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**FACTORS ASSOCIATED WITH UTILIZATION OF LABOUR AND DELIVERY
HEALTH SERVICES BY WOMEN IN LUSAKA DISTRICT FACILITIES**

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REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING**

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DECLARATION

I, **Jeane Ngala Banda**, hereby declare that this Dissertation represents my own work and has not been presented either wholly or in part for a degree at the University of Zambia or any other University. I further declare that all the sources I have cited have been indicated and acknowledged using complete references.

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Signature (Supervisor)..... **Date**.....

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CERTIFICATE OF COMPLETION OF DISSERTATION

We, Dr Dorothy Chanda and Mrs Maurren Makoleka having supervised and read this Dissertation are satisfied that this is the original work of the author under whose name it is being presented. We confirm that the work has been completed satisfactorily and approve it for final submission.

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Head of Department

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Department of Nursing Sciences, School of Medicine, University of Zambia

CERTIFICATE OF APPROVAL

This Dissertation of JEANE NGALA BANDA on FACTORS ASSOCIATED WITH UTILIZATION OF LABOUR AND DELIVERY HEALTH SERVICES BY WOMEN IN LUSAKA DISTRICT HEALTH FACILITIES, ZAMBIA has been approved in partial fulfillment of the requirements for the award of the Degree of Master of Science in Nursing by the University of Zambia

Examiner I

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Examiner II

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ABSTRACT

This study focused on women's utilization of labour and delivery health services in Lusaka urban district health facilities. Utilization of labour and delivery health services can ensure that women are attended to by skilled personnel and link them to referral system in case of any complications. However, delivering in health facilities is still challenging in Sub-Saharan region including Zambia, despite the importance of institutional deliveries in preventing maternal and neonatal morbidity and mortality. The aim of this study was to determine factors that are associated with utilization of Labor and delivery health services by women in Lusaka district health facilities.

This cross sectional study was carried out using both qualitative and quantitative approach to collect data from three hundred and seventy three postnatal women (15-45years) who had given birth six(6) months and below prior data collection. Stratified random sampling was used to select six (6) study sites, systematic sampling was used to select three hundred and forty three (343) respondents for quantitative data while purposive sampling was used to select thirty (30) respondents for qualitative data respectively. Three Focus Group Discussions (FGDs) were conducted in three health centers namely Kanyama, Chawama and George health facilities. Interview schedules and FGDs guide were used to collect data.

Data from interview schedules were entered and analyzed using Statistical Package for Social Sciences (SPSS) version 22.0 for windows and presented using frequency tables, pie charts, and histogram and cross tabulations. The Chi-square test was used to test the association among variables and multivariate logistic regression analysis was carried out to predict the outcome. Statistical significance was set at 0.05 and strength of statistical association was assessed by odds ratio (OR) with 95% confidence interval. Content analysis was used to analyse data from the Focus Group Discussions and the most use full information that merged from the discussion was selected and used to illustrate the main points.

The results showed utilization levels were at 89% while non-utilization stood at 11%. After multivariate logistic regression, maternal education (Odds=3.5, CI, 1.046-11.861, P-value=0.042), Antenatal care visits (Odds=9.8, CI, 1.248-76.769, P-value=0.030) and transport affordability (Odds=4.7, CI-1.707-12.975, P-value=0.003) were factors which were significantly associated with utilization of labour and delivery health services in Lusaka district health facilities.

In this study, utilization of labour and delivery health services was optimal while non-utilization stood at 11%. Therefore, the study recommends that there is need for Ministry of Education to support women's education beyond primary education and the health providers to continuously sensitize women on importance of early antenatal care booking and complete the four recommended visits because during antenatal care, women are given information on birth preparedness and on benefits of utilising labour and delivery health services. For further research, there is need to conduct a community based study on home deliveries so that more information from women who don't register home births is obtained.

Key words: Utilization, Labour, Delivery, Health facilities, Women.

DEDICATION

To my beloved late husband Dr Joseph Banda who always wanted me to achieve the best in my academic work.

To my beloved sons Dabila and Dalitso for being patient when you also needed my support in your academic work.

To my beloved mother Mrs Christine Chidongo Ngala and my late dad Mr Albert F.Ngala for the love.

My beloved sister Florence Ngala for taking care of my boys and the entire family for the love and encouragement rendered to me.

Above all, my dedication to my dear God for his mercies, love and guidance always.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care.
DHO	District Health Office
ERES	Excellence in Research Ethics Converges
FANC	Focused Antenatal Care
HIV	Human Immunodeficiency Virus.
HMIS	Health Management Information Systems
IPT	Intermittent Presumptive Therapy
ITN	Insecticide Treated Nets
MCH	Maternal and Child Health
MDG	Millennium Development Goals
SMAGs	Safemotherhood Action Groups
PMTCT	Prevention of Mother-to-Child Transmission
UNAID	United Nations Joint Program on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization
ZDHS	Zambia Demographic and Health Survey

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Utilization of health care services is an important determinant of health and has particular relevance to public health and developmental issues in low income countries (World Health Organization (WHO), 2005). Furthermore, utilization of health care services for the most vulnerable and under privileged populations have been recommended by WHO as a basic Primary Health Care concept. In addition, it has been suggested that, health care should be universally accessible without barriers based on affordability, physical accessibility, or acceptability of the services.

The utilization of labour and delivery health services by women ultimately depends on their satisfaction of services they receive. In addition, their satisfaction depends on how they perceive the services received from health care providers in either health institutions or their homes in rural settings (Kumar et al., 2008). However, Kumbani et al., (2013), states that utilization of labour and delivery health services depends on the availability and the quality of care women receive from skilled birth attendants in the health institutions. Women may deliver in health facilities, but still have poor perinatal and neonatal out comes because of the sub-standard quality of care. The quality of care frame work reflects both the provision of care and women's actual experience of that care. Furthermore, it was indicated that, understanding women's experience of care is critical as it contributes to the use of health services and perinatal out comes. When women have a choice, they will go to health facilities they perceive better quality of care, regardless of distance. Literature also suggests that women encounter socio-cultural and economic factors that may hinder them from accessing skilled attendance during labour and delivery (Kumar et al., 2008).

Deliveries in health facilities can ensure that women are attended to by skilled personnel and also link them to referral system in the case of any complications (UNICEF 2012;Nai-Perg and Slow-li, 2013). However, delivery in health facilities is still challenging in developing countries where a higher number of women attend antenatal clinic but about half of them deliver in their homes without assistance of skilled professionals (Gwamaka, 2012).

Despite the importance of institutional deliveries in preventing maternal deaths, about 42% of births in developing countries were delivered outside the facility and 32% were attended to by trained skilled personnel. The factors that were cited attributing to women not receiving care are, inadequate services at the facilities, poverty, distance, lack of information and cultural practices (WHO, 2012; Nai-Perg and Slow-li, 2013).

Zambia is among countries in the Southern Africa Sub-Saharan region with high percentage of Antenatal Care attendance (Ministry of Health (MOH), 2008). According to Zambia Demographic Health Survey (ZDHS), (2013-14), states that in urban areas, the proportion of women who received ANC from a skilled attendant now stands at 99%, while in rural areas is at 94%. The percentage of deliveries by skilled personnel improved from 47% to 64%, an increase of 17% from 2007 ZDHS. The report further states that, 17% of deliveries were assisted by traditional birth attendants while 15% by relatives and others. The main reasons cited for home deliveries in Urban areas especially in Lusaka was short labour while in rural areas was because of distance and inadequate transport.

Studies have been conducted in Nigeria and Gambia on pattern of utilization of Antenatal and Labour and delivery health services, the results revealed that utilization of Antenatal health services were relatively high; however most women delivered at home without skilled attendants. This poor utilization was attributed to advanced labour, long distance and adherence to traditional practices (Bawa and Onadeka, 2004; Jallow, 2007).

A report by WHO/UNICEF/UNFPA and World Bank in 2010, states that, although the maternal mortality rates is reducing in Zambia, there is still a long way to achieve the MDG 5 target of 162/100,000 live births in 2015. This indicates that access and quality of Emergency Obstetric and Neonatal Care (EMONC) remains a challenge.

However, ZDHS (2013-2014), reported that Zambia has recorded a drop in Maternal Mortality rate from 591/per 100,000 live births of 2007 to 398/100,000 live births in 2013-2014. The report further indicates that, the under-five mortality also reduced to 75 from 119 per 1000 live births while infant mortality reduced from 70 % to 45% over two decades. Utilization of labour and delivery health services in Zambia will create an opportunity to further reduce the high maternal and infant mortality rates.

1.1.2. Over view of Health Service Delivery in Lusaka Urban Health Facilities

The district has thirty (30) health facilities and nine (9) health posts/sub-centres. Among the thirty (30) health facilities, eleven (11) offer labour and delivery health services and provide Basic Emergency Obstetric and Neonatal Care (BEMoNC). The labour and delivery facilities are Matero Reference, Chawama, Kanyama and Chilenje first level facilities, also Kalingalinga, Mtendere, Bauleni, Ngombe, George and Chainda Health Centers. Chainda Labour ward was commissioned recently in 2015. These facilities provide basic treatment for obstetric complications as well as stabilizing patients before referring them to Comprehensive Emergency Obstetrics Care Units (University Teaching Hospital and Levy Mwanawasa General Hospital) (LDHO, 2014). The Health facilities serve a population of 2,012,164 in Lusaka Urban District. The district has a population density of 5328 people per square kilometre and growth rate of 4.9% per year according to CSO, 2010.

Currently, Lusaka Urban District establishment of midwives is approximately estimated at 307 and only 222 midwives provide maternity care services in all the facilities (LDHO, 2014). This number of available skilled birth attendants indicates a critical shortage of staff to provide quality care to women utilising the services. In order to provide quality labour and delivery services, the facilities requires skilled trained attendants to offer satisfactory services to women who seek for the services. The Health facilities offers Antenatal and Postnatal care services daily during week days and during weekends in selected health centres to encourage male involvement. Labour and delivery health services are provided twenty four hours in all delivery health facilities.

The Gold Standard for optimal utilization of maternal health care in Zambia is based on WHO guidelines which recommend four ANC visits according to gestation. However, women with discomforts, special needs and conditions that lie beyond the scope of basic care or other problems require additional visits (WHO, 2003). Despite women attending ANC, they still deliver in their homes without the attendance of skilled professionals.

Table: 1 Focused Antenatal Care: 4 Visits ANC Model Outlined in WHO Clinical

First Visit: Before end of 14 weeks	Second Visit: About 24weeks	Third Visit:28 - 32weeks	Four Visit: About 36weeks
<p>- History taking</p> <p>-Personal information</p> <p>-Menstrual and contraceptive history</p> <p>-Present pregnancy</p> <p>-Daily habits/life style</p> <p>-Obstetric history</p> <p>-Medical History</p> <p>-Physical Examination</p> <p>-Blood testing</p> <p>-HIV (voluntary)</p> <p>-RPR</p> <p>-HB</p> <p>-Advice and Counsel</p>	<p>-Assess maternal And fetal well-being.</p> <p>-Exclude Pregnancy Induced Hypertension(PIH) and Anaemia.</p> <p>-Give preventive Measures.</p> <p>-Review and modify birth and emergency plan.</p> <p>-Advice and Counsel</p>	<p>-Asses maternal and Fetal well-being.</p> <p>-Exclude PIH, Anaemia, Multiple pregnancies.</p> <p>-Give preventive measures</p> <p>-Review and modify birth and emergency plan.</p> <p>-Advice and counsel women.</p>	<p>-Asses maternal and fetal well-being.</p> <p>Exclude PIH, Anaemia, Multiple pregnancy, Mal presentations.</p> <p>-Give preventive measures.</p> <p>-Review and Modify birth and Emergency plan.</p>

Source: (WHO, 2003).

Table 1 shows the WHO recommended guidelines on Focused Antenatal.

1.1.2.1 Improvement in the Quality of Maternal Health Services

The Government of the Republic of Zambia (GRZ) is committed to the promotion of Maternal and Child Health services. Ministry of Health with the help of Irish Aid, decentralized the maternal health services in Lusaka Urban district in early 90s in order for women to be accessing Basic Emergency Obstetric and Neonatal Care in the facilities close to their homes. This was aimed at also decongesting the Comprehensive Emergency

Obstetric and Neonatal Care Units. However, this initiative did not produce an impact on reducing congestion in University Teaching Hospital.

To promote access and utilization of maternal health services, the government abolished user-fees for all maternal and child health services so that even the vulnerable women can access and utilise the services. UNICEF also funds programmes and interventions aimed at improving the care to mothers and children, particularly supporting the delivery of cost effective, evidence-based, high impact interventions at various service delivery levels in Zambia (UNICEF, 2009).

The United States Government (US) supports the Government of Zambia in the implementation of the new health worker strategy to increase the number of Community Health Workers available to deliver Community Based health services (USG/Zambian Government interagency Team, 2012). In addition, they also work to strengthen community groups such as, the Safe motherhood Action Groups (SMAGs) whose role is to promote early Antenatal, male involvement in Maternal, Neonatal and Child Health (MCH) issues and facility based deliveries. The health providers with the help of SMAG members sensitize communities on the importance of utilising maternal health services. Furthermore, a new unit of reproductive health has been established under the department of Public Health in the Ministry of Health to co-ordinate and promote maternal health services in Zambia. To increase human resource crisis and to respond to the increased disease burden in Zambia, the Ministry of Health in collaboration with the General Nursing Council of Zambia (GNC) developed the Direct Entry Midwifery programme (DEM) in 2007(GNC, 2007). Besides, the Ministry of Health also increased the training of general nurses and Midwives from 1552 in 2007 to 2000 in 2013 (Mukuka, 2014). This is in an effort to improve the quality of health care provided in the facilities.

1.2 Statement of the Problem

In Zambia, 99% of households in urban areas live approximately within five kilometres to a health facility, compared to 50% in rural areas (UNICEF, 2010). Therefore, women in rural areas have limited access to maternal health services compared to women in urban areas. In Lusaka Urban District, the communities around labour and delivery facilities live within a radius of 5kms. Under normal circumstance, pregnant women who live within 5kms radius of health facilities should be delivering at these facilities due to easy accessibility.

On the contrary, the district is experiencing a decline in institutional deliveries in the health facilities evidenced by a downward trend of 3.4% magnitude from 2010-2014 while there is an increase in home deliveries of 0.5% magnitude during the same period as illustrated in table 2 below. This steady increase in home deliveries is a source of concern in Lusaka district that upholds the promotion of health facility deliveries.

Table 2: Maternal Health Indicators

YEAR	ANTENATAL ATTENDANCE	REGISTERED INSTITUTIONAL DELIVERIES (Health center and Private Facilities)	PERCENTAGE %	REGISTERED HOME DELIVERIES	PERCENT AGE %
2010	62459	36912	59.0	3596	5.8
2011	67276	37181	55.2	3590	5.3
2012	67633	33944	50.1	3486	5.2
2013	71426	38062	53.2	4060	5.6
2014	65485	36416	55.0	4160	6.3

Source: LUSAKA DHO HMIS, 2014

Table 2 further shows that between 2010 and 2014, average of 54.6 % of deliveries were conducted in the health institutions.

This low coverage could be due to poor perception and satisfaction of the clientele who opt to deliver in their homes or communities where an average of 5.6 % of all deliveries take place. The table further illustrates that an average of 60.2 % deliveries were registered at Lusaka urban health and private facilities while the outcome of an average of approximately 40% of the pregnant women who attended the ante natal care services cannot be accounted for as they did not utilise the labour and delivery facilities in Lusaka urban district health facilities. This revelation is a great source of public health concern.

The causes of under-utilization of maternal health services may include, socio-cultural factors which may influence women's health seeking behaviour, lack of transport and high poverty levels. It has also been speculated that the low utilization of maternal health services could be due to, among other factors, the perceived mandatory HIV testing during pregnancy and if found positive at that facility women would prefer to deliver at home or at another facility due to stigma (Personal interview with Kanyama MCH in-charge). Also critical shortage of staff may cause work overload and leads to burn out syndrome in the health care providers.

Hence, providing care which might affect women's satisfaction, may lead women to deliver at home by non-skilled birth attendants.

The consequences of non-utilization of services are quite critical; apart from mothers encountering complications which may lead to increased maternal morbidity and mortality rates, the survival of the new born is also threatened. The communities may also record high percentage of orphans who may end up on the streets because of inappropriate care received in their homes.

Despite the efforts made by the Government and the collaborating partners to improve utilization of labour and delivery health services in Lusaka Urban Health Facilities, women are not fully utilizing the services close to their homes as evidenced in table 2. Hence, there is a need to conduct this study. The intended goal of decentralization of services was to provide cost effective quality maternal health services as close to the communities by skilled birth attendant.

1.3 THEORETICAL FRAMEWORK

Several frameworks for analysing utilization of health services were found in the literature. These includes; Rosen Stock's Health Belief Model, Young's Choice-making Model and Andersen's Health Behavioural Model (Rebhan, 2008). Of all these models, Andersen Health Behavioural Model analyses the differences in health service utilization from socio-demographic perspective. This study was guided by Andersen's Health Behavioural Model which was in line with the main objective of the study.

The model was initially developed in the late 1960s by Andersen and is used to understand why families use health services to define and measure equal access to health care and provide assistance in developing policies to promote equal access (Andersen, 1995). The behavioural model emphasizes on the multiple influence of health care service use and on health status.

Andersen's Health Behavioural Model also views access to health services as a result of decisions made by an individual, which are constrained by their position in society and the availability of health care services (Andersen, 1995). According to the model, healthcare utilization is a function of three major elements; Predisposing factors (e.g Social-demographics factors) Enabling factors (e.g family income) and health needs such as function disability and Chronic illnesses (Andersen, 1995; Rutaremwa et al., 2015).

Predisposing characteristics

This category represents the factors that would encourage pregnant women to utilize the health services. According to Andersen, an individual is more or less likely to use health services based on demographic factors, position within the social structure, and beliefs of health service benefits. An individual who believes that health services are useful for treatment will be likely to utilize health services. In this study, the predisposing characteristics that will predict the likelihood of individuals to utilize labour and delivery health services included; Age, parity, cultural health beliefs, knowledge levels and educational level of women.

Enabling characteristics

Certain resources need to be available even in the presence of predisposing characteristics. These resources are found within the family and the community. Family resources comprise of family income and the location of residence. Community resources incorporate access to health care facilities and the availability of professionals for assistance. The enabling characteristics in this study included family income, because it determines the amount of funds available to cover transportation facilities to the health Center and other costs. Other enabling factors that would influence women to deliver in a facility were Antenatal care visits as well as availability of medical supplies in labour and delivery facilities.

Need based characteristics

The need based characteristics in Andersen Behavioural Model refers to health status or illness and its severity as perceived by individuals or evaluated by health providers (Andersen, 1995; Ononokpono, 2013). Perceived need helped to understand care - seeking and adherence to a medical regime, while evaluated need was more closely related to the kind and amount of treatment that the provider renders to the patient.

In this research, the assumption on the use of health care services by individuals is most triggered by their experiences and need during pregnancy and Childbirth. Example, if a pregnant woman was treated well during pregnancy or previous labour and delivery, the woman was more likely to use the services again. Need based characteristic in this study were staff attitude, and previous experience during labour and delivery.

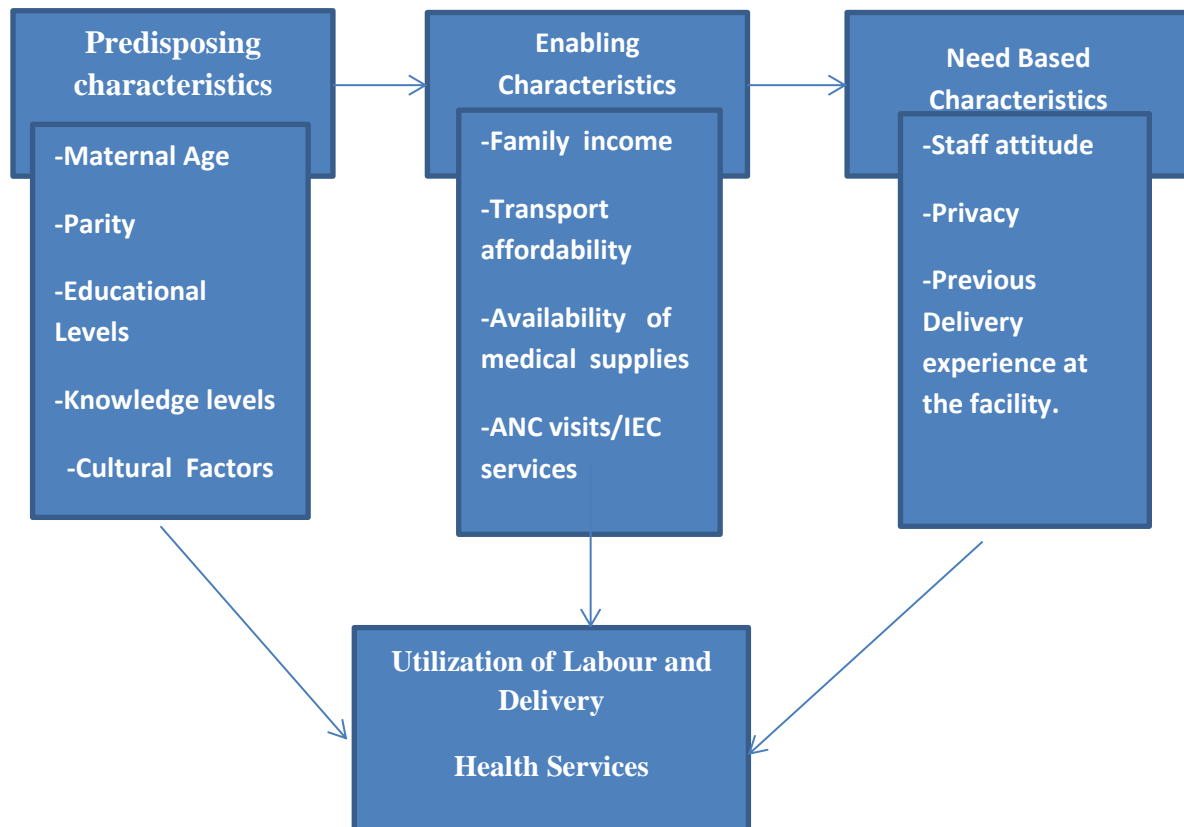


Figure 1: Modified Andersen Behavioural Model on Utilization of Labour and Delivery Services (Adopted from Andersen, 1995)

Andersen’s behavioural model does not specify which variables must be used to operationalize the need, predisposing and enabling factors (Andersen & Newman, 1973; Rebhan, 2008). Instead, the decision on how to operationalize them should derive from the theoretical relationship between the independent and dependent variables. As such, the choice of variables within the framework of need, predisposing and enabling factors, is up to each researcher.

The three categories of determinants developed by Andersen (1968 cited in rehbab, 2008); predisposing characteristics, enabling characteristics and need based characteristics determined the outcome variable which is utilization of Labour and Delivery Health services by women in Lusaka District Urban Health Facilities.

1.4 SIGNIFICANCE OF THE STUDY

This study was on factors associated with utilization of labour and delivery health services by women in Lusaka Urban health facilities. The study was prompted by the diminishing number of pregnant women utilizing labour and delivery health services in the facilities despite women attending antenatal care as well as residing within a radius of 5 Kms from the facilities.

In Lusaka Urban District, the average percentage of institutional deliveries from 2010 to 2014 according to table 2 were about 54.6 % and an average of home deliveries during the same period stood at 5.6%. This meant that there was need to find out the status of utilization of labour and delivery services in Lusaka Urban district health facilities.

Mrisho et al., (2007) conducted a study in Tanzania which showed that more than 90% of pregnant mothers attended Antenatal at least once during their pregnancy period but less than half delivered in the health facility. The major obstacle cited were distance and lack of money. On the contrary, some studies showed that physical proximity does not necessarily increase the use of delivery services (Thaddeu and Mainer,(1994); Shankwaya, 2008). Similarly, in a study conducted in Kazungula district by Shankwaya (2008) showed that there was a delivery centre in the middle of the village with delivery coverage of 6%. Therefore, the author indicated that there were other factors that deterred women from utilising maternal health services.

In Lusaka Urban, there was less information on studies done in this area thus creating a gap that needed to be filled by conducting this study. It was hoped that, the findings of this study will be used to inform policy makers to design strategies that would encourage utilization of labour and delivery health services and also conduct targeted IEC messages to pregnant women during ANC so that, they understand the importance of utilising labour and delivery health services within their communities. The health care providers would be able to improve service provision to pregnant women during labour and delivery. Consequently, the findings helped the researcher to identify gaps and specific areas of research in maternal health.

1.5. RESEARCH QUESTION

What are the factors that are associated with utilization of Labor and Delivery Health services by women in Lusaka District Urban Health Centers?

1.6.0 OBJECTIVES OF THE STUDY

1.6.1. General Objectives

To determine the factors associated with utilization of Labour and delivery health services by women in Lusaka Urban Facilities.

1.6.2. Specific Objectives

1.6.2.1 To determine the level of utilization of Labour and delivery health services among women in Lusaka urban district.

1.6.2.2 To identify demographic factors affecting women's utilization of labour and delivery health services.

1.6.2.3 To assess knowledge levels of women on the benefits of utilizing Labour and delivery services.

1.6.2.4 To determine whether health service related factors would encourage women to utilize labour and delivery health services.

1.6.2.5 To establish if cultural factors affects women's utilization of Labour and delivery health services in Lusaka urban district health facilities.

1.7.1 HYPOTHESIS

There is no association between utilization of labour and delivery health services with the following factors:-

- Demographic factors
- Knowledge on the benefits of institutional delivery
- Health service related factors
- Socio- cultural factors

1.8.0 DEFINITION OF TERMS

1.8.1. Conceptual definitions

1.8.2 Attitude - Feeling or opinion about something or someone or a way of behaving (Collins, 2009).

1.8.3 Parity - The number of children to which a woman has given birth (Collins, 2009).

1.8.4 Maternal Mortality rate - This is the number of all maternal deaths per 100,000 pregnancies that ended within a specific year (USAID, 2009).

1.8.5 Infant Mortality Rate - This is the number of deaths of infants less than one year of age per 1000 live births (USAID, 2009).

1.9.0 Operational definitions

1.9.1 Utilization - In this study utilization means the extent to which women utilizes labour and delivery services. Women who delivered in the facility utilised the labour and delivery health services while women who delivered at home did not utilise labour and delivery health services.

1.9.2 Skilled Attendants – In this study, this term refers to people with midwifery skills (Midwives, Doctors, and Nurses with midwifery education) who have proficiency in the skills necessary to manage or refer obstetric complications.

1.9.3 Service related factors - In this study, service related factors are attitude of skilled attendants to mothers, distance to the health facility and transportation affordability to the facilities to the health centre.

1.9.4 Knowledge - In this study, knowledge refers to what a mother knows about the benefits of delivering in the health facility. Women who scored 7-9 on knowledge questions about benefits of delivering at the facility were regarded to have high knowledge levels while 6-4 were regarded to have moderate knowledge levels while score of 3-0 were regarded to have low knowledge.

1.9.5 Women - In this study, it refers to adult female human beings who are in Child Bearing Age (15-49 years).

1.9.6 Young women - These are women in the age group 15-24 years.

1.9.6 Middle aged- These are women in the age group 25-34 years.

1.9.7 Elderly women – These are women in age group 35- 49 years.

1.9.8 Social cultural factors - In this study, socio-cultural factors refer to any cultural practice observed during labour and delivery by women.

1.10.0 Research Variables and Cut off points

Table 3 a: VARIABLES, INDICATORS AND CUT OFF POINTS FOR THE DEPENDANT VARIABLE AND DEMOGRAPHIC FACTORS

VARIABLE	INDICATORS	CUT OFF POINTS	QUESTION NO.
Dependent variable			
Utilization of labour and delivery health services	Delivery in the facility Delivery at Home	Yes No	Q13
Independent variable			
Age	Young mother Middle aged Elderly mothers	15-24 years 25-34years 35-49years	Q-1
Educational level of the mother	Not educated Some education Educated Very educated	No education Primary Secondary Tertiary	Q-5
Economic status	High income class Middle income class Low income class	-If the mothers household monthly income is \geq K1,500.00 -If the mothers household monthly income is K500-K1,000.00 -If the mothers monthly income is \leq K500.00	Questions 7
Parity	Low parity Medium High parity	1-2 Children 3-4 Children 5 and above	Q 8

Table 3 b: VARIABLES, INDICATORS AND CUT OFF POINTS FOR KNOWLEDGE LEVELS AND ANTENATAL CARE ATTENDANCE

VARIABLE	INDICATORS	CUT OFF POINTS	QUESTION NO.
ANC attendance	Yes No	If a woman attended ANC If a woman did not attend ANC.	10
ANC visits	Adequate Inadequate	3-4 visits 1-2 visits	11
Knowledge levels	High level Moderate level Low level	-A score between 7-9 on knowledge questions about benefits of delivering at the facility. A score of 4-6 on knowledge questions on the benefits of delivering at the facility. -A score below 1-3 on knowledge questions on the benefits of delivering at the facility.	18,19 20, 21 -22

Table 3b shows the variables, indicators and cut off points for knowledge levels and antenatal care

Table 3 c: VARIABLES, INDICATORS AND CUT OFF POINTS FOR SERVICE RELATED FACTORS AND SOCIAL CULTURAL FACTOR

VARIABLE	INDICATORS	CUT OFF POINTS	QUESTION NO.
Transport affordability	Yes	-If the mother did not perceive any problem of obtaining transport in utilising labour and delivery health services.	25
	No	-If the mother perceived problem of obtaining transport in utilising labour and delivery health.	
Attitude of the skilled attendant	Positive	Score of 6-9	28,30 31,32,35
	Negative	Score of 1-5	
Distance to the health facility	-Within reach of acceptable ministry of health distance to a health facility (0-5kms)	-Within 30 minutes' walk from home or 1hour walk from home.	23
	-Not within reach of acceptable Ministry of Health facility distance to a health facility (6-10,>10 kms)	-Within 2 hours or more than 2hours walk from home.	
Cultural beliefs	Yes	-If a mother observed any cultural practices during delivery	37
	No	If a mother did not observe any cultural practices during delivery	

Table 3c shows the variables, indicators and cut off points for service related factors and social cultural factors.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

This chapter provides information on the literature review. The purpose of literature review in this study was to identify factors associated with utilization of Labour and delivery health services from the works done by other researchers. A review of literature therefore, provided a road map for the development and implementation of the research.

The literature review on factors associated with utilization of labour and delivery health services have been arranged in such a way that they focus on the variables under study. This serves as a convenient way of organizing the work in building answers to the research questions.

2.2.0 Utilization of Labour and Delivery Health Services

Utilisation of essential obstetric care services contributes to the reduction of maternal and neonatal mortality and morbidity in low- income countries. Furthermore, institutional delivery service utilisation is one of the key proven intervention to reduce maternal deaths because it ensures, safe birth and increases the survival of most mothers and new borns (Ethiopian Demographic Health Survey 2011; Kebede et al., 2016). Several studies have been conducted worldwide on factors affecting health facility delivery and results showed that lack of money, lack of transport, staff attitude, cultures, perception of poor quality of health services were perceived as key determinants of place of delivery (Mrisho et al., 2007, Mgoma, 2010, Zulfuar et al., 2009; Gwamaka, 2012).

2.3.0 Demographic factors on utilization of Labour and delivery health services

2.3.1. Age and Parity

Several studies review demographic factors as influencing utilization of maternal health care services (Tenkorang, 2009; Kalule-sabili et al., 2014). Furthermore, a study done in Nepal and in southern part of Tanzania, both documented that multipara and old women tend to deliver at home than young women. This is because, young women tend to fear complications during birth hence utilizing health facilities (Mrisho et al., 2007, Bolam et al., 2006; Gwamaka,

2012). Similarly, in a study done in Uganda reviewed that younger (20-34 years) women are more likely to seek pregnancy related care services from the skilled attendant compared to mothers aged above 34 years (Okutu, 2011; kalule-sabili et al., 2014).

In Zambia 55% of women utilising labour delivery health services are young and 65% are primi-paras. Women, 35years and above with more than five children tend to deliver at home because they consider themselves as having experience in child birth (CSO, 2008; Shankwaya, 2009).

2.3.2 Education

Study conducted in Nepal showed a relationship between education and place of delivery. The study showed that those with poor education are more likely to deliver at home compared to educated women (Belam et al.,2006). This is similar to a study done in Bangaladeshi which indicated that 74% of women with more years in education deliver in the health facilities compared with 18% of women with no education.

2.3.3 Social economic factors on utilization of labour and delivery health services

Family income is an enabling factor that makes it possible for women to use the health delivery facility. A study done by Wang et al., (2011) on the use of skilled birth attendant in Sub-Sahara Africa and South East Asia revealed that over 90 % of women in the highest wealth quintile received skilled birth assistance for their last birth. Other studies also revealed that social economic factors has a strong influence on whether the woman will give birth in a facility or not (Stephenson et al., 2006; Shankwaya, 2009).

From the literature, socio-economic constraints deter women from utilising skilled attendants. Direct and indirect costs including opportunity costs may create an obstacle in utilising the services thus contributing to home deliveries.

2.4.4 Antenatal care attendance on utilization of Labour and delivery services.

A study conducted in India on the impact of Antenatal care visits on labour and delivery utilization revealed that women who made one to two ANC visits had 6.6% high chance of delivering in a facility compared to women who made no visits. While for women with three visits or more had 31% chance of utilising labour and delivery services (Priyanka et al., 2013). Therefore, prenatal care is an imperative factor for subsequent health care utilization because

women who make Antenatal Care visits are exposed to the health facilities and there is an opportunity to encourage them seeks subsequent care. However, in another study conducted in Ghana by Gwamaka (2012) revealed that, out of 363 women who attended ANC only 44.6% delivered in the facility while 56.4% delivered at home. The author attributed the low facility delivery to insufficient counselling during ANC as well as minimum time the health worker spends with women during counselling creating a missed opportunity to educate women on importance of institutional delivery.

This is similar to a study done in Tanzania which showed that more than 90% of women attended Antenatal care at least once during their pregnancy and approximately 62% attended Antenatal care four times or more but only less than 5 in 10 received skilled delivery at birth. This was attributed to failure of health providers to consistently communicate to women on the importance of skilled delivery during routine Antenatal visits (Magoma et al., 2010). On the contrary, in another study conducted by Essena and Sappor (2013) in East Ghana it was revealed that out of 371 women who attended ANC, 82.2% used skilled delivery services and only 17.5% used unskilled attendants at home.

In summary, pregnant mothers are encouraged to attend antenatal clinic at least four visits According to WHO recommendations as they received more information on the status of their pregnancy which in turn informs their decisions on the place of delivery.

2.4.0. Knowledge levels of women on utilization of labour and delivery services

A study done by Nai-peng and Swu-li (2013) in South Asia and Sub-Sahara Africa showed suggested that the non-utilization of maternal health services was due to lack of knowledge on the importance of giving birth in health facility and the location of the facility. The results further revealed that the low media exposure among women in the Sub-Sahara Africa and South Asia could be partly due to their low educational level and lack of media facilities.

In a study done in rural Nigeria on knowledge of Safe motherhood service showed that 90% of respondents had poor knowledge on the benefits of health facility delivery by skilled birth attendant and those that showed good knowledge on Safe mother hood practices obtained their information from the health workers in the health facilities, media and through community discussions (Okereke et al., 2013).

2.5.0 Health service related factors on Labour and Delivery

2.5.1 Distance and Transport

A study done in Tanzania revealed a strong association between distance and delivery in a health facility as 67.9% of women who lived more than 5kms from the facility delivered in other places compared to women (51.1%) who lived within 5kms delivered in the facility (Pembeni et al., 2007).

On the Contrary, a study conducted by Kitui et al. (2013) in Kenya showed no significant association between distance and delivery in the facility because 53% of deliveries took place outside the facilities despite 88% of women living within 5 km from the facility. The findings are similar to a study conducted in Gambia which showed that over 85% of the population live within the radius of 3kms from the health facility and over 97% live within 5kms from the facility but institutional delivery coverage is estimated at 30.1% (Jallow, 2007).

2.5.2 Privacy

Space is among many factors that can prevent health center delivery (Claeson et al., 2001; Shankwaya, 2009). Studies done in Tanzania and Zambia revealed that lack of privacy in some delivery centres deter women from utilising the facilities (Mrisho et al., 2007 and Shankwaya, 2009). In another study conducted in Zambia by Maimbolwa (2004), results revealed that in the maternity units there was generally shortage of drugs, supplies and equipment such as gloves and linen to cover the labouring woman and to dry/cover the newborns after birth.

2.5.3 Staff Attitude

Health providers' behaviour and attitudes are also determinant factor for a choice of place of delivery for pregnant mothers, some of the health workers are very rude, using abusive language and refusing to assist the patients, these attitudes prevent women from delivering in health facilities. Therefore, positive attitudes of health workers attract women to deliver in health facilities (Mrisho, 2007).

In Kazungula District health facilities, some health providers can be rude to women and disrespectful, this hinders women from utilising labour and delivery health services (Shankwaya, 2009).

The literature shows that, health service related factors such as distance, transport affordability, privacy, medical supplies and staff attitude influences women to utilize the health delivery facilities.

2.6.0 Socio-cultural factors on utilization of Labour and Delivery health services

A study done in Bangladesh revealed that health care use is the last option to utilize after traditional approaches have failed to treat the illness (Killewa et al., 2006; Mohamed, 2012).

In another study by Mrisho et al., (2007) in Tanzania, results showed that cultural beliefs influence home delivery. Women deliver at home secretly due to fear of prolonged labour that is perceived to be as a result of having affairs outside marriage during pregnancy.

The findings of Mrisho et al., (2007) on cultural beliefs during labour are similar to the findings of Maimbolwa (2004) in which the Mbusas (Women who implement traditional reproductive education and practice) believe that sexual relationship outside marriage is harmful and it could harm the unborn child and cause problems during labour such as prolonged labour or obstructed labour or death of the mother and her baby.

This is contrary to a study done in Zanzibar, in which the results indicated that socio-cultural characteristic are not the main factors that hinder women from seeking health care services (Mwisongo and Njau 2008; Mohamed, 2012).

In Zambia, it is believed that the placenta must be buried in a certain manner for a woman to continue bearing children. However, this is contrarily to the health facilities where the placenta is burned by incineration (Shankwaya, 2009). In China, burying the placenta underground is believed to be prevented from being stolen by evil spirits or being eaten by wild animals there by, ensuring that the babies have a long and healthy life (Loke, 2013).

Different individuals have different cultural values and these values may deter them from utilising delivery facilities. Knowing these cultures and addressing them could improve delivery coverage in the facilities.

CONCLUSION

Literature review has revealed that utilization of labour and delivery services by women are still generally low. Literature has shown that institutional deliveries by women is influenced by various factors such as educational level of the mother, knowledge of women

on the benefits of delivering in the facilities, cultural beliefs, attitude of skilled attendants, socio economic factors, age and parity of the mother.

Despite a steady increase in home deliveries and low levels of utilization of labour and delivery health services in Lusaka Urban Health facilities, there is less information to determine factors associated with utilization of labour and delivery services in Lusaka Urban. Hence, there searcher decided to conduct this study.

CHAPTER THREE

3.0 METHODOLOGY

3.1 INTRODUCTION

Research methodology is the entire strategy for the study, from the identification of the problem to the final plans of data collection (Castillo, 2009). It is essentially all procedures that researchers apply to describe, explain and predict phenomena and give the work plan of the research.

This chapter presents the methodology used in this study and is organized under the following sections: the research design, research setting, study population, sample size, sample selection, inclusion and exclusion criteria, data collection tools, data collection technique, validity and reliability, pilot study and ethical consideration.

3.2.0 RESEARCH DESIGN

Research design is an overall plan for collecting and analysing data, including specifications for enhancing the internal and external validity of the study (Polit & Beck, 2008). The design provides answers to the research questions and tests the research hypothesis. It spells out the basic strategies that may be adopted to develop information that is accurate and interpretable, (Polit & Beck, 2008). In this study, cross sectional using both qualitative and quantitative approach was used to collect data on study factors.

3.3.0 RESEARCH SETTING

This is a physical location or condition in which data collection takes place in a study (Burns Grove, 2009). In this study, 6 sites out of 10 sites providing labour and delivery services in Lusaka District were included. The sites were, Kanyama, Chawama, Bauleni, Mtendere, Matero reference and George health facilities. The study sites were chosen as study settings on the basis that they all offer Labour and delivery health services 24 hours on daily basis. The facilities also offer both preventive and curative services with Maternal, Neonatal and Child Health services. The centers have radios for easy communication with the Ambulance services in case of any referral to Comprehensive Emergency Obstetric and Neonatal Care

Unit. The study was done in the facilities where both interviews and Focus Group Discussions were conducted.

3.4.0 STUDY POPULATION

According to Polit and Hungler (2008) a study population is the entire population in which the researcher is interested in and to which he/she would like to generalize the results of the study. The study population were all post natal women in childbearing age (between 15-49 years). The study included both prim-paras and multi-paras.

3.4.1 Accessible Population

This is the portion of the target population to which the researcher has reasonable access (Burns and Grove, 2009). In this study, the accessible population comprised postnatal women in the child bearing age (15 – 49 years) who had delivered within 6 months prior data collection and were attending Childrens' clinic.

3.5.0 SAMPLE SIZE

A sample size is the total number of respondents to represent the population under study (Polit and Hungler, 2001). According to Lusaka District Community Health Offices (LDCHO, 2015) average utilization coverage between 2010 and 2014 calculated against women who accessed ANC during the same period was 55% (Lusaka DHMT, 2015). The sample size was calculated using the prevalence formula.

$$N = \frac{z^2 p (1 - p)}{d^2}$$

d^2

P = Proportion of service utilization in Lusaka Urban Health facilities

Z = 1.96 = standard normal variate at 95% confidence interval level

Confidence interval = 95%

$d = \pm 5\% = \pm 0.05 = \text{precision}$

$$n = \frac{1.96^2 \times 0.55 \times 0.45}{0.05^2} = 380$$

$$\frac{0.05^2}$$

$$n = 380$$

3.5.1 Number of Participants per Facility = Women in Child Bearing Age per Facility/Total Women in Child bearing Age in the Six sites X Total Sample size.

3.5.1.1 Kanyama First Level Hospital

37276/170913 X 380=**83 Participants**

3.5.1.2 George Health Centre

35238/170913 X 380=**78 Participants**

3.5.1.3 Chawama First Level Hospital

31266/170913X 380=**70 Participants**

3.5.1.4 Matero First Level Hospital

26636/170913x380=**59 Participants**

3.5.1.5 Mtendere Health Centre

21831/170913X380=**48 Participants**

3.5.1.6 Bauleni Health Centre

18666/170913X380=**42 Participants**

3.6.0 Sample Selection

Sampling involves selecting a group of people, events, behaviours, or other elements in which to conduct a study. The researcher used a stratified random sampling method to select the study units. Stratified random sampling is the type of sampling where the population is subdivided into homogenous subsets from which an appropriate number of elements are selected at random (Polit and Beck, 2003). Six (6) out of ten (10) labour and delivery health facilities were selected. Ten (10) facilities were organised into separate strata according to labour and delivery utilization coverage. Five (5) facilities with labour and delivery coverage above 60% were grouped separately and five (5) facilities with low coverage below 60% were also grouped separately. Five (5) small pieces of papers per strata with facility name written on each paper were placed in a box after folding them. The pieces of paper were then mixed thoroughly together by shaking the box. Then one piece of paper was blindfold picked at a time without replacing until 3 facilities were selected from each stratum making a total of 6

facilities. This was to give chance to every facility in the stratum to have equal chance of being selected.

Table: 4 Indicating facilities with coverage above 60%

No.	Health Facility	Total Population	Childbearing Age Population
1.	Kanyama First level Hospital	169435	37276
2.	Chawama First Level Hospital	142120	31266
3.	Chipata First level Hospital	147121	30895
4.	Matero Reference Health Center	121074	26636
5.	Ngombe Health Center	50733	11161

Source: LUSAKA DHO HIMS, 2014

Table 4 shows facilities with labour and delivery coverage above 60%. The following three (3) facilities were randomly selected;-Kanyama, Chawama and Ngombe health facilities.

Table 5: Indicating Facilities with coverage below 60%

No.	Health Facility	Population	Childbearing Age Population
1.	Chilenje First Level Hospital	104785	23053
2.	Kalingalinga Health Centre	81637	17960
3.	Bauleni Health Centre	84845	18666
4.	Mtendere Health Center	99234	21831
5.	George Health Center	160177	35238

Source: LUSAKA DHO HIMS, 2014

Table 5 shows facilities with labour and delivery coverage of below 60%. The following facilities were randomly selected; George, Mtendere and Bauleni health facilities making a total of six (6) facilities under study.

Systematic sampling technique was used to select the study participants. This is the arranging of the target population according to order scheme and select elements at regular intervals following the order list (Chaturvedi, n.d).

Systematic sampling involves selecting the elements at equal intervals. This method was chosen because it is convenient, less time consuming and easier to carry out. To use this method of sampling, the researcher had a sampling frame from which the sample size and sampling interval was determined. The sampling frame included Postnatal mothers who had delivered within six months prior data collection and were attending Childrens' clinic.

The formula for calculating sampling interval is as shown below:

$$K = N/n$$

(N= population size, n= sample size, K = sampling interval)

N=Average monthly Under 6 months Childrens' Clinic attendance

n=Sample size per facility

For facilities with big population approximate average under 6 months Childrens' clinic attendance was estimated at 1900 per month and per week 475, while for small facilities average Childrens' clinic attendance was estimated at 490 per month and per week 123.

1.0 Facilities with big population K=N/n

Kanyama First level Facility

$$K=475/83$$

$$K=6$$

George Health Centre

$$K=475/78$$

$$K=6$$

Chawama First Level Facility

K=475/70

K= 7

Matero First Level Hospital

K= 475/ 59

K= 8

For facilities with small population K=N/n

Mtendere Health Centre

K=123/52

K=3

Bauleni Health Centre

K=123/43

K=3

The sampling was conducted on any days of the visit at the study sites. The researcher and assistants conducted each six (6) to eight (8) interviews per day to leave time for sorting out and checking for completeness of questionnaires.

3.6.1. Inclusion criteria

Eligibility criteria are characteristics that delimit the population of interest (Polit and Beck, 2008). In this study, Postnatal women of reproductive age (15-49 years) and delivered within six months prior data collection, attending Children's Clinic and were able to give consent were included.

3.6.2 Exclusion criteria

The exclusion criteria were all the post mothers with babies above 6 months and those who refused to give consent. Respondents who had sick children were also excluded as well as women who were not in the child bearing age.

3.7.0 DATA COLLECTION TOOLS

3.7.1 Structured interview schedule (Appendix III)

In this study, a pre tested interview schedule, one in English and another translated into Nyanja were used to collect data. This was because some of the respondents might not understand English well while others might not be very comfortable with the local language. Data was collected over a period of twelve weeks. The tool had a set of pre-determined open and closed ended questions with the same wording and order of questions. Closed ended questions allowed quick recording of responses and saved on time (Basavanthappa, 2007) while open ended questions allowed free response and therefore information was more and valid.

The interview schedule was chosen as a data collection tool because it gives the interviewer chance to observe any non-verbal cues, allowed for probing and allows for clearing of any misunderstanding during interviews.

The interview schedule comprised of five (5) sections. Section A, comprised of questions on the respondents' demographic data. Section B comprised of questions eliciting information on utilization of labour and delivery health services. Section C, had questions on knowledge levels of mothers on the benefits of delivering in the health facility. Section D, comprised of questions on service related factors while Section E, comprised of questions on socio-cultural factors.

The disadvantages of using an interview schedule are that the presence of the interviewer may prevent the interviewee from giving precise and accurate responses if the interviewee is not verbally expressive, and that research assistants need to be trained in data collection. This challenge was minimized by creating rapport with the participants, ensured uniform understanding and recording of responses. Assistant researchers were used also in the pilot study to note any areas where there would be need for more emphasis.

3.7.2 Focus Group Discussion (FGDs) Guide (Appendix IV)

Focus Group Discussions (FGDs) were conducted in three (3) health facilities namely Kanayama, Chawama and George health facilities. Focus group discussion were chosen as one of the study designs because it allows the study participants to exchange ideas and discuss, agree or disagree on certain concepts, experiences and challenges that they encounter while

utilizing labour and delivery health services (Kitzinger, 1994; Kevern and Webb, 2001; Curtis and Redmond, 2007; Parahoo, 2007; Shaha, 2011; Chanda et al., 2013).

Three (3) FGDs were conducted. The researcher employed theoretical sampling to determine the number of FGDs. Theoretical sampling is a well-defined sample according to Barton 2011; Kani, 2013 and that it systematically aimed at reaching saturation. Thirty (30) respondents from the three health facilities were selected using purposive sampling and according to their willingness to participate in the discussions. The first group comprised of 11 respondents, second group 10 respondents while the third group comprised of 9 respondents. They only participated in the FGDs. Participants who took part in FGDs were prim- paras and multi-paras in Child bearing Age (15-49 years) who had delivered six months prior data collection and were able to give consent. Women who were not in the Child bearing age and had children above six months were not included in the study. Also women who didn't consent were excluded.

The Focus Group Discussion Guide comprised of the following selected sub themes relating to factors associated with utilization of Labour and Delivery Health services as well as some selected themes from the adopted Andersen behavioural theoretical model guiding the study.

Sub-themes

- Institutional deliveries and Home deliveries
- Women's previous experience during labour and delivery
- Attitude of health care providers during labour and delivery.
- Transport affordability and other costs
- Traditional and cultural practices done during labour and delivery.
- Perceived quality of care.

According to Polit and Hungler, (2008) state that FGDs may fail to bring out peoples' views because some people may be uncomfortable to express their views or describing their experiences in front of the group. Participants were encouraged to actively participate by giving each one of them chance to express their views. They were assured of confidentiality and anonymity of all data collected and this encouraged maximum participation (Appendix IV A).

3.7.1 Validity

The validity of the instruments used in this study was maintained by ensuring that all aspects of variables under study on factors associated with Labour and delivery health services were included in the questionnaire for the respondents. The tool contained clearly phrased questions for the participants to respond and to understand. Maternal and Child Health experts and research supervisors also examined the questions to determine whether they would bring out the desired responses on the variable under study. Methodological triangulation was also used to examine complex concepts by combining qualitative and quantitative methodologies within the study.

3.7.2 Reliability

Reliability may be affected by deficiency in the instrument or inconsistency in taking readings from the instrument. Reliability of the questionnaire was measured by pre-testing it. During the pre-test, participants were asked if there were any questions they did not understand. All questions were asked to each participant in the same sequence with probes made. Open-ended questions in the questionnaire provided an opportunity to respondents to add their own ideas thereby bringing out issues not thought of when designing the data collection tool. FGDs were conducted to solicit respondents options and experiences. The research assistants were trained in research methods for three (3) days to ensure consistency and uniformity in data collection. The research assistants were the psychosocial counsellors trained in Safe motherhood Action Groups (SMAGs) who understands the local language and have good communication skills. The assistants also participated in the pilot study so that they are able to note any areas where there would be need for more emphasis.

3.8.0 DATA COLLECTION TECHNIQUES

The data collection technique that were used for this study were face to face interview and FGDs.

3.8.1 Data Collection Technique for Quantitative Data

The study respondents were interviewed using an interview schedule translated into Nyanja and another one in English. Each study respondent was interviewed in a private place in MCH department for 20 to 30 minutes. All interviews were conducted between 09:00 and

16:00 hours. Sorting out and checking for completeness of questionnaires was done every day before leaving the study site. Self-introductions were made by the researcher and research assistants to each respondent before starting each interview to create rapport and make respondents relax. Interviewers were expected to follow instructions on interview schedule to standardize the interview technique. Questions were asked the way they were written, without influencing the answers. The questions not understood by respondents were repeated without paraphrasing them or indicating the direction of the answer. The researcher and the assistants endeavoured to ensure respondents' comfort at all times by considering their priorities and needs. Respondents were politely asked to repeat answers not understood by the interviewers. All the responses were recorded right away to avoid missing any of them. Respondents were thanked at the end of each interview.

3.8.2 Data Collection Technique for Qualitative Data

FGDs were conducted in the facilities' MCH department where a private room was provided. The researcher used FGDs guide to moderate the discussions. At the start of every Focus Group Discussion, the researcher welcomed the respondents and thanked them for being part of the study. The researcher then introduced herself/ the research assistants and clarified the questions under discussion. Thereafter, and depending on the literacy level of the group, the researcher either gave the consent form to read and be signed by respondents or read the consent form to the respondents and a thumbprint was done. The respondents were then requested to introduce themselves and this included their age at time of delivery, parity, marital status and education level. After participants had introduced themselves by only mentioning their initial of their first name and demographic information collected, then a pre-discussion talk was conducted before the main discussion, whose aim was to break the ice and identify dominant participants (Creswell, 2009).

The researchers encouraged respondents to freely and actively participate and were assured of confidentiality. A number of discussion points were used to guide the FGDs to encourage participants to elaborate issues of particular importance. The discussions lasted for approximately 45 minutes. At the end of each discussion, participants were given a chance to ask questions which were answered. Each participant was thanked at the end of the discussion.

3.9 PRE-TEST

Pretesting of the data collecting tools was done at Ngombe health centre on 10% of the study population which was 38 respondents. Ngombe health centre is located 30km south-east of Lusaka. It is a government run medium urban clinic with a catchment population of 50,733 (Lusaka DHO, 2015). The health centre provides both curative and preventive services, Maternal, Neonatal and Child Health services as well as Labour and delivery health services. The centre was selected for conducting the pilot study because it has similar characteristics to the study population that were included in the main study. Systematic sampling was used to select thirty (30) respondents and interview schedule was used while purposive sampling was used to select eight (8) respondents for FGDs. Respondents were women in Child bearing age who had delivered six months prior data collection. After pre-testing, a few adjustments were made to the interview schedule as follows:-

- In section C (Knowledge level), question 18 and 19 were removed from Section A (Demographic data) and placed under Section C.
- Question 35 was initially on question 30
- The current question 30 was from question 31.
- In Section D, question 32 was added and total questions under health related factors came to 14.
- Question 34 was initially reading. “Would you recommend to use the clinic to your friends and relatives”. The sentence was reconstructed to “Do you think you can recommend the use of the clinic to your friends and relatives”.
- Focus Group Discussion Guide- the sub themes were re-arranged to aid flow of information.

3.10 ETHICAL CONSIDERATION

Ethical approval to conduct the study was sought from Excellence in Research Ethics and Science Converge (ERES). Permission was also obtained from Provincial Medical Office, Lusaka Province and District Health Offices in order to gain access to health facilities that were to participate in the study. On accessing the said facilities, permission was also obtained from the health centre in-charges.

Furthermore, consent was sought from the respondents. The respondents were informed about the main objective of the study which is to determine the factors associated with utilization of labour and delivery health services in Lusaka Urban health facilities. Confidentiality and anonymity was maintained by avoiding indicating any names on the structured interview schedules instead, code numbers were used. The respondents were that they won't be remunerated in any form and that they were allowed to freely withdraw from the study at any time without suffering any consequences. Interviews and discussions were conducted in privacy offered by staff in Maternal, Neonatal and Child Health department. The Semi - structured interview schedules, tapes and note books were kept locked at all times and only accessible to the principal investigator.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION OF STUDY FINDINGS

4.1 INTRODUCTION

This chapter presents both quantitative data derived from semi-structured interview schedule and qualitative data from Focus Group Discussions (FGDs). It further describes the processing and analysis of data. Data analysis is defined as the systematic organization and synthesis of research data and testing of the research hypothesis using the data (Polit & Beck, 2008). Data was collected using Interview schedules and FGDs guide.

Three hundred and Seventy three (373) respondents participated in this study with the response rate of 98%. Interview schedule were used on Three hundred and forty three (343) respondents while FGDs guide was used on thirty (30) respondents who participated in the three (3) FGDs. The study was conducted in six (6) selected labour and delivery health facilities within Lusaka urban district health centres. Pretesting of data collection tools was done at Ngombe health center.

4.2.0 DATA PROCESSING AND ANALYSIS

4.2.1 DATA ANALYSIS

4.2.1.1 Quantitative Data

After data was collected, the data collecting instruments were checked for completeness, consistency and accuracy daily. Categorization of open ended questions which involved reading through all responses and grouping of answers that belonged together was done. Codes were assigned to each category, entered and analysed using SPSS version 22.0 windows. Closed ended questions were assigned numerical codes and entered in the computer and analysed using SPSS version 22.0 windows. Confidence interval was set at which is the range in which the population parameter is estimated to be (Burns and Grove, 2009). The cut off point for statistical significance was set at 5%. Therefore, only P-value of less than or equal to 0.05 was considered to be statistically significant there by, rejecting the null hypothesis. Chi-square test was used to test the association between dependent and independent variables. The dependent variable included utilization of labour and delivery health services. The independent variables included; Age, Parity, education levels, family income, Antenatal care attendance,

knowledge of women on the benefits of delivering in the health facilities, health service related factors included availability of transport, distance and Staff attitude.

4.2.1.2 Qualitative Data

After every FDG the recorder was played to check the accuracy of the information obtained. The study respondents were asked to clarify any information. The data from FGDs were transcribed and translated from Nyanja to English. Content analysis was used to analyse data from FGDs. Content analysis involves analysis of the content narrative to identify prominent themes and patterns among themes (Burns and Grove, 2009). A full report of FGDs on information discussed was prepared. The most useful information that emerged from the three (3) FGDs was selected to illustrate the main ideas.

4.3.0 DATA PRESENTATION

4.3.1 Quantitative Data

The research findings have been presented according to the layout of questions and sections of the interview schedule. Some have been grouped to give an overall picture. The data have been presented using different forms such as frequency tables, bar charts, and pie charts and cross tabulations. Frequency tables are suitable because they summarize findings in a meaningful way for easy understanding. Charts were used to prevent monotony in data presentation. Cross tabulation were helpful in showing relationships between variables.

Table 6 in section A represents the demographic data of respondents, the tables, pie charts and bar charts in section B represents utilization of labour and delivery health services, section C, represents the respondents knowledge levels on the benefits of utilising labour and delivery health services, section D, represents health related factors while pie chart in section E represents respondents cultural practices observed during labour and delivery.

4.3.2 Qualitative Data

The data obtained from the FGDs were summarised using narrative. The information was interpreted and the most useful quotations that merge from the discussion have been presented.

SECTION A

Table: 6 Respondents Demographic Characteristics (n=343)

Mothers demographic characteristic	Frequency	Percentage (%)
Mothers Age Group in years		
15 – 24	127	37.0
25 – 34	167	48.7
35 – 49	49	14.3
Total	343	100.0
Marital Status		
Single	35	10.2
Separated	18	5.2
Married	283	82.5
Divorced	5	1.5
Widowed	2	0.6
Total	343	100.0
Education		
No formal education	12	3.5
Primary	142	41.4
Secondary	166	48.4
Tertiary	23	6.7
Total	343	100.0
Occupation		
House wife	192	56.0
Formally employed	27	7.9
Self employed	100	29.2
Other	24	7.0
Total	343	100.0
Parity		
1 – 2	205	59.8
3 – 4	98	28.6
5 +	40	11.7
Total	343	100.0
Family Income		
Less than K500	91	26.5
K500 to K1,000	172	50.1
Above K1,500	80	23.3
Total	343	100.0

Table 6 shows that respondents 167(48.7%) were between 25-34 years. The age range was between 15-44years and mean age (years) of the respondents in this study was 26.87 with standard deviation of 5.9. One hundred and sixty six respondents (48.4%) had attained secondary school education. Majority of the respondents 283 (82.5%) were married and more than half 205(59.8%) had 1-2 children. Most respondents 192(56%) interviewed were house wives. The study also revealed that respondents 172(50%) were in the middle income class indicating that they had household family monthly income of between K500 - K1000.

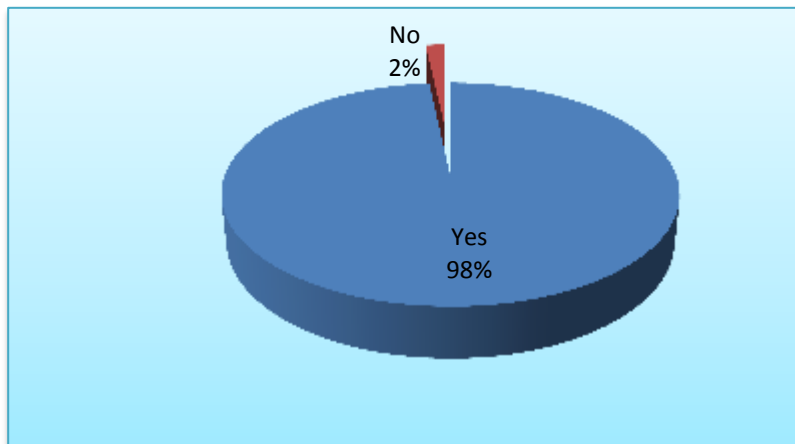


Figure 2: Antenatal care attendance in the previous pregnancy (n=343)

Figure 2 shows that majority of the respondents 337(98%) attended antenatal care clinic while 6(2%) did not attend antenatal care.

Table 7: Reasons given by the respondents for not attending Antenatal clinic(n=6)

Reasons for not attending Antenatal care clinic	Frequency	Percentage
Didn't see the need	1	16.7
Long distance to the facility	1	16.7
Didn't have transport	1	16.7
Bad attitude of health workers	1	16.6
Gave birth before antenatal care could start	1	16.7
Lack of Time	1	16.7
Total	6	100

Table 7 shows respondents' reasons for not attending antenatal clinic. One respondent 1(16.7%) mentioned that she didn't see the need, while others said, did not have transport, bad health workers' attitude as reasons for not attending antenatal care.

Table 8: Number of antenatal care visits by respondents (n=337)

Antenatal care visits	Frequency	Percentage
Once	10	3.0
2 times	51	15.1
3 times	143	42.4
4 times	133	39.5
Total	337	100.0

Table 8 shows that majority of the respondents 143(42.4%) attended antenatal care 3 times followed by respondents 133(39.5%) who attended antenatal care 4 times. Respondents who had 1-2 ANC visits were categorised as having inadequate ANC care while respondents who had 3-4 visits were categorised as having adequate ANC care.

SECTION B: UTILIZATION OF LABOUR AND DELIVERY HEALTH SERVICES

This section is on respondents labour and delivery utilization levels which is a dependant variable. To determine utilisation levels of labour and delivery health services, respondents who delivered from home were deemed not to have utilized the services, while those who delivered from a health facility (Health center, Hospital and Private hospital) were deemed to have utilized the labour and delivery health services

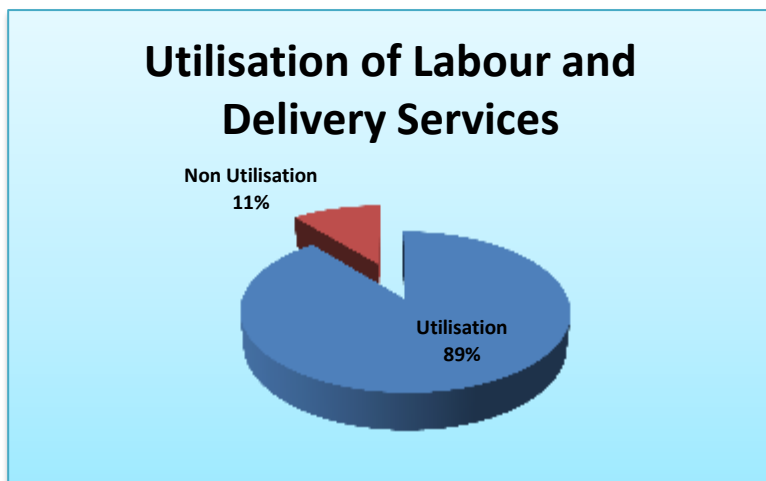


Figure 3: Utilization levels (n=343)

Figure 3 shows that majority of the respondents 306(89%) utilised labour and delivery health services while 37 (10.8%) did not.

Table 9: Respondents' place of delivery and intended place of delivery (n=343)

Place of Labour and delivery	Frequency	Percentage
At home	37	10.8
At the health Center	210	61.2
At the hospital	92	26.8
At private hospital	4	1.2
Total	343	100.0
Intended Place of delivery		
Yes	226	65.9
No	117	34.1
Total	343	100.0

Table 9 shows that a larger proportion of participant 210(61.2%) indicated that they delivered their last child at the health center, followed by participants 92(26.8%) who reported delivering from the hospital and 4(1.2%) at the private hospital, while 37(10.8%)

reported delivering from home. The table further shows that respondents 226(65.9%) delivered at the intended facility while 117(34.1%) respondents reported delivering from a different place they did not intend to deliver from.

Table 10: Where did you intend to deliver from? (n=117)

Intended place of Delivery	Frequency	Percentage
At home	1	0.9
At health center	101	86.3
At a private hospital	4	3.4
At Government hospital	11	9.4
Total	117	100.0

Table 10 shows that three quarters of the respondents 101(86.3%) reported originally intending to deliver from a health centre of their choice while only 1 (0.9%) intended to deliver from home.

Table 11: Reasons for the place of delivery (n=342)

Reasons	Frequency	Percent
Lack of Transport	30	8.8
Bad staff attitude	13	3.8
Long distance	6	1.8
Sudden onset of labour	45	13.2
Others	256	74.9
Total	342	100.

Table 11 shows that approximately three quarters of the respondents 256(74.9%) gave varied reasons for their place of delivery under ‘others’ while 45(13.2%) of the respondents cited sudden onset of labour. The remaining respondents 19 (5.5%) cited bad staff attitude and distance 6(1.8%) as reasons for the place of delivery.

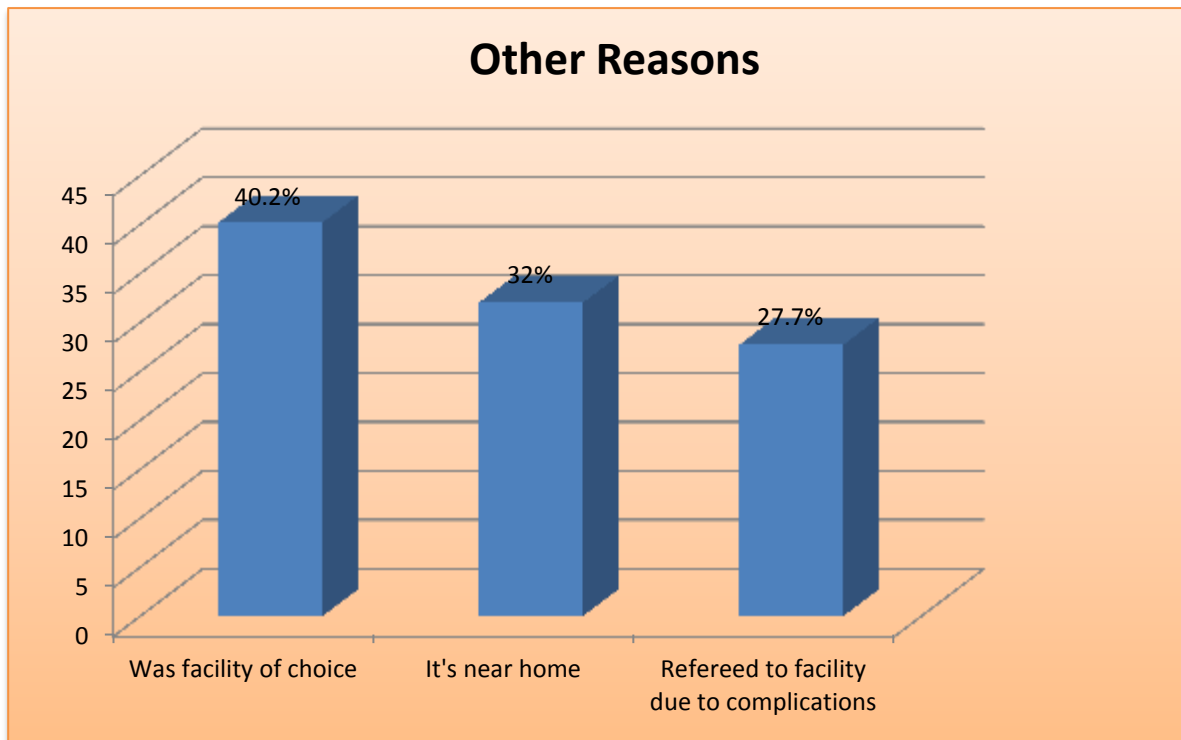


Figure 4: Other reasons for delivering at a place delivered from(n=256)

Figure 4 shows that majority of the respondents 102(40.2%) delivered from a facility of their choice while 71(27.7%) of the respondents mentioned that they were referred to the hospital due to complication

Table 12: Suggestions given by respondents to encourage women to utilise labour and delivery facilities (n=343)

Suggestions to encourage facility deliveries	Frequency	Percentage
PMTCT services are available if delivery is done at the clinic	22	6.4
Women should be informed always that, trained health workers care for mother and baby and help in case of any complications if delivery is conducted at the facility.	275	80.2
Health workers should conduct IEC on complications that may occur if delivery is conducted by unskilled attendant.	22	6.4
Introduce Incentives for clinic delivery	7	2.0
Introduce legislation to compel clinic delivery	13	3.8
No response	4	1.2
Total	343	100.0

Table 12 shows that majority of the respondents 275(80.2%) mentioned that women should be informed always during pregnancy that, trained health workers care for mother and baby and help in case of any complications if delivery is conducted at the facility. While respondents 7(2%) mentioned that the health facility should be providing incentives for mothers come for facility delivery

SECTION C: KNOWLEDGE LEVELS ON THE BENEFITS OF DELIVERING IN THE FACILITY

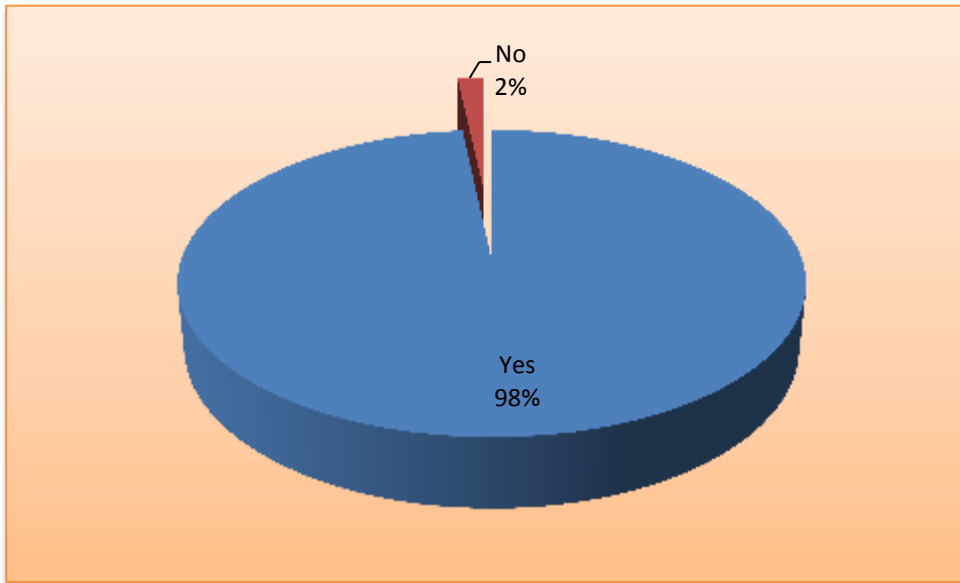


Figure 5 : Have you ever heard about the benefits of delivering in the clinic (n=343)

Figure 5 shows that majority of the participants 337(98.3%) mentioned that they had heard about the benefits of clinic delivery while 2% did not.

Table 13: If yes, where did you hear it from (n=337)

Responses	Frequency	Percentage
Health provider	164	48.7
Community health worker	94	27.9
Relative	55	16.3
Friend	20	5.9
Radio and TV	4	1.2
Total	337	100.0

Table 13 shows that almost half of the respondents 164(48.7%) heard about the benefits of facility delivery from the health providers followed by respondents 94(27.9%) who heard from the community health workers.



Figure 6: Importance of health facility delivery (n=343)

Figure 6 shows that majority of the respondents 340(99.1%) knew the importance of health facility delivery while a meagre 3(1%) did not know.

Table 14: If yes, what are the benefits of facility delivery (n=337)

Benefits of facility Delivery	Frequency	Percentage
Delivery is conducted by a trained birth attendant who is able to identify danger signs.	245	72.7
The baby can be attended to in case of complications.	255	75.7
There are doctors to attend to me in case of emergency.	256	76.0
Prevention of neonatal umbilical sepsis by using sterile equipment when cutting the cord	120	35.6
Prevention of puerperal sepsis by using sterile delivery packs during delivery	82	24.3
PMTCT services are available when you deliver in the clinic	19	5.6

Table 14 shows the analysis of the multi response question on the benefits of facility delivery which shows that, there were 337 respondents who mentioned at least one benefit. Out of those

respondents, 256 (76%) cited the presence of doctors attending to them in case of emergency as the benefit, and of the total responses, this accounted for 26.2%. Two hundred and fifty five 255 (75.7%) of the respondents said the baby can be attended to in case of complications, and this made up 26.1% of the total responses. Two hundred and forty five (72.7%) of the respondents said delivery is conducted by a trained birth attendant who is able to identify danger signs, and this benefit amounted to 25.1% of the total responses. Prevention of neonatal umbilical sepsis by using sterile equipment when cutting the cord was the benefit, which made up 12.3% cited by respondents 120 (35.6%). Prevention of puerperal sepsis by using delivery packs during delivery made up 8.4% of the total responses, and was mentioned as a benefit by 82(24.3%) respondents.

Table 15: Complications which may occur when delivering at home (n=339)

Complications	Count	Column Responses %	
Bleeding after delivery	266	43.1	
Neonatal umbilical sepsis	64	10.4	
Puerperal sepsis	22	3.6	
Retained placenta	183	29.7	
Others	82	13.3	

Table 15 shows the multi response tabulation. A total of 339 respondents had mentioned at least one complication and of those, majority of the respondents 266(78.5%) mentioned bleeding after delivery as complication of home delivery followed by respondents 183(54%) who cited retained placenta as a complication. Respondents 82 (24.2%) had mentioned complications classified as ‘Other’, followed by respondents 64(18.9%) who mentioned neonatal umbilical sepsis and 22(6.5%) respondents mentioned puerperal sepsis as a complication.

Table 16: Other complications cited by respondents (n=82)

Other Complications	Frequency	Percentage
Death of Mother or Baby	37	45.1
Baby not presenting head first	18	21.9
Infection of Baby or Attendant	8	9.8
High B.P	7	8.5
Baby not crying	3	3.7
Failure of baby to come out	6	7.3
High baby temperature	3	3.7
Total	82	100.0

Table 16 shows that the respondents 37(45.1%) cited death of mother or baby to be among complications that can occur during home delivery, followed by respondents 18(21.9%) who cited baby not coming out head first as a complication which may arise when delivery is conducted at home.

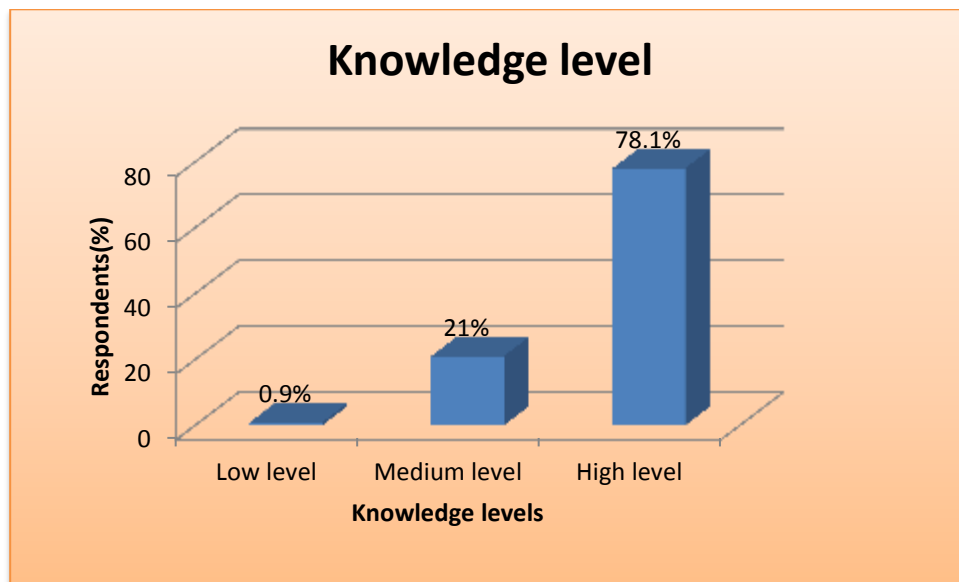


Figure 7: Overall knowledge levels (n=343)

Figure 7 above shows that majority of the respondents 268(78.1%) were deemed to have high knowledge levels, followed by respondents 72(21%), who were deemed to have medium knowledge levels while respondents 3(0.9%) were deemed to have low knowledge levels.

SECTION D: HEALTH SERVICE RELATED FACTORS

This section comprises of respondents data on health related factors. Questions on distance to the facility, time taken to reach the facility, means of transport used by pregnant women, transport affordability when going for labour and delivery health services, staff attitude during labour and question on privacy during labour and delivery were asked.

Table 17: Health Related Factors (n=343)

Time taken to reach the clinic	Frequency	Percentage
Within 30 minutes- 1hour	308	89.8
2 hours or more.	35	10.2
Total	343	100.0
Means of Transport		
Private car	51	14.9
Public transport	262	76.4
Ambulance	1	.3
Walking	29	8.5
Total	343	100.0
Transport Affordability		
Yes	277	80.8
No	66	19.2
Total	343	100.0
Availability of Labour and delivery Health services		
Yes	287	83.7
No	56	16.3
Total	343	100.0

Table 17 shows combined health related factors. The table shows that majority of the respondents 308(89.8%) reported reaching the health facility within thirty (30)minutes to one hour while respondents 35(10.2%) reported taking 2hours or over to reach the health facility. Three quarters of the respondents 262(76.4%) mentioned that they use public transport when going for labour and delivery services while, respondents 29 (8.5%) mentioned walking

as a form of transport. The results shows that majority of the respondents 277(80.8%) were able to afford the cost of transport when going for labour and delivery health services, while some respondents 66 (19.2%) could not afford. Most of the respondents 287(83.7%) confirmed that the labour and delivery health services were within their communities.

Table 18: Accessibility of labour and delivery services (n=287)

Accessibility	Frequency	Percentage
Readily accessible	271	94.4
Available Day time only	16	5.6
Total	287	100.0

Table 18 shows that majority of the respondents 271(94.4%) confirmed that the services were readily accessible while respondents 16(5.6%) said the services were available during the day only.

Table 19 : Happy with the services provided at the facility

	Frequency	Percentage
Happy with the services provided at the facility delivered from.		
Yes	254	83.0
No	52	17.0

Table 19 shows that majority of the respondents 254(83%) were happy with the services provided at the facility they delivered from, while 52(17%) said no.

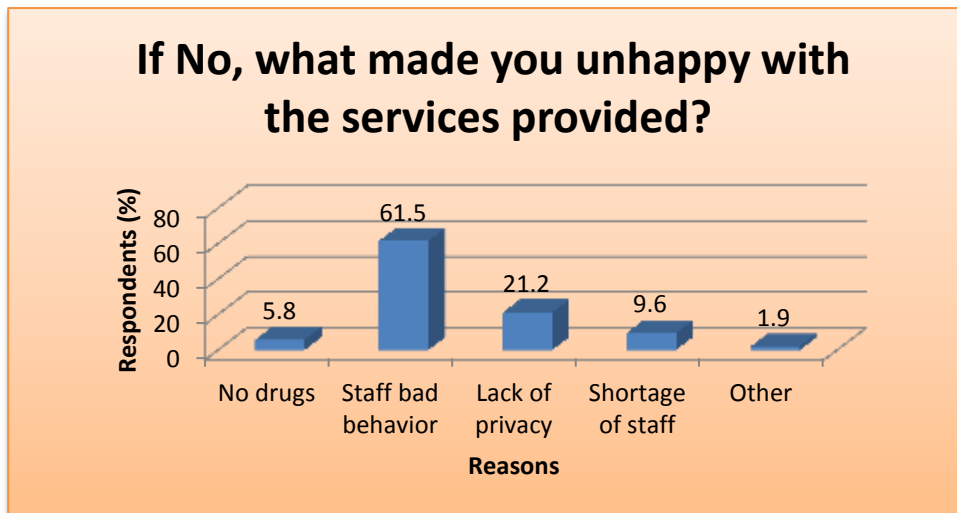


Figure 7: Reasons for not being happy with the services provided (n=52)

Figure 7 shows that most of the respondents 32(61.5%) cited bad staff behaviour as a reason for being unhappy with the services provided followed by respondents 11(21.1%) who cited lack of privacy as a reason of being unhappy with the services.

Table 20: Waiting time, skilled attendant explaining procedure before and after and privacy during labour and delivery (n=306)

Waiting time	Frequency	Percent
0 - 10 minutes	191	62.4
11 - 20 minutes	44	14.4
21 - 30 minutes	17	5.6
Over 30 minutes	54	17.6
Total	306	100.0
Skilled attendants explaining procedures to respondents before being attended to.		
Always	178	58.2
Sometimes	87	28.4
Rarely	11	3.6
Never	30	9.8
Total	306	100.0
Skilled attendants explaining their findings after attending to respondents		
Yes	249	81.4
No	57	18.6
Total	306	100.0
Privacy		
	Frequency	Percentage
Always	160	52.3
Sometimes	72	23.5
Rarely	20	6.5
Never	54	17.6
Total	306	100.0

Table 20 shows some of the health related factors such as waiting time, staff explaining procedures before and after being attended to and provision of privacy during labour. More than half of the respondents 191(62.4%) mentioned that they waited between 0 and 10 minutes while 54(17.6%) mentioned that they waited over 30minutes before they were attended to in labour. The table also revealed that more than half of the respondents 178(58.2%) said health workers always explain procedures before attending to them, while 30(9.8%) of the respondents said they never explain. Majority the respondents 249(81.4%) mentioned that skilled attendants explained their findings after attending to them while 57(18.6%) said no. Lastly, table 20 shows that respondents 160(52.3%) mentioned that health workers always provided privacy when in labour while 54(17.6%) said no.

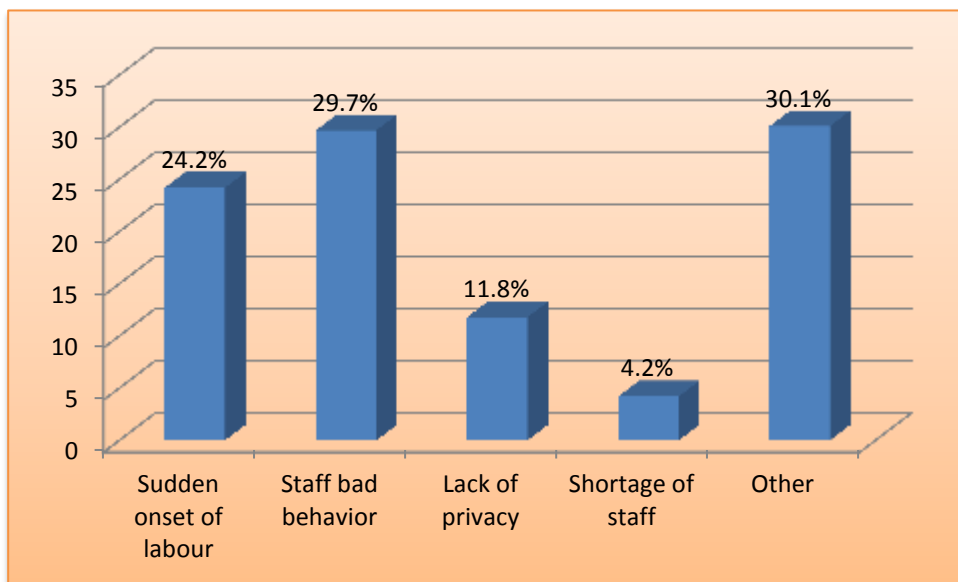


Figure 8 : Reasons for not utilising the nearest health facility by women (n=306)

Figure 8 shows that majority of the respondents 92(30.1%) mentioned category under ‘other’ which is lack of labour and delivery requirements as a reason that makes women not to deliver in the nearest facility.

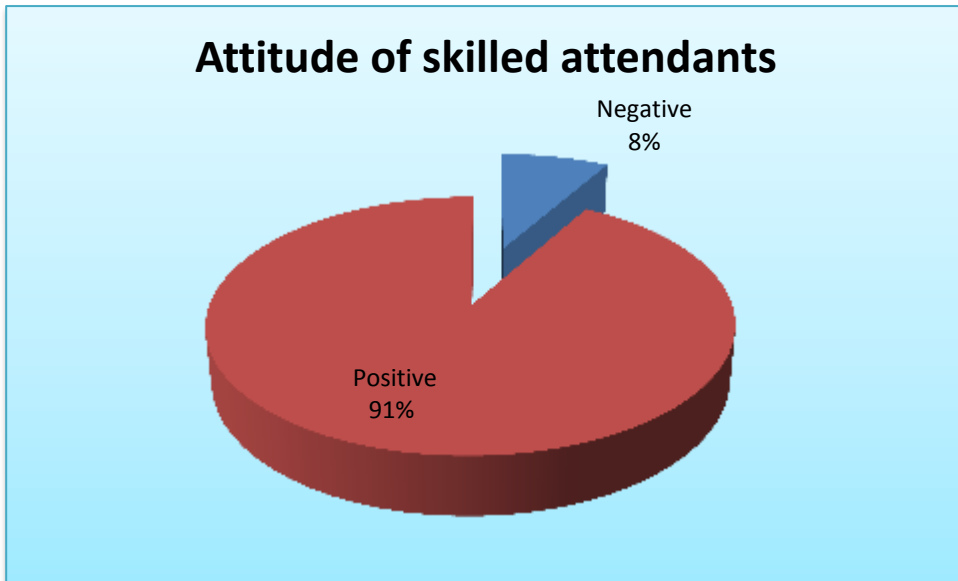


Figure 9: Overall staff attitude (n=306)

The study revealed that majority of the respondents 278(90.8%) reported good attitude of skilled attendants while respondents 28 (8.2%) reported negative attitude of skilled attendants.

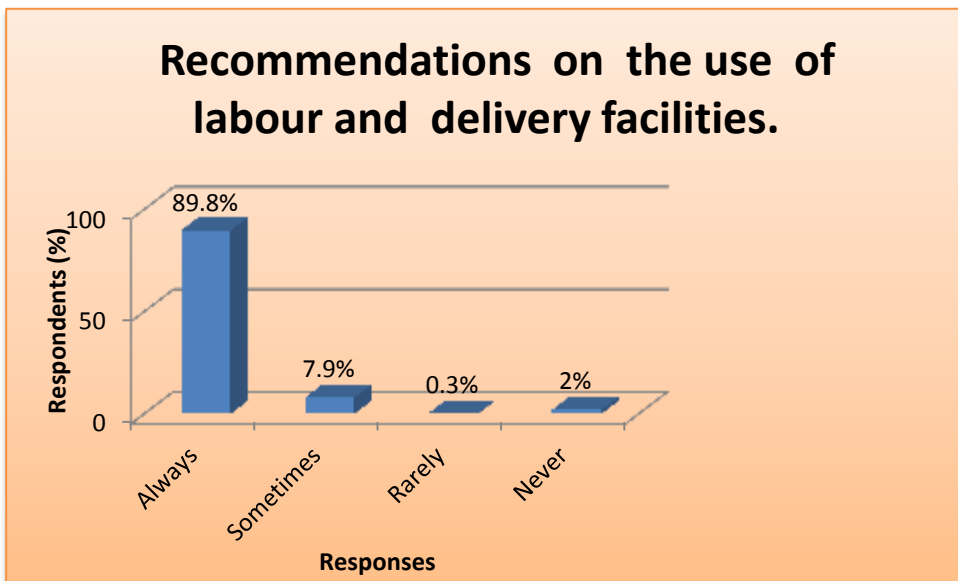


Figure 10: Recommendations on the use of labour and delivery health services (n=306)

Figure 10 shows that three quarters of the respondents 274(89.8%) would recommend the use of the facility to their friends or relatives, respondents 6(2%) said they would never recommend.

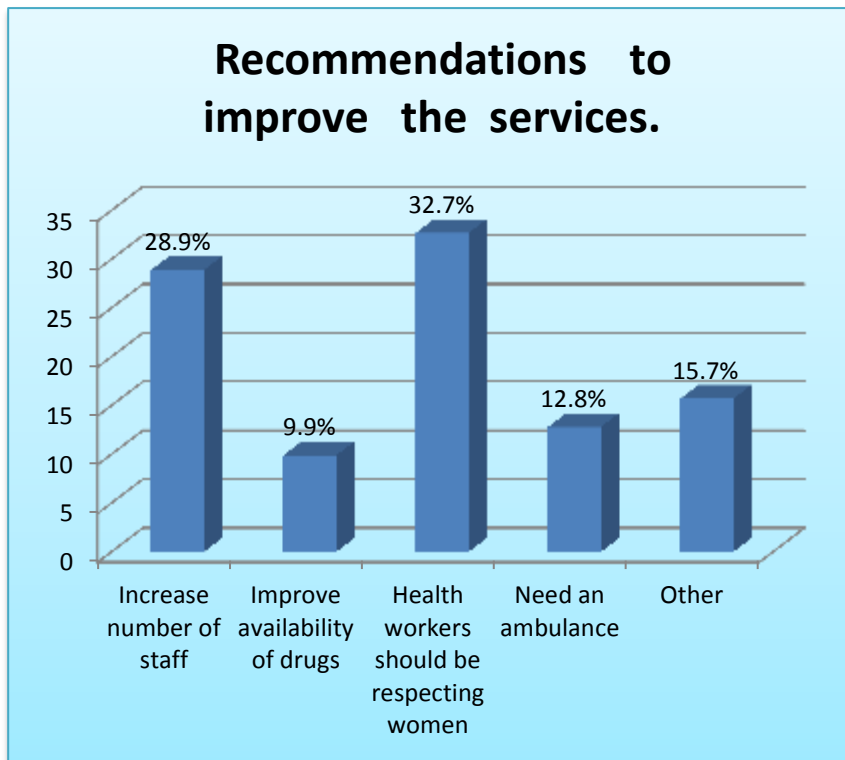


Figure 11: Recommendations to improve the services (n=343)

Figure 11 shows that respondents 112 (32.7%) mentioned that health workers should be respecting women in labour, followed by respondents 99(28.9%) who mentioned that the number of staff should be increased.

Table 21: Other recommendations (n=54)

Other recommendations	Frequency	Percentage
All is well, no complaints	15	27.8
Build more clinics and provide generators in labour wards	10	18.5
Government should be providing labour and delivery requirements (gloves and cotton wool)	3	5.6
Improve on privacy	11	20.4
Improve on sanitation	8	14.8
Reduce on referrals	7	7
Total	54	100.0

Table 21 shows that respondents 11(20.4%) recommended that facilities should improve on privacy.

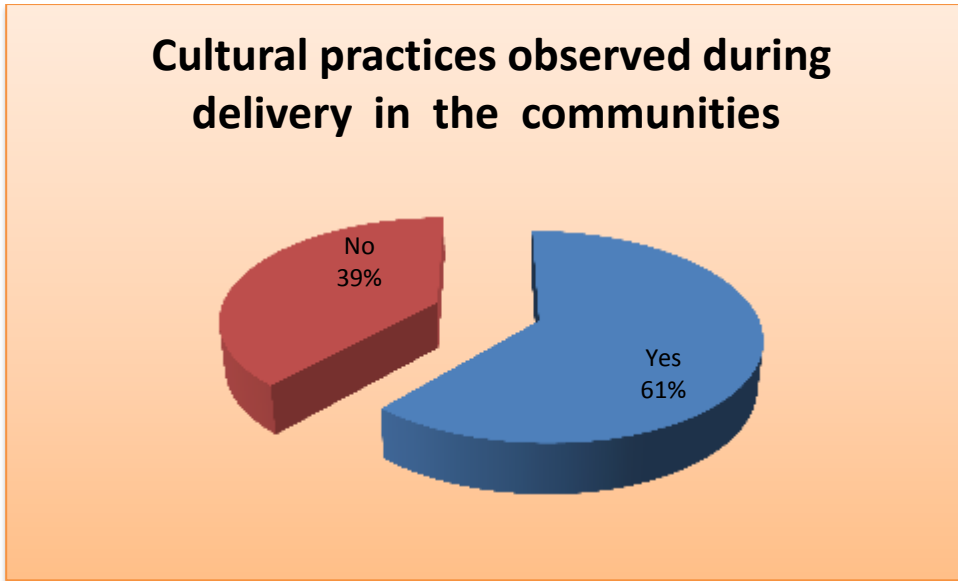


Figure 12: Observed cultural practices during labour and delivery in the communities (n=343)

Figure 12 shows majority of the respondents 211 (61%) confirming observing cultural practices during labour while respondents 132 (38.5%) said no.

Table 22 : Labour and delivery cultural practices done in the communities (n=211)

Practices	Frequency	Percentage
Traditional medicine are taken for quick delivery	162	76.8
Traditional practices are done and herbs are taken to prevent complications which may come due to ICHILA	49	23.2
Total	211	100.0

Table 22 shows that three quarters of the respondents 162(76.8%) cited taking of the traditional medicine to quicken the process of labour while 49 (23.2%) of the respondents said that cultural practices are done to prevent complications which may occur due

‘INCHILA’. ICHILA can either be a man having extra marital affairs while the partner is pregnant or a pregnant woman having extra marital affairs.

SECTION E: ASSOCIATIONS BETWEEN MAJOR STUDY VARIABLES

The utilization levels were correlated with each of the major variables in order to establish the associated factors contributing to utilization of labour and delivery health services.

Table 23: Association between respondents demographical characteristics and utilization of labour and delivery health services (n=343)

Independent variable	Utilization levels		Total	P-value=<0.05	Chi-square
	Utilization%	Non-utilization%			
AGE				0.14	8.871
15 - 24	114(89.8)	13(10.2)	127		
25 - 34	154(92.2)	13(7.8)	167		
35 - 49	38(77.6)	11(22.4)	38		
Total	306	37	343		
Educational levels	Utilization	Non-utilization		0.000	20.769
No formal education	11(91.1)	1(8.3)	12		
Primary	114(80.3)	28(19.7)	142		
Secondary	158(95.2)	8(4.8)	166		
Tertiary	23(100)		23		
Total	306	37	343		
Family Income				0.053	5.871
Less than K500	76(83.5)	15(16.5)	91		
K500 to K1,000	154(89.5)	18(10.5)	172		
Above K1,500	76(95)	4(5)	80		
Total	306	37	343		
Parity				0.006	10.286
1 – 2	191(93.2)	14(6.8)	127		
3 – 4	84(85.7)	14(14.3)	167		
5 +	31(77.5)	9(22.5)	49		
Total	306	37	343		

Table 23 shows association between demographic characteristics of the respondents with utilization of labour and delivery health services. Two factors were significantly associated with utilization of labour and delivery health services. Educational levels and Parity of women. Respondents who attained tertiary education 23 (100%) and secondary education 158(95.2%) utilized labour and delivery health services (P-value 0.000) than women with no formal education or primary education. Women with low parity 191(93.2%) utilized labour and delivery health services compared to medium and high parity women. From the chi-square results, the observed trend was found to be statistically significant (P-value-0.006)

Table: 24 Association between Antenatal care attendance/Antenatal care visits with Utilization of labour and delivery (n=343)

Independent Variables	Utilization levels		Total	P-Value<0.05	Chi-square
Antenatal Attendance	Utilization	Non utilization		0.02	9.757
Yes	303(89.9)	34(10.1)	337		
No	3(50.0)	3(50.0)	6		
Total	306	37	343		
Number of antenatal visits	Utilization	Non utilization		0.023	5.181
1-2 times	50(82%)	11(18%)	61		
3-4 times	253(91.7%)	23(8.3%)	276		
Total	303	34	337		

Table 24 shows that women 303(89.9%) who confirmed antenatal care attendance utilized labour and delivery health services. The chi-square results were found to be statistically significant (P-value = 0.02). The number of antenatal care visits was also significantly associated with utilization of labour and delivery health services. Respondents 253(91.7%)

who attended antenatal visits 3-4 times utilized the labour and delivery health services than women who attended antenatal clinic 1-2 times (P-value 0.023).

Table 25: Association between Knowledge levels and utilization of labour and delivery health services (n=343)

Independent variable	Utilization		Total	P-value <0.05	Chi-square
Knowledge levels	Utilization	Non-utilization		0.004	10.885
Low	1(33.3)	2(66.7)	3		
Moderate	67(93.1)	5(6.9)	72		
High	238(88.8%)	30(11.2)	268		
Total	306	37	343		

Table 25 shows that respondents 67(93.7%) with medium knowledge levels utilized labour and delivery health services. Chi-square results showed that there is a significant relationship between the two variables (P-value 0.004).

Table 26: Association between distance to the clinic, transport affordability and staff attitude with Utilisation of Labour and delivery (n=343)

Independent Variables	Utilization levels		Total	P-Value<0.05	Chi-square test
	Utilization	Non utilization			
Distance				0.015	5.901
Within reach(30minutes–one hour)	279(90.6%)	29(9.4%)	308		
Not within reach(two hours and over)	27(77.1%	8(22.9%)	35		
Total	306	37	343		
Transport affordability	Utilization	Non-utilization		0.000	9.757
Yes	260(93.9)	17(6.1)	277		
No	46(69.7)	20(30.3)	66		
Total	306	37	343		
Staff attitude				0.00	32.584
Negative	16(57.1%)	12(42.9)	28		
Positive	290(92.1%)	25(7.9)	315		
Total	306	37	343		

Table 26 shows the association between distance to the facility, transport affordability and staff attitude with utilization of labour and delivery health services. The three factors were statistically significant. The respondents 279(90.6%) who reported to be within reach of the facility utilised labour and delivery health services (P-value-0.015). Utilization increased in respondents 260 (93.9%) who could afford transport costs during labour and delivery compared to respondents 46(69.7%) who could not afford (P-value 0.000). The observed relationship was found to be statistically significant. Utilization increased also among respondents 256 (92.1%) who reported positive staff attitude compared to respondents 16(57.1%) who reported negative staff attitude. The relationship was found to be statistically significant (P-value- 0.00).

Table 27: Association between Culture Practices and Utilisation of labour and delivery (n=343)

Independent variable	Utilization levels		Total	P-Value= <0.005	Chi-square
Culture Practices	Utilization	Non utilization		0.423	0.642
Yes	186(88.2)	25(11.8)	211		
No	120(90.9)	12(9.1)	132		
Total	306	37	343		

Table 27 shows that utilization increased in respondents 120 (90.9%) who did not report observations of cultural practices during labour and delivery compared to respondents who reported an observation. The chi-square results show that the observations were not statistically significant (P-value-0.423).

Binary Logistic Regression determining the Demographic factors, ANC visits Knowledge levels, Health related factors and Cultural factors associated with utilization of Labour and delivery health services.

Binary logistic regression analysis was used to determine the true predictors of utilization of labour and delivery health services and adjusting for confounding factors. The results of the univariate logistic regression revealed that Parity, Maternal education, ANC attendance, knowledge levels, Positive staff attitude, distance and transport affordability were associated with utilization of labour and delivery health services.

Table 28: Binary logistic regression determining factors associated with utilization of labour and delivery health services.

Predictor	Odds	P-value	CI-95%
Parity			
1 - 2	Ref-0.000		
3 - 4	0.440	0.040	0.201-0.963
5 +	0.252	0.003	0.101-0.633
Educational levels			
Primary and no education	Ref-0.000		
High educational levels	5.249	0.000	2.323-11.861
Antenatal care attendance	8.912	0.009	1.730-45.900
Knowledge levels			
Low	Ref-0.000		
Medium	26.800	0.012	2.058-349.001
High	15.867	0.026	1.396-180.282
Distance			
No	Ref-0.000		
Yes	2.851	0.019	1.186-6.850
Transport Affordability			
Transport Affordability	6.650	0.000	3.241-13.642
Staff attitude			
Negative	Ref-0.000		
Positive	10.011	0.000	4.184-23.957

(Source: Author's own analysis, 2016)

Multivariate Logistic Regression Model on factors associated with utilization of Labour and delivery health services.

The multivariate logistic regression model was the final analysis done in order to determine the effect each independent variable had on utilization of labour and delivery health services while adjusting for the other variables as confounders. Logistic regression analysis was used as opposed to linear regression because the outcome (dependent) variable (Utilization levels) was a binary or dichotomous variable assuming the values 1 or 0 (1= Utilization and 0=Non -utilization) and not a continuous numeric variable. Odds Ratio measures of effect were

obtained as described in table 29. All the variables were considered for entry into the multivariate logistic regression model. The following were the factors which were entered, Age, Parity, Family income, Antenatal care attendance and Antenatal visits, Knowledge levels of women on benefits of facility delivery, service related factors such as staff attitude, distance and transport affordability. The results of the multivariate logistic regression analysis were obtained. The level of significance was set at p -value=0.05.

Table 29: Multivariate Logistic Regression Model

Independent variable		Odds Ratio	95% Confidence interval	P- value (0.05)
Age	15 - 24	Ref-0.000		
	25 - 34	1.358	0.329-5.823	0.657
	35 - 49	0.558	0.098-3.168	0.510
Parity	1 - 2	Ref-0.000		
	3 - 4	.280	.069-1.136	0.075
	5 +	.305	.057-1.638	0.166
Educational level	Low Educational level	Ref-0.000		
	High educational levels	3.5	1.046-11.861	0.042
Family income	Less than K500	Ref -0.000		
	K500 to K1,000	1.777	.614-5.145	0.289
	Above K1,500	1.488	.367-6.032	0.578
Knowledge levels				
	Low	Ref-0.000		
	Medium	1.887	0.048-74.540	0.735
	High	1.880	0.058-60.736	0.722
Antenatal care visits	1-2 Visits	Ref-0.000		
	3-4 Visits	9.7	1.248-76.769	0.030
Staff attitude	Negative	Ref-0.000		
	Positive	1.296	.193-8.682	.789
Transport affordability	Non- affordable	Ref-0.000		
	Affordable	4.706	1.707-12.975	0.003
Distance				
	No	Ref-0.000		
	Yes	1.480	0.347-6.305	0.596

(Source: Author's own analysis, 2016)

Table 29 above shows knowledge levels, attitude, distance classification, family monthly income, and parity did not impact significantly on the model.

The following factors were found to be significant; maternal education, Antenatal care visits and transport affordability.

The odds of utilizing labour and delivery health facilities for those who could afford transport were 4.7 times higher than those who could not afford. This effect was statistically significant (OR 4.7, P=0.003). Respondents who attained secondary and high levels of education were 3.5 times more likely to utilise labour and delivery services than respondent with primary or no education levels(OR 3.5, P-value=0.042).

On the other hand, after adjusting for the confounding effects of the rest of the independent variables, the odds of utilizing labour and delivery health services for those who had 3-4 Antenatal visits were 9.7 times more likely to utilize labour and delivery health services than those with 1-2 visits(OR 9.78, P-value= 0.030).

4.3.0 QUALITATIVE DATA

4.3.1. ANALYSIS OF QUALITATIVE DATA

All the respondents were postnatal mothers in the child bearing age with children below 6 months attending children's clinic from within the catchment areas of the three health facilities of Lusaka Urban district namely; Kanyama, George and Chawama health facilities. Each facility had one FGDs which comprised of the following;-

FGD 1- George comprised of 11 respondents, ten were married and one single. Five (5) respondents had secondary education, two (2) had primary education while tertiary and no education had one each respectively. Five (5) of the respondents had children 1-2, Two (2) had 3-4, while two (2) also had 5 and above children.

FGD 2- Chawama comprised of nine (9) respondents and were all married. Five (5) respondents had secondary education, three (3) had primary education, while three (3) respondents had no education. Four (4) of the respondents had children 1-2, three (3) had 3-4, while two (2) also had 5 and above children.

FGD 3- Kanyama comprised of ten (10) respondents, eight (8) were married and two(2) were single. Five (5) respondents had secondary education, two (2) had primary education while two (2) respondents had no education and one(1) had tertiary education. Four (4) of the respondents had children 1-2, Five (5) had had 3-4, while two (3) had 5 and above children respectively

Table 30: Overall demographic characteristics of FGD respondents (n=30).

Characteristic	Frequency	Percentage
Age		
15-24	12	40
25-34	10	33.3
35-49	8	26.6
Total	30	100
Parity		
1-2	13	43.3
3-4	10	33.3
5 and Above	7	23.3
Total	30	100
Educational level		
No education	5	33.3
Primary	7	23.3
Secondary	15	50
Tertially	3	10
Total	30	100
Marital Status		
Married	26	86.6
Single	4	13.3
Total	30	100

Table 30 above shows that majority of women were in the age category of 15-24 years representing 12(40%) and most of them were married 26(86%). Secondary education was the most highest level of education attained by half of the respondents 15(50%) and 13(43.3%) had 1-2 children.

4.3.2.0 Utilization of Labour and Delivery Health Services

The researcher came up with the main theme Utilization of labour and delivery health services which had 6 sub-themes with one or two categories per sub-theme.

4.3.2.1 Reasons for institutional and home deliveries

Majority of the respondents mentioned that they delivered in the health centres. Among women who delivered in the health center said, they opted to deliver at the same clinic they registered for antenatal care while others mentioned that they preferred delivering at the nearest facility in the community they live because no transport costs will be required. **FGD 2, Para 2** narrated, *“I delivered at the clinic because this is where I booked for my antenatal care... and during ANC nurses always informed us on importance of delivering in the clinic.*

While in FDG 1 a Para 1 woman said; *“I delivered at this health centre because it is near my home. Therefore, I don’t need any transport to come to the clinic for labour and delivery”.*

FDGs revealed that some women who delivered in the health centres by passed their nearest facility and delivered in another facility where they perceived receiving good care during labour and delivery. A Para 3 in FGD 2 also narrated, *” I didn’t deliver at this clinic because the care given to women in labour is not so good ...nurses are few against many patients in labour...I went to Chilenje clinic where there is good care by nurses.”*

Despite majority of women delivering in the health facilities the discussions also revealed that participants who delivered at home didn’t intend to deliver home while for some respondents had planned to deliver at home due to various reasons.

FGD 2, Para 4 stated, *“I always go to the village in my seven month of pregnancy to deliver at my mother’s home in Liteta village... i hear a lot of stories in these clinics that nurses don’t care well for patients in labour so, I fear delivering in the clinic...my mother is a TBA in the village and conducts deliveries to most women within our village without any problems”.*

Some women delay going to the health center until labour is advanced and end up delivering before reaching the delivery centre. A Para 3 in FGDs 3 narrated; *“I delivered in the car on my way to the clinic because I thought labour was far and waited for a long time at home ...unfortunately delivered before reaching labour ward”*. While other women who delivered at home intended to deliver in a facility but due in-adequate preparations for labour and delivery requirements ended up delivering at home.

FGDs 1, Para 3 mentioned, *“I wanted to deliver at the clinic but delivered at home because I didn’t prepare anything for the baby (baby clothes, Pads, Jik and gloves etc).... They could have (nurses) shouted at me for not bringing materials to use during delivery.”* A Para 5 participant during FGD 1 also narrated why she delivered at home;-

“I delivered at home due to quick labour and I refused to report to the clinic immediately for registration and to be examined because they (Nurses) could have made me pay for delivering at home.”

Women who delivered at the hospital also explained that it was not intentional to deliver at the hospital but due to various reasons were referred to hospital while for others they planned to deliver in a private hospital.

A Para 5 woman narrated, *I was forced to go to UTH because the nurses I found on duty told me they were not able to feel any baby after examination. I use to come for antenatal care and was confirmed pregnant and that day i was in labour...when I reached the hospital admission ward (UTH) I delivered well and yet I was told at this clinic that there was no pregnancy(FDG 2).*

During the same FGD a Para1 also stated, *“I delivered at a private hospital because my husband has a medical scheme from his work place... so, we go to any private hospital of our choice to access health services.*

A Para 2 woman concluded during FGD 1 on the benefits of health facility delivery and disadvantages of delivering at home. *“I always deliver at the health center because hospital or clinic delivery is the best...you can be helped in case of any complications compared to home delivery... were there are no nurses to help ending up dying or losing a baby in case of complications”*.

4.3.2.2 Influence of previous experiences during labour and delivery

Women's previous experience with health services provided in the facilities tend to influence future use of health care services. This is a need base characteristic which can influence women to utilise labour and delivery health services (Anderson, 1995). Women get information from relatives and friends about quality of health services offered in the clinics. The use of health care services by individuals is most triggered by their experiences and need during pregnancy and Childbirth (Andersern,1995).

FGD 2 Para 5, narrated, *“My neighbour told me not to deliver at this clinic (George) because they (nurses) don't provide privacy. You will find that there are also young mothers who come to deliver and you are in the same room seeing everything done on an elderly mother... so I decided to go to Chingwere clinic where they cared for me well “.*

A Para 3 during FGD 1 also explained her previous experience during labour which made her vow not to go back to the same health centre for delivery. *“During my last delivery, the maids and nurses made me mop the floor with my bear hands...they were very harsh on me and to the other patients in the ward...i delivered on the floor because they were not coming to check on me whenever i called for help...no privacy was provided telling me that it was what I wanted to deliver in the ward... do you think I can come back for delivery at this clinic?’*

Other participants also narrated their previous experience and recommended the use of the clinic in their subsequence deliveries as narrated by a Para 2 women in FGD 3 below;

“In my previous pregnancy i delivered here at this clinic because they cared for me well, i interacted with the nurses on duty and after each examination they were explaining to me everything until i delivered, Privacy was provided throughout... for me i will be using the same health center for delivery.

4.3.2.3 Positive and Negative attitude of the health care provider

Staff attitude is also thought to be a need - based factor that can influence women to utilise the services. Women mainly will consider attitude of nurses or midwives when deciding where to seek delivery health services. Poor reception at the facility and not being attended to were highlighted during FGDs.

FGDs 1 Para 1, stated, *“When I was in labour I went to the clinic and found two nurses on duty, after examining me I was just told to go and do exercises in the Postnatal ward without telling me the findings after examination...i was in pain and whenever i called for help i was shouted at ... telling me that am just lazy... I pleaded with the nurses, please I feel like baby is coming and they just said, will come when we see the babys’ head...I ended up delivering all by myself in the postnatal ward...my baby did not cry at birth until we were referred to UTH D-block.”*

Any woman in labour expert support and good care. They expert midwives to monitor the progress of labour and to explain findings after each examination.

Not been checked in labour may be viewed as poor providers’ attitude in the facilities as narrated by a Para 1 in FGD 1;-

“I was received well by the nurses I found during the day shift, but when it came to the night nurses they didn’t want to hear any woman calling for help, they were not understanding and threatening every one that they will be referred to UTH if they keep on screaming as result, throughout my labour i was scared of being referred to UTH for operation”.

Despite having women expressing negative attitude of health care providers during labour and delivery some women expressed having found nurses who were polite and giving them reassurance at every stage of labour. For example, a Para 4 woman narrated during FGD 3;

“I go to Kanyama main clinic for delivery... i always find nurses who are very polite and give reassurance during labour, some nurses are naturally gifted from God...despite having a lot of patients in labour they are always on your side until they knock off”.

4.3.2.4 Transport availability and opportunity costs

Transport is one of the enabling resource which provides an individual with the means to utilize labour and deliver health services. Lack of readily available means of transport may deter some women from delivering at the health facility. Hence, most of them end up delivering at home. This is well illustrated in the responses below;-

“In my community (Kanyama west) women normally use taxi and public buses during the day when going to Kanyama main clinic which is the nearest delivery center. However, in the night it is very difficult to find a taxi and very expensive such that most women don’t afford and end up delivering in their homes” (FGD 3 Para 1).

Despite women complaining about non availability of transport especially in the night others explained that during antenatal care nurses talk about birth plan. This is confirmed by response from a Para 4 woman below;

“During antenatal clinic they (nurses and community workers) always inform us to keep money for transport in case of any emergency as well as to keep money for food. Also to buy in advance what is required during delivery... I kept money for transport and arranged with a taxi driver...When labour started I just called the driver who dropped us at the clinic in the night...if transport money is kept and transport is arranged in advance most women don’t have problems coming to the clinics for delivery”.

Some women because of inadequate transport money resort to alternative ways of reaching the delivery facility. This was testified by a Para 2 during FGD 2.

“During labour i walked to the clinic because I didn’t keep any money for the taxi, luck enough, it was during the day and managed to reach the clinic for delivery”.

4.3.2.5 Traditional and cultural practices done during labour and delivery

Cultural practices during labour and delivery is one of the predisposing characteristic that influences women to utilize labour and delivery health services. Taking of herbs to quicken labour was mostly mentioned by the respondents during FGDs and most women gave birth before reaching the facility or reached the facility in second stage of labour.

The traditional and cultural practices during labour and delivery have a great influence on labour. This is well described by a Para 5 woman in FGD 3 who had the first three deliveries on the way to the clinic;

“There are a lot of traditional practices done before going for delivery if one wants to deliver fast... for me on all my children I just pick soil from the cross roads where people pass very much, soak it in water and drink just before starting off from home because if one delays can deliver on the way like I did on my first three babies.”

Some women are afraid to be seen practising any cultural practices they feel, if seen may influence the attitude of a health care provide. This has been narrated by a participant during FGD 2 who had experiences during delivery of her four children.

“I always tie a stone on corner of my Chitenge and un tie immediately I reach the labour ward door. I deliver very fast...nurses should not see you doing it because they become suspicious and the treatment becomes bad in labour ward.

From the FGDs it was also reviewed that some respondents do cultural practices in labour to prevent complications due to ICHILA (It can be a man having extra marital affairs while wife is pregnant or pregnant woman having extra marital affairs).

A testimony of a Para 3 woman, *“When I was admitted in Labour I took long to deliver... my mother in-law and my grandmother got soil from where a dog had delivered mixed it with water and brought it to the clinic in a Coca-Cola bottle and gave it to me ... that the delay in labour could be due to ‘ICHILA’ drink this mixture and you will deliver fast....I agreed because my husband has several women, I could have died (FGD 1 Para 3 narrated).*

During the same FGD a Para 3 also had this to share;- *“Some women if their husbands have multiple partners, they are advised to soak their husbands waist belt together with socks and drink that water before going to the clinic ...then it will help to prevent complications....Nurses will not allow you to drink in the ward so all the practices are done at home....if found with herbs they (Nurses) get the herbs and throw”.*

To some women it is a family custom to take herbs while pregnant to prevent complications and if not adhered to, they are blamed if any complications arise. A Para 2 narrated;-

“My grandmother always prepare some herbs (Pawpaw tree roots) for her pregnant grandchildren to drink during pregnancy to prevent any complications which may arise during labour....I refused to take the herbs because my church don’t allow us to take traditional medicine but to use anointing Oil blessed by our pastor....During labour I started bleeding and my grandmother blamed me for not following instructions. I was referred to UTH and was operated on (Para 1, in FDG 1).

The FGDs revealed that cultural practice are done in the communities during labour and delivery for quickening process of labour as well as prevention of complications. It has also been revealed that these practices are not allowed in the facilities and some women do not practice any cultural during labour due to their religious background.

4.3.3.6 Quality of care

Perceived quality of services plays a major role in determining a place of delivery. Women by pass their nearest clinics and access services at tertiary hospital where they perceive receiving quality services. Services at the health center are said to be free but there are some hidden

costs that may deter women from utilising labour and delivery health services (buying of Cord clamps, gloves and sanitary towels). A Para 2 narrated in FGD 2;-

“We receive good care at this clinic and the services are free ...but the problem is that, they always ask if we have brought materials to use during labour...like Jik, cotton wool, gloves and cord clamps...These things should be made available like at UTH because not all women afford to buy these materials... That is why some of us we go straight to UTH because no one will ask me for gloves and Jik, everything is available.”

Facility cleanliness is one of the factors that may influence the decision to deliver at the facility. Inadequate cleanness, inadequate water in the shower rooms was constantly mentioned as poor quality of services in the labour ward that may hinder women from using the services.

FGD 3 Para 3 stated, *“the services are very good at this clinic...the problem is that the labour ward is small, shower rooms are not clean and sometimes no water in the toilets and after delivery, one need to bath which is very difficult”*.

Women also expect to find a bed to rest when in labour and after delivery. Inadequate bed space was constantly mentioned as poor quality of service in the health centers. A Para 1 also narrated;-

“Most of the time we sleep on the floor because the beds are always occupied making it difficult for the nurses to examine us...It is not ideal to share a bed in labour because there are a lot of diseases such that you end up getting sick after delivery ... Government should extend the labour wards to accommodate all patients admitted in labour”(FGD3).

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 INTRODUCTION

Institutional delivery service utilization is one of the key and proven interventions to reduce maternal deaths. It ensures safe delivery, reduces risk of complications and increases the survival of most women and newborns (Abeje et al., 2014). However, most deliveries in developing countries occur at home without skilled birth attendants.

The main objective of the study was to determine factors associated with utilization of Labour and delivery health services by women in Lusaka District Urban Health Centers. The study respondents were postnatal women in Child bearing Age who had delivered six months prior data collection. Data were collected using an Interview schedule and Focus Group Discussion Guide.

This chapter discusses factors associated with utilization of labour and delivery health services by women in Lusaka Urban district. Drawing on quantitative data, the results of this study indicated that majority of the women utilized labour and delivery health services. The factors which were associated with utilization of labour and delivery health services after multivariate regression were maternal education, transport affordability and number of antenatal care visits.

5.2 Demographic characteristics of the respondents

The demographic characteristics of the respondents are shown in Table 6. Most respondents interviewed were in the age group 25-34 years (48.7%) followed by age group 15-24years 127(37.0%) and age group 35-49years (14.3%) respectively. The possible explanation for this is that, these were the eligible target population in the reproductive age group. Majority of the respondents 283(82.5%) were married and half of the respondents 192(56%) were house wives therefore, marriage could be a source of income for some married women. Majority of the respondents 205 (59.8%) had children 1-2. The possible explanation of this could be that most of them are in child bearing age and could be planning to have more children looking at the age group. Furthermore, a good number of respondents 98(28.6%) had children 3-4. Accordingly to ZDHS 2013-14 data, state that the desired family size by Lusaka

women is 4.1 children. Therefore, women could have planned to have the desired family size of 3-4 children.

Table 6 shows that most women interviewed 166 (48.4%) had secondary education. This could be because women who accessed basic junior secondary education (Grade 8-9) were also put in the category of secondary education (Grade 10-12). The other reason could be that most schools in Lusaka have been up graded to basic schools and most women could have accessed grade 8 and 9. According to ZDHS (2013-14) data, state that in urban areas women are six (6) times more likely to have secondary education than rural women(24% verses 4%).

In this study, only respondents 27(7.9%) were formally employed. The possible explanation for this could be that respondents 23(6.7%) had tertiary education and according ZDHS (2013-14) report state that, women with more than secondary education (70%) are most likely to be employed than women with no education or primary education.

Half of the respondents 172(50.1%) were in the mid income class with a family monthly income of between K500-K1000 while a good number 91(26.5%) were in the low income class with family monthly income of less than K500. The possible explanation for this is that, women with secondary education and above may have an opportunity to be employed and earn a good salary while women with low educational levels may not find a good paying job.

5.3 Utilization of labour and delivery health services.

In this study utilization of labour and delivery health services was optimal 306(89.%) while non-utilization stood at 11% (Figure 3). This finding is in agreement with CSOs' (2015) findings which showed that the proportion of births delivered in the health facilities was 89.9% in Lusaka while home delivery was at 10%. However, the utilization of labour and delivery health services was found to be higher than that recorded by Lusaka district health office which is less than 60%. The results can be explained by the fact that, latest information was collected from the respondents on different health facilities they utilised during labour and delivery in Lusaka. Out of the respondents 306(89%) who utilized labour and delivery health services, majority of the respondents 210 (61.2%) delivered in the district health centres, 26.8% at the hospital (UTH) and 1.2% delivered in the private institutions (Table 9).

The observed increase in utilization could be attributed to readily accessibility of labour and delivery health services by most respondents (94.4%) (Table 18) and lesser transportation costs (Table 17) which is an enabling characteristic which could influence women to deliver in the health facilities. This is consistent with the study done in Addis Ababa city in which 82.3% of urban women gave birth in health institutions (Ethiopia Demographic Health Survey Preliminary Report, 2011; Abeje et al., 2014).

In this study the proportion of women who delivered at home was less (11%) compared with other studies in developing countries like Malawi (42%) and Ethiopia (21.2%) (Palamuleni, 2011; Abeje et al., 2014). However, it is encouraging to compare the proportion of home deliveries with that found by ZDHS (2013-2014) which indicated that home deliveries at national level was at 47%. A possible explanation for this might be that, this study was carried out in Lusaka urban district where women are likely to deliver in a health facility (89%) compared to rural women (58%). Another possible explanation for this is that, women had high perceived benefits of institutional deliveries (98%) (Figure 5) and most of them knew the complications which may occur during home deliveries (Table 15). However, the other reason for the low proportion of home delivery could be non-birth registration for some deliveries conducted at home by unskilled attendants especially if the delivery was event free. This was also supported by information obtained from respondents during FGDs, For example, Para 5 woman in FGD 1 stated that, she delivered at home due to quick labour and didn't visit the facility immediately after delivery to register the home birth and to be examined.

5.4 Association between demographic factors with utilization of Labour and delivery health services.

Literature reveals that, maternal age, parity, maternal level of education and women's occupation influence women to utilize labour and delivery health services (Gwamaka, 2012). In this study, middle aged women 25-34 years (92.2%) (Table 23) utilized labour and delivery facilities compared to the young women aged 15-24 years (89.9%) and the older women above 35 years (77.6%). The possible explanation for this could be that, the older women may consider themselves experienced and feel not requiring skilled assistants to help during labour and delivery in the facilities. Maternal age in this study was not statistically significant (P-value=0.14). This is also similar to the study done in Kenya in which showed that maternal age was not a factor that would influence women to deliver and being assisted

by skilled attendants in the facility (Kawakatsu et al., 2016). The findings of this study are also in line with the study done in Botswana which revealed that teenagers often did not use health facilities for delivery (Letamo and Rakgoasi 2003; Shankwaya, 2009). Literature reveals that women below 19 years and women above 35 years are at greater risk of developing complications compared to the middle aged (25-34years) (Gwamaka, 2012). Shankwaya (2009) also noted that young women consider themselves at risk of developing complications because they have never delivered before and so utilize labour and delivery health services more than the elderly women. This information is in line with information obtained during FGDs from a Para 1 woman who mentioned about the benefits of delivering in the facility, “*facility delivery is the best because one can be helped in case of any complications compared to home deliveries*”.

In this study, parity was associated with utilization of labour and delivery health services (P-value 0.006) and after multivariate logic regression adjusting for confounders, parity was not one of the predictors influencing women to utilize labour and delivery health services. Respondents (93.3 %) with low parity delivered in the facility compared to medium parity women (85.7%) and high parity women (77.5%). The reasons could be that low parity women may fear developing complications during labour and delivery compared to high parity women who consider themselves experienced especially if their home deliveries were complication free. Similarly, studies done in Kenya showed that women with more children were likely to deliver at home compared to the single parity women (Bazant, 2008; Gwamaka, 2012).

Maternal education is the most important determinants for health services use (Ensor and Cooper 2004; Gwamaka, 2012). It is also one of the predisposing characteristic in this study which could influence women to utilise labour and delivery health services. Educational level in this study was found to have a strong relationship with utilization of labour and delivery health services. Women who attained secondary education (95.2%) and tertiary education (100%) were 3.5 times more likely to utilize labour and delivery health services than women who attained primary education (80.3%) and none (OR= 3.5, CI-1.0-11.861, P-value=0.042). The possible explanation for this could be that educated women are more aware of health problems, know more about the availability of health care services, and use the information more effectively to maintain or achieve good health status. In addition, it could be that educated women will also make a decision where they want to deliver from. This is consistent with the study done by Mustafa and Mukhtar (2015) in Sudan. The

results showed that women with high educational levels tend to utilize labour and delivery health services than women with no education (OR=1.929-95% CI, 1.380-2.697, P=0.001). Similarly, study done by Rav et al., (2013) in India, showed that women who completed secondary education and above preferred institutional deliveries than the non-educated women.

Economic status is an enabling characteristic which could influence women to use the health services. Lack of income is known to be a barrier to delivery at the facility (Ogolla, 2015). In this study, respondents (95%) (Table 23) who were in the high income class utilised labour and delivery health services compared to their counterparts in low and medium income classes. The reason could be that availability of income help women to pay transport costs and buy other requirements needed during labour and delivery hence, influencing women to deliver in the facility. However, high income was not one of the predictors which influenced women to deliver in the facility (OR, 1.4, CI 0.367-6.032, P=0.578). This is in agreement with the study done in Nepal in which the results revealed that economic status insignificantly influenced place of delivery (Bolam, 1998; Ogolla, 2015).

5.4.1 Antenatal care attendance visits associated with utilization of labour and delivery health services

The WHO has recommended that health workers should help women to prepare for child birth (Kerber et al., 2007; Khanal et al., 2014). As a result of such preparation during ANC mothers are likely to utilise health facility for child birth. Antenatal care visits is an enabling characteristic in this study which encouraged women to utilise Labour and delivery health services. Respondents 253(91.7%) (Table 24) who attended ANC 3-4 visits utilised labour and delivery health services. The reason could be that during ANC women are provided with Information, Education and Communication about the importance of facility delivery. This information is evidenced by information obtained during FGDs in which a Para 2 in FGD 2 mentioned that, she delivered at the clinic because the health providers always informed them about the importance of delivering at the clinic during ANC visits.

The association between antenatal care visits and utilization of labour and delivery health services was strongly significant as women who attended ANC 3-4 times were 9.7 times more likely to deliver in the health facility compared to women who made less visits (OR=9.7, P-value=0.030). This is consistent with the study done by Priyanka et al.,(2013) in which the results showed that women who had 3 or more ANC visits were likely to utilize labour and

delivery services compared to women who had 2 or less visits. The study is also similar with other studies done in Rwanda and Tanzania where the odds of delivering in the health facility for women who attended ANC more than 3-4 visits were higher than those who attended once (Umurungi, 2010; Gwamaka, 2010).

Contrary, Magoma et al., (2010) reported that out of 90% of women who attended Antenatal care, 62% had made four visits but only less than 50% delivered in the facility. Failure of health providers to consistently communicate to women on the importance of skilled delivery during routine ANC was the contributing factor.

5.5 Knowledge levels of women associated with utilization of labour and delivery health services.

Knowledge levels of women on the benefits of facility delivery is a predisposing factor that may encourage women to utilize labour and delivery services. The study showed that respondents' knowledge levels were high 268(78.1%). The possible explanation for this outcome could be that majority of the respondents 253(91.7%) had made 3-4 ANC visits which gave them an opportunity to interact with the health providers and obtained information on the benefits of facility deliveries. This strongly emphasizes the need for the health workers and community based agents like SMAGs to increase awareness on early ANC booking and on importance of having four recommended ANC visits so that women obtain information on importance of facility deliveries. This picture proves the findings obtained in Nepal which indicated that health workers are the key source of information about safe motherhood services (Buhta, 2008; Okereke et al., 2013). However, the findings of this current study are inconsistent with the findings obtained by Okereke et al.,(2013) in Nigeria which indicated that 90% of women had poor knowledge on the benefits of facility delivery.

In this study, after adjusting for confounders in multivariate analysis knowledge level of women was not one of the factors which influenced women to utilise labour and delivery health services.

5.6 Service related factors associated with utilization of labour and delivery health services

5.6.1 Transport affordability

Transport affordability is one of the enabling factor which could influence women to utilize labour and delivery health services.

In this study the odds of utilizing labour and delivery facilities for women who could afford transport were 4.7 times higher than those who could not afford transport. This effect was statistically significant (OR 4.7, CI 1.707- 12.975, P=0.003). The possible explanation for this is that, there is accessibility of health services in urban district with lesser transportation costs. Furthermore, health education given by the health workers on birth plan during ANC services encourages mothers to deliver in the facility. On the contrary, the poor physical access to the health facilities with high transportation costs in rural areas hinder women to deliver in the health facilities (Habte and Demssie, 2015).

This was also supported by information obtained from participants during FGDs. Example, Para 3 in FDG 1 mentioned that during antenatal clinic health providers or community workers always remind women to keep money for transport in case of any emergency such that when labour started she just called the driver who dropped them at the clinic in the night. This is similar to the study done by Ononokpono (2013) in Nigeria, in which the results indicated that transport was significantly associated with utilization of labour and delivery health services. This is also in line with a study done by Habte and Demssie (2015) in Ethiopia who indicated that women who were able to afford transport costs from home to the health facilities were 2.5 times more likely to give birth in a health facility than their counterparts.

Other studies done in Zambia indicated that non-availability of transport influences women's choice of delivery (Stekelenburg, 2004; Shankwaya, 2009).

5.6.2 Distance

The study revealed that respondents (90.6%) (Table 26) who stated that they take 30minutes to one hour to reach the health facility utilized labour and delivery health services. The possible explanation for this observation could be availability of labour and delivery clinics within the communities. Respondents 287(83.7%) confirmed availability of labour and delivery health services in their communities while 16.3% did not (Table 17). FGDs also supported the

information that women who live within the radius of 5km from the facility utilize labour and delivery health services as depicted in following statement, *“I delivered at this health centre because it is near my home...It is just 10 minutes’ walk to the clinic...Therefore, I don’t need any transport to come to the clinic for labour and delivery”*. However, distance was not statistically significance after multivariate logistic regression. This is similar to the study done by Kitui et al., (2013) which indicated that there was no significant association between distance and delivery in the facility. Other studies done in Nepal and Kenya indicated that distance was a factor which determines place of delivery for women (Shrestha et al.,2012 and Ogolla, 2015).

5.6.3 Staff Attitude and Privacy

Staff attitude and privacy are a need base characteristic that influences women to utilise labour and delivery health services. According to the theoretical model of health facility utilization states that, the outcome from health facility use and the perception of need significantly determines place of delivery for women (Anderson, 1995; Kitui et al., 2013).

Majority of the respondents (92.1%) who reported positive staff attitude utilized labour and delivery health services compared to respondents (57.1%) who reported negative staff attitude. Positive staff attitude was also supported by information obtained during FGDs in which a Para 4 woman in FGD 3 stated the following *“I go to Kanyama main clinic for delivery...i always find nurses who are very polite and give reassurance during labour, some nurses are naturally gifted from God...despite having a lot of patients in labour they are always on your side until they knock off”*.

In this study majority of respondents 254(83%) (Table 19) stated that they were happy with the services received during labour and delivery while 17% were not. The reasons given by the respondents who were not happy with the services were staff bad attitude (61.1%) and lack of privacy (21.2%). During FDGs it was also noted that some participants get information from their friends or relatives about the services rendered in labour wards which intend determines their place of delivery as in the following statement; *“My neighbour told me not to deliver at this clinic (George) because they (nurses) don’t provide privacy. You will find that there are also young mothers who come to deliver and you are in the same room seeing everything done on an elderly mother... so i decided to go to Chingwere clinic where they cared for me well “*. This picture is in line with the findings obtained in a study done in rural parts of Tanzania which indicated that staff attitude and poor treatment

including lack of privacy at health facilities discouraged women from delivering in health facilities (Kitui, et al., 2013).

This is also similar to a study done in Kazungula, Zambia, in which the results indicated that some health providers can be rude to women and disrespectful, this hindered women from utilising labour and delivery health services (Shankwaya, 2009). However, in this study it's interesting to note that staff attitude was not statistically significant after controlling for other confounders.

5.7 Cultural practices associated with Utilization of labour and delivery

Cultural factor is one of the predisposing characteristic that suggests the likely hood of utilizing maternal health services. This study reveals that utilization increased in respondents (90.9%) who did not report an observation on any cultural practices than their counterparts (88.2%) who observed cultural practices (Table 27). This could be that respondents 211(61%) who observed cultural practices during labour and delivery practiced and their labour accelerated and ended up delivering at home than their counterparts who did not observe any cultural practices 132(38.5%) (figure 12).

The results obtained during FGDs also affirms that there are cultural practices observed in the community as depicted in the following statements;- *“There are a lot of traditional practices done before going for delivery if one wants to deliver fast... for me on all my children I just pick soil from the cross roads where people pass very much, soak it in water and drink just before starting off from home because if one delays can deliver on the way like I did on my first three babies”*(Para 6 narrated in FGD 3). A para 3 in FGDs 1 also narrated; *“Some women if their husbands have multiple partners, they are advised to soak their husbands waist belt together with socks and drink that water before going to the clinic ...then it will help to prevent complications.* The statements are consistent with the findings of Mrisho et al., (2007) in Tanzania on cultural beliefs during labour and findings of Maimbolwa (2004) in Zambia. However, the chi-square results showed that the observations were not statistically significant (P-Value= 0.423). This is consistent with the study done in Zanzibar in which the results indicated that social cultural characteristics are not the factors that hinders women from seeking labour and delivery health services (Mwisongo and Njau, 2008; Mohammed, 2012).

5.7 APPLICATION OF THE THEORETICAL FRAMEWORK TO THE STUDY FINDINGS

This study was guided by Andersen's Behavioral Model of Health Services Utilization. Andersen Health Behavioural Model analyses the differences in health service utilization from socio-demographic perspective. Moreover, the model suggest that the key elements that can influence health care behaviour and utilization of health services by women are predisposing characteristics, enabling resources and need based characteristics.

Predisposing Characteristics

Predisposing characteristics suggest the likely hood that women will need to utilise labour and delivery health services. The predisposing characteristics in this study were Maternal age, Parity, Maternal Education, Knowledge of women on the benefits of utilising labour and delivery health services and cultural factors.

In this study, women in the age group 25-34 years (92.2%) and women in the age group 15-24 years(89.8%) utilised labour and delivery health services compared to the older women (77.6%) in the age category 35-49 years. Young women tend to fear complications therefore, they are likely to deliver in a facility.

Cultural factors is one of the predisposing characteristic which could influence women to utilise labour and delivery health services. In this study, respondents (90.9%) who did not observe any cultural practices utilised labour and delivery health services than their counterparts (88.2%) who observed. Cultural practices deter women from delivering in the facility. Women who take traditional herbs to accelerate labour end up delivering at home. This information is also supported by information obtained during FGDs in which a woman confirmed taking herbs to speedy up labour and ended up delivering at home. However, the study established that cultural beliefs were not a factor that influenced women's utilization of labour and delivery health services.

The study revealed that respondents (93.2%) with children 1-2 utilised labour and delivery health services than women (77.5%) with children above 5. This may be due to the assumption that grandmulti-parae are more experienced than those with children 1-2. Prim-paras consider themselves to be predisposed to complications hence they are more likely to utilise labour

and delivery health services. However, in this study after adjusting for confounders parity was not one of the predictors which influence utilisation of labour and delivery health services.

According to the study findings, women with secondary education (95.2%) and women with tertiary education (100%) utilised labour and delivery health services. Balola and Fahisi (nd), indicated that, attainment of basic education is identified as an important factor associated with greater decision making power and higher chances of comprehending health information on importance of delivering in a health facility. Furthermore, higher levels of education may consequently influence women to decide on the place of delivery. This is in line with Andersen theoretical model which states that an individual who believes that health services are useful for treatment will be likely to utilize the health services (Anderson, 1995). In this study maternal education was one of the predisposing characteristic strongly influenced women to utilise labour and delivery health services.

In addition, the study revealed that majority of women (93.1 %) with moderate knowledge on the benefits of delivering in the facility utilised labour and delivery health services. Knowledge of women on the benefits of utilising labour and delivery health services is a predisposing characteristic which influenced them to utilise labour and delivery health services. Therefore, there is need by the health providers and community health workers to sensitise women on the benefits of utilising labour and delivery health services.

Enabling Characteristics

The enabling resources in this model were those resources that provided individuals with the means to use health care services (Andersen, 1995). Certain resources need to be available to families or individuals in order to utilise health services.

The study established that enabling factors such family income, transport affordability during labour and delivery health services and ANC visits provided women with the mean to utilise labour and delivery health services. The study revealed that women (95%) who had family income above K1500 and women (93.9%) who could afford transport costs during labour utilised labour and delivery health services. Income is an enabling factor if when available will help women to pay for transport costs and other costs during labour and delivery hence, influencing women to utilise labour and delivery health services. In addition, the study revealed that Antenatal care visits influenced women to deliver in the facility. Women (91.7%) who had 3-4 ANC visits delivered in the clinic. Frequency in ANC

visits influence women to deliver in the facility because during each ANC women are encouraged to deliver in the facility. ANC visits as an enabler were strongly associated with utilisation of labour and delivery health services.

Need based characteristics

The need based characteristics in Andersen behavioural Model refers to health status or illness and its severity as perceived by the individuals or evaluated by health providers (Andersen 1995; Ononokpono, 2013). In this study the need based characteristics were staff attitude, Privacy, previous delivery experience at the facility.

The study established that, use of health care services by individuals was mostly triggered by their experiences and need during pregnancy and childbirth. According to the information obtained from FGDs, women stated that inadequate medical supplies such as surgical gloves, sanitary pads and cord clamps influenced them to have a negative perception towards utilizing labour and delivery services. Women may not see the importance of utilising the services if there are inadequate medical supplies during their previous delivery in the facility. They may prefer to by-pass the nearest facility and access services in a private health sector where they may perceive quality services.

The study also revealed that previous experience of women during labour may influenced them to utilize the services. This was also supported by information obtained during FGDs in the following statement;

“In my previous pregnancy I delivered here at this clinic because they cared for me well, I interacted with the nurses on duty and after each examination they were explaining to me everything until i delivered, Privacy was provided throughout... for me I will be using the same health centre for delivery. The study revealed that inadequate cleanness and inadequate bed space deter women from utilising labour and delivery health services .This is according to the information obtained during FDGs narrated ; “The services are very good at this clinic...the problem is that the labour ward is small, shower rooms are not clean and sometimes no water in the toilets and after delivery, one need to bath which is very difficult”.

5.8.0 IMPLICATIONS OF THE STUDY FINDINGS TO NURSING/MIDWIFERY

5.8.1 Nursing Practice

The study findings showed that almost half of the respondents (48.7%) heard about the benefits of facility delivery from health workers and 27.9% heard from the Community Health Workers (CHW). CHWs are most of the time in the communities where these women are found. There is need therefore, for the midwives to work closely with Community Based Agents such as SMAGs and equip them with adequate information on Safe-motherhood activities for them to provide adequate information to women and their families in the communities on the benefits of facility delivery. This will encourage majority of women to utilise labour and delivery health services.

5.8.2 Nursing research

From the literature review, it was found that few research which included health providers as study respondents have been done. Therefore, there is need for the nurse researchers to conduct future research which will include health providers to solicit more information on health service related factors. On the other hand, there will also be need to conduct a community based study on factors associated with home deliveries so that information from women who don't register home births is obtained.

5.8.3 Nursing Administration

The study revealed some reasons why women do not utilise the nearest health facilities in their communities. Respondents (30.1%) cited lack of labour and delivery requirements (Sanitary pads, JIK, Cord clamps, Cotton wool and mattress covers) as reasons for not utilising labour and delivery health services. Others, (29.7%) cited staff bad attitude as reasons. Respondents (32.7%) recommended that health workers should be respecting women in labour while other respondents (28.9%) recommended that the number of midwives should be increased for the services to improve. Therefore, there is need for the nursing/midwifery administrator to ensure that labour ward in-charges order adequate surgical supplies and this will encourage women to deliver in the nearest health centers. More midwives should also be deployed in labour wards to promote quality care to the labouring women. More technical support visits should also be done in labour and delivery centers to guide the midwives on midwifery issues.

5.8.4 Nursing Education

The study found that respondents 76.8% mentioned that traditional medicines are taken to quicken the process of labour. Therefore, there is need for the nurse educator to formulate IEC

materials on the consequences of taking herbs during pregnancy and labour this will discourage women from taking herbs.

5.9 CONCLUSION

The current study determined utilization levels of labour and delivery health services among women in Lusaka District Health Facilities. The results of this study revealed that utilization of labour and delivery health services by women were optimal (89%) compared to (55%) recorded by Lusaka District Health Office. Maternal education, transport affordability, and ANC attendance visits were found to be significant factors associated with utilization of labour and delivery health services. Therefore, health providers and Community Based Agents should continue to raise awareness on early ANC booking and on the importance of having the four recommended visits because during ANC routine visits women obtain information on birth plans. On the other hand, there is also need for the Ministry of Education to support women's education.

6.0 RECOMMENDATIONS

As a measure to encourage facility deliveries in the health institutions and to reduce home deliveries among women in Lusaka, the following are the recommendations which may improve service utilization.

- 6.1.0 Ministry of Health, district maternity co-ordinator and district health promotion officer needs to put in place measures to strengthen IEC programs on media and in the facilities to campaign against harmful community cultural practices that acceralate labour process leading to home deliveries.
- 6.2.0 Ministry of Health and other stake holders need to train more SMAGs on Safe-motherhood activities so that they can help educate women in the communities they live on importance of early ANC booking and facility deliveries.
- 6.3.0 Ministry of Health in conjunction with district health office should provide sufficient delivery supplies to the public facilities so that delivery services can be free in reality.
- 6.4.0 Ministry of Health should continue working with Ministry of Education and other stake holders to ensure that opportunities are given to the girls to go to school especially beyond primary school as education has an impact on women's' decision on the place of delivery.

6.5.0 District health providers and community health workers should encourage early ANC booking and completion of at least four recommended ANC visits as those attending ANC acquire more information on the benefits of facility deliveries.

6.6.0 A qualitative study approach which should involve health providers to have an understanding on the factors associated with labour and delivery health services in the facilities should be undertaken.

7.0 STUDY LIMITATIONS

7.1 Respondents may have failed to bring out their views during FDGs because some clients may be shy to talk about their experiences in front of the group especially that the groups were a mixture of young and older women. This was minimized by encouraging women to participate and assuring them of confidentiality.

7.2 Considering that the study was conducted in the facilities, there was possibility that issues related to attitude of skilled health workers were under reported. This was minimised by creating a rapport with respondents and maintaining a non-threatening attitude.

7.3 Recruitment of FGD participants was not always easy because of inadequate rooms in the facilities which delayed the process of data collection. This was minimized by working closely with the MCH in-charges and conducive room were provided at all times.

8.0 STRENGTH OF THE STUDY

Applying mixed approach of quantitative and qualitative approach in data collection was a strength in this study. Qualitative research was done and understood well the association between some service related factors, demographic factors and utilization of labour and delivery health services.

9.0 DISSEMINATION AND UTILIZATION OF FINDINGS

The results of the study were presented to the Department of Nursing Sciences, School of Medicine, and University of Zambia (UNZA). Then, the results was later presented at the postgraduate seminar week on 27th June to 1st July, 2015 held at UNZA. The results will also be presented to various stake holders involved in the provision of maternal health services at various forums such as, workshops and conferences. Lusaka District Health Offices which was

the study site will be given a copy of the study results report. The results will also be presented to participants and community based agents during community stake holders meetings.

The results will be published in African Journal of Midwifery. In addition, five copies of the bound research report were printed and submitted to the following;

1. Department of Nursing Sciences
2. UNZA Medical Library and Main Library
3. Ministry of Health
4. Researcher

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APPENDIX I: INFORMATION SHEET

TITLE OF STUDY:- FACTORS ASSOCIATED WITH UTILIZATION OF LABOUR AND DELIVERY HEALTH SERVICES IN LUSAKA URBAN

My names are Jeane Ngala Banda, I am pursuing Masters of Science Nursing Degree training at the University of Zambia, School of Medicine, at the Department of Nursing Sciences.

In partial fulfilment of my training in Masters of Science Nursing Degree program, I'm required to undertake a research project of which my topic is stated above. The main objective of this study is to determine the Factors associated with utilization of Labour and delivery Health services in Lusaka Urban.

I wish to inform you that participation in this study is voluntary and therefore; you are free to withdraw at any stage of the study if you so wish. You will be asked questions on knowledge levels on the benefits of delivering in a health facility, cultural beliefs, attitude of skilled attendant and distance/transport to the health facility. You will also be expected to give information on your demographic data. Any information given will be kept in confidence and no name will be written on the interview schedule.

There are no monetary benefits from this study but you will benefit from the study results by improving ways of educating the women to utilize skilled birth attendants. The information that you will give will assist the researcher to determine factors associated with utilization of labour and delivery health services and the findings will be used by policy makers and other organizations in finding ways to improve utilization of skilled birth attendants by women.

If you are willing to participate in this study, you will be asked to sign consent or thumb print for agreement. Please ask where you are not clear for clarification.

APPENDIX IB : INFORMATION SHEET NYANJA VERSION

ZOLENGEZEDWA PA PEPALA

MUTU WA MPUNZIRO: ZINTHU ZOKHUDZA UBELEKI NDIPONSO KAPEREKEDWE KA ZOKHUDZA UMOYO M'MAKILINIKI YA MU MZINDA WA LUSAKA URBAN DISTRICT

Madzina anga ndine Jeane Ngala Banda, ndiri kuimba maphunziro a digiri ya ukacenedwe a Sayansi a unamwino pa Universit ya Zambia.

Mu kukwaniritsa pang'ono kwa maphunziro achulidwa pamwamba apa. Phunziro ili ndilofunika pa zinthu zokhudza ubeleki ndiponso kaperekedwe ka zokhudza za umoyo m'makilini mu mzinda wa Lusaka urban.

Ndikudziwitsani kuti ngati mufuna kutengako mbali mu maphunziro awa muyenera kudzipereka ndiponso muli nalo ndanga losatengako ngati mwasintha, ndi kuleks nthawi ili yonse, mudzayankha mafunso pa zimene mudziwa za bwino obelekera ku cipatala, kuphunzira, miyambo, makhalindwe ya anthu odziwa nchinto yobeleketsa ndi kumalo kocokela obeleka ndi mayendedwe kufika ku kiliniki. Mudzayenera kundipatsa nkhani ya umoyo wanu. Nkhani zonse zidasungidwa mwa cinsinsi. Ndiponso dzina silidzalembedwa pa pepala.

Palibe malipiro a ndalama pa maphunziro awa koma mudzaona zinthu za sintha mu njira zophunzitsiramo azimai kugwiritsa a namwino pobeleka. Uthenga umene mudzapatsa mfufuzi udzathandizira kuti zinthu zokhudza za umoyo ndi zopezeka zace akulu-akulu a nchito ndi mabungwe ena kupeza njira za a namwino za bwino zothandizira azimai pobeleka.

Ngati muli ndi cidwi kutengako mbali ku maphunziro awa, mudzafunsidwa ku sayina fomu ya cilolezo. Conde funsani pamene simunamvetsetse.

APPENDIX II: CONSENT FORM

DECLARATION

I have been explained to and I understand the nature of the research in which I have been requested to participate. The opportunity to ask questions about the research was given and I have been answered to my satisfaction.

I therefore agree to participate.

Ihere by called the respondent understands the guidelines of this study and I am willing to participate in the study.

Dated thisday of2015.

Signature/ thumb print of respondent.....

Witness.....

PERSONS TO CONTACT FOR PROBLEMS OR QUESTIONS

1. Jeane Ngala Banda University of Zambia. Department of Nursing Sciences. P.O. Box 50110, Lusaka. Cell: 0977 894155
2. Dr D.C Chanda and Mrs M. Makoleka.University of Zambia, Department of Nursing sciences. P.O. Box 50110, Lusaka. Cell: 0977847323 and 0977862284
3. The Chairman, Research Ethics Committee, University of Zambia. P.O. Box 50110, Lusaka. Phone no. 260- 1- 256067

APPENDIX IIB: CONSENT NYANJA VERSION

ZOLENGEZEDWA NDI CILOLEZO

Colinga ca maphunziro awa afotokozedwa kwa ine ndipo ndamvetsa colinga, phindu, mabvuto, kusakhalitsidwa bwino ndi cisinsi ca maphunziro awa.

Ndibvomekeza ndi izi:

Ine,

Ngati Ine ndabvomera kutengako mbali kumaphunziro awa, ndingaleke nthawi ili yonse kupanda kufotokoza ndiponso kutengako mbali m'maphunziro awa pa kudzipereka..

Siginecala..... Tsiku

(Siginecala ya otengako mbali kapena cidindo ca cala ca cikulu)

Siginecala..... Tsiku

ANTHU OFUNSA NGATI MULI NDI MABVUTO KAPENA MAFUNSO:

1. Jeane Ngala Banda. University of Zambia. Department of Nursing Sciences. P.O. Box 50110, Lusaka. Cell: 0977 894155
2. Dr D.C Chanda and Mrs M. Makoleka. University of Zambia, Department of Nursing sciences. P.O. Box 50110, Lusaka. Cell: 0977847323 and 0977862284
3. Mtsogoleri, Biomedical Research Ethics Committee, University of Zambia, P.O. Box 50110. Lusaka

APPENDIX III : DATA COLLECTING TOOL

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPT OF NURSING SCIENCES

STRUCTURED INTERVIEW SCHEDULE

TOPIC: FACTORS ASSOCIATED WITH UTILIZATION OF LABOUR AND DELIVERY HEALTH SERVICES IN LUSAKA URBAN HEALTH FACILITIES

PLACE OF INTERVIEW:

DATE OF INTERVIEW:

NAME OF INTERVIEWER

SERIAL NUMBER OF INTERVIEW SCRIPT:

INSTRUCTIONS FOR THE INTERVIEWER:

Introduce yourself to the respondent and explain the reason for the interview.

1. Do not write the name of the participant on the interview schedule.
2. Circle the most appropriate response given by the participant to the question for closed ended questions.
3. Fill in the answer on the spaces provided for open ended questions.
4. All the information provided by the respondent should be kept in strict confidence.
5. Provide time for the respondent to ask questions at the end of the interview.

Thank the respondent at the end of each interview.

**SECTION A: DEMOGRAPHIC DATA
ONLY**

FOR OFFICIAL USE

1. How old were you on your last birthday?

.....

2. What is your marital status?

a. Single

b. Separated

c. Married

d. Divorced

e. Widowed

3. If married, what is your husbands'

Occupation?

a. Un employed

b. Formally employed

c. Self employed

d. Other, specify.....

.....

4. What is your Religion?

a. Christianity

b. Islamic

c. Hinduism

d. Any other, specify.....

5. What is your level of education that you have attained?

a. No formal education

b. Primary

c. Secondary

d. Tertially

6. What is your occupation?

a. House wife

b. Formally employed

- c. Self employed
- d. Other specify

7. What is your monthly family income?

- a. ≤ K 500.00
- b. K 500- K1,500.00
- c. ≥ K1,500.00
- d. Others specify.....

8. How many children do you have?

- a. 1-2
- b. 3-4
- c. 5 and above

9. How old is your last child?

- a. 1 month-2months
- b. 3-4months
- c. 5 -6 months

10. Did you attend Antenatal clinic

In your last pregnancy?

- a. Yes
- b. No

If No skip to question 12.

11. If yes, how many times did you attend Antenatal clinic?

- a. Once
- b. 2 times
- c. 3times
- d. 4 times

12. If No, Why?

- a. Didn't see the need.
- b. Long distance to the facility
- c. Didn't have transport.
- d. Bad attitude of health workers
- e. Others specify.....

.....

SECTION B: UTILIZATION LEVEL

13. Where did you deliver your last child?

- a. At Home
- b. At the health Facility
- c. At the Hospital
- d. At private hospital

14. Was that the place you intended to deliver from?

- a. Yes
- b. No

If yes, skip to question 18.

15. If No, where did you intend to deliver from?

- a. At Home
- b. At Health Centre
- c. At a Private Hospital
- d. At Government Hospital
- e. Other specify.....

.....

16. What are the reasons that made you deliver where you delivered from?

- a. Lack of transport
- b. Long distance
- c. Sudden onset of labour

- d. Bad staff attitude
 - e. Others specify.....
-

17. What suggestions would you give to Encourage women to utilize labour and delivery of services.

.....

.....

.....

.....

SECTION C: KNOWLEDGE LEVEL

18. Have you ever heard about the benefits delivering in the clinic?

- a. Yes
- b. No

19. Where did you hear it from?

- a. Health provider
- b. Community health worker
- c. Relative
- d. Friend
- e. Others specify.....

20. Do you know the benefits of delivering in a health facility ?

- a. Yes
- b. No

21. If yes, to question 20, list the benefits of delivering in the health facility?

a. Delivery is conducted by a trained birth attendant who is able to identify danger signs of pregnancy like :

- High blood pressure
- Swollen limbs
- Mal-presentations of the foetus detected during

- abdominal palpation
- b. Prevention of puerperal sepsis by using sterile Delivery packs during delivery.
- c. Prevention of Neonatal umbilical sepsis by using sterile equipment when cutting the cord
- d. There are doctors who will attend to me when any emergency arises.
- e. The baby can be attended to when any complications arises
- f. Others, specify.....
.....

22. Mention two complications which may occur when you deliver at home?

- a. Puerperal sepsis
- b. Bleeding after delivery
- c. Retained Placenta
- d. Neonatal umbilical sepsis
- e. Others specify.....

SECTION D: HEALTH SERVICE RELATED FACTORS ON DISTANCE AND STAFF ATTITUDE

23. How long does it take to get to your clinic?

Converted to Kms (0-2, 3-5, 6-10,>10) kms

- a. less than 30 minutes
- b. within 1 hour
- c. within 2 hours
- d. more than 2 hours

24. What means of transport do pregnant women use when going for labour and delivery services?

- a. Private car
- b. Public transport
- c. Ambulance
- d. Others specify.....

25. Are you able to afford cost of transport when going for labour and delivery?

- a. Yes
- b. No

26. Are the labour and delivery health services near the community you are coming from?

- a. Yes
- b. No

27. If yes to question 26, how accessible are the services?

- a. Readily accessible
- b. Available sometimes
- c. Not accessible
- d. Other, specify.....

28. Did you feel happy with the services provided at the Facility where you delivered from?

- a. Yes
- b. No

29. If No, to question 28, what made you feel unhappy with the services provided?

- a. Inadequate drugs, linen
- b. Staff bad behaviour
- c. Lack of privacy
- d. Shortage of staff
- e. Other specify.....

30. How long did you wait at the health clinic before you were attended to?

- a. 0-10 minutes
- b. 11-20 minutes
- c. 21-30 minutes
- d. Over 30 minutes

31. Did skilled attendants explain procedures before attending to you in labour?

- a. Always
- b. Sometimes
- c. Rarely
- d. Never

32. Did skilled health providers explain their findings after attending to you in the facility you delivered from ?

- a. Yes
- b. No

33. Did the health worker provide privacy by screening the bed

Or by providing curtains when you were in labour?

- a. Always
- b. Sometimes
- c. Rarely
- d. Never

34. Do you think you can recommend the use of the clinic to your friends or relatives?

- a. Always
- b. Sometimes
- c. Rarely
- d. Never

35. What do you think makes women not to deliver at the nearest health facility?

- a. Sudden onset of labour
- b. Bad staff behaviour
- c. Lack of Privacy
- d. Shortage of Staff
- e. Lack of baby layette
- f. Other specify.....

36. What recommendations would you make to improve the services at this facility?

- a. Increase number of staff
- b. Improve availability of drugs
- c. The health workers should be respecting women
- d. Need an ambulance
- e. Others, Specify.....

SECTION E: SOCIO-CULTURAL BELIEFS

37. Are there any cultural practices observed during delivery in your community ?

- a. Yes
- b. No

38. If yes, explain the labour and delivery cultural practices Observed in your community?

.....
.....
.....

Thank you very much for taking your time to answer these questions.

APPENDIX 111 B DATA COLLECTING TOOL NYANJA VERSION

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

CHIGAO CA MAPHUNZIRO A UNAMWINO

**MUTU: ZINTHU ZOKHUDZA UBELEKI NDIPONSO KAPEREKEDWE KA ZOKHUDZA UMOYO
M'MAKILINIKI MU MZINDA WA LUSAKA URBAN DISTRICT**

MALO YA KAFUKUFUKU

TSIKU LA KAFUKUFUKU

DZINA LA MFUFUZI

NAMBALA YA PEPALA YA KAFUKUFUKU

MALANGIZO A MFUFUZI

Uzani munthu oyakha mafunso ndi kumuza cimene mufuna pakukambilana kwanu mu kafukufuku.

- 1. Musalembe dzina la munthu pa pepala lanu.**
- 2. Ikani kamuzele kozungulira pa yankho yobveka bwino imene wayankha pa funso lofunsidwalo.**
- 3. Lembani mayankho mumalo opatsidwa mu mafunso.**
- 4. Zonse zimene mwakambitsana ziyenera kukhala za cinsinsi.**
- 5. Patsani nthawi munthuyo kuti nayenso afunse mafunso potsiriza kukambilana .**

Yamikani munthuyo pakutha, ko kukambilana naye.

CIGAO A: DEMOGRAPHIC DATA

FOR OFFICIAL USE ONLY

1. Kodi munali ndi zaka zingati patsiku
Lobeleka?

.....

2. Kodi ndinu wokwatidwa?

- a. Msimbe
- b. Wokwatidwa
- c. Tinalekana
- d. Wofedwa

3. Ngati ndinu wokwatidwa, kodi amuna anu
agwira nchito yotani?

- a. Sangwira nchito
- b. Angwira nchito
- c. Amadzisebenzera
- d. Zina nchito nenani.....

.....

4. Kodi ndinu achipembedzocanji?

- a. Mkristu
- b. Mu slamu or Munasala
- c. Mu Hindu
- d. Nenani Konse kumene

mupembedza

5. Munafika pati ku sukulu
muma phunziro?

- a. Sindinaphunzire
- b. Primary
- c. Secondary
- d. College/University

FOR OFFICIAL USE ONLY

6. Kodi mugwira nchito ?

a. Muzimai wapa nyumba

b. Ndimagwira nchito

c. Ndimadzingwirira ndekha

d. Zina nchito nenani.....

.....

7. Pa mwezi mulandila zingati?

a. Zoncepera pa K500

b. K500-K1500

c. Kuposa K1500

d. Zina, nenani.....

8. Muli ndi ana angati?

a. 1-2

b. 3-4

c. 5 ndikutsogolo

9. Mwana wotsirizira ali

ndi zaka zingati?

a. Mwenzi umodzi

b. Miyezi iwiri

c. Miyezi itatu

d. Miyezi inai

e. Miyezi isano

Ndi umodzi

10. Munali kupita ku

Cipimo camimba?

a. Inde

b. Iai

Ngati bakana, funsani funso la 12

11. Ngati bakamba inde, munapitako

Kangati ku cipimo ca mimba

ku Chipatala?

- a. Kamodzi
- b. Kawiri
- c. Katatu
- d. Kanai

12. Ngati bakana, cifukwa ciani cimene simunapitile ku cipimo camimba?

- a. Panalibe
- b. Cipatala cilikutali
- c. Ndinalibe mayededwe/ Ndalama
- d. A namwino alibe khalidwe
Labwino.

SECTION B: KAGWILITSIDWE KA ZINCHITO ZA KUCHIPATALA ZOKHUDWA UBELEKI - (UTILIZATION LEVEL)

13. Kodi munabelekela kuti mwana
wanu wotsirizira?

- a. Ku nyumba
- b. Ku Cipatala

14. Amenewo, kodi anali malo amene munafunikila kubelekelako?

- a. Inde
- b. Iai

Ngati inde, funsani funso 18.

15. Ngati iyai, kodi mudayenera kuberekera kuti?

- a. Ku Nyumba
- b. Ku Clinic
- c. Ku Cipatala kolipila
- d. Ku Cipatala ca boma
- e. Kwina nenani.....

16. Kambani zifukwa zimene munabelekela kumalo omwe mwachula?

a. Mayendedwe anavuta

b. Kunali kutali

c. Zinayamba mwadzidzi

d. Makhalidwe oipa a namwino

17. Kodi muli ndimau yomwe

mungathe kuuza azimai kuti

azipita ku Cipatala masiku obeleka akayandikila?

.....
.....

CIGAO CA C: KUDZIWA ZOFUNIKILA PA KUBELEKA (KNOWLEDGE LEVEL)

18. Kodi munamvapo za ubwino wobalila ku cipatala?

a. Inde

b. Iai

19. Munamva kwa ndani?

a. Namwino

b. Wophunzitsa za ukhondo

c. Wapabanja

d. Bwenzi

e. enanso chulani.....

20. Mudziwa kuti ndi cofunikira kubelekela ku Cipatala?

a. Inde

b. Iai

21. Ngati inde, kufunso 20, fotokozani mwamundanda ubwino wobelekela ku Cipatala.

a. Othandizila kubeleka ndi muthu amene anaphunzila zonse zokudza kubeleka ndipo ndi

kudziwanso ngati pali zobvuta za mimba monga;

- Kukwera kwa magazi or BP

- Miendo kutupa/kuvimba

- Mwana amene akhara mu malo wopindikana

b. Kuchingiza wobereka matenda monga, thupi kutentha,

kuchoka vonukha ku ukhazi, koma akaberekera ku

cipatala zinthu zofunikira ziriko zomuthandizira

pakubereka kwake.

c. Kuchingiriza matenda ya pa m'combo pokhala ndi

zida zoyenera pakudula mu m'combo wa mwana.

d. Asing'anga angapatsidwe makhwala kapena

thandizo lililonse pamene apezedwa ndi bvuto.

e. Mwana angapatsidwe makhwala pamene

apezedwa ndi bvuto

f. Zina, chulani.....

22. Chulani zinthuziwiri zimene zingathe kucitika ngati mubalira kunyumba?

a. Matenda monga , thupi kutetha, ku coka

vonunkha ku ukazi yama bwera.

b. Kucoka magazi ambiri mutabala

c. Cibaliro kucedwa kucoka

d. Matenda yapa m'combo ku mwana

e. Zina, chulani.....

CIGAO CA D: ZINCHITO ZIKHUDZA UMOYO (HEALTH SERVICE RELATED FACTORS)

23. Nthawi bwanji imene mutenga pofika

ku cipatala ?

- a. Mphindi 30 sizikwana
- b. Ola limodzi cabe
- c. Maola awiri cabe
- d. Amapitapo maola awiri

24. Kodi azimai apakati amayenda bwanji

popita kukabala ndi pobwerera?

- a. Galimoto yao
- b. Magalimoto yolipira
- c. Ambulance
- d. Zina, Chulani.....

25. Kodi mukwanitsa kulipira ndalama

popita ndi kubwerako pobereka?

- a. Inde
- b. Iai

26. Kodi kuliko kobalira pafupi ndi

kumene mukhala?

- a. Inde
- b. Iai

27. Ngati inde, ku funso 26, kodi

zikwaniritsidwa bwanji?

- a. Zikwanilitsidwa mwacangu
- b. Nthawi zina zimakhhalako
- c. Sizikwanitsidwa
- d. Zina, chulani.....

28. Kodi muli okondwela ndi zinthu zimene

anakucitilani kumene munabalira?

- a. Inde
- b. Iai

29. Ngati iai, ku funso 28, ndi ciani

cimene simunakondwere naco?

- a. Kunalibe mankhwala
- b. Makhalidwe a namwino ogwira siuli bwino
- c. Kunalibe cinsinsi
- d. Ogwira nchito anali ochepera.
- e. Zina, chulani.....

30. Kodi munakhala nthawi bwanji kuyembekeza kuti amuoneni?

- a. 0-10mphindi
- b. 11-20mphindi
- c. 21-30mphindi
- d. Kupitirira mphindi 30

31. Kodi odziwa nchito amakuuzani zofunika pamene sanakuoneni?

- a. Nthawi zonse
- b. Nthawi zina
- c. Kamodzi-kamodzi
- d. Palibe

32. Kodi anawino ana kudziwitsani zinthu zomwe anapeza pamena anakupimani nimalo omwe munabelekelamo?

- a. Inde
- b. Iai

33. Kodi namwino anali na cinsinsi pamene munali kubeleka?

- a. Inde
- b. Iai

34. Kodi mungauze anzanu /abanja ku kabelekela ku cipatala?

- a. Nthawi zonse
- b. Nthawi zina
- c. Kamodzi-kamodzi
- d. Palibe

35. Kodi munganiza cimene cilenga

akazi osabelekela ku cipatala cili pafupi apo ndi kumene akhala ndi ciani?

- a. Mimba kuuka mwadzidzi
- b. Mkhalidwe woipa wa anchito
- c. Kunalibe cinsinsi
- d. Ogwira nchito ndi ochepera
- e. Zina, chulani.....

36. Kodi ndi zinthu zotani zimene muganizira kuti zinthu zikome?

- a. Ogwira nchito akhale ambiri
- b. Mankhwala azipezeka
- c. Ogwira nchito za umoyo ayenera kupatsa ulemu
- d. Pafunika ambulance
- e. Zina, chulani.....

CHIGAO CA E: MIYAMBO

37. Kodi kuliko za miyambo zimene zimacitika pathawi yobeleva?

- a. Inde
- b. Iai
- c.

38. Ngati inde, fotokozani pakubeleva za miyambo imene ipezeka kwanu.

.....
.....
.....

Zikomo kwambiri popeza nthawi ndi kuyakha mafunso awa.

APPENDIX IV: INFORMATION SHEET FOR FOCUS GROUP DISCUSSIONS

Number of informants _____

Composition of informants _____

Language used during interview _____

Date: _____ **Duration:** _____

Place: _____

BRIEF

Purpose of the study

This study in which you are being asked to participate is being undertaken in partial fulfilment of my postgraduate studies at University of Zambia. This part of the study is being undertaken in order to find out what factors are associated with utilization of labour and delivery health services in LDCHC. Apart from being a requirement for my studies, the study will also contribute to the generation of knowledge, which will be used to influence policy-makers as they develop policies to improve the quality of care in our labour and delivery facilities.

Choice

Be informed that you have the right to choose to participate in this study and can withdraw in the process of the group discussion whenever you wish to do so without any prejudice. You will be given the opportunity to ask any questions before, during and after the discussion. You can also choose to or not to answer any questions or contribute to the discussion. I will not be looking for any wrong or right answers about your views on the topic. The topic will last between 35 – 45 minutes and be recorded on a cassette recorder.

Procedure

I will be leading the discussion in which you will be asked to share experiences and views about the topic with other members of the group.

Ground Rules

In order to foster the discussion, these rules will be observed by the group.

1. Only one person should speak at a time.
2. Group members should respect each other's opinion.
3. Whatever has been discussed in this discussion should not be talked about outside the room/group.

APPENDIX IV B: FOCUS GROUP DISCUSSION GUIDE

The questions were asked under the following categories for clarity.

1. Institutional deliveries and Home deliveries

- a. Where did you deliver your baby?
- b. Was that the place you intended to deliver from?
- c. What were the reasons of delivering where you delivered from?

2. Influence of previous experience during Labour and delivery

- a. Please describe what were your experiences of labour and delivery where you delivered from?
- b. Did you interact with the Midwife during labour and delivery?
- c. Were you examined eg. Physical examination and BP check during Labour and delivery?
- d. Did the Midwife tell you about her findings after examining you?
- e. Did the Midwife provide privacy when attending to you in labour?

3. Positive staff attitude and negative staff attitude during labour and delivery health services.

- a. How was the reception of the health care provider where you delivered from?
- b. Were the health care providers on your side whenever you called for help?
- c. Did the health care provider monitor your labour when you were admitted to labour ward?

4. Transport affordability and other costs

- a. What means of transport do women in labour use when going to the facility?
- b. Is it readily available?
- c. Are the costs affordable to use the available transport?

5. Practices done during labour and deliver

- a. Kindly describe the labour and delivery traditional practices observed in the community?
- b. Are those practices allowed in the healthy facility

6. Quality of care

- a. Were you satisfied with the care rendered where you delivered from?
- b. What were your expectations where you delivered from.?
- c. Was the environment clean?
- d. Were the medical supplies available to use by the care providers E.g Cord clamps, Sanitary towels, Jik etc.

APPENDIX V : Showing Main theme, Sub-themes and Categories

No.	Main Theme	Sub-theme	Categories
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1.	Utilization of Labour and Delivery Health Services.	Institutional deliveries and Home deliveries	-Reasons for Institutional deliveries. -Reasons for Home deliveries.
2.		Women previous experiences during Labour and Delivery.	-Influence of previous experience during Labour and delivery
3.		Attitude of the health care provider	-Positive staff attitude -Negative staff attitude
4.		Transport and other Costs	-Transport availability and opportunity costs.
5.		Traditional and Cultural Practices	- Traditional Practices done to quicken the process of labour and delivery. - Traditional practices done to prevent complications during labour.
6.		Perceived Quality of care	-Quality of care

**APPENDIX VI:
RESEARCH BUDGET**

BUDGET CATEGORY	UNIT COST (ZMK)	QUANTITY	TOTAL
1. STATIONERY			
a) External hard drive	500.00	x 1	500.00
b) Bond paper	30.00	x10	300.00
c) Pens	2.50	x10	25.00
d) Pencils	2.50	x 4	10.00
e) Rubbers	5.00	x2	10.00
f) Note book	8.00	x2	16.00
g) Tippex	12.00	x2	24.00
h) Bag for questionnaires	150.00	x1	150.00
i) Stapler	25.00	x1	25.00
j) Staples	10.00	x1 Box	10.00
k)Tape recorder	250.00	x1	250.00
SUBTOTAL			1320.00
2. PERSONNEL			
a) Lunch allowance			
Principal researcher	50.00	1 x 30 days	1,500.00
Research assistant	50.00	3 x 30 days	4,500.00
b)Transport or fuel			2000.00

SUBTOTAL			8,000
3. SERVICES			
a) Ethics committee	1, 000.00	1	1,000.00
b) Data entry	500.00	1	500.00
c) Data analysis	1 000.00	1	1,000.00
d) Photocopying proposal	0.30	100 x3	300.00
e) Photocopying questionnaire	0.30x9pages	380	1026.00
f) Photocopying report	0.30	100x4	400
g) Binding	50.00	4 copies	200.00
h)Printing Picture Report	1500.00	1	1500.00
SUBTOTAL			5,926
TOTAL			15,246
CONTINGENCY FUND10%			1,524.6
GRAND TOTAL			K 16,770.6

JUSTIFICATION FOR THE BUDGET

1. Stationery was required for paper work.
2. Allowances for the researchers was required because the team was collecting data throughout the day, away from their homes for 30days.
3. Funds were needed for photocopying and binding of the proposal and reports.
4. Contingency fund which is 10% of the budget required for any extra costs due to inflation and for any eventualities

5. APPENDIX VII: RESEARCH WORK PLAN

	TASK TO BE PERFORMED	DATES	WEEKS	PERSONNEL	DAYS REQUIRED
1.	Literature review	Continuous		Researcher	
2.	Submit topic to the supervisor	February, 2015	1	Researcher	7 days
3.	Submit first draft copy of proposal to the supervisor	February, 2015	2- 4	Researcher	12 days
4.	Finalize research proposal	March to April, 2015	5- 9	Researcher	28 days
5.	Data collection tool	April to April, 2015	10- 11	Researcher	10days
6.	Submit final draft copy of proposal to supervisor	13 th to 24 th April, 2015	11-13	Researcher	14 days
7.	Presentation of the research proposal to the department	7 th May, 2015	14-15	Researcher	1 day
8.	Amending the corrections	7 th May to 14 th 2015	16- 17	Researcher	7 days
9.	Presentation of research proposal to graduate forum	21 st May, 2015	18- 19	Researcher	1 day
10.	Amending the corrections	22 nd May to June 2015	20- 21	Researcher	7 days
5	Clearance from Ethical Committee	14 th September to 28 th September, 2015	22 -24	Ethical committee	14 days

6.	Pilot study	1 st Oct to 7 th Oct , 2015	25	Researcher	7 days
7.	Data collection	8 th Oct to 11 th December, 2015	26- 34	Researcher	60 days
8.	Data analysis	14 th December to 28 th January, 2016	35- 37	Researcher	28 days
9.	Report writing	29 th Feb to 28 th Mar , 2016	38- 42	Researcher	28 days
10.	Submission of draft copy of research report to supervisor	1 st April to 8 th Apr 2016	43- 46	Researcher	7 days
11.	Finalizing research report and binding	10 th April to 30 th April, 2016	47- 51	Researcher	21 days
12.	Deposition of final research report	20 th May,2016	52- 56	Researcher	
13.	Monitoring and evaluation	Continuous		Researcher	

APPENDIX VIII: Application Letter for Authority

University of Zambia,
School of Medicine,
Department of Nursing Sciences,
P.O Box 5110,
Lusaka.
9th September, 2015

The District Medical Officer,
Lusaka District Community Health Offices,
P.O Box 50827,
Lusaka.

Dear Sir/Madam,

**REF: REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH STUDY IN
LUSAKA URBAN LABOUR DELIVERY HEALTH FACILITIES.**

I am a 2nd year masters student at the University of Zambia, School of Medicine, in the Department of Nursing Sciences pursuing Masters of Science in Nursing.

In partial fulfilment for the award of Masters of Science in Nursing, I am required to conduct a research study in the final year of training. My research topic is titled

**“FACTORS ASSOCIATED WITH UTILIZATION OF LABOUR AND DELIVERY
HEALTH SERVICES BY WOMEN IN LUSAKA URBAN DISTRICT FACILITIES”.**

For this reason, I hereby requesting for permission to carry this study in your respectable institutions of Labour and Delivery facilities namely, Bauleni, George, Kanyama, Chawama, Matero Reference Center and Mtendere Health Facilities. Pilot study to be conducted at Ngombe Health Facility.

Kindly find attached a copy of my proposal.

Thanking you in anticipation for your favourable response.

Yours faithfully,

Jeane Ngala Banda.