Royal College of Nursing

The RCN Research Society is pleased to announce:

RCN International Nursing Research Conference 2017

Wednesday 5 – Friday 7 April 2017

University of Oxford Examination Schools, 75 - 81 High Street, Oxford, OX1 4BG, United Kingdom

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

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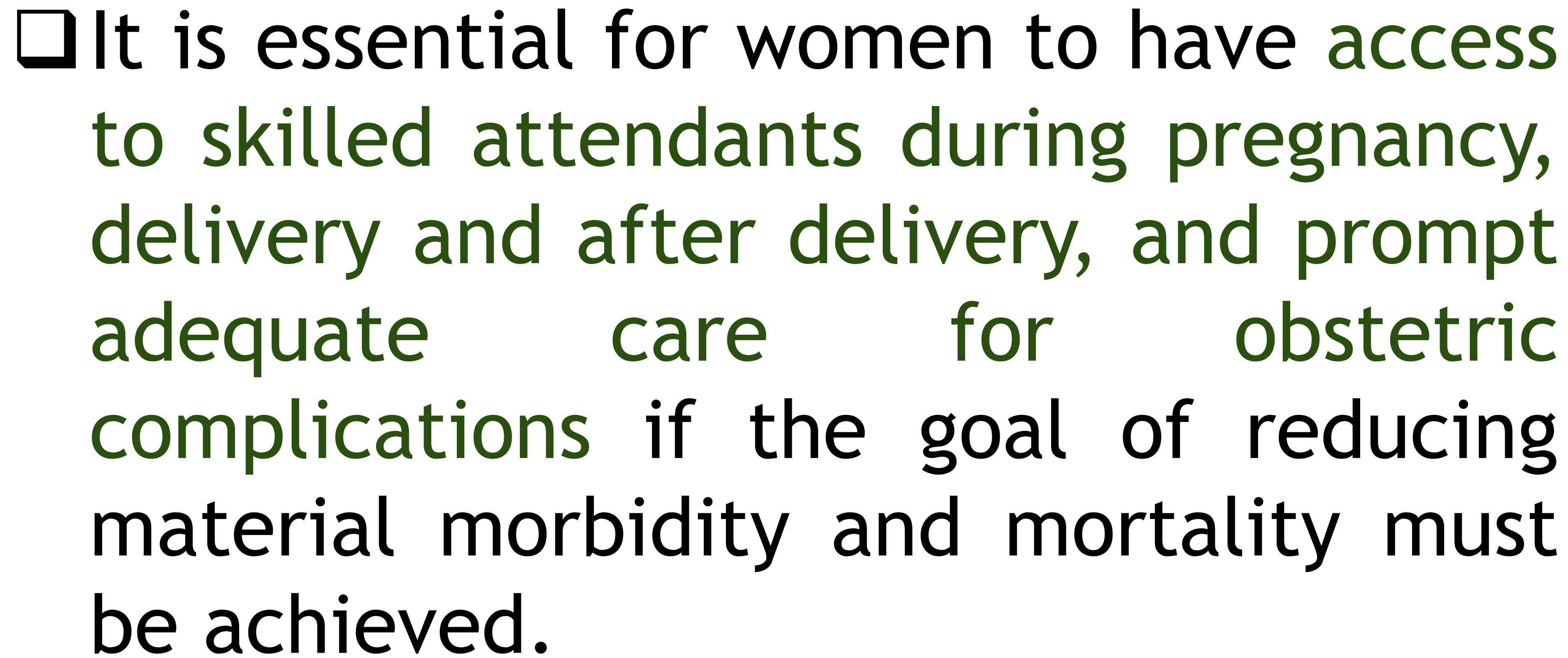
BACKGROUND

- The majority of Nigerian women live in the rural areas where the burden of reproductive ill health is higher.
- The high levels of maternal morbidity and mortality that are prevalent throughout Nigeria are as a result of many factors, including problem recognition and decision-making during emergencies leading to delayed actions, as reported by many studies.



- It is essential for women to have access to skilled attendants during pregnancy, delivery and after delivery, and prompt adequate care for obstetric complications if the goal of reducing material morbidity and mortality must be achieved.

- Health gains and healthy lives require more than just the provision of services, but such services has to be well utilized.

However, the use of skilled providers in developing countries including Nigeria remain low according to the demography and health survey.

Osubor KM, Fatusi AO,Chiwuzie JC (2006) Maternal health-seeking behavior and associated factors in a rural Nigerian community. *Maternal and Child Health Journal*, *10 (2): 159-169*.

Gill K (2007) Women deliver for development. *Lancet*, *370:1347-1357*.

Graham WJ, Bell JS, Bullough CH (2001) Can skilled attendance at delivery reduce maternal mortality in developing countries. *Safe Motherhood Strategies: A Review of the Evidence, 17: 97-130*.

National Population Commission and ICF Macro (2009) *Nigeria demographic and health survey 2008*: Key findings.Maryland: NPC and ICF Macro.

- Based on the health promotion approach as outlined by Ottawa Charter, "engaging the rural communities in the defining, designing, planning, and taking collective action in issues that affect their health will contribute to the empowerment of women, families, and communities by increasing their influence and control of material health, as well as increase access and utilization of quality skilled care by women during pregnancy, delivery and post-partum".

World Health Organization (2000) *Making pregnancy safer. Paper for discussion*. Geneva: World Health Organization.

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

Rhoes H (2001) Digital libraries and education: Trends and opportunities. *D-Lib Magazine, 7 (7/8): 1-9.*

Wang CC, Burris M (1997) Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education and Behaviour, 24 (3): 369-387*

THE PROBLEM

- In Cross River State, Nigeria, only 34,890 of women attend labour by skilled attendants while the majority deliver at home, and this situation is worse in the rural communities.
- This contributes to the high ratio of maternal mortality currently being 1,513.4:100,000 live births in the state

Archibong EI, Agan TU (2010) Reviewed of policies and programs for reduction of maternal mortality and promoting maternal health in Cross River State, Nigeria. *African Journal of Reproduction Health, 14 (3): 137-142.*

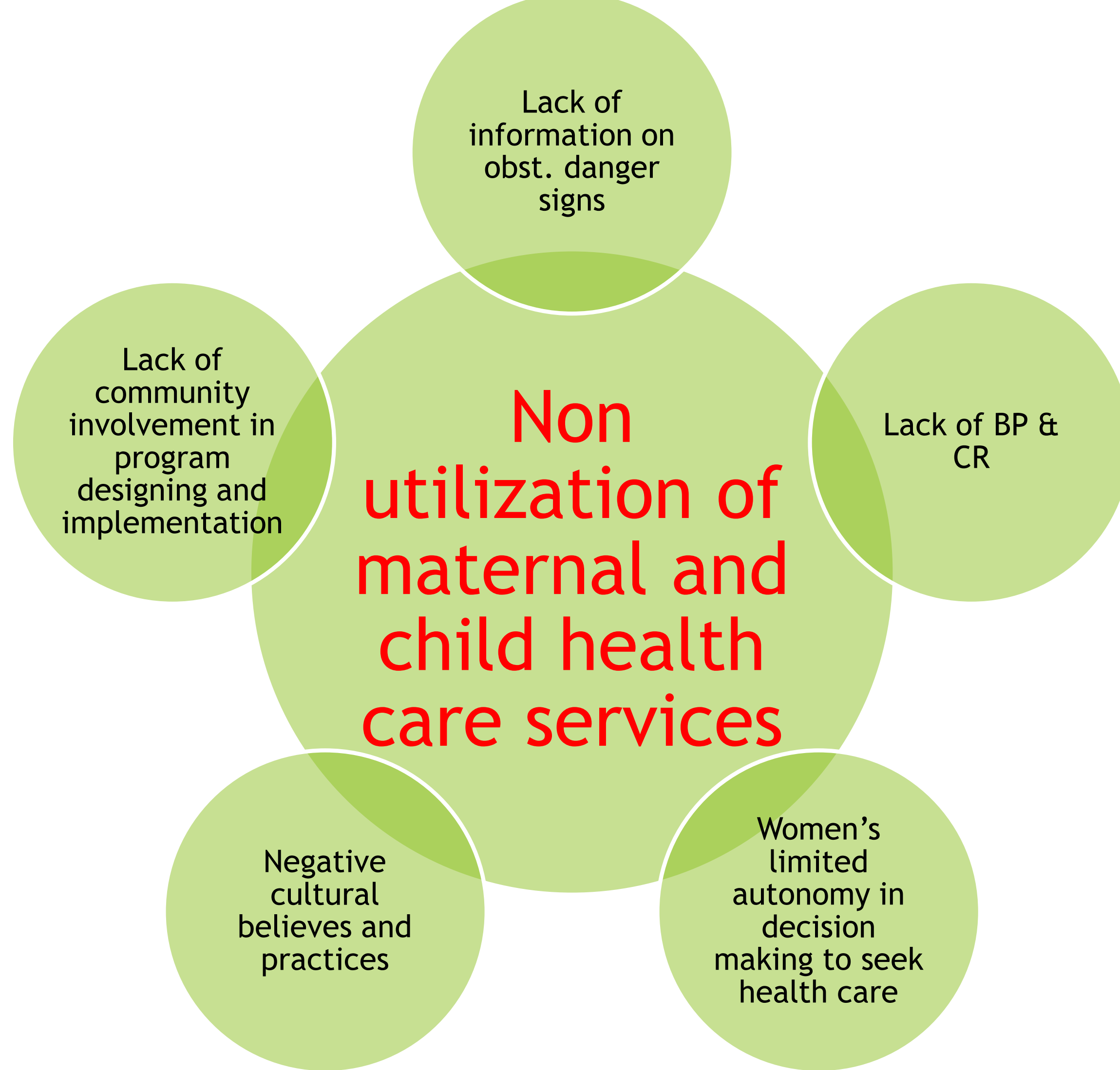
- Despite some interventions by the federal and state governments such as;

- Free maternal and child health services
- National Midwives Service Scheme (NMSS)

Majority of women especially in the rural communities do not use these services.

- Findings from studies revealed factors responsible for these to include:

Ekabua JE, Ekabua KJ, Odusolu P, Agan TU, Iklaki CU, et.al (2011) Awareness of birth preparedness and complication readiness in southeastern Nigeria. *ISRN Obstet Gynecol*. Published online 2011 July 25. doi: Accessed and retrieved online on Aug. 26th, 2012



These causes delays in seeking appropriate care, thus hampering rural women's full participation in safe motherhood initiatives.

- In identifying this as an area that require further research in Cross River State, Nigeria, Photovoice was identified as an innovative participatory action research method that offers unique contributions to women's health, especially in rural low income settings.
- Photovoice has been proven to be effective in;

- a variety of settings and diverse populations
- enhancing understanding of community needs
- improving M&C health care service utilization.

Wang C, Cash JL, Powers LS (2000). Who knows the streets as well as the homeless? Promoting personal and community action through photovoice. *Health Promotion Practice, 1 (1): 81–89.*

Fullerton JT, Killian R, Gass PM (2005) Outcomes of a community-and home-based intervention for safe motherhood and newborn care. *Health Care for Women International, 26 (7): 561-576.*

AIMS OF THE STUDY

- The aims of the study were to:
- Engage community members (pregnant women and new mothers) through a participatory approach (photovoice) to highlight problems regarding pregnancy, birth practices and service utilization.
- Identify possible solutions and make recommendations on communities' role in the prevention of maternal health complications in the rural communities of Cross River State, Nigeria.

METHODS

- Study which was part of my Ph.D research, was done between March and May, 2016.
- **Design**: Qualitative (combined focus group discussions within photovoice participatory approach)
- Using a participatory method with a qualitative approach results in:

- The investigation of the phenomena in an in-depth and holistic fashion,

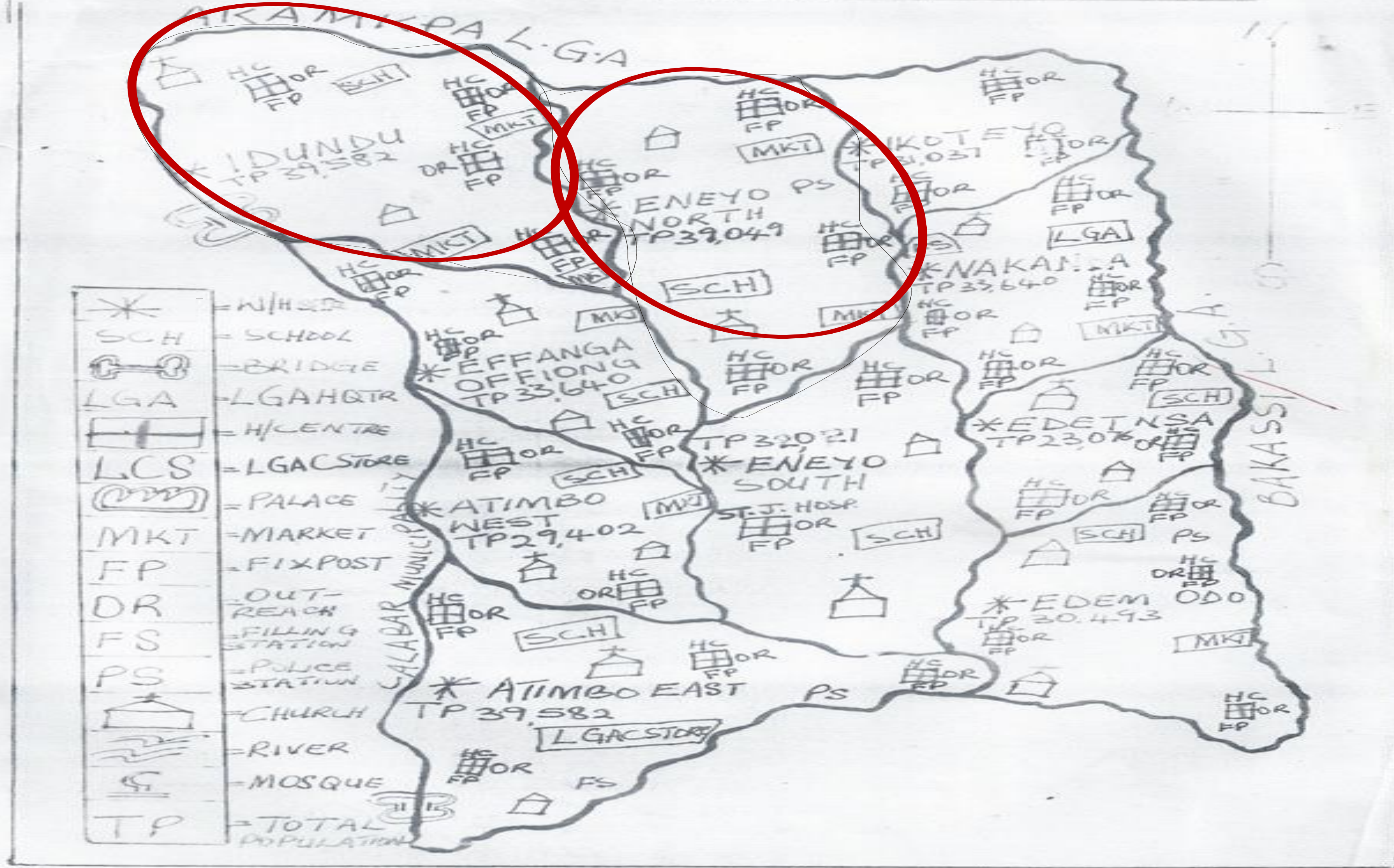
- The research could explain the relationships between the social, cultural, political, physical environments and the individual by analyzing the story they tell,
- The complexities and the process of participants real life experiences were delved into, and
- Participants in this case, were not subjects of research, but rather, were active contributors to research as they participated in all phases of the research process.

- **Setting**: Two (2) communities were purposively selected from Akpabuyo Local Government Area of Cross River State, Nigeria

  Community A - Idundu

  Community B - Anyanghanse

- The choice of these communities was based on their record of low utilization of maternal and child healthcare services from the local government PHC records.



SOCIAL MAP OF AKPABUYO L.G.A 2014
TOTAL POPULATION 341134
AKAMKPA L.G.A
IDUNDU
TP 39,582
ENEYO NORTH
TP 39,049
IKOT EYO
NAKANDA
TP 33,640
EFFANGA OFFIONG
TP 33,640
EDET NSA
TP 23,076
TP 32021
ENEYO SOUTH
ST. J. HOSP
ATIMBO WEST
TP 29,402
EDEM ODO
TP 30,493
ATIMBO EAST
TP 39,582
LGACSTORE
CALABAR MUNICIPALITY
BAKASSI L.G.A
W/H = SCHOOL
SCH = SCHOOL
= BRIDGE
LGA = LGA HQTR
= H/CENTRE
LCS = LGA C STORE
= PALACE
MKT = MARKET
FP = FIX POST
OR = OUT-REACH
FS = FILLING STATION
PS = POLICE STATION
= CHURCH
= RIVER
= MOSQUE
TP = TOTAL POPULATION

- **Participants and selection:** Twenty (20) women of reproductive age who met the inclusion criteria of
- Being pregnant at any given gestational age
- Have recently given birth (babies within 12 months of age)

Were purposively selected, ten (10) each from the two (2) rural communities under study – Idundu and Anyanghanse.

- Entry was gained into the communities through the Clan Heads, who then introduced the two (2) community women leaders to the researcher to assist in identifying the participants in their communities based on the inclusion criteria.

- **Sampling**: Non-probability purposive sampling was used. The aim was to choose individuals who will most benefit the study. It was assumed that pregnant women and new mothers will form a rich source of information for the study.

INSTRUMENTATION AND DATA COLLECTION

- Photovoice process

Step 1: Photovoice community engagement group.

This was done in two (2) phases:

1

Recruitment of the photovoice group

Venue: the respective community Town Halls for Groups A & B

- Orientation on photovoice study
  - What photovoice entails
  - Photovoice ethics
  - Study methodology
  - Camera use
  - Types of photos to take based on study focus

(Audio recording & field notes taken during the meeting which lasted 1 hour).

2

Photovoice Training

Three days after the first meeting

Venue: same as meeting 1

- Disposable cameras shared to participants
- Review on camera use and practice
- Review on photovoice ethics
- Emphasy on study focus and photos to take

(photos were to cover where women seek care during pregnancy, where they deliver, common complications, birth preparedness and complication readiness, family/community support)

Participants were given three (3) weeks to take photos

Step 2: Photovoice focus Groups

At the end of three (3) weeks, two (2) focus group discussions (FGD) were held with the participants

FGD I: Aimed to select and group photos, as well as tell stories/narratives around the photos taken

FGD II: To validate the findings of FGD I

- Participants from communities A & B returned their cameras to the facilitator (Researcher) through their women leaders for development of the photo films and printing.

FGD I:

- Two days after the return of cameras, participants from both communities A & B (n = 15, 8 & 9 respectively) were gathered in the community A town hall to check photo quality, select and group photos and discuss issues around the photos through story telling and narratives.
- Five (5) participants who were absent from family commitment reasons sent in their apologies through their women leader.

- A total of ten (10) photos were selected, grouped and categorized under;

A - Domestic Activities and healthcare practices of pregnant women

B - Attitude and access to healthcare services by pregnant women and mothers.

- The following photovoice guideline questions were posted to start the FGDs using the acronym SHOeD based on the Wang & Redwood – Jones, 2001 recommendations.

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

The first four questions explored the current situations and possible reasons for their situations, while the last question addressed possible future community actions to address the situation.

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

- Through these, the participants were able to reflect on their lives and communities in terms of the study focus via the dual voice of visual and spoken narratives, serving as agents of authentic change.
- The photovoice FGD session was recorded and notes taken alongside.

Wang CC, Redwood-Jones YA (2001) Photovoice ethics: Perspectives from flint photovoice. *SAGE Journal of Health Education and Behaviour, 28 (5): 560-572*

Carlson ED, Engebretson J, Chamberlain RM (2006) Photovoice as a social process of critical consciousness. *Qualitative Health Research, 16(6):836-852.*

Wang CC, Pies CA (2004) Family, maternal, and child health through photovoice

DATA ANALYSIS

- Data generated from the participants’ stories and narratives was analyzed using Tesch’s eight-step method of coding as follows:
  - The researcher carefully read through all the transcriptions, making notes of ideas that came to mind.
  - Selected one FGD and read it to try to get meaning in the information, writing down thoughts coming to mind.
  - Arranged the similar topics in groups by forming columns, labelled major topics; unique topics; and leftovers.
  - The researcher abbreviated the topics as codes and wrote the codes next to the appropriate segment of the text.
  - Then observed the organisation of data to check if new categories or codes emerged.
  - The researcher found the most descriptive wording for the topics and converted them into categories. The aim was to reduce the total list of categories by grouping topics together that relate to each other. Lines drawn between the categories indicated interrelationship of categories.

- A final decision was then made on the abbreviation of each category and the codes were arranged logically.
- The data material belonging to each category was put together in one place and preliminary analysis performed.
- Recoding of the data was done.

❑ **FGD II: Members checking and verification**

A week after the photovoice FGD I, participants were gathered for verbal feedback on the analysis of the findings and the themes that emerged. This lasted for 50 minutes and field note of agreement taken.

Tesch R (1990) Qualitative research: Analysis types and software tools. Bristol: Falmer

VALIDITY AND RELIABILITY OF QUALITATIVE DATA

The model for trustworthiness in qualitative data; credibility, dependability, confirmability, transformability and authentiaty, as identified by Lincoln & Guba (1985) was strictly maintained.

Lincoln YS, Guba EG (1985) Naturalistic inquiry. In N. K. Denzin, and Y. S. Lincoln, (Eds.), *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

ETHICAL CONSIDERATIONS

- **Ethical clearance was obtained from**
  - Ministry of Health, Cross River State, Nigeria;
  - The Chairman, Akpabuyo LGA of Cross River State, Nigeria; the community heads, and the women leaders;
  - Informed consent was obtained from the participants for all phases of the study.

- All the participants were assured of anonymity and the right to withdraw at any time during the study without prejudice

❑ Photovoice ethics:

The following Photovoice ethics and methods were strictly adhered to throughout the Photovoice process:

(1) individuals have a right to privacy in both private and public spaces;

(2) participants need to understand and identify contexts in which consent is needed before photo-taking;

(3) the safety of participants must be considered as photographs produced can cause embarrassment;

(4) participants should own the prints and negatives they produce to prevent commercial exploitation and appropriation;

(5) photos taken should be developed by the researcher and should not be shared with anyone but the researcher;

(6) digital copies of the images remained on the researcher's password-protected computer until data analysis was completed; and since there may be the need to include visual data into research reports. Anticipating this, an exception was built into the consent process requesting the use of certain photos that may reflect member-checked themes.

Wang CC, Redwood-Jones YA (2001) Photovoice ethics: Perspectives from flint photovoice. *SAGE Journal of Health Education and Behaviour, 28 (5): 560-572*

RESULTS

PARTICIPANTS' DEMOGRAPHICS (N=20)

Table 1: Participants demographics

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

PHOTOVOICE PROCESS

A total of 10 photographs were selected and used for the photovoice narratives. They were shared into 2 groups:

A – Domestic Activities and healthcare practices of pregnant women

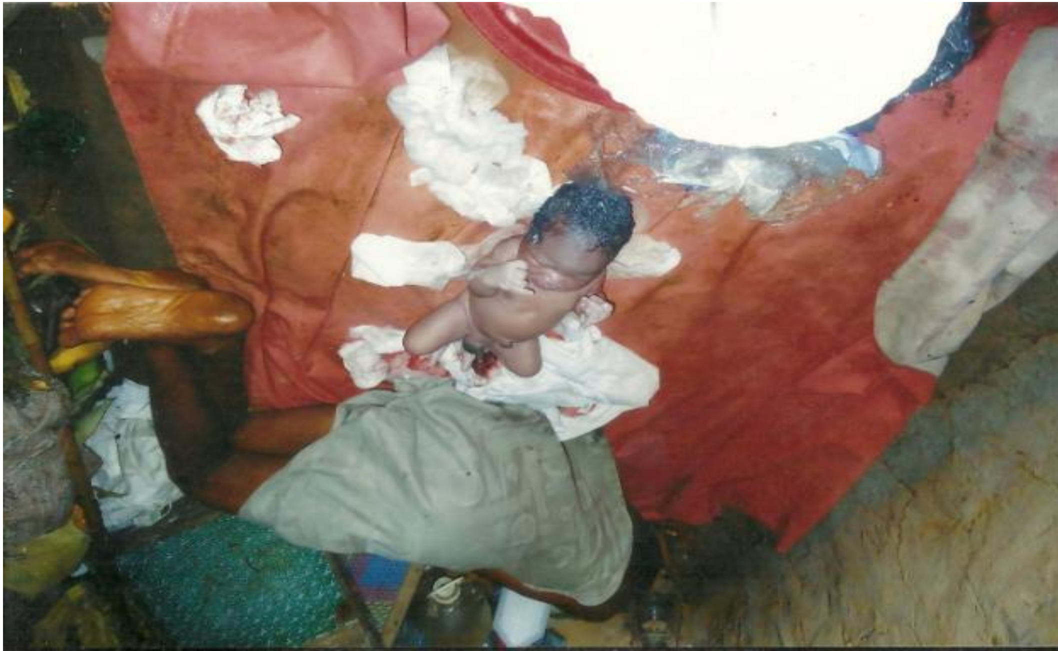
	Mother with baby working on farm (Photograph 2)
	Pregnant woman sweeping (Photograph 3)
	Pregnant woman carrying wood (Photograph 4)
	Pregnant mother shopping (Photograph 5)
	Pregnant mother shopping (Photograph 6)

B - Attitude and access to health care services by pregnant women and mothers

Pregnant woman with a young man (photograph 7)

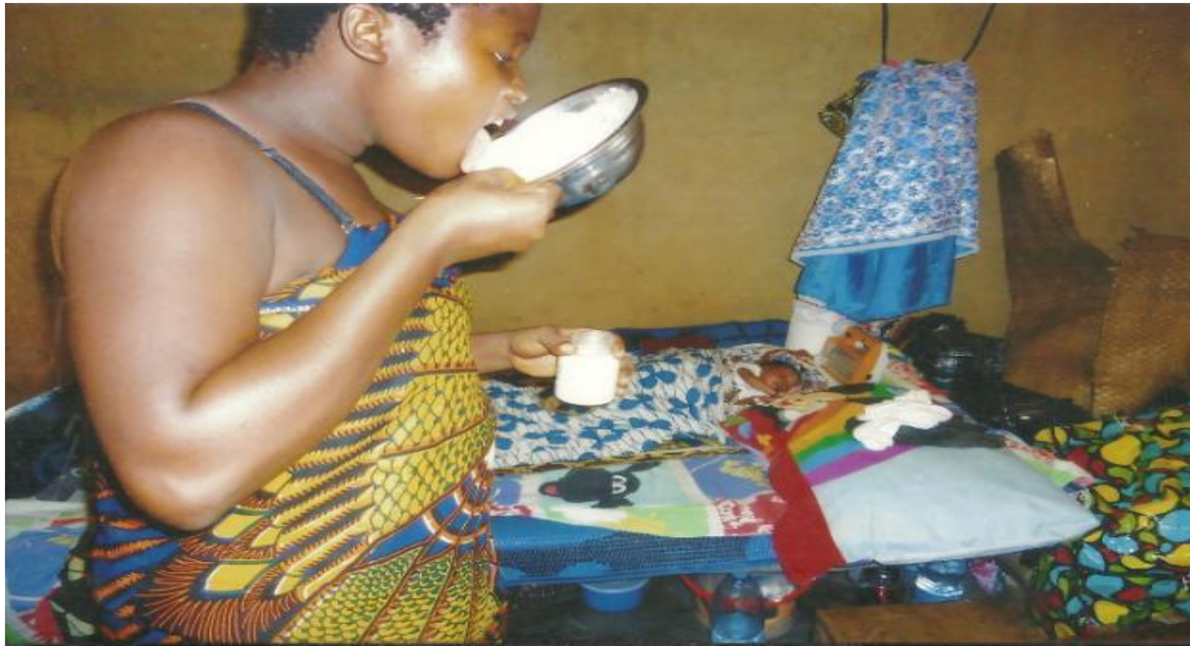
Traditional birth attendant house (Photographs 8 & 9):

A prayer altar is always evident in a TBA's delivery room (Photograph 9)



Baby delivered (Photographs 10 & 11):

A popular TBA in the community standing in front of her delivery room with a gloved hand shortly after taking the delivery shown in photograph 10



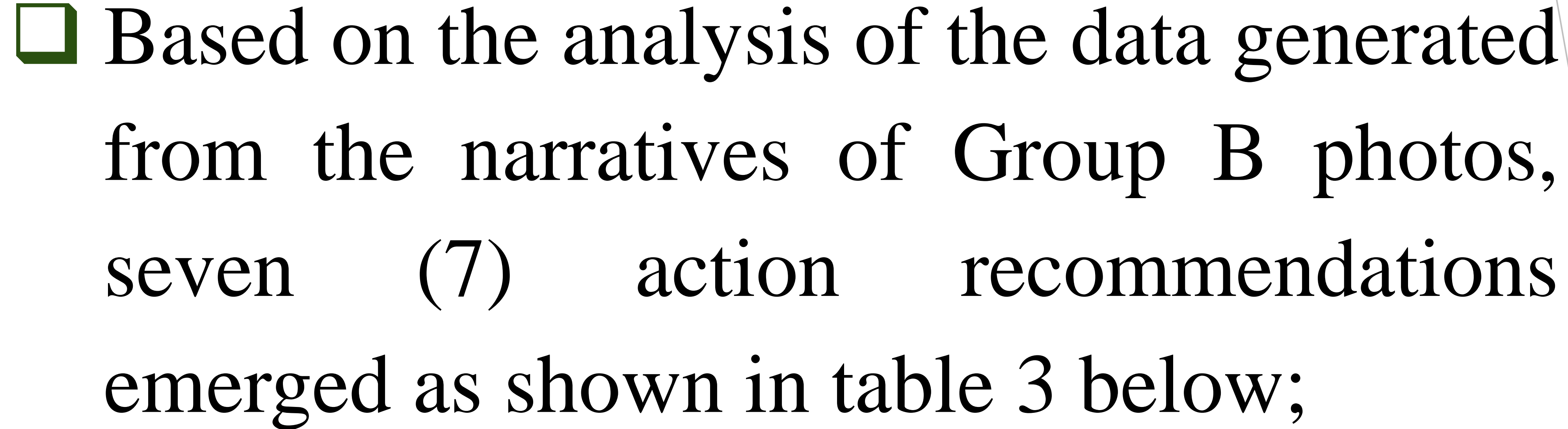
*Mother feeding baby (**Photograph** 12)*

*Waiting at the clinic (**Photograph** 13)*

THEMES EMERGING FROM PHOTOVOICE

- Based on the analysis of the data generated and transcriptions from the narratives of group A photos, four (4) themes with sub-themes and three (3) actions emerged, as shown in table 2 below.

Themes	Sub Themes
1. Cultural practices impacting on maternal health	• Heavy household chores carried out by mothers is culturally accepted • Cultural respect for men and subscription to traditional male and female roles
1. Lack of adequate information about maternal and child health issues	• Strenuous work by pregnant women is seen as exercise to reduce prolonged labour • Lack of awareness about the health impact of strenuous household chores • Attitudes about appropriate clothing during pregnancy
1. Poverty	• Working to raise money for family • Lack of money for appropriate clothes
1. Lack of help and support for pregnant women	• Lack of help and support from husband • Traditional male and female roles
Actions Identified Through Photovoice	
A. Recognising and Strengthening the role of men to support women during pregnancy	• The husbands are best placed to provide this support • Challenges in addressing cultural norms and roles
A. Strengthen the role of community to support women during pregnancy	• The extended family can also provide support • Community sensitisation on maternal health issues
A. Improve maternal health education in terms of domestic activities and pregnancy	• Need for education on self-care



- Based on the analysis of the data generated from the narratives of Group B photos, seven (7) action recommendations emerged as shown in table 3 below;

Themes	Sub Themes
1. Men are sole decision-makers regarding place of delivery	• Men escort their wives to the birth place for various reasons • Men bear the financial burden of healthcare services
1. High preference for TBAs	• High patronage of TBAs by the community women • Communal living in TBA homes • Spirituality in TBA homes • Physical proximity to service point • Confidence in TBAs as a first choice • Past experience ad belief that first place of birth is safe • Poverty and low cost of TBA services
1. Low preference for orthodox healthcare facilities	• Lack of knowledge about availability of free healthcare for women and children in healthcare facilities • Past experiences of negative attitude of healthcare providers • Fear of health facility injections and operations • Absence of healthcare providers on duty at night • Perceived costs of health services
1. Poor knowledge of maternal and child care in TBA homes	• TBA's lack of knowledge on proper delivery procedures and care • Lack of education on care of the newborn
1. High recognition of importance of immunization	• Utilisation of immunisation services by women • High level of community involvement in awareness-creation on benefits of immunisation

RECOMMENDATION ACTIONS IDENTIFIED FOR ACCESS AND ATTITUDES	
A. Free treatment in healthcare facilities	• 'Free' treatment should be free in the real sense • Community involvement in raising awareness of free health services
A. Involvement of husbands in ANC	• Men as sole decision-makers should be involved in ANC • Challenges in addressing cultural norms and roles
A. Spirituality in service delivery	Strong faith in prayers and fasting to God during pregnancy for protection should be integrated in health service delivery
A. Community support	• Influence of community heads through levies and sanctions to emphasise importance of utilisation of healthcare facility • Constitution of influential women group to monitor the activities of pregnant women in the community • Use of community structures such as village announcers, churches, women groups, community heads, etc. in emphasizing facility delivery
A. Motivation to attend health services	• Receptive attitude of care-providers • Occasional gifts to women who utilise orthodox facilities to encourage them and motivate others • Availability of 24-hour services
A. TBA training and facility/TBA collaboration	• Knowledge and skills for proper delivery practices of mother and childcare. • TBA/Facility collaboration

DISCUSSION/CONCLUDING STATEMENTS

The following concluding statements were derived from the study based on the discussions of the themes that emerged;

1. Mothers and pregnant women continue to play traditional roles such as doing household chores due to poverty and cultural roles. This necessitates **identifying ways to include the husband in the planning of maternal care**
2. Maternal health literacy is low with poor knowledge of maternal health care and self-care, child care, appropriateness of TBA home birth for specific pregnancies, lack of knowledge bout availability of free health care for women and children and there **is a need to identify a strategy to improve maternal health literacy in the community**
3. Husbands play a key role in decision making and support of the women during pregnancy and there are challenges in changing these cultural norms. The community could play a role in shaping this role to a more supportive role and identify **ways to include the husband in the planning of maternal care**

4. The importance of spirituality in maternal and child health cannot be overemphasized and strategies should be identified on how to integrate spirituality in orthodox health services and through the **integration of the role of the TBA within an overall collaborative model of maternal health care**
5. Strategies for **improving access and attendance to orthodox maternal health services could include raising awareness** about free treatment, receptive attitude of care-providers and occasional gifts to women who utilise orthodox facilities to encourage them and motivate others as well as the availability of 24-hour services,
6. The community role in support for the pregnant women could be increased and community **sensitization would increase the community's role as a resource for maternal health literacy**

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

- The findings of this study and the recommendations from participants however, explain in part results from other investigators who have examined and tested various strategies of engaging community members in the designing, planning, and implementing programs that promote the utilization of skilled maternal healthcare services by pregnant women and mothers in the poor rural settings, thereby preventing maternal health complications.

Iliyasu, et al. (2010); Odimegwu, et al. (2005); Magoma, et al. (2010); Doctor, et al. (2012); Tweheyo, et al. (2010); Iliyas, et al. Abdulraheem, et al. (2012); Oshonwoh, et al. (2014); Azad, et al. (2010); Pyone, et al. (2014); Imogie, et al. (2002); Ofili AN, Okojie OH (2005); Imogie AO (2000); Onah, et al. (2006); Gwatkin, et al. (2005); Society of Gynaecology and Obstetrics of Nigeria (SOGON) (2004); Tripathy, et al. (2010); Lassi, et al. (2010); World Health Organization (2005); Bergstrom S, Goodburn E (2001); Sibley, et al. (2012).

- The present study did not cover the implementation of the participants' recommendations, specifically the formation of the community engagement group. Hence, this and the evaluation of their effectiveness should be the focus of further research.

IMPLICATIONS FOR POLICY

Findings have implications for Nursing practice, education and research

- There must be a collaborative approach between the rural communities and nursing/ midwifery and other health professionals, for the purpose of constituting a Community Engagement Group (CEG), to achieve the prevention of maternal health complications in rural communities.
- The government or orthodox healthcare providers should use the CEG as their contact point within the communities while carrying out healthcare initiatives.
- Providers of orthodox healthcare should be given re-orientation on attitudinal change in the course of their dealings with rural community members.
- The experiences of the consumers of the healthcare services within the rural communities and that of the members constituting CEGs should be explored using qualitative methodologies.

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LESSONS LEARNED

- It has been demonstrated that active involvement by communities is critical to the success of interventions, and is best ensured if the initiative and responsibility for implementation comes from the community.
- Through Photovoice, each partner was able to bring unique strengths to the process with the core purpose of communicating the intended relationship between planned activities, delivery processes, and targeted outcomes.

YOUR VIEWS?

LET’S SHARE