribed
 - Not to take drugs unless prescribed by the doctor, midwife or nurse at the clinic / hospital
 - Take drugs as explained
 - Avoid self medication
- Ensure compliance with prescription

24. Dressing in Pregnancy:

- Be aware of culturally acceptable dressing for women
 - Advise women to wear free and comfortable dresses
 - Encourage them on appropriate shoes

Newborn Health Messages

1. Immediate newborn care

- Skilled birth attendant and facility delivery is important because it ensures safety of lives of mother and baby
- Encourage facility based delivery
- Assure women of willingness to support all through
- Ensure conducive environment for delivery
- Keep environment warm
- Explain why necessary to keep baby warm (overexposure of the baby to cold can lead to death)
- Do not expose the baby to direct sun
- Do not put baby on any cold surface
- Counsel mother on care of newborn

2. Clean delivery practices

- Encourage facility based delivery; it is the best option
- Encourage individual birth plan (IBP)
- Encourage use of Mama Kit
- Educate that clean environment prevents infection of mother and baby during delivery

3. Care of cord

- Cutting cord with hygienic material prevents infections and death of newborns

- Educate mother and caregivers to:
 - Avoid touching the stump unnecessarily
 - Keep cord stump loosely covered with clean clothes
 - Fold diapers and clothes below the stump
 - Clean soiled stump area with soap and water and dry completely
 - Clean the cord regularly with spirit or gentian violet to prevent infection
 - Wash hands properly before and after cleaning the cord

4. Care of the eye

- Inspect babies' eyes immediately after delivery
- Advise mother to:
 - Keep baby's eyes clean with water and cotton wool to prevent infection
 - Observe babies' eyes daily for discoloration, discharge etc
 - Take baby to the clinic / hospital immediately she sees any change in colour or condition of the baby's eyes

5. Take newborn for immunization

- Ensure availability of vaccines in facility
- Newborns should be taken for immunization
- A baby must receive the first vaccines soon after birth
- Explain that:
 - The baby needs immunization after birth to protect against the endemic childhood killer diseases, including tetanus.
 - Vaccines are safe and free.
 - All children with minor illnesses such as fever, cough, malnutrition or disability can be vaccinated
 - Take your child under five years to the nearest health centre for immunization
 - Immunization protects child from diseases that disable or kill them
- Explain the immunization schedule
- Encourage caregivers to complete immunization for their newborns to save them from killer diseases
- Encourage caregivers to always bring the child's vaccination card and health card with them during visits to the health centre

6. Breast Feeding of the Newborn

- Educate during ANC and IWC
- Teach on care of the breast as follows:
 - Pulling the nipple after oiling in cases of flat or retracted nipples
 - Need to seek medical attention where nipples are persistently inverted
- Ensure mother knows that
 - Breast milk is the best for the baby
 - Exclusive breastfeeding from birth up to 6 months and on demand has advantages
 - Complimentary feeding can be introduced from 6 months using locally sourced food items
 - Baby's suck stimulates milk production – the more he / she sucks the more the milk
- Dispel myths about colostrum
- Initiate breastfeeding early:
 - Assist mothers to initiate early breastfeeding
 - Start breastfeeding within 1 hour of birth
 - Keep baby in bed with mother or within reach immediately after birth
 - Give baby the first milk (colostrum) immediately after delivery. It is nutritious and has antibodies to help keep baby health
 - Ensure baby attaches well to the breast to reduce breast problems for the mother and exhaustion / discouragement for the baby
- Teach, demonstrate, assist and encourage to position baby properly
 - Proper positioning - Show the mother how to hold her baby. She should:
 - Make sure the baby's head and body are in a straight line
 - Make sure the baby is facing the breast, the baby's nose is opposite her nipple
 - Hold baby's body close to her body
 - Support the baby's whole body, not just the neck and shoulders
 - Attachment of the baby on the breast - Show the mother how to help her baby to attach. She should:

- Touch her baby's lips with her nipple
- Wait until her baby's mouth is opened wide
- Move her baby quickly onto her breast, aiming the infant's lower lip well below the nipple
- Signs of good attachment - Look for signs of good attachment:
 - Breastfeed with the nipple and the brown area surrounding the nipple
 - Mouth wide open
 - Lower lip turned outwards
 - Baby's chin touching breast
 - Proper attachment allows baby suck well
 - Look for signs of effective suckling (that is, slow, deep sucks, sometimes pausing)
 - If the attachment or sucking is not good, try again. Then reassess
- How to wind baby after each feed
- Advise her on the need to allow baby feed and remove his mouth from the breast
- Encourage mother to allow baby to feed well before disengaging his mouth from the breast
 - At each feeding, let the baby feed and release the breast, and then offer second breast.
 - At the next feeding, alternate and begin with the second breast
- At night let baby sleep with mother within easy reach
- Mention the advantages of breastfeeding for the baby:
 - Early exclusive breastfeeding helps the growth of newborn
 - A complete meal
 - Contains all the nutrients the baby needs to grow and continues to provide high-quality nutrients and helps protect against infection up to two years of age or more.
 - Contains antibodies that gives immunity to the baby
 - Reduces risk of respiratory tract infections, gastro-intestinal tract irritations e.g. diarrhoea
 - Reduces the skin reaction caused by foreign elements in artificial feeds
 - Helps in the baby's intellectual growth
 - Is readily available at all times for the baby
- Mention the advantages of breastfeeding for the mother:
 - Reduces the risk of postpartum haemorrhage by helping the mother's uterus to contract after birth
 - Encourages emotional relationship, or bonding, between mother and infant
 - Breastfeeding exclusively day and night can help delay a new pregnancy providing contraception (Lactational amenorrhoea)
 - Lowers the rate of breast and ovarian cancer in the mother
 - Promotes a faster return to mother's pre-pregnancy weight.
- Advise to:
 - Drink plenty of clean and safe water while breastfeeding
 - Eat more and healthier foods while breast feeding
 - Rest as much as possible
 - Seek counsel from the health worker if need help with positioning the baby, what to do if have to leave baby for a while
 - Seek help (or come back to see you) if the baby is not feeding well or if she has any difficulties with breastfeeding, sore nipples or painful breasts.
- If is necessary to express breast milk, show the mother how to do this and show her how to feed expressed milk by cup.
- Refer to infant feeding counsellor if necessary
 - Do not force the baby to take the breast
 - Do not interrupt feed before baby wants
 - Do not give any other feeds or water
 - Do not use artificial teats or pacifiers

7. Warmth for Newborn

- Ensure mother knows that newborn needs more clothing and warmth than older children and adults
- Advise her to:
 - Dress baby and not to expose unduly
 - In cold, to put a hat on baby's head and cover with extra blanket in cold nights

8. Safety for newborn

- Provide mother with safety tips to protect newborn from harm:
 - Do not put baby on his / her face to avoid suffocation; better on back or side

- Do not use soft pillows for newborn baby
- Keep baby away from smoke or people smoking so that the breathing is not disturbed
- Keep baby away from sick children and adults
- Check the temperature of water before using it to bath baby
- Watch bigger children when with newborn
- Avoid introducing sharp or blunt objects into orifices
- Avoid harmful practices such as female genital mutilation, scarification etc

9. Disease Prevention

- Wash face and neck daily
- Bath baby when necessary
- Dry baby's body well, dress and keep warm
- Wash bottom when soiled and dry properly
- Wash hands with soap and water before and after touching the newborn and adults to prevent infection and disease transfer to the newborn and cross infection

10. Recognizing dangers signs in the newborn:

- Take baby to clinic / hospital immediately if you notice any of the following:
 - Difficult breathing
 - Fits
 - Fever
 - Feels cold
 - Bleeding
 - Stops feeding / difficulty feeding / feeds less than every 5 hours
 - Diarrhoea
 - Pus coming from the eyes
 - Irritated cord with pus or blood
 - Yellow eyes or skin

11. Care of the low birth weight baby using Kangaroo Mother Care (KMC):

- LBW babies can be salvaged using kangaroo method of nursing
- Explain KMC to mothers of LBW babies
- Explain the importance

Child Health Messages

1. Exclusive Breast Feeding (EBF) for 6 months:

- A child starts a healthy life with exclusive breastfeeding
- Promote exclusive breastfeeding in your community
 - During the first 6 months of life, baby needs nothing more than breast milk; Breastfeed baby exclusively for the first six months
 - Colostrum (first yellow milk) is very important for baby's health, do not throw it away
 - Baby does not need water, other milk, cereals, tea, juices, herbal concoctions, etc in addition to breast milk
 - Breast milk contains the exact amount of water and nutrients the baby needs
 - Breast milk is easily digested by baby's system
 - Baby's body uses mother's breast milk more efficiently
 - Breast milk protects baby against infections and allergies
 - Mother's breast milk helps baby grow and develop well

2. Feed children with energy-rich and nutrient-dense complementary foods from 6 months while continuing breastfeeding up to 24 months:

- Introduce enriched complementary foods from 6 months for proper growth and development of baby
- Encourage to breastfeed up to 24 months
- Explain importance of breastfeeding up to 24 months
- Encourage the use of spoon and plates to feed babies 6 months and above and explain importance
- Educate and demonstrate complementary foods choice, preparation and feeding at ANC and IWC

3. Growth Monitoring and promotion (GMP):

- Proper growth monitoring of a child helps early detection of poor growth and development
- Weigh child regularly and properly
- Counsel caregivers after weighing the child
- Motivate mothers by giving pluses or some positive reinforcers
- Important to chart weight

4. Psycho-social and mental development:

- Encourage adequate child stimulation from the womb
- Discuss benefits and methods of early child stimulation (Early stimulation of children encourages proper mental and psycho-social development)
- Discuss use of local toys made with local materials

5. Adequate micro-nutrients through diet and supplementation

- Educate on provision of energy-rich and nutrient-dense complementary foods for all children from local sources
- Teach how to identify vitamin A / iodine fortified foods and salt in the market
- Advise to include fruits and vegetables in children's meals
- Discuss local sources
- Demonstrate dietary diversification
- Encourage to give child different kinds of food for proper growth and development

6. Take child to complete full course of immunization

- Maintain good routine immunization practice
- Educate during ANC and IWC on full course of immunization
- Explain benefits of immunization to caregivers (to protect from childhood killer diseases)
- Encourage caregivers to take their children for full immunization before their first birthday
- Educate caregivers on how to manage the unpleasant reactions of immunization

7. Home management of infections

- A child with malaria must take a full course of antimalarials treatment, even if the fever disappears
- Take a child with fever to a trained health worker immediately for appropriate treatment
- Breastfeed children with fever as often as possible
- Educate caregivers on appropriate / correct home treatment for infections (e.g. use of antimalarials) to prevent deaths
- Diarrhoea drains out too much liquid out of a child's body. So, give the child extra drinks to replace the lost liquid
- Give increased fluid like Oral Rehydration Salts solution (salt and sugar solution) solution or rice water and zinc when a child has diarrhoea
- Take a child with diarrhoea to a health worker if there is blood in stool or fever

Resource Materials:

F.M.O.H (2005) *Family Planning Training for Physicians and Nurses/Midwives - National Training Manual* Abuja, Distributed by COMPASS Project with funding from USAID/Nigeria. This publication was originally produced under the VISION Project.

F.M.O.H (2009) *Programme Communication Plan for Maternal, Newborn and Child Health*, Federal Ministry of Health, Abuja (**Unpublished – development in progress**).

F.M.O.H, PATHS, DFID & WHO (2005) *Training Manual on Life Saving Skills for Nurses/Midwives* Abuja, PATHS Nigeria/Federal Ministry of Health, Nigeria.

F.M.O.H, USAID & COMPASS (2006) *National Clinical Service Protocol for Obstetric and Neonatal Care*, Abuja, Federal Ministry of Health Abuja, Nigeria.

F.M.O.H, WHO., PATHS, UNFPA, UNICEF & DFID (2005) *Behaviour Change Communication Strategy for the National Reproductive Health Policy and framework*

Kaduna State Government (2009). *Obstetric and Perinatal Records*. Kaduna, Kaduna State Government of Nigeria (Accessed on 3rd April 2009).

UNICEF Basic Messages - Maternal & Newborn Child Health (MNCH), UNICEF (Accessed 2009).

WHO (2009). Counselling for maternal and newborn health care : a handbook for building skills **Part 3 Topics**, Department of Making Pregnancy Safer, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

WHO (2009). Counselling for maternal and newborn health care : a handbook for building skills. **Annex 1: Information and Counselling Sheets from the PCPNC** Department of Making Pregnancy Safer, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

WHO (2009) Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice **Integrated Management of Pregnancy and Childbirth 2nd Edition**, Department of Making Pregnancy Safer World Health Organization, Geneva.

Trainer's Guide

Review of the Use of Information, Education, and Communication (IEC) Materials

Drawing Exercise:

- Request participants to take out their pencils / pens and papers for an exercise.
- Explain that you will ask them to draw an animal based on a verbal description.
- Say you will read the description only twice, and then give them three minutes to draw the animal.
- Tell them that drawing skills are not important.
- Read the description:

The body is large. The limbs are short and large, armed with strong, blunt toes. There is a small tail. The head is rather flat and set on a short, thick neck. The ears are very big and long. Its long nose ends in a circle in which nostrils open. The mouth is small with a very long thick tongue.
- At the end of three minutes, ask the participants to hold up their drawings
- Tell the group that you had a very clear idea what you wanted them to draw and gave very specific verbal instructions.
- Then show the slide(s) of the elephant (and animals mentioned by participants)
- Read the description and point to each part of the picture on the overhead
- Ask participants:
 - Was it easy or difficult to draw the animal based on my description?
 - Why?
 - Why not?
 - What lessons can be drawn from the exercise?
- Possible responses:
 - A picture is worth a thousand words
 - Pictures can prevent misunderstanding
 - The listener assumed she understood what the speaker said
 - The speaker assumed she was giving clear instructions
 - The words were not enough to help understand what was being communicated

Barriers to Using IEC Materials

- Why don't providers use IEC materials?
 - They are not available (stored away or not at the service site)
 - Don't know the importance of using
 - Lacking knowledge on how to use them
 - Language barrier (if in the local language)
 - They need more time to use
 - Negligence
 - Assume client already knows so no need to see them
 - Not told by supervisor to use them
 - Using them takes too much time
- How can the problem of not using IEC support materials be overcome?
 - Using this list, identify ways to overcome the problem of not using IEC materials in counselling.
 - Brainstorm as a group and write responses on a flip chart

Resource Materials:

F.M.O.H (2005). Family Planning Training for Physicians and Nurses/Midwives - National Training Manual Abuja, Distributed by COMPASS Project with funding from USAID/Nigeria. This publication was originally produced under the VISION Project.

the David & Lucile Packard Foundation and Johns Hopkins Bloomberg School of Public Health Centre for Communication Programs (2006). An Interpersonal Communication And Counseling (IPC/C) Skills Training Manual For Health Care Providers - Trainers' Guide, FIRST KLASS, Ku Saurara!

WHO (2001). information, education and communication - lessons from the past; perspectives for the future, Department of Reproductive Health and Research, World Health Organization, 1211 Geneva 27, Switzerland or via e-mail from: rhrpublications@who.int World Health Organization WHO/RHR/01.22 Distr.: General.

Exercise on Values Clarification and Review of Messages

- Read a statement from the core messages and allow participants to indicate whether they agree or disagree
- Identify issues participants disagreed with
- Ask participants who agree / disagree with those issues to explain why they hold their respective opinions

- Ask participants if any of the responses given by others surprised them
- Ask how participants feel about their colleagues' opinions and why
- Ask why the opinions are different though all are trained midwives

Be ready to address the possible responses from participants

- Some may be :
 - Defensive
 - Judgmental
 - Ambivalent
 - Afraid to express opinion
 - Angry at being forced to make a decision
- Use this opportunity to have participants discuss these reactions
 - Why can it be so difficult to express our values and beliefs?
 - What do we risk by doing so?

Resource Material:

F.M.O.H (2005). Family Planning Training for Physicians and Nurses/Midwives - National Training Manual Abuja, Distributed by COMPASS Project with funding from USAID/Nigeria. This publication was originally produced under the VISION Project.

Counselling

Role Play

- 2 participants volunteer to be midwife and client
- Both interact and midwife counsels on birth preparedness
- Performance is reviewed by all using the Parts A and B of the checklist

QUESTIONS

Annexure 2(c)

Participant’s Code:

1. The use of posters about MNCH messages as *replacement* for interpersonal communication is a *misuse* of the MNCH posters or IEC material True False

Four examples of IEC materials useful for MNCH communication and counselling are:

- 2.
3.
4.
5.

6. The social principles and standards held by individuals or groups that influence their daily life activities, decisions and attainment of their goals is best described as:

- a. Rules
b. Regulations
c. Values
d. Social laws

7. Intrapersonal communication is talking to oneself while interpersonal communication is talking to one person or a small group of persons True False

8. The *Sender* in the communication process at the clinic or hospital is *always* the health worker while the *Receiver* is the client, her family or community True False

Four examples of non-verbal communication are:

- 9.
10.
11.
12.

13. At the *intention phase* of the behaviour change process the individual has made up her mind to change and the next phase for *everybody* that has an intention is the *action phase* when she actually does it. True False

14. The rule in ethical practice is “do to others what you expect them to do to you” therefore the midwife should examine herself, clarify her values and make necessary changes in her behaviour first, before reaching out to the client. True False

Every client has the right to:

- 15.
16.
17.

18. The service components of Primary Health Care in Nigeria are

- a. 12
b. 8
c. 10
d. 9

19. Harnessing community resources to achieve common community vision and encouraging people at the community level to participate and support development programmes for sustainability is

- a. Community orientation
b. Community restructuring
c. Community mobilization
d. Community action

20. Who takes *more* responsibility for the decision in counselling?

- a. The provider
b. The client

- c. Both client and provider
- d. The health team

Two of the roles / responsibilities of Men and Women Groups in the community in promoting MNCH include:

- 21.
- 22.

23. Which of these influences our values?

- a. Politics
- b. Religion
- c. Technology
- d. All of the above
- e. None of the above

What does the acronym “GATHER” stand for in the counselling process?

- 24. **G**
- 25. **A**
- 26. **T**
- 27. **H**
- 28. **E**
- 29. **R**

The *three delivery modes* into which selected interventions for MNCH have been package in Nigeria are *Family-oriented / Community-based services*,

- 30. *and*
- 31.

32. When can counselling be initiated?

- a. Routinely for some clients with special conditions
- b. When client requests for counsel
- c. When providing either curative or preventive health services
- d. All of the above

33. The Millennium Development Goals 4 and 5 are:

- a. Reduce child mortality and Improve maternal health
- b. Improve child health and Reduce mother death
- c. Reduce childhood illnesses and Reduce mothers’ death
- d. Improve child mortality and improve maternal mortality

34. The target year for achievement of the Millennium Development Goals is:

- a. 2014
- b. 2020
- c. 2015
- d. 2010

Mention four **major** causes of maternal deaths in Nigeria

- 35.
- 36.
- 37.
- 38.

39. Neonatal conditions account for about of Under-5 mortality in Nigeria

- a. 10%
- b. 14%
- c. 26%
- d. 23%

40. To “strengthen the capacity of individuals, families and the community to take necessary MNCH actions at home and to seek appropriate health care promptly” is one of the strategic objectives of the integrated maternal, newborn and child health strategy in Nigeria.

True False

MARKING SCHEME

Annexure 2(d)

1. The use of posters about MNCH messages as *replacement* for interpersonal communication is a *misuse* of the MNCH posters or IEC material **True** **False**

Four examples of IEC materials useful for MNCH communication and counselling are:

- 2.
- 3.
- 4.
- 5.

(Pamphlets, Leaflets, Flipcharts, Real Objects, Models, Posters, Wall Charts, Family Planning Commodities, Photographs, Radio, Audiocassettes, Cassette Recorders, Videocassettes, Video Player and Television)

6. The social principles and standards held by individuals or groups that influence their daily life activities, decisions and attainment of their goals is best described as:

- e. Rules
- f. Regulations
- g. Values**
- h. Social laws

7. Intrapersonal communication is talking to oneself while interpersonal communication is talking to one person or a small group of persons **True** **False**

8. The *Sender* in the communication process at the clinic or hospital is *always* the health worker while the *Receiver* is the client, her family or community **True** **False**

Four examples of non-verbal communication are:

- 9.
- 10.
- 11.
- 12.

(Facial expressions – frowning, furrowing brow, smiling; Hand gestures; Hand shaking; Hand holding; Laughing; Gentle patting / therapeutic touch; Leg / foot gestures; Eye gestures – e.g. rolling eyes; Eye contact; Body posture / position; Finger drumming; Toe /foot tapping; Folded arms)

13. At the *intention phase* of the behaviour change process the individual has made up her mind to change and the next phase for *everybody* that has an intention is the *action phase* when she actually does it. **True** **False**

14. The rule in ethical practice is “*do to others what you expect them to do to you*” therefore the midwife should examine herself, clarify her values and make necessary changes in her behaviour first, before reaching out to the client. **True** **False**

Every client has the right to:

- 15.
- 16.
- 17.

(Information, Access to Services, Informed Choice, Safe Services, Privacy and Confidentiality, Dignity, Comfort and Expression of Opinion, Continuity of Care)

18. The service components of Primary Health Care in Nigeria are

- a. 12
- b. 8
- c. 10
- d. 9

19. Harnessing community resources to achieve common community vision and encouraging people at the community level to participate and support development programmes for sustainability is

- a. Community orientation
- b. Community restructuring
- c. Community mobilization**
- d. Community action

20. Who takes *more* responsibility for the decision in counselling?

- a. The provider
- b. The client**
- c. Both client and provider
- d. The health team

Two of the roles / responsibilities of Men and Women Groups in the community in promoting MNCH include:

- 21.
- 22.

(Information sharing; Mobilization of peers; Mobilization of resources; Planning, implementing, evaluating and sustaining programmes)

23. Which of these influences our values?

- f. Politics
- g. Religion
- h. Technology
- i. All of the above**
- j. None of the above

What does the acronym “GATHER” stand for in the counselling process?

- 24. **Greet**
- 25. **Ask**
- 26. **Tell**
- 27. **Help**
- 28. **Explain**
- 29. **Return**

The **three delivery modes** into which selected interventions for MNCH have been package in Nigeria are *Family-oriented / Community-based services*,

30. *and*

31.

(Population-oriented outreach mobile specialty clinics; Individually-oriented clinical services (health facility level)

32. When can counselling be initiated?

- a. Routinely for some clients with special conditions
- b. When client requests for counsel
- c. When providing either curative or preventive health services
- d. **All of the above**

33. The Millennium Development Goals 4 and 5 are:

- a. **Reduce child mortality and Improve maternal health**
- b. Improve child health and Reduce mother death
- c. Reduce childhood illnesses and Reduce mothers' death
- d. Improve child mortality and improve maternal mortality

34. The target year for achievement of the Millennium Development Goals is:

- a. 2014
- b. 2020
- c. **2015**
- d. 2010

Mention four major causes of maternal deaths in Nigeria

35.

36.

37.

38.

(haemorrhage, infections, toxemia / eclampsia , unsafe abortion, obstructed labour, malaria, anaemia)

39. Neonatal conditions account for about of Under-5 mortality in Nigeria

- a. 10%
- b. 14%
- c. **26%**
- d. 23%

40. To “strengthen the capacity of individuals, families and the community to take necessary MNCH actions at home and to seek appropriate health care promptly” is one of the strategic objectives of the integrated maternal, newborn and child health strategy in Nigeria.

True **False**

Checklist for the Assessment of Midwife-Client Interaction

Annexure 2(e)

Process Criteria	Key: √ = Yes X = No NI = Not indicated in the particular case / situation				
	Date				
A – Inter-Personal Communication					
Sender – Midwife: Introduction: 1. Welcomed client to clinic 2. Introduced self 3. At same level with client (language, pace, position)					
Verbal Communication (C-L-E-A-R): 1. Clear and audible 2. Listened / Patient / Did not interrupt 3. Encouraged client on desired behaviour 4. Acknowledged client’s responses 5. Repeated / Reflected on what said 6. Kept It Simple and Sensible (KISS) (client did not say she did not understand / could not hear frequently)					
Non-verbal Communication (R-O-L-E-S): 1. Relaxed (not hurriedly conducted, not anxious) 2. Opened up and approachable 3. Leaned forward tolerably 4. Eye Contact was maintained tolerably 5. Sat squarely (and Smiled tolerably)					
Messages: 1. Appropriate for client / group 2. Correct (In line with developed messages) 3. Should/Could be done and adopted					
Channel / Medium – 1a. Group session 1b. Individual counselling 1c. Group talk followed by individual counselling 1d. Question and answer / Exchange of information / instruction only (Client or Midwife initiated) 2. Use of IEC materials / Job Aids e.g. leaflets 3. Reference to electronic media - radio /TV jingles etc 4. Reference to print media – newspapers etc 5. Reference to Community MCH support 6. Conducive environment – Privacy, Noiseless, etc					
Receiver - Client 1. Requested for information, responded to / asked questions freely (comfortable / relaxed) 2. Attentive					
Feedback – 1. Allowed client(s) to respond/ask questions 2. Answered question(s) 3. Client(s) expressed satisfaction / understanding 4. Assured client(s) of readiness to assist always					

Checklist for the Assessment of Midwife-Client Interaction (Contd.)

Process Criteria	Key: ✓ = Yes X = No NI = Not indicated in the particular case / situation				
Date					
B – Counselling (A + GATHER)					
GATHER					
1. Greet the client politely, warmly					
2. Ask her about herself, her family and how she is feeling					
3. Tell her what is going to happen during her visit and about any other specific issues concerning her condition					
4. Help her to be comfortable, to understand her situation, to take a decision or find a solution to a problem					
5. Explain any pre/post-procedure care or instructions, including use, and side effects of drugs, nutritional contents of local food, nutritional needs of pre-natal and post-natal mothers					
6. Return visit, referral and or follow-up. Explain these to client and her relatives					
C – Documentation (Process documented)					
Group					
6. Topic					
7. Attendance					
8. Special lessons useful for future planning (e.g. unusual question asked or uncommon household practice / myth revealed)					
9. Documentation in clinic record book (e.g. ANC, postnatal, IWC, family planning)					
10. Signature					
Individual					
1. Issues covered and decisions documented in client's record appropriately (completeness, accuracy, legibility, timeliness, signature etc)					
Assessor's Remarks (Self / Peer / Researcher / Others) :					
Client's Remarks / Comment					
Assessor's Signature					



SCHOOL OF NURSING UNIVERSITY OF KWAZULU-NATAL, 5TH FLOOR,
DESMOND CLARENCE BUILDING, HOWARD CAMPUS, DURBAN, 4041, SOUTH
AFRICA

19th February 2010

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Invitation to the Capacity Building Workshop on Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State

I wish to invite you to the capacity building workshop for participants in the above project which has been scheduled for Wednesday 3rd – Friday 5th March 2010 at the Ministry of Health School of Midwifery, Tudun Wada, Kaduna (8:30 a.m. – 5:00 p.m. daily).

Thanks for your continued cooperation.

B. O. Akin-Otiko (Student Number 209506880)
(B.Sc. (Nursing), D.H.A.M., MPH, FWACN)

Local Address:

Nurse Tutors Programme
(Federal Ministry of Health)
Department of Education Technical
C.S.T. PMB 2021
Kaduna Polytechnic
Kaduna

Tel: 0803 7213 522; 08058912326

Email: wumiakinotiko@yahoo.com; 209506880@ukzn.ac.za

Cc:

Most important things I have learned

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The skills or abilities I have developed

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What I would like to improve

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What I will start doing now

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What I would like to see change in midwifery practice and education:
In Kaduna State:

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.....
.....

In Nigeria

.....
.....
.....
.....

Participant Code.....

EVALUATION FORM (Group) Capacity Building Workshop:

S/N	ACTIVITY	COMMENTS
1.	Introduction	
2.	Review Sessions	
3.	Group Work	
4.	Time management	
5.	Duration of the Workshop	
6.	Workshop Materials	
7.	Achievement of Project Objectives 3,4, & 5 (Intervention Phase)	
8.	Feeding	
9.	Venue	
10.	Transportation Fee	

General Comments:

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Client's Identification Sheet (Woman)

Annexure 3(a)

Family Name Habila
First Name Jumai
Middle Name Fausat
Occupation Housewife
Doctor / Obstetrician -
ANC Registration No. 201006
Genotype AA
Blood Group O^{+ve}
Address Habila's Compound Behind the Market
Date of Birth 01 /01/ 1975
Religion -
Age 35 years
Parity G3P2⁺⁰
Date of First Visit 01/ 06/ 2010
EGA at First Visit 32weeks
Last Menstrual Period (LMP) 20/ 10/ 2009
Expected Date of Delivery (EDD) 27/ 07/ 2010
Husband's Name & Occupation Ibrahim Habila (Farmer)
Husband's Blood Group O^{+ve}
Nearest Health Centre to Home Project Facility
Kilometers from Home 1 Km

CLIENT'S DATA BASE (History)**Social History**

Marital Status: Single Married Divorced Widowed Separated
Alcohol Use: Never Light Moderate Heavy
Cigarette Smoking: Never Light Moderate Heavy

Previous Medical History

Anaemia Breast Lump Bronchial Asthma Diabetes High Blood Pressure
 Gonorrhoea Syphilis Tubal Disease Rheumatic Fever Heart Disease
 Kidney Disease Tuberculosis Chicken Pox **as a child**
 Jaundice / Liver Disease Sickle Cell Anaemia Bleeding Disorder
 Epilepsy Allergies (Specify) **Chloroquine (Itching)**

Obstetric History

	Total Previous Pregnancies		No of Living Children						2
	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	
Date of Birth	2005	2007							
Duration of Pregnancy	Full Term	Full Term							
Birth Weight	Unknown	Unknown							
Sex	Male	Male							
Labour (hours)	Unknown	Unknown							
Birth Place	Home	Home							
Instrumentation	Nil	Nil							
Complications: Pregnancy	Nil	Nil							
In Labour	Nil	Cord Round Neck							
Condition of Child									
Alive	Alive	Alive							
Dead (age)	-	-							
Dead (cause)	-	-							

Current History

Dizziness / Fainting Spells	Nil
Vomiting	Nil
Urinary Symptoms	Nil
Vaginal Discharge	Nil
Frequent / Severe Headache	Nil
Swelling of Hands, Feet / Ankles	Nil
Vaginal Bleeding	Nil
Other Symptoms	Nil

Previous Surgeries:	1st	2nd	3rd	4th	5th	6th	7th	8th
Kind		Nil						
Date								
Diagnosis								
Where Done								

CLIENT'S DATA BASE (Physical Examination)

ANTENATAL ATTENDANCE	Case 1
Tetanus Toxoid 1 st Dose	01/06/2010
Tetanus Toxoid 2 nd Dose	-

Case:

Pregnant woman comes in with two types of unlabelled drugs in paper tucked in her bag.

Woman greets the midwife.

She asks the midwife “Please can I continue to use these drugs? (Brings drugs out of bag and shows midwife – *Prochlorperazine Maleate 5mg tablets and Vitamin B Complex tablets*) I used them during my last pregnancy”

If asked about the source: She replies “I bought them from the chemist in the market; I just bought them I have not taken them I said let me ask in the hospital first”

Evaluation of Workplace Experiences Post-Intervention Annexure 3(b)

How have the following helped you in implementing your action plan / meeting your expectations with respect to Behaviour Change Communication?

Item	Not Helpful	Helpful	Very Helpful	Reason for Response
The checklist				
The Training Manual				
The Messages				
The Monthly Visits				
The Facility – Supervisor, Colleagues, other professionals				
The Facility– Structures, Drugs and Supplies etc				
The clients				
The Community				

Other Comments (Requests, Recommendations, etc)

.....

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.....

.....

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SCHOOL OF NURSING UNIVERSITY OF KWAZULU-NATAL, 5TH FLOOR,
DESMOND CLARENCE BUILDING, HOWARD CAMPUS, DURBAN, 4041, SOUTH
AFRICA

29th June 2010

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.....
.....

Invitation to the Last Interactive Session on Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State

I wish to invite you to the last interactive session for participants and validation team members involved in the above project. The one-day meeting has been scheduled for Thursday 29th July 2010 at the Ministry of Health School of Midwifery, Tudun Wada, Kaduna starting at 9 a.m.

The forum is to afford participants and validation team members the opportunity to verify the project's records and reports as well as to attend to other interests that may be raised in the course of the deliberations.

Thanks for your continued cooperation and sustained interest in the project.

B. O. Akin-Otiko (Student Number 209506880)
(B.Sc. (Nursing), D.H.A.M., MPH, FWACN)

Local Address:

Nurse Tutors Programme
(Federal Ministry of Health)
Department of Education Technical
C.S.T. PMB 2021
Kaduna Polytechnic
Kaduna

Tel: 0803 7213 522; 08058912326

Email: wumiakinotiko@yahoo.com; 209506880@ukzn.ac.za

Summary of the Interactive Session on Challenges of Rural Midwifery Practice / Networking Held As Part of The Capacity Building Workshop For Midwives To Facilitate Behaviour Change Communication Process (For Maternal, Newborn And Child Health) At Primary Health Care Level Of Midwifery Practice In Kaduna State Nigeria On 3rd - 5th March 2010 At State School Of Midwifery, Tudun Wada, Kaduna

Preamble:

This research project is aimed at facilitating behaviour change communication for maternal, newborn and child health at the primary health care level of midwifery practice in Kaduna State Nigeria. This was the view of addressing some underlying determinants of maternal, newborn, and child morbidity / mortality through enhanced interpersonal communication and counselling skills of midwives and provision of friendly services.

The project has been severally described as important, relevant, and timely in view of the obvious serious problems of unacceptably high maternal and child mortality rates in the country, the communication gap between the midwives and their clients, and the need for improved relationship between midwives and their colleagues or other members of the health team.

A preliminary assessment of the strengths and weaknesses of midwives with respect to behaviour change communication for maternal, newborn and child health in Kaduna State was carried out on 27th – 29th January 2010 by the participating midwives. The midwives were recruited from facilities in eight local government areas selected in collaboration with the ministries of Health and Local Government, from the three senatorial zones of Kaduna State. During the assessment process, findings from the FGD conducted among women in the communities where the facilities are located, IDI of a key midwife informant in each facility, personal data of interested midwives, and facility data were reviewed by the midwives.

At the end of the assessment exercise, a capacity building workshop to address the identified gaps and provide opportunity for the midwives to network for support / required resources (human and material), were recommended by the midwives. Topics of interest to the midwives were put together to form the content of the workshop. They included: Introduction to Behaviour change Process, Introduction to Integrated Maternal, Newborn and Child Health (**IMNCH**), Review of Primary Health Care (**PHC**), Marketing of MNCH Services Using Client-Centred and Customer Service Approaches, Review of Communication and Interpersonal Communication / Counseling (IPCC) Skills, Counseling, Review of the Use of Information, Education & Communication (IEC) Materials, Community Mobilization, Review of Core MNCH Messages, and Value Clarification.

The capacity building workshop was held on 3rd – 5th March 2010. Participatory methods were employed and participants had ample opportunity for individual and group activities. The pre- and post- test scores showed appreciable increase in knowledge as in Figure 1 below. An interactive session on Challenges of Rural Midwifery Practice / Networking came up on the last day of the workshop with the expectation that the session would afford the midwives the opportunity to meet the people in authority to press home their demands, and help chat a way forward for improved maternal, newborn and child care in the state.

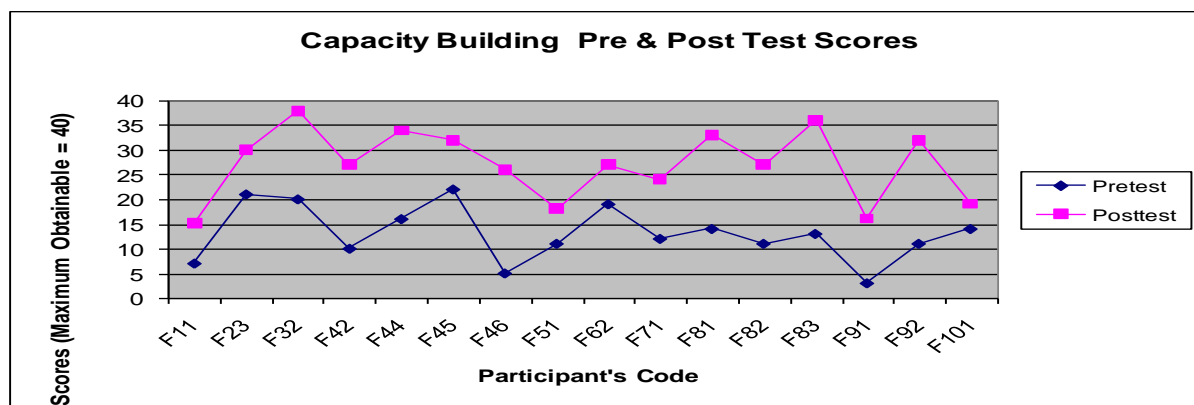


Figure 1: Participants' Pre- and Post- Test Scores

The Interactive Session on Challenges of Rural Midwifery Practice / Networking

Attendance:

Alhassan Aliyu Gamagira	Director, Primary Health Care, Kaduna State Ministry for Local Government, Kaduna
Abdul Aliyu	Director Nursing Services, Kaduna State Ministry of Health, Kaduna
Zainab Umar	Assistant Director Nursing Services, Kaduna State Ministry of Health, Kaduna
Habiba Lolo (Mrs)	Principal, School of Midwifery, T/Wada, Kaduna
Safiya Isa	Vice Principal, School of Midwifery, T/Wada, Kaduna
Ade Adejorin	Chief Lecturer, Department of Social Development, Kaduna Polytechnic, Kaduna
S. A. Fagbemi	Chief Lecturer, Department of Mass Communication, Kaduna Polytechnic, Kaduna
Julie R. Amoka	Midwifery Programme Coordinator, School of Post Basic Nursing Programmes, ABUTH, Zaria
A. M. A. Adebusuyi	Housewife, c/o the Researcher
Hadiza Lawal	Research Assistant, c/o the Researcher
Participating Midwives	From various Primary Health Care facilities and Rural Hospitals (see attached list)
B. O. Akin-Otiko	Researcher

Apology:

Hadiza Kwasallo Participant - PHC Department, Zaria Local Government

The interactive session lasted 93 minutes with attendance as shown above. The researcher presented some of the findings from the FGDs, IDIs, participants' data, and facility data which informed the design of the workshop in collaboration with the midwives. The DNS and DPHC presented short addresses recognizing the relevance of the project and the need for a wider coverage. They assured the participants of confidentiality and protection from any punitive action as a result of views they might express during the interactive session. The session was quite stimulating and helpful.

The summary of issues that were raised during the session and some suggestions made towards improving maternal, newborn and child care service delivery in the state are hereby presented.

Issues Raised by Participants and Others for Discussion:

- Gross shortage of manpower with many facilities having no midwife at all, while some have only one midwife who works 24/7
- Poor distribution of staff with majority in urban areas to the disadvantage of the rural areas
- Indiscriminate staff transfer which has negative effect on the midwives' work and implementation / stepping down of gains of training programs
- Poor capacity of staff at local level for community activities indicating the need for training on community processes to fill the gap between demand for and supply of services to promote maternal and child health.
- Most NGOs seek and pursue individual uncoordinated interests
- Conflict between midwives and nurses at the local government level, and the community health workers
- Midwives with dual qualification are employed on the same level as those with single qualification
- Lack of insecticide treated nets to encourage women to continue to come to health facilities
- Drugs and other items sent to the local government from the State Ministry of Health are poorly and unevenly distributed with the result that some clinics lack while others are wasting them, and the women abandon facilities that do not have the items and flock to the ones that have.
- Lack of family planning commodities in the facilities makes it imperative to buy them at high rates and sell to interested clients
- Lack of free MCH cards and free laboratory tests at the Family Health Unit Kafanchan make the facility lose its clients to other facilities.
- Client sent away (a times to private clinic) when there is no reliever to take over from health worker
- Turunku Rural Hospital needs water and a fence urgently to ensure availability of water and protect the hospital from invading farmers burning bushes
- Rigasa Rural Hospital needs chairs for clients, water and demarcation of delivery rooms

- There is so much craving to become the ‘in-charge’ by people who cannot ‘deliver’, who do not accept corrections, and who lack essential knowledge, attitudes and technical / professional skills and they are appointed as in-charges either because of connection or other means not in the best interest of service
- In-charges do not support those who attended workshops to implement what was learnt e.g. on family planning, PMTCT, etc despite the fact that clients need such services in the rural areas.
- In-charges refuse to sign applications of midwives to the ministry for further studies
- In-charges keep nominating themselves for workshops because the letters of invitation come to them and they see it as opportunity to meet their financial needs; some attend two workshops simultaneously
- Some midwives have never participated in any form of continuing education since graduation for up to 30 years in some cases while others have attended same or different workshops more than once because of the financial benefits
- Fake staffs (dental and laboratory technicians, nurses, etc) recruited into both the state and local government services
- Doctors, nurses, and midwives are WHO recognized skilled attendants for maternal health care but some midwives are subordinate to some CHEWs even where there are public health nurses with nursing and midwifery qualifications, this makes the work suffer.
- Need to implement the content of the document on quantification of nursing and midwifery certificates as HND equivalent without further delay.
- Cultural differences and language barrier are major barriers to effective behaviour change communication
- Participants want to have a certificate of attendance for their immense participation in this project
- Some attended workshops before and were yet to be given certificates

Responses:

- The willingness of the present administration to provide quality health care for the people and to support initiatives in this direction was acknowledged
- The DNS appreciated the need to build capacity of other personnel in the state and pledged to support participants to step down the workshop at their facilities and serve as resource persons for interpersonal communication (IPC) in the state
- The DNS & DPHC intend to meet and discuss how to bridge the gap in capacity of staff in the rural areas for efficient community oriented service delivery
- Suggestion to maintain and check records of facilities that have specially trained midwives made, so that subsequent trainings will cater for facilities that lack such staff e.g. LSS, IMCI, PAC, PMTCT counselling etc
- Midwives are advised to link up with Society for Family Health and Planned Parenthood Federation of Nigeria for affordable family planning commodities and insecticide treated nets
- Appeal was made to involve the nurse / midwife / public health educators in this type of workshop in future so that it could enrich the training of the students and go a long way in adding to the number trained in such skills to cater for the public
- Information was given that 2 billion mosquito nets for households have been given to Kaduna state thereby solving the challenge of lack of mosquito nets
- Informed that decision had already been taken that those ‘fake’ dental and laboratory technicians were not going to be employed and so surprised to learn that they were employed
- Complaints about fake personnel already received at the ministry and recommendation for screening of all health workers by the state ministry of health would be made to help check out those that are not licensed.
- DPHC promised to communicate the issues of fake staff, indiscriminate staff transfers, and I/C, in-charges to the Local Government Service Board.
- People at the session opined that the appointment of in-charges should be based on merit, looking at the qualification and the performance of prospective in-charges and not on sentiments.
- Midwives should inform the ministry of happenings in their facilities with respect to the in-charges as the ministry is not aware of most of the complaints brought against the in-charges.
- The participants were informed that a forum of matrons comes up every two months at the ministry to discuss pertinent issues.
- In-charges to be directed by DNS to provide necessary support for implementation of gains at workshops etc
- Suggested that the Ministry of Health, Ministry for Local Government, and the Local Government Service Board in collaboration with the various professional groups / association would need to meet and consider the Federal Ministry of Health’s circular on the issue of heading of primary health care settings. The circular was said to recommend a doctor / gynecologist or staff nurse / midwife with CHO. Informed that what operates currently, is to appoint any capable person within the primary health care since the issue is a ‘highly explosive’ one.

- All dually qualified personnel who have not been properly placed on appointment were advised to apply and their cases would be given due consideration
- Report of this session should be prepared by the researcher to initiate action requesting the Nursing and Midwifery Council of Nigeria to officially communicate the document on quantification of nursing and midwifery certificates to the various states of the federation for implementation
- Informed that the needs of Rigasa Rural Hospital are receiving adequate attention as the ministry is making a lot of efforts towards providing all the amenities and facilities
- MCH cards issue will be looked at by the stakeholders because the facility is a primary care facility but the free cards is a state project
- Informed that with respect to indiscriminate transfer, the ministry has the list of all LSS trained midwives and that care is taken in posting them; and that step down training is encouraged so that others can take over, however sometimes transfer of such staff is inevitable
- It was recognized that everybody needs constant on-the-job-training like this; even it might be refresher courses. It is believed such would enhance the effectiveness by refreshing one's memory and making one more effective.
- An appeal was made for policy makers to ensure that this workshop is organized for the local government and state to attend to issues related to behavioural change; and they should continue to address the challenges being raised by the participants.
- Any facility or person that intends to step down any training will be adequately supported and motivated by the government in every possible way once the proposal is detailed and relevant, and the beneficiaries of the step down workshop would be equally recognized
- Present administration has unprecedented number of nurses undergoing various training programmes and an approach to ensure fair opportunity for staff in each facility to benefit from continuing education has been developed by the DNS
- All those sponsored to attend workshops are expected to present reports on return indicating what they observed, knowledge gained and how the knowledge / skills can be advanced and actions initiated to assist the profession.
- Participants were informed that they could visit the health education and health promotion unit of the ministry as well as their LGA headquarters for IEC materials; and the DDPHC MOH for job aids
- The issue of certificate for this project is to be discussed before the completion of the project and certificates will be issued at the final session in June / July 2010 by the grace of God.

Conclusion:

The DPHC and DNS commended the researcher for the session and provided the participants with their respective contacts to enable them maintain a link and ask for / receive help when necessary. The researcher was requested to forward the particulars of the participants to the directors too, so that they could be contacted as resource persons when necessary. Similarly, the researcher was requested to forward a report of the interactive session to the Ministry of Health for necessary action.

The participants' high level of interest and commitment was commended. They were reminded that what is expected is the transformation of our women and that they would be seeing the researcher on the field monthly. There would be a one-day family meeting to round up the project when through with the monthly monitoring.

The researcher appreciated the guests and the participants who also appreciated the session.

B. O. Akin-Otiko

c/o Nurse Tutors Programme

(Federal Ministry of Health)

Department of Education Technical

C.S.T. PMB 2021

Kaduna Polytechnic

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RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : sshrec@ukzn.ac.za

2 DECEMBER 2009

MS. BO AKIN-OTIKO (209506880)
SCHOOL OF NURSING

Dear Ms. Akin-Otiko

PROTOCOL REFERENCE NUMBER: HSS/0482/09D
PROJECT TITLE: "Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State".

EXPEDITED APPROVAL

This letter serves to notify you that your revised documents have been reviewed and granted full approval by the Chair of the Social Sciences & Humanities Research Ethics Committee.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. Please use the above reference number for all correspondence/queries relating to this study. Enquiries can be send to sshrec@ukzn.ac.za

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Best wishes for the successful completion of your research protocol.

Yours faithfully


.....
PROFESSOR STEVEN COLLINGS (CHAIR)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

cc. Supervisor (Prof. BR Bhengu)
cc. Ms. C Dhanraj

MINISTRY OF HEALTH, KADUNA STATE

All Communications to be Addressed to:
THE HON. COMMISSIONER
Quoting Reference and Date
Tel: (062) 248048
(062) 248252



Independence Way,
P.M.B. 2014,
Kaduna,
Kaduna State, Nigeria.
E-mail: smohkaduna@yahoo.com

MOH/ADM/744/T/9

12th October 2009

Bridget Akin – Otiko,
University of Kwazulu –Natal,
Durban – South Africa,

RE- REQUEST FOR PERMISSION TO CONDUCT RESEARCH FOR STUDY PURPOSES.

Please, refer to your Head of Department letter to the Hon. Commissioner on the above subject

I have been directed to convey approval to you.

Please, note that you are to observe all ethics guiding research. You are also to give this Ministry a copy of your work after completion,


GIDEON B. WAYO
Deputy Director Hospital Services (Diagnostics)
For: Honourable Commissioner

MINISTRY FOR LOCAL GOVERNMENT

KADUNA STATE

YAKUBU GOWON WAY,
P.M.B. 2083
KADUNA.

TELEPHONE: (062)242358

Ref: S/MLG/755/VOL.T/13



Date: 19th October, 2009

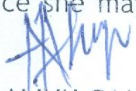
The Hon. Chairman,
.....
.....

REQUEST FOR PERMISSION TO CONDUCT RESEARCH FOR STUDY PURPOSES

I am directed to inform you that approval has been granted to Ms Bridget Akin-Otiko, student Number 209506880 I from University of Kwazulu-Natal, Durban, South Africa for the above activity in your Local Government.

2. The Primary Health Care facility at
has been scheduled for the study.

3. You are requested to give her all the assistance she may require, please.


ALHASSAN ALIYU GAMAGARA
Director, Primary Health Care

✓ CC: Ms. Bridget Akin-Otiko
University of Kwazulu-Natal,
Durban, South Africa.

Above for your information, please.


ALHASSAN ALIYU GAMAGARA
Director, Primary Health Care

Print

Page 1 of 1

From: wumi akin-otiko (wumiakinotiko@yahoo.com)
To: sufyanmb@yahoo.com;
Date: Tue, January 19, 2010 3:46:28 PM
Cc:
Subject: Re: Permission To Use IPCC Training Material

Dear Sir,

I am grateful

B. O. Akin-Otiko

--- On **Mon, 1/18/10, Muawiyya Sufiyan** <sufyanmb@yahoo.com> wrote:

From: Muawiyya Sufiyan <sufyanmb@yahoo.com>
 Subject: Re: Permission To Use IPCC Training Material
 To: "wumi akin-otiko" <wumiakinotiko@yahoo.com>
 Date: Monday, January 18, 2010, 9:06 AM

Thanks alot Wumi, Im happy to hear that you're through with your prelim work. Pls go ahead and make use of any aspect of the manual that you may find useful, In any case that's what the manual is meant for. Have a wonderful and successful traning session! Pls don't hesitate to contact me where you think I can assist.

Dr Sufiyan

--- On **Mon, 1/18/10, wumi akin-otiko** <wumiakinotiko@yahoo.com> wrote:

From: wumi akin-otiko <wumiakinotiko@yahoo.com>
 Subject: Permission To Use IPCC Training Material
 To: "Mu'awiyah Sufiyan" <sufyanmb@yahoo.com>
 Date: Monday, January 18, 2010, 1:54 AM

Dear Sir,

I wish to inform you that I am through with my preliminary survey and hope to have the first interactive session with the midwives next week.

In case we decide on the nature of the capacity building program and find some components of your material useful, I will like to have your permission to use them please. Such sections used will be duly acknowledged.

Thanks for your continued cooperation.

B. O. Akin-Otiko

Project title: Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State

Aim of project: The study is to appraise and facilitate behaviour change communication for maternal, newborn and child health at the primary health care level of midwifery practice in Kaduna State Nigeria.

Name of researcher: Bridget Omowumi Akin-Otiko

Affiliation: University of KwaZulu-Natal, Durban, South Africa

Qualification: BSc. Nursing; M.P.H.; D.H.A.M.

Contact details: School of Nursing, 5th Floor, Desmond Clarence Building, Howard College Campus, University of KwaZulu-Natal, 4041, Durban, South Africa
Tel. +27 0789 305272
Email: wumiakinotiko@yahoo.com; 209506880@ukzn.ac.za

Name of supervisor: Professor B. R. Bhengu

Affiliation: University of KwaZulu-Natal, Durban, South Africa

Contact details: School of Nursing, 5th Floor Desmond Clarence Building, University of KwaZulu-Natal, Howard Campus, Durban, 4041, South Africa
Telephone: +27 31 2601134
Email: bhengub2@ukzn.ac.za

You have been invited to participate in a study that will contribute to my doctoral thesis. Your participation is entirely voluntary. If you agree to participate, you will be required to answer a set of questions related to the practice of Behaviour Change Communication for Maternal, Newborn and Child Health at your workplace and the strategies that can be employed to facilitate it. You will not receive payment for granting the interview and no fee is required from you. Please note that the interview will be audio-recorded.

If you wish to withdraw from the interview, you are free to do so at any time without fear of recrimination or negative consequences.

At all times, your personal contributions will be kept confidential. Your name will not appear in any publications, reports or other documents pertaining to this research project.

For further inquiry please contact:

Mr Sugan Reddy,
Faculty office,
Faculty of Health Sciences,
Westville campus F Block,
University of KwaZulu-Natal,
Durban. 4041. South Africa.
Phone number: 27 31 260 7209.



B. O. Akin-Otiko

**Facilitation of Behaviour Change Communication Process for Maternal,
Newborn and Child Health at Primary Health Care Level of Midwifery
Practice in Kaduna State**

Informed Consent Form:

I..... (full names of Key Informant for IDI) hereby
confirm that I understand the contents of the information sheet and the nature of the research project,
and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the study at any time, should I so desire.

.....
SIGNATURE OF KEY INFORMANT FOR IDI

.....
DATE

Project title: Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State

Aim of project: The study is to appraise and facilitate behaviour change communication for maternal, newborn and child health at the primary health care level of midwifery practice in Kaduna State Nigeria.

Name of researcher: Bridget Omowumi Akin-Otiko

Affiliation: University of KwaZulu-Natal, Durban, South Africa

Qualification: BSc. Nursing; M.P.H.; D.H.A.M.

Contact details: School of Nursing, 5th Floor, Desmond Clarence Building, Howard College Campus, University of KwaZulu-Natal, 4041, Durban, South Africa
Tel. +27 0789 305272
Email: wumiakinotiko@yahoo.com; 209506880@ukzn.ac.za

Name of supervisor: Professor B. R. Bhengu

Affiliation: University of KwaZulu-Natal, Durban, South Africa

Contact details: School of Nursing, 5th Floor Desmond Clarence Building, University of KwaZulu-Natal, Howard Campus, Durban, 4041, South Africa
Telephone: +27 31 2601134
Email: bhengub2@ukzn.ac.za

You have been invited to participate in a study that will contribute to my doctoral thesis. Your participation is entirely voluntary. If you agree to participate, we will work together in collaboration with a number of midwives in Kaduna State to look at our practice of Behaviour Change Communication for Maternal, Newborn and Child Health and take appropriate action for our professional development in this area. The work will require five to six contacts over about six months from November 2009 – April 2010. You will not receive payment for your participation and no fee is required. However, provision will be made for your transport fare and feeding, whenever you are required to work outside your location during the period of the exercise.

If you wish to withdraw from the study, you are free to do so at any time without fear of recrimination or negative consequences.

At all times, your personal contributions will be kept confidential. Your name will not appear in any publications, reports or other documents pertaining to this research project.

For further inquiry please contact:

Mr Sugan Reddy,
Faculty office,
Faculty of Health Sciences,
Westville campus F Block,
University of KwaZulu-Natal,
Durban. 4041. South Africa.
Phone number: 27 31 260 7209.



B. O. Akin-Otiko

**Facilitation of Behaviour Change Communication Process for Maternal,
Newborn and Child Health at Primary Health Care Level of Midwifery
Practice in Kaduna State**

Informed Consent Form:

I..... (full names of participant) hereby confirm
that I understand the contents of the information sheet and the nature of the research project, and I
consent to participating in the research project.

I understand that I am at liberty to withdraw from the study at any time, should I so desire.

.....
SIGNATURE OF PARTICIPANT

.....
DATE

Project title: Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State

Aim of project: The study is to appraise and facilitate behaviour change communication for maternal, newborn and child health at the primary health care level of midwifery practice in Kaduna State Nigeria.

Name of researcher: Bridget Omowumi Akin-Otiko

Affiliation: University of KwaZulu-Natal, Durban, South Africa

Qualification: BSc. Nursing; M.P.H.; D.H.A.M.

Contact details: School of Nursing, 5th Floor, Desmond Clarence Building, Howard College Campus, University of KwaZulu-Natal, 4041, Durban, South Africa
Tel. +27 0789 305272
Email: wumiakinotiko@yahoo.com; 209506880@ukzn.ac.za

Name of supervisor: Professor B. R. Bhengu

Affiliation: University of KwaZulu-Natal, Durban, South Africa

Contact details: School of Nursing, 5th Floor Desmond Clarence Building, University of KwaZulu-Natal, Howard Campus, Durban, 4041, South Africa
Telephone: +27 31 2601134
Email: bhengub2@ukzn.ac.za

You have been invited to participate in a study that will contribute to my doctoral thesis. Your participation is entirely voluntary. If you agree to participate, you will be required to conduct focus group interviews on women in nine selected communities in Kaduna State in Hausa language. It will involve you accompanying me on my field trips to those communities in November 2009 for the interviews; transcribing the recorded interviews verbatim in Hausa; and translating the Hausa versions to English. The materials, your transportation to and from, and feeding while at site will be provided for. You will also be paid the agreed sum of for the work.

If you wish to withdraw from the study at any time, you are free to do so without fear of recrimination or negative consequences.

At all times, your personal contributions will be kept confidential. Your name will not appear in any publications, reports or other documents pertaining to this research project.

For further inquiry please contact:

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B. O. Akin-Otiko

**Facilitation of Behaviour Change Communication Process for Maternal,
Newborn and Child Health at Primary Health Care Level of Midwifery
Practice in Kaduna State**

Informed Consent Form:

I..... (full names of research assistant) hereby
confirm that I understand the contents of the information sheet and the nature of the research project,
and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the study at any time, should I so desire.

.....
SIGNATURE OF RESEARCH ASSISTANT (FGD)

.....
DATE

Project title: Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State

Aim of project: The study is to appraise and facilitate behaviour change communication for maternal, newborn and child health at the primary health care level of midwifery practice in Kaduna State Nigeria.

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Qualification: BSc. Nursing; M.P.H.; D.H.A.M.

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Email: bhengub2@ukzn.ac.za

You have been invited to participate in a study that will contribute to my doctoral thesis. Your participation is entirely voluntary. If you agree to participate, you will be required to appear as a patient in the hospital seeking counsel from the midwife on a prearranged issue. It will involve you accompanying me on my trips to health facilities in eight Local Government Areas of Kaduna State, where midwives who are participating in the study work. The exercise will take place from Monday 21st – Friday 25th June 2010. The materials, your transportation to and fro, and feeding while at site will be provided for. You will also be paid the agreed sum of for the work.

If you wish to withdraw from the study at any time, you are free to do so without fear of recrimination or negative consequences.

At all times, your personal contributions will be kept confidential. Your name will not appear in any publications, reports or other documents pertaining to this research project.

For further inquiry please contact:

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B. O. Akin-Otiko

**Facilitation of Behaviour Change Communication Process for Maternal,
Newborn and Child Health at Primary Health Care Level of Midwifery
Practice in Kaduna State**

Informed Consent Form:

I (full names of research assistant) hereby confirm that I understand the contents of the information sheet and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the study at any time, should I so desire.

.....
SIGNATURE OF RESEARCH ASSISTANT
(SIMULATED PATIENT)

.....
DATE

Project title: Facilitation of Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State

Aim of project: The study is to appraise and facilitate behaviour change communication for maternal, newborn and child health at the primary health care level of midwifery practice in Kaduna State Nigeria.

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You have been invited to participate in a study that will contribute to my doctoral thesis. Your participation is entirely voluntary. If you agree to participate, you will be required to work with me and other professionals to review the research process from time to time and offer your advice. It will involve you attending not more than four scheduled meetings and completing some assigned tasks independently. The proposed period of engagement is between October 2009 and April 2010. You will not receive payment for your participation. However, all work materials will be provided, your transport fare and feeding in respect of scheduled meetings will be supplied.

If you wish to withdraw from the study at any time, you are free to do so without fear of recrimination or negative consequences.

At all times, your personal contributions will be kept confidential. Your name will not appear in any publications, reports or other documents pertaining to this research project.

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B. O. Akin-Otiko

**Facilitation of Behaviour Change Communication Process for Maternal,
Newborn and Child Health at Primary Health Care Level of Midwifery
Practice in Kaduna State**

Informed Consent Form:

I..... (full names of validation group member)
hereby confirm that I understand the contents of the information sheet and the nature of the research
project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the study at any time, should I so desire.

.....
SIGNATURE OF VALIDATION GROUP MEMBER

.....
DATE

Information Sheet (Focus Group Discussion - Women):**Annexure 5(f)**

Project title: Behaviour Change Communication Process for Maternal, Newborn and Child Health at Primary Health Care Level of Midwifery Practice in Kaduna State

Aim of project: The study is to appraise and facilitate behaviour change communication for maternal, newborn and child health at the primary health care level of midwifery practice in Kaduna State Nigeria.

Name of researcher: Bridget Omowumi Akin-Otiko

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You have been invited to participate in a study that will contribute to my doctoral thesis. Your participation is entirely voluntary. If you agree to participate, you will be required to participate in a discussion related to the Process of Behaviour Change Communication for Maternal, Newborn and Child Health at Primary Health Care Level in Kaduna State and how we can improve it. You will not receive payment for your participation and no fee is required from you. Please note that the discussion will be audio-recorded.

If you wish to withdraw from the study, you are free to do so at any time without fear of recrimination or negative consequences.

At all times, your personal contributions will be kept confidential. Your name will not appear in any publications, reports or other documents pertaining to this research project.

For further inquiry please contact:

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Faculty of Health Sciences,
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University of KwaZulu-Natal,
Durban. 4041. South Africa.
Phone number: 27 31 260 7209.



B. O. Akin-Otiko

**Facilitation of Behaviour Change Communication Process for Maternal,
Newborn and Child Health at Primary Health Care Level of Midwifery
Practice in Kaduna State**

Informed Consent Form:

I..... (full names of woman) hereby confirm that I understand the contents of the information sheet and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the study at any time, should I so desire.

Domains*	Constructs	Interview questions
(1) Knowledge	Knowledge Knowledge about condition/scientific rationale Schemas+mindsets+illness representations Procedural knowledge	Do they know about the guideline? What do they think the guideline says? What do they think the evidence is? Do they know they should be doing x? Do they know why they should be doing x?
(2) Skills (Skills)	Skills Competence/ability/skill assessment Practice/skills development Interpersonal skills Coping strategies	Do they know how to do x? How easy or difficult do they find performing x to the required standard in the required context?
(3) Social/professional role and identity (Self-standards)	Identity Professional identity/boundaries/role Group/social identity of the source? Social/group norms Alienation/organisational commitment	What is the purpose of the guidelines? What do they think about the credibility Do they think guidelines should determine their behaviour? Is doing x compatible or in conflict with professional standards/identity? (prompts: moral/ethical issues, limits to autonomy) Would this be true for all professional groups involved?
(4) Beliefs about capabilities (Self-efficacy)	Self-efficacy Control—of behaviour and material and social environment Perceived competence Self-confidence/professional confidence Empowerment Self-esteem Perceived behavioural control Optimism/pessimism	How difficult or easy is it for them to do x? (prompt re. internal and external capabilities/constraints) What problems have they encountered? What would help them? How confident are they that they can do x ? despite the difficulties? How capable are they of maintaining x? How well equipped/comfortable do they feel to do x?
(5) Beliefs about consequences (Anticipated outcomes they/attitude)	Outcome expectancies Anticipated regret Appraisal/evaluation/review Consequents Attitudes Contingencies Reinforcement/punishment/consequences Incentives/rewards Beliefs Unrealistic optimism Salient events/sensitisation/critical incidents Characteristics of outcome expectancies—physical, social, emotional; Sanctions/rewards, proximal/distal, valued/not valued, probable/improbable, salient/not salient, perceived risk/threat	What do they think will happen if do x? (prompt re themselves, patients, colleagues and the organisation; positive and negative, short term and long term consequences) What are the costs of x and what are the costs of the consequences of x? What do they think will happen if they do not do x? (prompts) Do benefits of doing x outweigh the costs? How will they feel if they do/don't do x? (prompts) Does the evidence suggest that doing x is a good thing?
(6) Motivation and goals (Intention)	Intention; stability of intention/certainty of intention Goals (autonomous, controlled) Goal target/setting Goal priority Intrinsic motivation Commitment Distal and proximal goals Transtheoretical model and stages of change	How much do they want to do x? How much do they feel they need to do x? Are there other things they want to do or achieve that might interfere with x? Does the guideline conflict with others? Are there incentives to do x?

(7) Memory, attention and decision processes	<ul style="list-style-type: none"> Memory Attention Attention control Decision making 	<ul style="list-style-type: none"> Is x something they usually do? Will they think to do x? How much attention will they have to pay to do x? Will they remember to do x? How? Might they decide not to do x? Why? (prompt: competing tasks, time constraints)
(8) Environmental context and resources (Environmental constraints) Environmental stressors	<ul style="list-style-type: none"> Resources/material resources (availability and management) Person x environment interaction Knowledge of task environment 	<ul style="list-style-type: none"> To what extent do physical or resource factors facilitate or hinder x? Are there competing tasks and time constraints? Are the necessary resources available to those expected to undertake x?
(9) Social influences (Norms)	<ul style="list-style-type: none"> Social support Social/group norms Organisational development Leadership Team working Group conformity Organisational climate/culture Social pressure Power/hierarchy Professional boundaries/roles Management commitment Supervision Inter-group conflict Champions Social comparisons Identity; group/social identity Organisational commitment/alienation Feedback Conflict—competing demands, conflicting roles Change management Crew resource management Negotiation Social support: personal/professional/organisational, intra/interpersonal, society/community Social/group norms: subjective, descriptive, injunctive norms Learning and modeling 	<ul style="list-style-type: none"> To what extent do social influences facilitate or hinder x? (prompts: peers, managers, other professional groups, patients, relatives) Will they observe others doing x (i.e. have role models)?
(10) Emotion (Emotion)	<ul style="list-style-type: none"> Affect Stress Anticipated regret Fear Burn-out Cognitive overload/tiredness Threat Positive/negative affect Anxiety/depression 	<ul style="list-style-type: none"> Does doing x evoke an emotional response? If so, what? To what extent do emotional factors facilitate or hinder x? How does emotion affect x?
(11) Behavioural regulation	<ul style="list-style-type: none"> Goal/target setting Implementation intention Action planning Self-monitoring Goal priority Generating alternatives Feedback Moderators of intention-behaviour gap Project management Barriers and facilitators 	<ul style="list-style-type: none"> What preparatory steps are needed to do x? (prompt re individual and organisational) Are there procedures or ways of working that encourage x?

(12) Nature of the behaviours

Routine/automatic/habit
Breaking habit
Direct experience/past behaviour
Representation of tasks
Stages of change model

What is the proposed behaviour (x)?
Who needs to do what differently when, where, how, how often and with whom?
How do they know whether the behaviour has happened?
What do they currently do?
Is this a new behaviour or an existing behaviour that needs to become a habit?
Can the context be used to prompt the new behaviour? (prompts: layout, reminders, equipment)
How long are changes going to take?
Are there systems for maintaining long term change?

(Source:Michie et al., 2005 pp 30-31) www.qshc.com Downloaded from qshc.bmj.com on 29 May 2009

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To whom it may concern

I have read and edited, for

English language usage, the

Thesis written by Bridget Akin-Otiko

to fulfil the requirements of her

degree of Doctor of Philosophy

(Nursing) at The University of

KwaZulu-Natal.

Rhuladman B.A., U.E.D., B.Ed
(U.N., Pmb.)

18th March, 2011