



Published in final edited form as:

Int J Gynaecol Obstet. 2019 May ; 145(2): 164–169. doi:10.1002/ijgo.12788.

Women's experience with group prenatal care in a rural community in northern Nigeria

Sunday E. Adaji^{1,*}, Adenike Jimoh², Umma Bawa¹, Hajara Ismail¹, Abiola A. Olorukooba³, Hamdalla Adelaiye³, Comfort Garba⁴, Anita Lukong⁵, Suleiman Idris⁶, and Oladapo S. Shittu¹

¹Department of Obstetrics and Gynaecology, Ahmadu Bello University, Zaria, Nigeria.

²College of Health Science, Bingham University, Jos, Nigeria.

³Department of Paediatrics, Ahmadu Bello University, Zaria, Nigeria.

⁴CBS Research Group, PRHI, Ahmadu Bello University, Zaria, Nigeria.

⁵Department of Nursing Sciences, Ahmadu Bello University, Zaria, Nigeria.

⁶Department of Community Medicine, Ahmadu Bello University, Zaria, Nigeria.

Abstract

Objective: To assess women's experience of group prenatal care in a rural Nigerian community.

Methods: In an observational study, consenting pregnant women were enrolled in a group prenatal care program based on the CenteringPregnancy model from July 1, 2010, to June 30, 2011, in Tsibiri, Nigeria. Women were interviewed before joining the group and postnatally. A predesigned pro forma was used to assess group behavior during sessions. Descriptive and inferential statistics were applied to data.

Results: In total, 161 women enrolled, and 54 of 72 scheduled prenatal sessions took place. The average number of visits was three per woman, with good group interaction and cohesion. Mothers who could mention at least five out of eight danger signs of pregnancy increased from 1.4% (2) to 13.3% (14) ($P < 0.001$, 95% CI 4.28–19.52), while mean knowledge score for danger signs increased from 31% to 47.8% ($P < 0.001$, 95% CI 0.86–2.16). Commitment to birth preparedness plans was impressive. The mothers enjoyed the group sessions and shared the lessons they learned with others.

Conclusion: Group prenatal care was feasible and acceptable to women in the present study setting. Comparative trials would be helpful to demonstrate the benefits of the tested model in low-income settings.

*Corresponding author: Sunday E. Adaji, c/o PHRI Secretariat, Ahmadu Bello University Teaching Hospital, P.M.B 06 Shika- Zaria, Nigeria, unyiwa@yahoo.com.

Author contributions

SEA contributed to the design of the study, interpretation and analysis of the data, writing and revising the manuscript. UB contributed to the interpretation of the data and writing the manuscript. AJ, HI, AAO, HA, CG, AL, and SI contributed to the interpretation of the data, and writing and revising the manuscript. OSS contributed to the design of the study, and revising the manuscript.

Conflicts of interest

The authors have no conflicts of interest.

Synopsis:

This study suggests that group prenatal care in resource-constrained settings could be beneficial and could contribute to improvements in maternal and newborn outcomes.

Keywords

Group prenatal care; Maternal health; Nigeria; Rural community; Women's experience

1 INTRODUCTION

In 2016, WHO estimated that 830 women died daily from preventable causes related to pregnancy and childbirth, with 99% of them in low-income countries. Compared to urban settings, women living in rural communities are at higher risk of pregnancy and childbirth complications [1]. There is evidence that providing skilled care before, during, and after childbirth could reduce risks and improve outcomes for women and newborns [2]. Providing such care in low-income settings is hampered by factors including the availability and management of resources and the acceptability and utilization of the care available by community-dwelling women [3]. Research work continues on how to provide skilled care to women who are difficult to reach with existing care models.

In the present study, a group prenatal care model was piloted, patterned after CenteringPregnancy, a multifaceted model of group care that integrated three major components of care—*health assessment, education, and support*—into a unified program [4]. Underpinning the model was the assumption that, by using a participatory approach, community-dwelling women, when supported and provided with a safe space, could take on more responsibility to improve outcomes for themselves and their newborns.

The typical CenteringPregnancy model, in which mothers attended group sessions for their prenatal care within a hospital, was associated with reduced preterm births, improved birth weight, and increased maternal weight gain in pregnancy, as well as adequacy of prenatal care and maternal satisfaction with care [5]. An association between CenteringPregnancy and postpartum family planning has also been documented [6], as well as a positive correlation between CenteringPregnancy and adolescent health behavior in the perinatal period [7]. However, there have been concerns about a lower perception of the value of prenatal care as well as a low tendency to engage in some health-seeking behaviors among CenteringPregnancy mothers [8].

Group prenatal care has been gaining worldwide attention as an alternative to traditional one-to-one care [9]. In Sub-Saharan Africa, there have been pilot studies suggesting the feasibility and acceptability of this model [10]. A Cochrane and recent WHO reviews provide insights into the potential benefits of group prenatal care [11,12]. However there are still gaps in the experience of this model and how best to integrate it into existing maternal health care programs.

The aim of the present study was to describe women's experience of community-level group prenatal care with regards to participation, group cohesiveness and support, retention of

knowledge of danger signs of pregnancy learned, fidelity to birth preparedness plans developed, and enjoyment of the sessions.

2 MATERIALS AND METHODS

A prospective observational study was conducted in Tsibiri, a village in northern Nigeria, from July 1, 2010 to June, 30 2011. A baseline survey carried out prior to the study showed that Tsibiri had a population of 1490. Key maternal health indices in Tsibiri are shown in Table 1. The first cohort was recruited within the Primary Health Care Center in the community. Women were registered into four groups: those giving birth for the first time, those with one to four previous deliveries, and those with more than four previous deliveries. A separate postnatal group was created. Subsequently, other interested women were enrolled into the groups using this template. Women who were found to have complicated pregnancies at the initial assessment were referred to a nearby hospital. Ethical approval was obtained from the Institutional Review Board of the Population Council, New York, and the Ethical Clearance Committee of Ahmadu Bello University, Zaria, Nigeria. Written permission was granted by the Ministry of Health, and verbal permission was given by the community leaders. Participation by individuals in the study was voluntary, with written consent, and women were informed that they could exit at any point, if they so wished, without incurring any sanctions.

Only registered members of the group attended the group sessions, and men were not invited to attend the meetings.

Six female facilitators were trained in community-based participatory research methods, informed consent, and the protection of human subjects. They were also trained in facilitation skills, providing prenatal and postnatal care in a group setting, and health education. A research midwife and a team of traditional birth attendants (TBAs) were trained in data collection at the community level.

A handbook was developed to guide the mothers' group activities. Key themes covered included (1) knowing your body, (2) common discomforts of pregnancy, (3) hygiene, (4) nutrition during pregnancy, (5) danger signs of pregnancy and childbirth, (6) preparations for emergency, (7) breastfeeding, and (8) baby care.

The group sessions took place for a period of one year using an activity schedule developed with the mothers' input. Each session was facilitated by two trained female facilitators and took place in a house volunteered by a member of the community, and it lasted for a period of 3 hours. Each session consisted of an ice breaker, followed by private clinical assessment of the individual women. During clinical assessment, the women were asked about their health; their height, weight, and blood pressure were measured; and their abdomen was palpated. Urinalysis was also performed for each woman. Some of the women, who had received training, helped with weighing their colleagues, under the watchful eyes of the service providers. All care conformed with local guidelines [13]. This was followed by a group discussion on a specific topic on maternal health that was facilitated by one of the researchers. Next, the women took turns to demonstrate cooking of a healthy meal of their

choosing, and a closing activity selected from the handbook ended each session to reinforce key issues discussed for the day.

Knowledge assessment was performed for each woman at the point of entry into the group and 1 week after the pregnancy for knowledge of the danger signs of pregnancy and what they would do or what they did to prevent pregnancy complications. The women were also interviewed about preparations for labor and delivery, and availability of support during labor and childbirth, including circumstances when complications developed. Clinical findings were entered into a predesigned and pretested pro forma adapted from the prenatal recording tool of a nearby hospital. During the group meetings, one facilitator assessed group dynamics using a pretested tool which was designed by the study group. Data on pregnancy outcomes were collected by TBAs during visits to the women's homes using a system of color-coded bottles and pebbles that were validated weekly by a research midwife. These outcomes were discussed in another article.

SPSS for Windows, Version 24.0 (IBM, Armonk, NY, USA) was used to analyze data. Simple frequencies were computed with means, and proportions were compared where $P < 0.05$ was considered statistically significant, and at a 95% CI. McNemar's Z-test for paired proportions was used to assess retention in women's knowledge of danger signs of pregnancy and commitment to birth preparedness plans.

3 RESULTS

During the study, 54 group sessions were held out of the intended 72 (75%), with a total of 161 participating mothers. The mothers' age ranged from 13 to 40, with a median of 22, while their parity ranged from 0 to 12, with a median of 3 (Table 2).

Out of 161 enrolled into the program, 105 continued and had a cumulative attendance of 392. The 56 mothers who dropped out remained in the register, but were excluded from further analysis beyond enrolment. The attendance per mother ranged from a minimum of 1 to a maximum of 11, with a median of 3. A total of 290 out of the 392 attendances (74%) were associated with full participation in the day's activities and judged to be "complete" visits.

The mothers interacted with each other, learned from each other, and functioned as a group (Table 3). They demonstrated significant retention of knowledge of the key danger signs of pregnancy and childbirth acquired during group sessions (Table 4). The mothers were also asked about what they would do in preparation for childbirth and/or a pregnancy complication at the time of enrollment. Their responses were compared with what they actually did afterwards in preparation for childbirth (Table 5). This showed fidelity of the mothers to the plans they made at the time of enrolment. Mothers' satisfaction with the group activities was assessed using the parameters shown in Table 6. Only 48 mothers completed the satisfaction questionnaire; these mothers enjoyed being part of the group, planned to keep in touch with each other as well as share their experience with their spouses and other women.

4 DISCUSSION

The findings of the present study showed that group prenatal care was feasible even in a rural community. The women demonstrated their enthusiasm by their active participation with good group interaction and cohesion. The group sessions helped them to learn and retain knowledge of key danger signs of pregnancy and enhanced their fidelity to their birth preparedness plans. They also utilized the opportunity to develop a new social and support network.

The women's acceptance of the model of care and their enthusiasm for participation echoes the findings by previous authors [14]. During group sessions, the mothers learned from each other and showed support, connection, and understanding with each other, corroborating the findings of McNeil et al. [14], with a minimum of disruption and disrespect. However, while the findings of these previous authors were based on qualitative interviews conducted after delivery, the present study findings were based on real-time observations carried out while the group sessions were going on, and so they were less likely to be affected by recall bias.

In terms of group processes, the sessions were observed to be peer group-like in most cases, with little or no display of didactic, classroom-like behavior. This conversion from didacticism to interaction and discussion within a group space was one of the key strengths of group prenatal care when compared to conventional prenatal care [15]. Furthermore, during sessions the majority of the mothers were observed to easily connect with each other, sharing their experiences with others and forming new relationships. The evolution of such social networks is also considered a core benefit of group prenatal care, with some studies showing an association with improvement in psychosocial function [16]. This benefit is of special significance in the setting of the present study, where "purdah," the cultural practice of social confinement of women, is still rife and a major contributor to unsupervised home births [17].

Mothers in the present study were able to retain knowledge of danger signs of pregnancy to a significant extent. A comparison of knowledge before and after birth showed that the group scores had increased, as well as the proportion of women who knew about the individual danger signs. One systematic review demonstrated that group prenatal care mothers have better prenatal care knowledge compared to mothers who attended the conventional prenatal care [18].

The finding that the proportion of women who implemented birth preparedness plans was significantly higher than those who indicated that they had plans initially was important, especially in the study setting and similar settings where women have little or no voice nor any control over their reproductive health. Birth planning and complication readiness are reportedly low in such settings [19]. It may be that the group process and new social network developed galvanized some of the mothers to take more responsibility for their own health. Some authors have reported better birth preparedness plans and improved commitment to such plans among participants of group prenatal care [14].

The majority of mothers in this study enjoyed being in the company of other women, made new friends, and planned to keep in touch. They even shared the lessons they learned with

their female friends and spouses. This suggested an impact of the prenatal sessions beyond the meeting rooms to family and community levels, which could engender more social support for mothers. Interestingly, Chae et al. [20] have shown that group prenatal care confers higher perception of family and friends' support compared to traditional prenatal care. It is difficult to forecast if such eagerness by mothers to disseminate their acquired knowledge would have any bearing on the future of group prenatal care in the study community.

Although the model of group prenatal care used in the present study was patterned after the CenteringPregnancy model, it was implemented within a rural community setting, outside of a health care facility. Reports of group prenatal care outside of health care facility settings are rare in the English-language literature. A key strength of the model was the removal of a physical barrier between health facilities and the community, which could be a factor in under-utilization of maternity services [21]. This factor was of special significance in the setting of the present study, where the uptake of conventional prenatal care was a mere 51% [Population and Reproductive Health Initiative (PRHI), Ahmadu Bello University, Zaria, Nigeria: 2007, unpublished report].

Group prenatal care, more so at the community level, was new in the part of the world represented by the study. Setup required a huge mobilization effort at the community level. Such strategies have been shown to work well for maternal health care provision in Sub-Saharan African countries [22] and should be an essential component in the design of community-based models such as in the current study, especially in conservative communities.

The study engaged doctors in contrast to trained midwives used in other CenteringPregnancy programs. The chief reason for this was the dearth of midwives with the level of community orientation required for the study design. It would seem logical to train midwives to the level of facilitative proficiency required for group prenatal care, a case already made by some authors [23].

A key limitation to the present study was its non-comparative design. However, Kennedy et al. [24] demonstrated that group prenatal care is associated with mothers' increased satisfaction of care as well as adequacy of prenatal care when compared to individual care. Hopefully, the present study findings will stimulate such comparative studies in the future. The occurrence of communal unrest in neighboring communities, which led to cancellations, was another limitation. Future researchers would need to consider this important factor before approaching such a community.

In conclusion, the experience of women in the present study suggested that there could be a place for group prenatal care in resource-constrained settings. Careful planning, as well as tapping into existing skills and resources, could help to develop a more realistic and cost-effective model that, if scaled up, could contribute to improvements in maternal and newborn outcomes.

Acknowledgments

The study was funded by the Population Council under Sub-award SR1012M-5. The authors would like to thank the Population Council for this opportunity. The study team also benefitted from the UC Berkeley Global Research Training in Population and Health in Nigeria; 2006-11NIH Grant Number: 1 D43 TW007696-01 and hereby express their appreciation.

References

1. Alkema L, Chou D, Hogan D, Zhang S, Moller A-B, Gemmill A, et al., Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *The Lancet*, 2016 387(10017): p. 462–474.
2. Adegoke AA, van den Broek N, Skilled birth attendance-lessons learnt. *BJOG*, 2009 116 Suppl 1: p. 33–40. [PubMed: 19740170]
3. Saad-Haddad G, DeJong J, Terreri N, Restrepo-Mendez MC, Perin J, Vaz L, et al., Patterns and determinants of antenatal care utilization: analysis of national survey data in seven countdown countries. *J Glob Health*, 2016 6(1): p. 010404. [PubMed: 27231540]
4. Reid J, Centering Pregnancy: a model for group prenatal care. *Nurs Womens Health*, 2007 11(4): p. 382–8. [PubMed: 17883755]
5. Picklesimer AH, Billings D, Hale N, Blackhurst D, Covington-Kolb S, The effect of Centering Pregnancy group prenatal care on preterm birth in a low-income population. *Am J Obstet Gynecol*, 2014 206(5): p. 415 e1–7.
6. Hale N, Picklesimer AH, Billings DL, Covington-Kolb S, The impact of Centering Pregnancy Group Prenatal Care on postpartum family planning. *Am J Obstet Gynecol*, 2014 210(1): p. 50 e1–7. [PubMed: 24018309]
7. Trotman G, Chhatre G, Darolia R, Tefera E, Damle L, Gomez-Lobo V, The Effect of Centering Pregnancy versus Traditional Prenatal Care Models on Improved Adolescent Health Behaviors in the Perinatal Period. *J Pediatr Adolesc Gynecol*, 2015 28(5): p. 395–401. [PubMed: 26233287]
8. Shakespear K, Waite PJ, Gast J, A comparison of health behaviors of women in centering pregnancy and traditional prenatal care. *Matern Child Health J*, 2010 14(2): p. 202–8. [PubMed: 19184385]
9. Carter EB, Temming LA, Akin J, Fowler S, Macones GA, Colditz GA, et al., Group Prenatal Care Compared With Traditional Prenatal Care: A Systematic Review and Meta-analysis. *Obstet Gynecol*, 2016 128(3): p. 551–61. [PubMed: 27500348]
10. Patil CL, Abrams ET, Klima C, Kaponda CP, Leshabari SC, Vonderheid SC, et al., Centering Pregnancy-Africa: a pilot of group antenatal care to address Millennium Development Goals. *Midwifery*, 2013 29(10): p. 1190–8. [PubMed: 23871278]
11. Catling CJ, Medley N, Foureur M, Ryan C, Leap N, Teate A, et al., Group versus conventional antenatal care for women. *Cochrane Database Syst Rev*, 2015(2): p. CD007622. [PubMed: 25922865]
12. Tuncalp O, Pena-Rosas JP, Lawrie T, Bucagu M, Oladapo OT, Portela A, et al., WHO recommendations on antenatal care for a positive pregnancy experience-going beyond survival. *BJOG*, 2017 124(6): p. 860–862. [PubMed: 28190290]
13. Nigeria FMOH, National Clinical Service Protocol for Obstetric Care, F.M.o. Health, Editor. 2008: Nigeria.
14. McNeil DA, Vekved M, Dolan SM, Siever J, Horn S, Tough SC, Getting more than they realized they needed: a qualitative study of women's experience of group prenatal care. *BMC Pregnancy Childbirth*, 2012 12: p. 17. [PubMed: 22436393]
15. Xaverius PK, Grady MA, Centering pregnancy in Missouri: a system level analysis. *ScientificWorldJournal*, 2014 2014: p. 285386. [PubMed: 24693234]
16. Ickovics JR, Reed E, Magriples U, Westdahl C, Schindler Rising S, Kershaw TS, Effects of group prenatal care on psychosocial risk in pregnancy: results from a randomised controlled trial. *Psychol Health*, 2011 26(2): p. 235–50. [PubMed: 21318932]

17. Wall LL, Dead mothers and injured wives: the social context of maternal morbidity and mortality among the Hausa of northern Nigeria. *Stud Fam Plann*, 1998 29(4): p. 341–59. [PubMed: 9919629]
18. Lathrop B, A systematic review comparing group prenatal care to traditional prenatal care. *Nurs Womens Health*, 2013 17(2): p. 118–30. [PubMed: 23594324]
19. Hailu M, Gebremariam A, Alemseged F, Deribe K, Birth Preparedness and Complication Readiness among Pregnant Women in Southern Ethiopia. *PLOS ONE*, 2011 6(6): p. e21432. [PubMed: 21731747]
20. Chae SY, Chae MH, Kandula S, Winter RO, Promoting improved social support and quality of life with the CenteringPregnancy® group model of prenatal care. *Arch Womens Ment Health*, 2017 20(1): p. 209–220. [PubMed: 27988822]
21. Rurangirwa AA, Mogren I, Nyirazinyoye L, Ntaganira J, Krantz G, Determinants of poor utilization of antenatal care services among recently delivered women in Rwanda; a population based study. *BMC Pregnancy Childbirth*, 2017 17(1): p. 142. [PubMed: 28506265]
22. Muzyamba C, Groot W, Tomini SM, Pavlova M, The role of Community Mobilization in maternal care provision for women in sub-Saharan Africa- A systematic review of studies using an experimental design. *BMC Pregnancy Childbirth*, 2017 17(1): p. 274. [PubMed: 28851299]
23. Novick G, Reid AE, Lewis J, Kershaw TS, Rising SS, Ickovics JR, Group prenatal care: model fidelity and outcomes. *Am J Obstet Gynecol*, 2013 209(2): p. 112 e1–6. [PubMed: 23524175]
24. Kennedy HP, Farrell T, Paden R, Hill S, Jolivet RR, Cooper BA, et al., A randomized clinical trial of group prenatal care in two military settings. *Mil Med*, 2011 176(10): p. 1169–77. [PubMed: 22128654]

Table 1

Key maternal health indices of Tsibiri.

Indicator	Value
Median age at marriage	15 years
Median age of first childbirth	19 years
Ever used any contraceptive method	15%
Current use of any contraceptive method	3.4%
PNC provided by SBA	51%
SBA at birth	3.6%
Delivery within a health facility	3.2%
Maternal mortality ratio (per 100 000 livebirths)	1400
Availability of birth services within local PHC facility	None

Abbreviations: PHC, primary health care; PNC, prenatal care; SBA, skilled birth attendant.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2

Age and parity of mothers.

Age (n=158)	No	%
14	8	5.1
15–19	32	20.3
20–24	56	35.4
25–29	28	17.7
30–34	23	14.6
35–39	10	6.3
40–44	1	0.6
Parity (n=159)		
0	26	16.3
1–4	85	53.5
5	48	30.2

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 3

Assessment of interactions and group cohesion during sessions [N= number of sessions].

Measures of interaction ^a	None (0)	One to few (1)	About half (2)	Most to all (3)
Share information, ideas, personal feelings and experiences (<i>n</i> =50)	1 (1.9)	3 (5.6)	15 (29.6)	31 (59.3)
Appear disengaged—head down, avoid eye contact (<i>n</i> =52)	15 (27.8)	32 (61.1)	1 (1.9)	4 (7.4)
Appear disrespectful—side conversations, coming and going from group (<i>n</i> =47)	24 (48.1)	18 (35.2)	2 (3.7)	3 (5.6)
Overly talkative—interrupt other participants or facilitator (<i>n</i> =50)	15 (29.6)	29 (55.6)	5 (9.3)	1 (1.9)
Supportive/understanding of other participants, their experiences and opinions (<i>n</i> =55)	1 (1.9)	18 (33.3)	34 (63.3)	2 (3.0)
Measures of cohesion	Response		Frequency	Percentage
Did the session feel like a “classroom” or a “peer group”? (<i>n</i> =51)	Felt like a classroom		3	5.6
	Not sure		10	18.5
	Felt like a peer group		38	72.2
How much were participants involved and connected as a cohesive group? (<i>n</i> =51)	Participants involved		3	5.6
	Participants partly involved		10	18.5
	Participants fully involved		38	72.2
Was the group a safe space for women to share experiences and opinions? (<i>n</i> =52)	Not safe		1	1.9
	Partially safe		7	13.0
	Safe		44	83.3

^aValues are given as number (percentage) unless indicated otherwise.

Table 4

Acquisition of knowledge of danger signs of pregnancy.

Indicator	At entry to the group (n = 138)	After delivery (n=105)	P-value	95% CI
Aggregate scores				
Women who could list at least 5 out of 8 danger signs ^a	2 (1.4)	14 (13.3)	<0.001	4.28–19.52
Mean knowledge score of group	31%	47.8%	<0.001	0.86–2.16
Individual danger sign ^a				
Bad headache	46 (33.3)	56 (53.3)	0.002	6.80–33.20
Blurred vision	8 (5.8)	22 (21.0)	<0.001	5.65–24.75
Seizures	24 (17.4)	62 (59.0)	<0.001	29.43–53.77
Swollen legs	20 (14.5)	54 (51.4)	<0.001	24.84–48.96
Excessive bleeding	70 (50.7)	82 (78.1)	<0.001	15.07–39.73
Retained placenta	10 (7.2)	49 (46.7)	<0.001	28.19–50.81
Prolonged labour	30 (21.7)	62 (59.0)	<0.001	24.81–49.79
Infection	34 (24.6)	43 (41.2)	0.008	3.92–29.28

^aValues are given as number (percentage).

Table 5

Commitment to birth preparedness plan

Preparatory activity	Planned before birth ^a (n= 138)	Actually done in preparation for childbirth ^a (n=105)	P-value	95% CI
Clean room	47 (34.1)	66 (62.9)	<0.001	15.80–41.80
Take standing permission from husband	10 (7.2)	28 (26.7)	<0.001	9.16–29.84
Purchase materials for birth	36 (26.1)	56 (53.3)	<0.001	14.33–40.07
Purchase materials for baby	54 (39.1)	76 (72.4)	<0.001	20.65–45.95
Inform nearby TBA	19 (13.8)	34 (32.4)	0.001	7.12–30.08
Set aside funds	15 (10.9)	44 (41.9)	<0.001	19.39–42.61
Nothing	37 (26.8)	9 (8.6)	0.001	8.23–28.17

Abbreviation: TBA, traditional birth attendant.

^aValues are given as number (percentage).

Table 6Mothers' satisfaction with group sessions and development of new social network.^a

Parameter	Yes	No	P-value	95% CI
Enjoyed being with the other women in this group (n=48)	48 (100)	0 (0)	<0.001	97.2–102.8
Got to know new women in this group who you didn't know before (n=48)	45 (93.8)	3 (6.3)	<0.001	75.73–99.27
Planned to keep in contact with any of the other women (n=47)	43 (91.5)	4 (8.5)	<0.001	69.60–96.40
Shared lessons learnt with spouse (n=48)	31 (64.6)	17 (35.4)	0.007	7.98–50.42
Shared lessons learnt with other women (n=48)	29 (61.7)	19 (38.3)	0.036	1.87–44.93

^aValues are given as number (percentage).

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript