

**THE UNIVERSITY OF ZAMBIA**

**SCHOOL OF MEDICINE**

**DEPARTMENT OF POST BASIC NURSING**

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**A STUDY TO DETERMINE THE KNOWLEDGE ATTITUDE AND PRACTICE  
OF WOMEN IN CHILD BEARING AGE (15-49 YEARS) TOWARDS  
DANGER SIGNS IN PREGNANCY IN LUSAKA URBAN**

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**A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF  
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DECLARATION

I hereby declare that the work presented in this study,  
for the Bachelor of Science in Nursing, has not been  
presented either wholly or in part for any other Bachelor  
of Science Degree and is not being currently submitted  
for any other degree.

SIGNED....*Agon*..... DATE....1-11-95.....

SIGNED....*[Signature]*..... DATE....10/11/95.....  
SUPERVISING LECTURER

STATEMENT

I hereby certify that this study is entirely the result of my own independent investigation. The various persons and sources to which I am indebted are clearly indicated in this paper and in the references.

SIGNED.....*Coog*.....  
CANDIDATE

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**DEDICATION**

To my daughter Margaret



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**ABSTRACT**

The main objective of the study was to determine the knowledge, attitude and practice among women of child bearing age (15 - 49 years) towards danger signs in pregnancy in Lusaka Urban.

Literature reviewed was based on level of education, socio-cultural economic factors and Information Education and Communication (IEC) flow as they relate to danger signs in pregnancy.

This was an exploratory study conducted in Bauleni, Chilenje and Woodlands residential areas which are high density, medium density and low density respectively. These are located in the seventh (7th) zone of the eight (8) zones of the Lusaka Urban. The residential areas were selected randomly using multistage process. Data was collected using a structured interview schedule from a hundred (100) respondents selected by Quota sampling at household level, and two group of Focus Group Discussions. Data was analysed manually using a pocket calculator.

The results from the study revealed that the majority of the respondents regardless of their age, parity or educational background had slight knowledge of

danger signs in pregnancy. The majority has friends as source of information on danger signs in pregnancy. The respondents stated that the woman suffering from any danger<sup>sign</sup> in pregnancy should decide what to do. The practice and attitude was stated to be good despite the high prevalence of inadequacy of knowledge on danger sign in pregnancy. However, the hinderances to good practice cited were social economic constraints such as in-sufficient money and involvement of other relatives in the decision making process.

From the above findings, it was recommended that the Ministry of Health through the Lusaka Urban Health Management Team, Maternal and Child Health Department, other ministries, agencies and organisations intensify Information Education and Communication on danger signs in pregnancy to women, partners, significant others and those in the transport network (such as United Taxis and Transport Association) in order to promote maternal health.

**LIST OF ABBREVIATIONS**

- AIDS - Acquired Immune Deficiency Syndrome
- ARC - AIDS Related Complex
- FGDs - Focus Group Discussions
- MCH - Maternal and Child Health
- MOH - Ministry of Health
- NGOs - Non-Governmental Organisation
- PHC - Primary Health Care

## CHAPTER 1

### BACKGROUND INFORMATION

Lusaka Urban is the capital city of Zambia. It is located within the Lusaka Province. According to the 1990 Census the projected population for 1995 for Zambia is 9,233,258 and for Lusaka in particular is 1,326,446. Zambia's annual growth rate is 3.2%. The growth rate varies according to provinces, Lusaka being the highest with the rate of 5.7% (Ministry of Health (MOH), 1994).

The structure of the Zambian population is skewed towards the base with the population of those under fifteen (15) years old account to almost half the total population. Women in childbearing age group (15-49 years) accounts for twenty two percent (22%) of the population (MOH 1994).

Lusaka Urban is an industrial commercial and distributive centre. The population characteristics of the city vary greatly. The range from the very rich to the very poor and the educated to the uneducated. Therefore, the lifestyle and health related behaviour differ to a certain extent. Due to rapid industrialisation and corresponding increase in population a large number of the population live in the squatter overcrowded compounds with obvious low standard of living.

Lusaka Urban is divided into eight (8) Zones for administrative purposes in the delivery of health services. There is one central hospital - The University Teaching Hospital (UTH). It is a referral hospital for both hospitals and health centres across the country.

There are twenty-two (22) Government health centres and several privately run health institutions in Lusaka Urban which offer curative and preventive health services. There are nine Government health centres which offer maternity services on twenty-four (24) hour basis, eight of which are run with the aid of the Irish Government.

The high total fertility rate of 6.5% (MOH, 1994) coupled with low educational level of women (Gaisie et al, 1993) make women vulnerable to too many, too close pregnancies. This has adverse effect on maternal health.

Although pregnancy is considered a route to self realisation and status and not a disease, culturally a pregnant woman is considered an endangered species. This can be seen in the way a woman is greeted after delivery (child-birth). In ChiBemba (Northern part of Zambia) they say, "Mwapusukeni" meaning congratulations, you have escaped death.

The ill health due to pregnancy and child-birth have often left many women handicapped physically, physiologically, emotionally, socially and economically, while others have died.

Such ill health and death rob families and community of caregivers and workforce (World Health Organisation (WHO), 199<sup>2</sup>). The death of the mother increases the likelihood of the death of her infant soon thereafter, (WHO, 1992).

In order to curb high infant mortality rates and high maternal morbidity and mortality rates the Government, Non Government Organisations (NGOs), private sectors and individuals have embarked on services to promote the health of women and children through the Maternal and Child Health (MCH) programme.

Chikunga (1994), reports that MCH services in Zambia started as early as the 1960s. By the 1980s the services were more organised using the principles of Primary Health Care (PHC). The principles are equity of service, intersectoral collaboration, community participation, disease prevention and control, and appropriate technology. The MCH services offer antenatal care, intranatal care, postnatal care, family planning, child growth monitoring and immunisation.

The other strategy the Government has undertaken in the promotion of the health of women and children is to train personnel such as midwives, obstetricians, traditional birth attendants and family health nurses.

Maternity services in Lusaka Urban have been strengthened by collaborative work of the Zambian and Irish Governments.

Using the PHC strategy and the principles of leadership, accountability and partnership, the Zambian Government forged to reform the health sector in 1992. This was in order to provide the Zambian with equity of access to effective quality health care as close to the family as possible. Thereby improve and promote the life and health of the people including the reduction of maternal morbidity and mortality (MOH, 1991).

In Zambia, available records show that the quality of life of women who become pregnant is adversely affected by preventable conditions. The improvement of the quality of life and the prevention of premature maternal death equally lie in good medical treatment and active participation of the women themselves and the community in which they live.

#### STATEMENT OF THE PROBLEM

Despite the efforts of the MCH services mothers and children have continued to be handicapped, suffer ill health or die due to pregnancy - and childbirth related causes most of which are preventable. The ill health or death of women rob the family and the community of caregivers and workforce.



In Zambia there is regional variations of maternal mortality rate and ratio. For instance, in Mongu maternal mortality ratio was reported in 1993 to be 889 per 100,000 live births and in Serenje it was 480 per 100,000 live births (MOH, 1994) while in Lusaka urban it was reported to be 450 per 100,000 live births (Ahmed, 1995). At national level it was 200 per 100,000 live births (MOH, 1994).

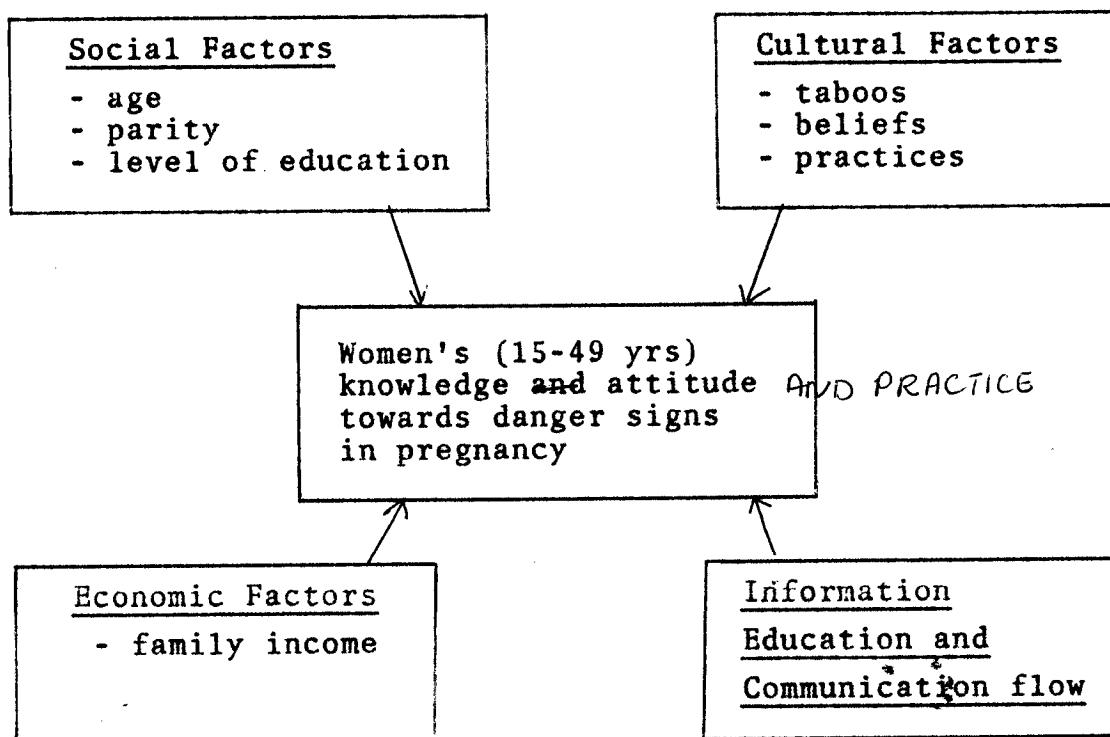
The causes of mortality vary. World wide, the leading causes are haemorrhage, pre eclampsia, eclampsia, abortion and obstructed labour (WHO, 1993). In Zambia maternal causes are attributed to haemorrhage, abortion, anaemia, preeclampsia, obstructed labour and puerperal infections. The causes vary in regions, for instance, in Mongu leading causes were toxemia of pregnancy/eclampsia and haemorrhage (Faber and Koster-Oyaken, 1994). In Lusaka Urban (UTH) the leading causes were abortive outcome 31%, malaria 14%, ARC/AIDS 12%, puerperal sepsis 11%, eclampsia 6% and haemorrhage 6% (Ahmed, 1995).

The causes of morbidity among women of child bearing age those related to pregnancy and child birth varies from place to place. In UTH the causes recorded are abortion, toxemia or pregnancy, anaemia of pregnancy and complications related to pregnancy and child birth (UTH 1994).

The majority of those women who suffer complications or die due to pregnancy related causes tend to seek medical advice later or never at all (Gaisie et al, 1993).

The researcher is of the view that women in child bearing age (15-49 years) may be lacking knowledge on danger signs of pregnancy and their effects. Hence their attitude does not encourage seeking medical advice early or compliance to advice given. It is for this reason that the research was carried out to try and answer the following broad questions: Do women in the child-bearing age in Lusaka urban know the danger signs in pregnancy? If they do, what is their attitude and practice with regard to danger signs.

The researcher's assumptions for the study are as shown on the diagram below:-



JUSTIFICATION FOR THE STUDY

The study seeks to address the level of knowledge and altitude of women in child bearing age towards danger signs in pregnancy. The information from the research findings will help in the formulation of policies and strategies in the prevention of ill health and premature death of women. This will not promote the health of women only but also the health of children and the community at large.

## OPERATIONAL DEFINITIONS OF TERMS

Danger sign in pregnancy: Presence of a condition that increases the chances of a pregnant woman or her unborn child dying or having poor health. These are fever, severe headaches, swelling of body (face, hands, feet) paleness, bleeding from the birth canal with or without pain, and draining liquor amnii (WHO (1994), Chirwa (1993)).

Child bearing age: Women aged 15 years up to 49 years.

Appropriate Medical Advice or Help: Advice or treatment for any danger sign in pregnancy obtained at the health centre or hospital.

Knowledge: Being able to mention a danger sign in pregnancy and its effects.

Attitude: The way respondents perceives danger signs.

Practice: Measures taken when or if a danger sign in pregnancy occurred.

Parity: Number of children a female has or has had.

Maternal death: Death occurring in a woman while pregnant or within 42 days after termination of pregnancy irrespective of the duration and site of pregnancy from any causes related or aggravated by pregnancy or its management but not from accidental or incidental causes (Myer, 1981)

Maternal Mortality Ratio: The risk of death among women once they are pregnant per 100,000 live births per annum.

Maternal Morality Rate: The number of maternal deaths per 100,000 live births in a year among women of reproductive age.

## CHAPTER 2

### LITERATURE REVIEW

#### INTRODUCTION

The health of women reflects their status in the society and their access to health care as well as other essential services (WHO, 1993). It also reflects the health and well-being of a society. This being so, Governments and Non-Governmental Organisations (NGOs) and private citizens have expressed their concerns through various fora, hence a number of works have been and continue to be carried out to reduce morbidity and mortality thereby improve maternal health.

The literature review is discussed under the following headings:

- Level of education
- Socio Cultural factors
- Economic factors
- Information Education and Communication.

### LEVEL OF EDUCATION

Education has an impact on a woman's confidence, status in community and ability to participate in decision making, both in her own home and her community.

Jacobson (1991), observes that limited education of women restricts their access to vital information regarding legal rights, health care and family planning.

Nyaphisi et al (1994), in the study of 'Risk factors associated with maternal mortality in Lesotho, Malawi and Zambia', using a Case-Control approach, observed that women who lacked education or had low education and those whose husbands lacked education did not attend antenatal clinic - those who did, only attended once or twice. They further commented that such women may not benefit from health education and information provided at the antenatal clinics and may not identify early signs of complications in pregnancy and seek help in good time.

Nsemukila (1994), in his report 'Maternal and Childhood Mortality in Zambia: Determinants and Trends 1965-1992', states that in Zambia women with little or no education tend not to use Maternal and Child Health and Medical facilities and hence form a large proportion of unbooked cases of hospital delivery that end in maternal death. Viegas et al (1992) are of the same opinion that lowly educated women do not use maternal health care facilities.

### SOCIO CULTURAL FACTORS

Man is a social being. This is reflected even in the way he values his relationship with other people especially the significant others. Hence, social and cultural factors influence behaviour that in turn affects the health of mothers and their children either positively or negatively (WHO, 1993).

The World Health Organisation Report of 1991, (1993) states that raised blood pressure and protein in urine which are early signs of pre-eclampsia may go unnoticed by the pregnant women and their families because of lack of diagnostic equipment at home. However, headache, excessive weight gain and oedema of extremities which are symptoms related to increased blood pressure which can easily be detected are considered normal that do not call for action. This may result in delay in seeking medical advice.

Hall (1992), in an article entitled 'Participation and Compliance in Maternal Care', states that the beliefs and practices of the society with regard to pregnancy may not correspond to those of professional health personnel. Similarly, Blanchet (1991), in a report of the Ethnographic study titled 'Save the Children', observed that traditional birth attendants in Bangladesh village when attending to women sought inappropriate local treatment before taking women for modern medical assistance.



Faber and Koster-Oyekan (1994), in the study 'Maternal Health, who cares?', which aimed at determining the utilization of maternal health care providers in Senanga and Sesheke districts, Zambia, observed the existence of a significant correlation between the occurrence of a pregnancy problems and the occurrence of a delivery problem. They also observed that most problems during pregnancy and delivery were dealt with first in the communities by local specialised providers, who have many remedies for maternal problems. This practice delayed timely referral to Rural Health Centre or Hospital.

World Health Organisation (1994), in the 'Home-Based Maternal Records' books reports a study of Yemeni women. It revealed that the women preferred to be attended to by their local women to meet their health needs related to pregnancy and child birth. This was in conformity with their local cultural background. The involvement of the women's union in identifying people with risk conditions, prompt seeking of medical help, supervising and follow up of women at home encouraged promotion of maternal health. The Women's Union worked in collaboration with husband, relatives and other community members.

### ECONOMIC FACTOR

The cost of health care may be one of the hinderances of a pregnant woman and her family to seeking medical advice promptly even when the danger sign is recognised. Hall, (1992) states that the cost may be in terms of transport or health care services.

Khani et al (1993), in an exploratory qualitative descriptive study into traditional practices and customs which have adverse effects on pregnancy and child-birth in Nkayi district, Zimbabwe, reports that poor socio economic status influenced home deliveries as mothers could not afford maternity fees.

Nyaphisi et al (1994), also observed that poverty made people less able to appropriately utilise available health services. This they stated could be because such people could not benefit from health education and information provided and may not identify early signs of complication of pregnancy in good time to seek help. More so if poverty is compounded with lack of education.

Jacobson (1991), reports that during the Safe Motherhood Conference for SADCC countries held in Harare in 1990, it was noted that lack of access to timely and effective health care was reported to be a critical problem in the SADCC region. Jacobson further states that the health care system in most SADCC countries are characterised by being too far from home, too few trained health care providers, too poorly equiped to identify or handle complication and too deficient in quality care.

Nyaphisi et al (1994) supports the afore mentioned report. Nyaphisi et al reports that women use health facilities nearer to their homes. In the event of illness during pregnancy women tend to be treated at home instead of going to a health facility. The poor access to maternal health care was attributed to long distances costly transport or lack of transport. The other factor was lack of essential laboratory tests (haemoglobin estimation, blood grouping, Syphilis serology and urine tests for sugar and urine) for women who availed themselves to these facilities meant that proper or early detection of complication was hampered. The high maternal mortality among women cared for by relatives, traditional birth attendants and village health workers suggested inadequate or low quality care rendered to women.

#### INFORMATION EDUCATION AND COMMUNICATION

Literature shows that women get information related to pregnancy and child birth from various sources within the community. These include family members, fellow community members and health workers.

This is supported by Dali et al (1991), in a report 'A study on knowledge attitude and practice of mothers-in-law regarding the intraconceptual care of their daughters-in-law before and after education sessions' in Mahankal, Nepal. Dali et al stated that mothers-in-law attend to

many births, provide postpartum care and generally control activities of the family members. After having lessons in maternal health and family planning the mothers-in-law showed improved knowledge, skill and attitudes towards better maternal health.

Ponnuraj (1994), in the 'report of the participatory rural (India) appraisal' showed that involvement of women in identifying health problems, planning and implementing corrective measures with the assistance of health workers helps the community appreciate its role in health promotion.

Myles (1981), states that one of the aims of antenatal care is to promote and maintain good physical and mental health during pregnancy through health education and health supervision.

Likwa (1994) and Gaisie et al (1993) states that in Zambia about 90 percent of health facilities provide antenatal care services. Sadly though, Ondolo (1988), in the study 'Reaching the Needy: Opportunities and Limitations' which was carried out to evaluate the Primary Health Care Project in Kabwe district, Zambia, reports that although 98 percent of the population study attended antenatal clinic, the majority started in the second trimester and their visits were infrequent. Therefore, the antenatal care which is said to be beneficial in reducing maternal and infant morbidity and mortality when sought early in pregnancy and continued through parturition (Viega et al, 1992), can be said to be of none or little effect to such women.

Bester (1992), in the 'Health Education in Pregnant Women', a research report on the utilisation of antenatal services by high risk primigravidae at the Tygerberg Hospital stated that patients had very little knowledge about the danger signs that may occur during pregnancy. The patients did not know the reasons for the examinations and tests performed during pregnancy, although it probably had no negative effect on the attendance of the antenatal clinics.

Faber and Koster-Oyekan (1994) reports that in Senange and Sesheke districts, Zambia, although many perceived bleeding during pregnancy to be a major risk, the minority went first for treatment to antenatal clinic or Rural Health Centre (RHC). The majority used herbs to stop the bleeding and went to RHC or hospital only if bleeding persisted. Faber and Koster-Oyekan also reports that swelling of body and legs was identified by few women as a major risk even though many women experienced it.

There is no information on what women in child-bearing age in Lusaka urban know about danger signs of pregnancy or their attitude towards such signs. However, the impression from the number of cases seen in the University Teaching Hospital and Health Centres show that most pregnant women with health problems are attended to at home before seeking medical help thereby delaying the initiation of appropriate medical treatment.

## CONCLUSION

The literature reviewed has been from the works of various authorities. The major issues that have been brought forth are:

- The health care seeking behaviour in the event of experiencing danger signs of pregnancy may be influenced by several factors.
- The health care seeking behaviour has an influence on the outcome of the pregnancy.
- There is need for research to be done in the area of knowledge, attitude, and practice with regard to danger signs of pregnancy.

## CHAPTER 3

### OBJECTIVES OF THE STUDY

#### GENERAL OBJECTIVES

To determine the knowledge, attitude and practice among women of child bearing age (15 - 49 years) towards danger signs in pregnancy in Lusaka Urban.

#### SPECIFIC OBJECTIVES

1. To determine the level of knowledge on danger signs in pregnancy among women in child bearing age.
2. To determine their attitude towards danger signs in pregnancy.
3. To find out the measures taken by these women when danger signs in pregnancy occur.
4. To find out the factors that influence the knowledge, attitude and practice of these women.
5. To make recommendations from the research findings towards prevention and management of women with danger signs in pregnancy to those interested in promoting maternal health.

## CHAPTER 4

### 4.0 RESEARCH METHODOLOGY

#### 4.1 Research Design

The study was non-experimental, exploratory, qualitative and quantitative. It was exploratory in that it sought to find out the knowledge, attitudes on danger signs in pregnancy and actions taken when they occur. The study was qualitative because it sought to identify and explore the knowledge, attitude and practices towards danger signs in pregnancy of the women in the child-bearing age (15-49 years) in Lusaka urban. It was quantitative in that the responses from the sample elements were given numerical values to quantify them. It was non-experimental as the subjects were not manipulated by the researcher.

#### 4.2 Variables

The variables are related to knowledge, attitude and practice towards danger signs in pregnancy. The major variables include socio cultural factors, economic factors, information education and communication flow.



VARIABLE	INDICATOR	CUT OFF POINTS
Knowledge	No knowledge	(1) Does not know any major problems in pregnancy that can endanger a woman's life.
	Slight	(2) Able to mention one or two major problems in pregnancy that can endanger a woman's life.
	Moderate	(3) Able to mention two major problems in pregnancy and their effects that can endanger a woman's life and the unborn child.
	Adequate	(4) Able to mention three or more of major problems and their effects that can endanger mother's life and her unborn child.

VARIABLE	INDICATOR	CUT OFF POINTS
Attitude	Bad	(1) Would not seek help from health centre/ hospital first
	Good	(2) Would seek help from health centre/hospital first
Practice	Bad	(1) Would seek help or advice from family members, friends or traditional healers first
	Good	(2) Would seek help or advice from the health centre or hospital first

VARIABLE	INDICATOR	CUT OFF POINTS
Parity	Nulipara	(1) Has had no child (Myles, 1981)
	Low Parity	(2) Has had 1 to 3 children
	Medium	(3) Has had 4 to 6 children
	High	(4) Has had 7 and more children
Income	Low	(1) Family monthly income below 50,000 Kwacha
	Medium	(2) Family monthly income between 50,000 and 100,000 Kwacha
	High	(3) Family monthly income above 100,000 Kwacha

#### 4.3 Research Setting

The study was undertaken in Lusaka Urban of Lusaka Province. The residential areas which were covered in the study were Bauleni in the high density area, Chilenje in the medium density area and Woodlands in the low density area. The residential areas were selected randomly because the records available did not reveal which area has a high maternal mortality and morbidity in Lusaka Urban.

#### 4.4 The Study Sample

##### Study Population

The target population for the study were women in child-bearing age (15-49 years) in Lusaka urban.

The sample size was one hundred (100) for interview schedule, and twelve (12) for focus group discussion.

The women who were interviewed were forty seven (47) in Bauleni, twenty six (26) in Chilenje and twenty seven (27) in Woodlands.

The two groups for the focus group discussion comprised of five (5) women in Chilenje and seven (7) women in Bauleni.

#### 4.5 Sampling Technique

A multistage sampling method was used since the sampling frame for individual units was not readily available. Lusaka urban is divided into eight (8) health zones. Of these one health zone (Zone 7) was randomly selected. The residential areas in Zone 7 were clustered into high density, medium density and low density areas. Then using simple random sampling one residential area (community) was selected from each density housing area. These were Bauleni (high density), Chilenje (medium density), and Woodlands (low density).

To select subjects for interview quota sampling was used. At household level the first female adult who met the age criterion at the selected household, was interviewed. Their participation was voluntary.

The main advantage of using the multistage sampling was that, a sampling frame of individual units was not required for the whole population. Quota sampling of individual subjects was found to be practical since the sampling frame was not available.

#### 4.6 Data Collection Techniques and Tools

The data was collected in September 1995 over a period of one week using a primary source. The following instruments were used:-

- Structured Interview Schedule
- Focus Group Discussion

### Structured Interview Schedule

A face to face interview using a questionnaire was conducted with women of childbearing age. The questionnaire had open-ended and closed-ended questions. The questionnaire was written in English and translated into vernacular when necessary during the interview. The interviewer filled the questionnaire in English.

Rapport was established with each interviewee before the interview, and privacy ensured. Interviewees were assured of confidentiality with their information and no names or addresses were asked for.

Interview schedule was used because

- respondents included literate and illiterate persons, hence the interview ensured uniformity of completing the questionnaire.
- Misunderstandings were corrected there and then, and probing questions asked.
- Questions needing, rephrasing were done without changing the original meaning.

### Focus Group Discussion

Two focus group discussions were conducted with women in childbearing age. One in Chilenje and another in Bauleni. None was conducted in Woodlands as it was difficult to organise one there. Participation was voluntary after being selected.

The topic for discussion and purpose of the discussion was explained after self introduction. The discussions were in Nyanja and ChiBemba. The researcher facilitated while the assistant took notes. The discussion took about forty (40) minutes each.

#### Field Test of Data Collection Tools

The field test using the questionnaire was carried out on 17th and 18th August 1995 on mothers living the hospital. Five mothers were selected using the simple random technique.

The test enabled the researcher to ascertain :

- (i) Reliability and Validity of data collection.
- (ii) Duration for each interview session with the respondents; and
- (iii) The appropriateness and the clarity of the language used.

After the field test a few alterations were made in the questions.

#### Ethical Consideration

No major ethical issues were involved. Permission to carry out the interview from residential areas was sought from the Lusaka Civic Centre - Housing and Social Services Department and from the Officer Commanding (Lusaka Urban) Zambia Police. Every effort was made to inform the subjects

understudy the purpose, nature of research, and how respondents were selected and usage of findings. This was done in such a way as to elicit appreciation and participation. Subjects were assured of confidentiality and anonymity of data.

#### 4.7 Limitation of the Study

The study was conducted within the major limitation of time, finances and busy schedule of the researcher (student).

The sampling method of individual subject was non-probability one (quota sampling), therefore the results can not be generalised to the whole population of women in childbearing age within Lusaka urban, but to the study population.

The interviewers in some instances were required to translate or paraphrase questions in vernacular as close to the idea as possible. This posed the possibility of distorting the idea.



## CHAPTER 5

### ANALYSIS, PRESENTATION AND DISCUSSION OF FINDINGS

#### DATA ANALYSIS

Data was collected through a structured interview scheduled administered to one hundred (100) female in the child bearing age (15-49 years). The respondents were forty-seven (47) from Bauleni residential area, twenty-six (26) from Chilenje residential area and twenty-seven (27) from Woodlands residential area.

The raw data was edited, responses to open-ended questions categorised and coded. Then the data was entered onto a master sheet. Analysis was done manually using a pocket calculator. Frequency counts, percentages and cross tabulation of important variables were done. The percentages were rounded up to the nearest whole number. Data from Focus Group Discussions (FGDs) was categorised and used in the narration of some figures.

#### PRESENTATION OF FINDINGS AND DISCUSSION

The findings were summarised in tabular form to facilitate interpretation.

The discussion using the findings was done in view of the main objective of the study. The main objective of the study was to determine the knowledge, attitude and practice towards danger signs in pregnancy among women of child bearing age (15-49 years) in Lusaka Urban.

#### DESCRIPTION OF THE RESPONDENTS

The age range of the study sample was from 15 years to 49 years. The majority 54% had primary education as the highest educational attainment, none had university education; 53% of the respondents were unemployed, 67% were married and 41% had low parity.

Table 1 Danger Signs in Pregnancy mentioned by  
Respondents (n = 100)

Danger Sign in Pregnancy mentioned	Responses		TOTAL
	KNOW	DON'T KNOW	
Bleeding in Pregnancy	35 (35%)	65 (65%)	100 (100%)
Severe headaches	33 (33%)	67 (67%)	100 (100%)
Swelling of body (face, hand, feet)	31 (31%)	69 (69%)	100 (100%)
High fever	30 (30%)	70 (70%)	100 (100%)
Pallor	18 (18%)	82 (82%)	100 (100%)
Draining liquor amnii	15 (15%)	85 (85%)	100 (100%)
TOTAL	162 (27%)	438 (73%)	600 (100%)

Table 1 shows that bleeding from the birth canal with or without pain was mentioned by 35% of the respondents.

The findings in Table 1 are similar to that were reported by Faber and Koster-Oyekan (1994) that many people in Senanga and Sesheke districts of Zambia, perceived bleeding during pregnancy to be a major risk even though minority attended health centre or antenatal clinic for treatment; but few women identified swelling of the body as a major risk even though many experienced the swelling of the body.

Table 1 also shows that less than half the respondents 27% were able to identify danger signs in pregnancy.

This may imply that women associate danger with a condition that cause drastic change in their ability to carry on their daily activities.

Table 2 Respondents' Age in relation to level of  
Knowledge of danger signs in Pregnancy  
(n = 100)

AGE GROUP	LEVEL OF KNOWLEDGE				Total
	No Know- ledge	Slight	Moderate	Adequate	
15-19 yrs	5 (28%)	9 (50%)	2 (11%)	2 (11%)	18 (100%)
20-24 yrs	9 (38%)	12 (50%)	3 (12%)	-	24 (100%)
25-29 yrs	3 (19%)	8 (50%)	5 (31%)	-	16 (100%)
30-34 yrs	1 (7%)	10 (72%)	3 (21%)	-	11 (100%)
35-39 yrs	2 (4%) <sup>18</sup>	5 (46%)	3 (27%)	1 (9%)	11 (100%)
40-44 yrs	-	5 (56%)	1 (11%)	3 (33%)	9 (100%)
45-49 yrs	-	5 (56%)	1 (11%)	3 (33%)	9 (100%)
TOTAL	20 (20%)	54 (54%)	20 (20%)	6 (6%)	100 (100%)

Table 2 shows that the majority of the respondents, 24% were aged 20-24 years, and 54% (majority) across the age groups had slight knowledge of danger signs in pregnancy.

The study findings revealed that those in risk age groups (below 19 years, 35 years and above) (Chirwa, 1993) had no knowledge or slight knowledge on danger signs in pregnancy. Among those aged 15-19 years 28% had no knowledge while 50% has slight knowledge. Those aged 35-39 years 18% has no knowledge and 46% has slight knowledge. Those aged 40-44 years and 45-49 years had 63% and 56% with slight knowledge respectively. The risk age groups are susceptible to women in the, anaemia, malaria and preeclampsia during pregnancy. Nyaphisi et al (1994) reported that in Lesotho, Malawi, Uganda and Zambia younger teenagers (aged 17 or above) and women aged 35 years and above were at a higher risk of maternal mortality.

The age group (20-24 years) with 38% no knowledge 50% slight knowledge level are those who are prone to have too close pregnancies due to unregulated pregnancies. They too are susceptible to problems in pregnancy as the others.

This implies that since the majority of women 54% have slight knowledge and 20% have no knowledge of danger signs in pregnancy they may not seek medical advice early enough to prevent their poor health or death. Hence women of all ages need to be informed on danger signs in pregnancy.

Table 3 Respondents' Parity in relation to level  
of knowledge of danger signs in pregnancy  
(n = 100)

PARITY	LEVEL OF KNOWLEDGE				TOTAL
	No Know- ledge	Slight	Moderate	Adequate	
NULLIPARA	9 (43%)	9 (43%)	2 (9%)	1 (5%)	21 (100%)
LOW	10 (24%)	20 (49%)	9 (22%)	2 (5%)	41 (100%)
MEDIUM	-	15 (75%)	4 (20%)	1 (5%)	20 (100%)
HIGH	1 (5%)	10 (56%)	5 (28%)	2 (11%)	18 (100%)
TOTAL	20 (20%)	54 (54%)	20 (20%)	6 (6%)	100 (100%)

Table 3 shows that the majority, 41% of the respondents had low parity. Out of 54% of those with slight knowledge, 20% were of low parity.

The study showed little difference in the levels of knowledge among women of different parity. This may imply that having children does not necessarily equip a woman with knowledge on danger signs in pregnancy.

The study also revealed that the majority of the nulliparae had no knowledge (43%) and slight knowledge (43%) of the danger signs that may occur in pregnancy. This finding is similar to that reported by Bester (1992) on 'Health education in pregnant women'. The report reviewed utilisation of Antenatal Care services by high risk primigravidae. It is stated that these patients had very little knowledge about the danger signs that may occur during pregnancy.

The findings of the study may imply that having children does not necessarily equip a woman with knowledge about danger signs in pregnancy. This may also imply that when one does not recognise the danger she is in, she may not act promptly and wisely to seek medical help to reduce maternal morbidity and mortality it will require that the women, especially those at risk by virtue of their parity are given appropriate advice on identification of danger signs as well as fertility regulation.



Table 4 Respondent's Level of Education and Level of Knowledge of danger signs in pregnancy  
(n = 100)

LEVEL OF EDUCATION	LEVEL OF KNOWLEDGE				TOTAL
	No Know- ledge	Slight	Moderate	Adequate	
NONE	-	5 (83%)	1 (17%)	-	6 (100%)
PRIMARY	13 (25%)	25 (48%)	13 (25%)	1 (2%)	52 (100%)
SECONDARY	7 (21%)	18 (55%)	5 (15%)	3 (9%)	33 (100%)
COLLEGE	-	6 (67%)	1 (11%)	2 (22%)	9 (100%)
UNIVERSITY	-	-	-	-	-
TOTAL	20 (20%)	54 (54%)	20 (20%)	6 (6%)	100 (100%)

Table 4 shows that the majority of the respondents, 52% has primary education as the highest educational attainment.

The findings in Table 4 agrees with the observations by Jacobson (1991), that limited education of women restricts their access to vital information which includes information on health care.

Nyaphisi et al (1994) also reported that women who lacked education or had low education may not benefit from health education and information provided at the antenatal clinics and may not identify early signs of complications in pregnancy.

As indicated in the study, it implies that the health workers involved in communicating health related information with the women in the study should consider their educational background to be able to communicate effectively. This may need use of symbols such as pictures, written or spoken words that can effectively inform the audience what the danger signs of pregnancy are, how they can be identified and what should be done if they occurred.

Table 5 Respondents' Employment status and level of knowledge of danger signs in pregnancy  
(n = 100)

EMPLOYMENT STATUS	LEVEL OF KNOWLEDGE				TOTAL
	No Know- ledge	Slight	Moderate	Adequate	
UNEMPLOYED	14 (26%)	28 (53%)	10 (19%)	1 (2%)	53 (100%)
SELF- EMPLOYED	3 (12%)	16 (61%)	3 (12%)	4 (15%)	26 (100%)
EMPLOYED	3 (14%)	10 (48%)	7 (33%)	1 (5%)	21 (100%)
TOTAL	20 (20%)	54 (54%)	20 (20%)	6 (6%)	100 (100%)

Table 5 shows that the majority of the respondents, 53% were unemployed.

Viegas et al (1992) reported that in Indonesia, Thailand and Phillipines women who work at home (unemployed or self employed) worked long hours, carried heavy loads and were commonly undernourished hence, performed poorly in pregnancy.

However, the findings of the research did not indicate the employed to be better equipped with knowledge compared to the self employed as shown in Table 5.

This implies that if the women will not be able to identify danger signs to which they are susceptible their general health will be adversely affected. This will eventually adversely affect their productivity in the family and community and hence perpetual poverty.

Table 6 Respondents Source of Information and Level of Knowledge of danger sign in pregnancy  
(n = 100)

SOURCE OF INFORMATION	LEVEL OF KNOWLEDGE				TOTAL
	No Know-ledge	Slight	Moderate	Adequate	
RELATIVE	-	23 (72%)	7 (22%)	2 (6%)	32(100%)
FRIENDS	-	21 (60%)	11 (31%)	3 (9%)	35(100%)
HEALTH WORKER AT HEALTH CENTRE	-	7 (70%)	2 (20%)	1 (10%)	10(100%)
HEALTH WORKER AT HOSPITAL	-	1 (100%)	-	-	1 (100%)
TRADITIONAL MIDWIFE	-	-	-	-	-
SCHOOL/ COLLEGE	-	2 (100%)	-	-	2 (100%)
DON'T KNOW	20 (100%)	-	-	-	20(100%)
TOTAL	20 (20%)	54 (54%)	20 (20%)	6 (6%)	100(100%)

Table 6 shows that the majority of the respondents, 35% cited friends as their source of information on danger signs in pregnancy.

The findings in Table 6 also shows that there is not marked difference in the levels of knowledge among those who had friends and relatives as source of information and those whose source was health worker.

The FGDs participants stated that friends and female relatives readily give advice on matters of life including danger signs in pregnancy even though there are no specific ritual teachings with regard to pregnancy and complications that may arise.

Some FGDs participants stated that the health talks at health centres during antenatal clinic and children's clinic sessions are given to big crowds. This to some women is suppressive in that they are reluctant to seek for clarifications. The attitude of some nurses also discourages asking for clarification.

WHO's study (1994) of Yemeni women found that the women preferred to have fellow local women attend to them during pregnancy, in identifying people with risk conditions and taking corrective measures.

This implies that cordial social association between the sender and receiver of information is necessary for effective communication.

The lack and slight knowledge of danger signs in pregnancy of the respondents indicates the likelihood of inadequate knowledge on danger signs in pregnancy among their friends and relatives. It also implies that health workers may not be keen on giving the information. This may reflect on the quality of information given at Antenatal clinics.

Table 7 Respondents' Level of Knowledge of danger signs  
in pregnancy and who should decide(s) what to  
do in an event of a danger sign  
(n = 100)

WHO SHOULD DECIDE	LEVEL OF KNOWLEDGE				TOTAL
	No Know- ledge	Slight	Moderate	Adequate	
SELF	11 (16%)	39 (56%)	14 (20%)	6 (8%)	70 (100%)
PARTNER	7 (29%)	11 (46%)	6 (25%)	-	24 (100%)
RELATIVE	1 (20%)	4 (80%)	-	-	5 (100%)
HEALTH WORKER	1 (100%)	-	-	-	1 (100%)
TOTAL	20 (20%)	54 (54%)	20 (20%)	6 (6%)	100 (100%)

Table 7 shows that the majority, 70% of the respondents regardless of their level of knowledge said that the individual should decide on what to do.



The majority of the respondents 54% had slight knowledge and 20% had no knowledge of danger signs in pregnancy. Since 70% of the respondents stated that the individual makes the decision the likelihood of making appropriate decision is diminished because of inadequate knowledge prevalent among the respondents.

It implies that since women would want to make decisions on matters that concern their health, they should be equipped with the correct information.

Table 8 Respondents' reasons for citing who should  
decide what action to take if a danger sign  
in pregnancy was experienced  
(n = 100)

WHO SHOULD DECIDE	Respondents' Reasons					TOTAL
	Feel the sick- ness	Head of house- hold	Respons- ible for Pregnancy	Has money for trans- port; medical bills	Knows better	
Self	70 (100%)	-	-	-	-	70 (100%)
Partner	-	11 (46%)	5 (21%)	8 (33%)	-	24 (100%)
Relative	-	-	-	2 (40%)	3 (60%)	5 (100%)
Health Worker	-	-	-	-	-	1
TOTAL	70 (70%)	11 (11%)	5 (5%)	10 (10%)	4 (4%)	100 (100%)

Table 8 show that the majority, 70% of the respondents said that the one experiencing the danger sign should decide what to do.

Some FGDs participants stated that although the woman may decide what to do such as going to the hospital or health centre (see Table 9) she may not go there straight. This is because she relies mostly on the partner for money for transport and medical bills. Sometimes the couple may want to consult older family members who play a part in the decision process because of their status.

Nsemukila (1994) also reported that many women failed to utilise health services in Zambia because of economic constraints. UNICEF, Zambia (1994) also reports that most women have dominated traditionally economically less rewarding activities making them economically dependant on the partners and relatives.

This finding also relates to the report of Dali et al (1991), of mothers-in-law in Mahankal, Dakar, who where invloved in providing intra conceptional care and controlling the general activities of the family. The education mothers-in-law intraconceptual care improved their knowledge, attitude and skills towards better maternal health.

This finding implies that Information Education and Communication (IEC) on danger signs in pregnancy should be extended to the partners and significant female relatives to enable them make decisions correctly.

Table 9 The respondents' practice and attitude in  
relation to level of knowledge of danger  
signs in pregnancy  
(n = 100)

Practice	LEVEL OF KNOWLEDGE				TOTAL
	No Knowledge	Slight	Moderate	Adequate	
GOOD	19 (95%)	47 (87%)	19 (95%)	5 (83%)	90 (90%)
BAD	-	5 (9%)	1 (5%)	1 (17%)	7 (7%)
DON'T KNOW	1 (5%)	2 (4%)	-	-	3 (3%)
TOTAL	20 (100%)	54 (100%)	20 (100%)	6 (100%)	100(100%)

Table 9 shows that the majority, 90% had good practice which reflected their attitude regardless of their level of knowledge of danger signs in pregnancy.

The study tried to determine the respondents practice which reflected their attitude. This was done by asking them what they would do if they experienced any of the listed danger sign in pregnancy.

The good practice stated by 90% of the respondents contradicts the report by Nsemukila (1994) which states that most of the women in Zambia who die due to pregnancy related causes attend health care services irregularly or none at all.

However, Nsemukila's report agrees with the FGDs participants comments that even though the women would want to attend health services promptly socio-economic constraints do not allow them to do so.

Table 10 Respondents' practice and attitude in relation  
to their family Income

(n = 100)

Practice	Family Income			TOTAL
	LOW	MEDIUM	HIGH	
GOOD	37 (92%)	41 (87%)	12 (92%)	90 (90%)
BAD	2 (5%)	4 (9%)	1 (8%)	7 (7%)
DON'T KNOW	1 (5%)	2 (4%)	-	3 (3%)
TOTAL	40 (100%)	47 (100%)	13 (100%)	100 (100%)

Table 10 shows that 90% of the respondents had good practice and attitude towards danger signs in pregnancy regardless of their family income.

The study sought to find out if family income has influence on the respondents' practice and attitude towards danger signs in pregnancy. The findings showed that there was no marked difference in practice and attitude despite the difference in family income.

However, the FGDs participants revealed that although they would rather go to the health centre or hospital when they experience any of the danger signs in pregnancy, they do not do so. The reason given was lack of money for transport and medical fees. This agrees with Nyaphisi et al (1994) report, which states that poverty has made people of Malawi, Lesotho, Uganda and Zambia less able to appropriately utilise available health services.

This implies that the respondents may not be aware of the provisions in the health sector of Zambia with regard to maternal and child health services which caters for pregnant women and those who are unable to or who are exempted from paying for health services.

The other finding in relation to practice were the comments by FGDs participants that, "it would be nice to have all the treatment and investigations done at the health centre without being referred to the U.T.H." They said that sometimes when a pregnant woman is referred to U.T.H., they do not have the needed money for transport or medical fees. Hence, they go back home and try other

measures. They only go back to the health centre or U.T.H. when the condition persists or worsens. Nyaphisi et al (1994) had also observed that in the event of illness during pregnancy there was a tendency for the women who died in the study population to be treated at home instead of going to a health facility.

This may imply that those that are referred to the U.T.H. may not be fully aware of the reasons for the referral hence, do not see the need for compliance.



Table 11 Customary measures in an event of danger signs in pregnancy (n = 100)

Danger Sign in Pregnancy	CUSTOMARY MEASURES						TOTAL
	Go to Hospital	Use herbs	Leave Alone	Prepare for delivery	Don't Know	Not Applicable	
BLEEDING FROM BIRTH CANAL WITH OR WITHOUT PAIN	5 (5%)	24 (24%)	2 (2%)	-	15 (15%)	54 (54%)	100 (100%)
SWELLING OF BODY (FACE, HANDS, FEET)	2 (2%)	9 (9%)	23 (23%)	-	12 (12%)	54 (54%)	100 (100%)
FEVER	6 (6%)	14 (14%)	8 (8%)	-	18 (18%)	54 (54%)	100 (100%)
PALLOR	3 (3%)	12 (12%)	8 (8%)	-	23 (23%)	54 (54%)	100 (100%)
HEADACHE	7 (7%)	13 (13%)	5 (5%)	-	21 (21%)	54 (54%)	100 (100%)
DRAINING LIQUOR AMNII	2 (2%)	11 (11%)	7 (7%)	11 (11%)	15 (15%)	54 (54%)	100 (100%)
TOTAL	25 (4%)	83 (14%)	53 (9%)	11 (2%)	104 (17%)	324 (54%)	600 (100%)

Table 11 shows that the popular measure, 14% in the event of any danger sign occurring in pregnancy is herbal use.

NB. 54% of the respondents did not know of any customary teaching with regard to danger signs in pregnancy.

The study reveals that herbs are used differently but the common routes of administration are oral (as herbal drink or added to porridge), insertion in the birth canal (for bleeding and draining problems) and massage. The FGDs participants said that these measures are often taken if the problem occurred before the eighth month. This is to preserve the pregnancy by preventing a miscarriage or premature delivery.

Out of the 46 respondents who knew customary practices indicated that no action is taken for swelling of the body. The FGDs participants revealed that most of the time swelling of the body is regarded as a sign of pregnancy and marked swelling usually indicates that the woman is carrying a male child or twins.

Headache was associated with malaria in combination with fever. Very few FGDs participants associated swelling of the body and headache with raised blood pressure in

pregnancy. This was also reported by WHO (1993) that headache and swelling of extremities in pregnancy is regarded as normal and do not call for action.

This there, shows that, the respondents have slight knowledge on preeclampsia which can be detected at home by observing for swelling of the body and headache. However, it also shows that the respondents are aware of some of the signs and symptoms that may indicate malarial infection which is equally dangerous to a pregnant woman.

### HEALTH SYSTEM IMPLICATION

The study revealed that most of the respondents had slight knowledge of danger signs in pregnancy, the attitude was good as well as the stated practice.

Most of the respondents got their information from friends. Very few respondents got the information from health workers. This implies that the health workers should take a leading role in educating the respondents about danger signs in pregnancy and the facilities for maternal health available in the community. For if they are well informed they will inturn teach others as revealed in the study. This will assist in promoting maternal health with the involvement of the community as advocated for in the primary health care and health reforms.

Therefore, there is need to intensify and modify IEC programmes towards these respondents. For if they are well informed and their energies well directed it can result in possession of adequate and re-enforcing of positive behaviour.

The findings may imply that the information Education and Communication (IEC) sessions held at the health centres have had no impact on the women or not much IEC in relation to danger signs in pregnancy are discussed.

## CHAPTER 6

### CONCLUSION AND RECOMMENDATIONS

#### CONCLUSION

The evaluation of the knowledge, attitude and practice towards danger signs in pregnancy of women of child bearing age in Lusaka Urban was worthwhile in contributing to improvement of maternal health/safe Motherhood programmes.

Conclusions drawn from the study were as follows:

1. Most of the respondents, 54% had slight knowledge of danger signs that may occur in pregnancy, regardless of their age, parity and educational attainment.
2. Although most women has slight knowledge of danger signs that may occur in pregnancy their attitude was good.
3. Although most of the respondents stated their practice to be good the Focus Group Discussions revealed that factors such as socio-economic constraints impede decision making process and the<sup>by</sup> affecting the decision to seek medical advice promptly.

## RECOMMENDATIONS

1. The Lusaka Health District Management Team with the health of MCH department of the Ministry of Health and interested agencies and organisations should intensify danger signs in pregnancy awareness campaign with some modification in the presentation of the information. The modification in presentation should take into consideration the audience's background such as age parity and educational level. The programme should be done throughout the year with the use of mass media (print such as bill boards, pamphlets, posters and electronic such as on radio and television).
2. All health workers should consider an encounter with and client of child bearing age as an opportunity to discuss the risk of danger signs in pregnancy and hence promote good practices.
3. The Information Education Communication (IEC) sessions should be done in small groups to encourage fruitful exchange of ideas.

The feasibility of including partners and significant others, such as female relatives, in the IEC sessions should be considered.

4. The use of health neighbourhood committee in the dissemination of information on danger signs in pregnancy in the community to aid in prevention and early identification affected persons should be encouraged. This will encourage community participation in the promotion of maternal health.
5. The Ministry of Health should collaborate with the administrators of United Taxis and Transport Association (UTTA) to share information on their role in promoting maternal health. This could include discussion of fares in case of emergencies.
6. Information on the availability of health services for pregnant women (such as criteria for exemption to pay medical fees) should be-made available to the health workers, social workers and the community.
7. A research on a wider scale to enable generalisation to the female population in child bearing age within Zambia would help plan strategies on a wider scale.

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ANNEX 1

RESPONDENT NO. \_\_\_\_\_

STRUCTURED INTERVIEW SCHEDULE

ON

THE KNOWLEDGE, ATTITUDE AND MEASURES TAKEN TOWARDS  
DANGER SIGNS IN PREGNANCY

WOMEN AGED BETWEEN 15 - 49 YEARS

Date of Interview \_\_\_\_\_ Month \_\_\_\_\_ Year 19 \_\_\_\_\_

Name of Residential Area \_\_\_\_\_

INSTRUCTIONS TO THE INTERVIEWER

1. Introduce yourself to respondent.
2. Explain the purpose of the interview and that  
all responses will be treated in strict confidence.
3. Individual names and addresses should not appear  
in the questionnaire.
4. Please ensure that all questions are answered and  
indicate response by ticking in the appropriate  
box(es) ☐ on filling in the space(s) provided.

SECTION A DEMOGRAPHIC DATA

FOR OFFICIAL  
USE

1. Age range in years

1. 15-19 years

2. 20-24 years

3. 25-29 years

4. 30-34 years

5. 35-39 years

6. 40-44 years

7. 45-49 years


--

2. What is your martial status?

1. Single

2. Married

3. Separated

4. Divorced

5. Widowed


--

3. How many children do you have?

1. None

2. 1-3

3. 4-6

4. 7 and more


--

4. What is the highest educational level  
you attained?

1. None

2. Primary

3. Secondary

4. College

5. University


--

FOR OFFICIAL  
USE

5. What is your employment status?

- 1. Unemployed
- 2. Self employed
- 3. Employed


--

--

6. Tribe \_\_\_\_\_

7. What is your family's income range  
month?

- 1. Below 50,000 Kwacha
- 2. 50,000 - 100,000 Kwacha
- 3. 100,000 - 150,000 Kwacha
- 4. Above K150,000 Kwacha


--

SECTION B KNOWLEDGE ON DANGER SIGNS IN PREGNANCY

8. Do you know of any major problem of  
pregnancy that may occur?

- 1. Yes
- 2. No


--

9. If Yes, what are the major problems  
of pregnancy that can put a woman's  
life in danger? (tick more than once)

--

- 1. Bleeding from the birth canal  
with or without pain
- 2. Swelling of body (face, hands, feet)
- 3. High fever
- 4. Pallor
- 5. Severe headaches
- 6. Draining Liquor Amnii


FOR OFFICIAL  
USE

10. What are the effects of the  
problem you have mentioned?

1. Bleeding from birth canal with  
or without pain \_\_\_\_\_  
\_\_\_\_\_
2. Swelling of body (face, hands,  
feet) \_\_\_\_\_
3. High fever \_\_\_\_\_  
\_\_\_\_\_
4. Pallor \_\_\_\_\_  
\_\_\_\_\_
5. Severe headaches \_\_\_\_\_  
\_\_\_\_\_
6. Draining liquor amnii \_\_\_\_\_  
\_\_\_\_\_

11. Which of the mentioned major  
problems of pregnancy are common  
in your community?

1. Bleeding from the birth canal  
with or without pain
2. Swelling of body (face, hands, feet)
3. High fever
4. Pallor
5. Severe headaches
6. Draining liquor amnii

FOR OFFICIAL  
USE

12. From whom did you first learn  
learn about the major problems  
of pregnancy that can put a  
woman's life in danger?

1. Relatives
2. Friends
3. Health worker at health centre
4. Health worker at hospital
5. Traditional midwife
6. Others specify \_\_\_\_\_


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SECTION C ATTITUDDE AND MEASURES TAKEN IN  
THE EVENT OF DANGER SIGNS IN  
PREGNANCY

13. If you were experiencing any of the  
major problems of pregnancy, what  
would you do?

1. Call a neighbour
2. Go to the nearest health centre/  
Hospital
3. Go to traditional healer
4. Call my mother
5. I would not know what to do
6. Others specify \_\_\_\_\_


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USE

14. Give reasons for your answer in  
question 13.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

☐

15. Who should decide what to do if  
you were to experience any of the  
major problems in pregnancy  
mentioned?

☐

1. Myself
2. My partner
3. My relatives
4. Others, specify \_\_\_\_\_


16. Give reasons for your answer in  
question 15.

☐

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

17. Does your custom teach on anything  
to do when major problems of  
pregnancy occur?

☐

1. Yes
2. No
3. I do not know


/69....



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USE

18. According to your customs, what would  
you do, if you experienced the following?

1. Bleeding from birth canal with  
or without pain.

---

---

2. Swelling of body (face, hands, feet)

---

---

3. High fever \_\_\_\_\_

---

---

4. Pallor \_\_\_\_\_

---

---

5. Severe headaches \_\_\_\_\_

---

---

6. Draining liquor amnii \_\_\_\_\_

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19. Do you have any comments on the subjects  
that we have discussed?

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☐☐

## ANNEX 2

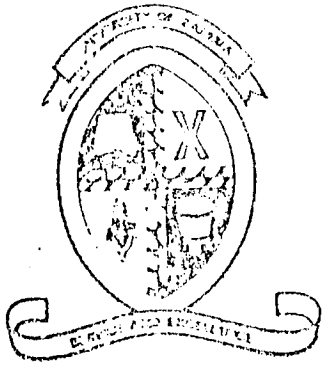
### FOCUS GROUP DISCUSSION GUIDE

#### Instructions

1. Introduce yourself and the topic.
2. Explain the purpose of the discussion.
3. Do not ask for names and addresses of respondents.
4. Take notes as discussion proceeds.

#### Questions for both women and men

1. What are the major problems in pregnancy?
2. What are their effects?
3. Which major problems are common in the community?
4. What are the taboos, and customary practices for women and men in the event of a pregnant woman experiencing any major problems?
5. What is the support and view of the spouse/partner, family members and community in the event of a major problem in pregnancy occurring (moral, practical, financial and attitude).
6. What would you suggest should be done to optimise care given to pregnant women.



SCHOOL OF MEDICINE  
UNIVERSITY OF ZAMBIA

P.O. BOX 50110, LUSAKA, ZAMBIA

Telephones:

258641 (Dean's Office)

211440 (University Teaching Hospital)

218767 (Pre-Clinical)

Telegrams: Unza. Lusaka.

DEPARTMENT OF POST BASIC NURSING

16th February, 1995

TO WHOM IT MAY CONCERN

I wish to confirm that.....CHONGO CHARITY N° 9224492..... is a  
Fourth Year BSc N student at the Department of Post Basic Nursing,  
School of Medicine, UNZA. The student is currently carrying out a  
Research Project entitled. The study to assess the  
knowledge, attitude and practices  
of the community in relation to  
danger signs in pregnancy in  
Lusaka urban.

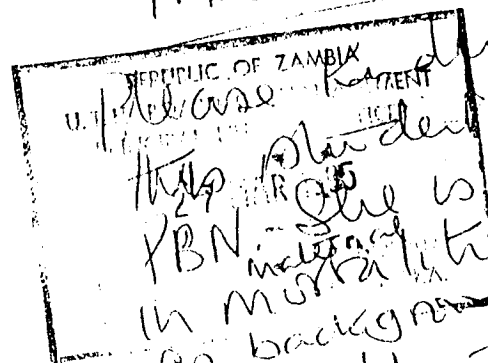
We shall be most grateful if you or your organisation can give what  
ever assistance the student may require.

Thanking you for your continued support and co-operation.

Patricia M. Ndele (Mrs)  
NURSING RESEARCH LECTURER

Metron OTC,

Could you assist Ms Chongo  
with some idea of our  
project/on for her thesis.



Mr Ahmed

Thank you

DEPARTMENT OF POST BASIC NURSING

21st July 1995

The Assistant Social Secretary  
Lusaka City Council  
P.O. Box 51612  
LUSAKA

*PHI Ndele*  
u.f.s. Mrs P. Ndele - Research Coordinator

Dear Sir/Madam,

re: RESEARCH STUDY : REQUEST TO COLLECT DATA

I am a fourth year student in the School of Medicine, Department of Post Basic Nursing of the University of Zambia, pursuing a Bachelor of Science Degree.

As part of the partial fulfilment for a degree programme, I am required to carry out a research study. My research topic is "To Determine the Knowledge, Attitude, and Practice of the Community in Relation to Danger Signs in Pregnancy in Lusaka Urban."

I intend to collect data from a random sample of household during the period August - September 1995. The purpose of this letter is to kindly ask for permission to enable me carry out the study in Lusaka Urban.

Thanking you in anticipation.

Yours faithfully,

*Chongo*  
Chongo Charity  
STUDENT - P.B.N.

c.c. Head - Post Basic Nursing



# Lusaka City Council

Director of Housing  
Telegrams: "CITY"  
Telephone: 250877  
Ext.  
Verbal Enquiries to:  
Mr.....

HOUSING & SOCIAL SERVICES DEPT.  
CIVIC CENTRE  
P.O. Box 30269  
LUSAKA  
Republic of Zambia

Refence: PPS/gn1  
HSS/14/75/22

27th July, 1995.

Ms Charity Chongo,  
University of Zambia,  
Department of Post Basic Nursing,  
School of Nursing,  
LUSAKA.

Dear Sir,

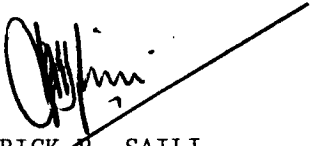
RE: RESEARCH STUDY IN LUSAKA CITY RESIDENTIAL AREAS:

Please be advised that your request to conduct a Research Study in selected residential areas of Lusaka in fulfillment of the Bachelor of Science Degree in Nursing has been approved.

You may accordingly, proceed to these areas and hope that you will be conscious of the political, social, cultural and security tenents of the people you will be dealing with.

We wish you all the best in your studies.

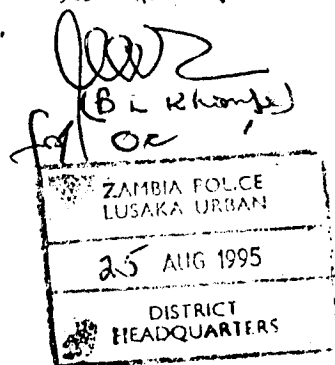
Yours faithfully,

  
PATRICK P. SAILI  
ASSISTANT DIRECTOR OF HOUSING AND  
SOCIAL SERVICES

for/TOWN CLERK

cc Officer Commanding (Lusaka Urban) Zambia Police.  
Commandant, Lusaka City Council Police.

*Noted.  
Paragraph two (2) must be  
strictly related to the research.*



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