THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST-BASIC NURSING

FACTORS CONTRIBUTING TO DELAY IN SEEKING MEDICAL CARE BY EXPECTANT MOTHERS WITH A HISTORY OF IMMEDIATE PREVIOUS CAESAREAN SECTION, AT THE UNIVERSITY TEACHING HOSPITAL,(U.T.H.) LUSAKA ZAMBIA

A STUDY SUBMITTED TO THE DEPARTMENT OF POST-BASIC NURSING, SCHOOL OF MEDICINE, UNIVERSITY OF ZAMBIA, IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE BACHELOR OF SCIENCE IN NURSING.

NURSING RESEARCH - NR 420

BY

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CONTENTS

LIST OF TABLES

DECLARATION

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

Signed: _____

CANDIDATE

Signed: _____

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 the references.

Signed: _____

CANDIDATE

ABSTRACT

The aim of the study was to identify the factors contributing to delay in seeking medical care when in labour, by the expectant mothers with immediate previous caesarean section, at the University Teaching Hospital.

A purposive non-probability sample of postnatal mothers having a history of immediate previous caesarean section, before this last delivery, was selected. The sample consisted of thirty (30) postnatal mothers. A semi-structured interview schedule was used to collect data.

Data were collected between 15th April and 15th June, 1988 and were analysed manually by the researcher. The findings of the study revealed that most of the mothers had lack of knowledge on the specific time when they were expected to report for hospital confinement. Some mothers reported late for fear of a repeat caesarean section. One mother had no transport, and the other one lacked a reliable person to keep her children during the period she was expected to have been in hospital.

Effective utilisation of the hospitals for delivery, by expectant mothers who have a history of immediate

previous caesarean section, could be attained through intensified health education on the importance of seeking early medical care. The health workers, through the team approach, should involve the community in making the expectant mothers accept the maternity services being offered in the health institutions through out Zambia.

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CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

1. INTRODUCTION

Mothers and children form the majority of the population in Zambia. Jelliffe and Williams stress that children are particularly vulnerable and subject to disease, therefore, measures should be carried out to make them less susceptible to avoidable diseases.[1] Shattock adds that the second 'at risk group is that comprising pregnant and the delivering women.[2] Therefore, several countries have set up health services to cater for mothers and children. The reasons for providing maternal and child health services to the community are, firstly, children are the future nation and therefore, should be properly managed to ensure their successful growth and development. Secondly, most diseases that cause morbidity and mortality in children and those associated with pregnancy are preventable. In addition, the maternal and child health services provide an appealing and appreciated introduction to rational medicine.[3]

Prenatal care is one of the maternal and child health services that is offered to expectant mothers at the health centres and hospitals. These prenatal clinics

are regarded as the back bone of well-run obstetric services in developed countries. This is because it is at these clinics that mothers 'at risk' are separated in time for appropriate management to achieve a successfull outcome of pregnancy. Therefore, complications arising from uncorrected medical and obsterical conditions are rarely encountered in labour wards in the institutions where the prenatal clinics are properly run.

The Zambian Party and its Government has established a national policy to improve and expand the health services to cover all parts of Zambia so that the services are within easy reach of every person regardless of race and creed.[4] These services that are provided are free and include "the maternity services" that are available in the rural and urban health centres including hospitals.

It has been observed that in the third world countries where mothers are exposed to a lot of obstetric risks, there seems to be under utilisation of the maternity services. Women especially those with a history of previous caesarean section seem to be unwilling to use the maternity services because of various reasons. One of the reasons is the previous hospital confinement which makes women in labour to be exposed to various forms of stressors including caesarean section in those who undergo the initial caesarean section. The immediate post-caesarean section period acts as a stressor and

interfere with the patient's accustomed pattern of life. This period is likely to cause frustration, fear and anxiety in the postnatal mother during the postnatal period and in most instances such fears of a possible subsequent caesarean section linger on during these women's reproductive life.

Midwives should, therefore, remember that patients have a right to quality care, respect, and dignity as human beings regardless of their colour, creed, political and social background. Miller agrees with this observation and adds that the patient has a right to life, his own identity and access to information relevant to his condition.[5] This means that the expectant mother should be given an explanation for each and every obstetric procedure that has to be performed on her.

Experience has shown that some mothers have expressed concern about their labour experiences to relatives, friends and sometimes to hospital authorities in the hope that tangible solutions can be sought to adequately meet their needs.

Depending on the previous experience, pleasant or unpleasant, the patients' attitudes towards the subsequent hospital deliveries will be based on these experiences. It is often stated that first impressions are lasting, therefore, the first hospital confinement experiences the patient undergoes get imprinted in her mind. It appears that the same factors may contribute to the

expectant mothers' decision to report late to the delivery rooms during subsequent deliveries especially if they have had previous caesarean section.

2. STATEMENT OF THE PROBLEM

Some maternal and child health workers have expressed concern over the under-utilization of the services especially the maternity services. It has been observed that the expectant mothers who have a history of immediate previous caesarean section delay in reporting for delivery until either labour becomes obstructed or the uterus ruptures. When this happens, the mothers expose themselves to a longer hospitalisation, physical disability or even unnecessary loss of life. To support the problems outlined above, Mhango, Rochat and Arkutu in their study conducted at the University Teaching Hospital in Lusaka stated that delays in bookings, referral and treatment were the chief identifiable problems in the cases of maternal deaths they investigated during the period of 1982 to 1983.[6]

Therefore, the expectant mothers who have had immediate previous caesarean section should know that it is important for them to register as early as twelve weeks gestational period for prenatal care and must attend regularly in order to have their problems identified early and advice given accordingly. The midwives and community health nurses have a major role to play in

making the clients see the need for seeking early prenatal and intranatal care. The expectant mothers should be given health education on the consequences of reporting late to the hospital for delivery after labour has commenced. All this should be done with the hope of reducing maternal and fetal mortality rates.

Maternal and fetal mortality rates serve as indices of the standard of obstetric care being provided and, therefore, efforts should be made to reduce the mortality rates through encouraging the expectant mothers to fully utilize the community maternal health services being provided. In order to reduce the maternal and fetal mortality rates arising from the ruptured uteri, the expectant mothers who have the history of previous caesarean section have time and again been advised to report for hospital confinement between thirty six to thirty nine weeks of gestation, before commencement of labour. The expectant mothers have sometimes not taken heed of the advice given, especially if the women affected are illiterate and had a caesarean section which resulted into a stillbirth. This is because the illiterate women have a often linked their stillbirth to the caesarean section and not to the underlying obstetric complication.[7] Kelsey further states that such women usually distrust hospital medicine and there is, therefore, no guarantee that they will report to the hospital for care in subsequent pregnancies and that in this situation the danger of scar

rupture is real.[8]

A review of the records at the labour ward at the University Teaching Hospital, Lusaka, between 19th January and 18th March, 1988 revealed that 2,821 deliveries were conducted out of which 8.4% were delivered by caesarean section. The records further reveal that indications for caesarean section were previous caesarean section (18.2%), Cephalo -Pelvic disproportion (11%) and sterilisation (4.2%). In addition, four (1.7%) mothers who came with a history of previous caesarean section had ruptured uteri and amongst them was a Public Health Nurse who reported late for hospital confinement.

The question of reporting late to hospital when labour is well established by mothers with the history of immediate previous caesarean section is an important issue for the obstetricians, midwives and Community Health Nurses. This research, therefore, proposed to study that question, 'The Contributing Factors to the Delay in Seeking Medical Care when in Labour by the Expectant Mothers with the History of Immediate Previous Caesarean Section.'

3. HYPOTHESES FOR THE STUDY

The hypotheses for the study are:-

1. There is a negative relationship between the mothers

with history of immediate previous caesarean section(s) and their attendance at the prenatal clinic.

2. Educated mothers attend the prenatal clinics more than the semi illiterate and illiterate women.

3. Lack of explanation given to the expectant mothers with the history of immediate caesarean section(s) on the possibility of undergoing trial of labour, prevent mothers from reporting early for medical care.

4. Expectant mothers with the history of immediate previous caesarean section(s) who live in distant homes from hospitals, report late for hospital confinement.

5. Grande-multiparous expectant women are more likely to appear late for medical care than low parity women.

4. OPERATIONAL DEFINITIONS

For the purpose of this study the following terms are operationally defined as:-

Delay in Seeking Medical Care:

Refers to an expectant mother reporting for hospital delivery when her cervical os dilation is 1 (one) centimetre and above.

Seeking Medical Care early:

Refers to an expectant mother coming for delivery after thirty six weeks gestational period and before the commencement of labour.

Hospital Confinement:

Refers to the delivery that is conducted in the hospital setting.

Prenatal:

Before birth.

Intranatal:

During labour.

Postnatal:

The period starting from delivery to five days after delivery.

Grande-multiparous women:

Women who have had more than four deliveries.

Fetus:

The unborn baby.

Immediate Previous Caesarean Section:

Refers to the history of having had delivered a baby through the abdominal and uterine walls during the last delivery.

Respondent

The postnatal mother having a history of caesarean section during the last one or more hospital confinement(s).

Illiterate:

Refers to a woman who has had no formal education.

Semi-illiterate:

Refers to a woman who has had only primary education and is able to read and write in the local language.

Educated:

Refers to the mother who has had at least twelve years of formal education.

5. PURPOSE OF THE STUDY

The purposes of the study were, firstly, to investigate the factors that contribute to the delay in seeking medical care when in labour by the expectant mothers who come with a history of immediate previous caesarean section. Secondly and lastly, to determine the type of health education to be emphasized to the mothers in order to minimize future complications that may arise in subsequent pregnancies following caesarean section.

6. OBJECTIVES OF THE STUDY WERE TO:

1. To determine whether the expectant mothers with a history of immediate previous caesarean section knew the implications of delay in seeking medical care when labour is established.
2. To determine whether the expectant mothers with immediate previous caesarean section were informed about the importance of hospital confinement for the subsequent pregnancies following caesarean section(s).

3. To identify the contributing factors to delay in seeking medical care when in labour by expectant mothers with the history of immediate previous caesarean section.

4. To use the research findings in planning the strategies to improve the current problem of non-compliance by the expectant mothers who come with the history of immediate previous caesarean section.

7. SIGNIFICANCE OF THE STUDY

The research findings will be used in planning the strategies for the delivery of maternity services for the expectant mothers having a history of immediate previous caesarean section so that complications like ruptured uterus, arising as a result of prolonged labour, especially in cases of cephalo-pelvic disproportion can be prevented.

CHAPTER 2

LITERATURE REVIEW

Delay in seeking medical care by expectant mothers starts as early as the antenatal period. What the expectant mothers forget is that prenatal care is vital in the prevention, identification and treatment of high risk conditions which may be medical or obstetrical. Margaret Miles lists some of the high risk expectant women as those with cephalo-pelvic disproportion, multiparity, multiple pregnancies, eclampsia and previous caesarean section.[9] Kelsey's study in Nigeria observed that the unbooked mothers had 31 operative delivery rate, compared to their counterparts who had received prenatal care and had only 10 operative rate.[10] This was because the expectant mothers who had some medical diseases, were treated before the onset of labour, and those who had cephalo-pelvic disproportion had their mode of delivery planned well in advance before the onset of labour. In a study conducted at the University Teaching Hospital in Lusaka, Zambia, the researchers observed that delays in booking, referral and treatment were the chief identifiable problems that contributed to maternal deaths.[11] However, the factors causing the delays were not investigated.

There are many reasons affecting the utilisation of health facilities in developing countries. Ben-Yousseff and Lesson state, "We assume that the actual utilisation rates will depend upon a complex of factors relating to the interaction between individuals who perceive a need for services and specific practitioners of facilities which are available to them."[12] Many factors may affect the utilisation of health services, be it in a developed or developing country. "Entry into the medical care system can be inhibited by a multitude of factors including financial barriers, physical availability of resources, limited provider hours, long waiting times at the places of service and attitudinal barriers."[13]

Lasker and Van Riddle in their study conducted in Zululand, South Africa, showed that attendance at the prenatal clinic is usually delayed because of uncertainty about the function of the clinic.[14]

Loynal observed that late attenders at the prenatal clinics did so because of distance between their homes and the maternity and child service facilities and also the length of time mothers have to wait before they are attended to.[15]

In Lusaka, Zambia, Kwendakwema discovered that most expectant mothers delayed in registering for prenatal

care because some mothers were out of town, some were healthy and some did not know when to register.[16] The findings outlined above indicate that the community needs to be educated on the importance of attending the prenatal clinics early.

It has been observed that some expectant mothers register early for prenatal care, and continue attending periodically until delivery. Others register late during the third trimester, and make that the only visit to the prenatal clinic. It is for this reason that Mbango, Mochant and Arkutu classified expectant mothers as having been 'booked' if they made at least two prenatal care visits to the health facility before delivery.[17] When investigating the value of the first visit at the prenatal clinics in Aberdeen, Pearson found that one third of the expectant mothers had attended the prenatal care clinics by the 12th week of gestation, and a quarter had not attended by the 18th week of gestation.[18] Goldberg and Craig in their study conducted at one of the Peninsula Maternity Service Hospitals in Cape Town, observed that about 69.5 of the expectant mothers had booked for prenatal care when they were between twenty and twenty eight weeks of gestation.[19] The latter may, however, be true for the Lusaka population. Raynal revealed that as opposed to the earlier

research findings, women in Kwazulu District in South Africa fully utilized the prenatal care services.[20] In Ghana it is said that about 90 of all the University Teaching Hospital maternity patients receive prenatal care.[21]

The expectant mothers' perceived susceptibility to obstetrical risks may dictate their compliance in seeking medical care. Pearson in Lidgla-Morgan, Britain, observed that expectant mothers with unhappy obstetric or medical disorders, such as diabetes mellitus, referred themselves promptly for prenatal and intranatal care.[22] Hall states that many studies have shown that the high parity expectant women are more likely to appear late for prenatal care and default appointments until labour commences.[23] This may explain why complications like rupture of the uterus still appears to be more frequent in the multiparous women.

There may be a lot of factors contributing to delay in seeking medical care when an expectant mother with the history of immediate previous caesarean section is in labour. These factors may be as follows:-

1. Lack of preparation for delivery during the mother's prenatal period.

2. The educational background of the mother may act a barrier to her perceived susceptibility to high risk pregnancy.

3. The distance women have to cover, especially if there is lack of transport in the area they live.

4. The previous caesarean section may act as a demotivator, especially if the mother is illiterate or semi-illiterate.

In Mercer, Hockley and Bostrom's study, 19 of the primiparous mothers who delivered by caesarean section perceived the child birth experience more negatively than those who had normal deliveries.[24]

Illiterate expectant mothers who have a history of previous caesarean may fail to take heed of the advice given to them to report to hospital before labour commences. In Kelsey's study most women who had obstetrical complications lacked prenatal care and were illiterates living in rural areas.[25] He also observed that the unbooked expectant mothers reported for delivery during the second and third stages of labour, and in most instances, intrauterine fetal death had taken place. The women were also exposed to other complications like uterine rupture, recurrence of the vesico-vaginal fistula, embrotomy, maternal and perinatal deaths.[26].

However, non-compliance to report early to hospital for medical care can also occur in the educated and those who have received prenatal care. In Nigeria, ten women with previous caesarean section, who had received prenatal care, developed rupture of the uterus. Upon investigation, it was discovered that five of these mothers had cephalo-pelvic disproportion which was detected at the prenatal clinic. Elective caesarean section had been planned, but all defaulted and went into labour at home. They failed to report to hospital until they developed obstructed labour. There was no maternal death, but there was one intrauterine death on admission and one early neonatal death.[27]

Squarre's study on the factors contributing to the patients' negative attitude towards surgery, at Kabue General Hospital in Zambia, established that patients had fear of dying, fear of being maimed and fear of the wrong operation being performed on them. Most of the patients, however, admitted that they would have been less frightened of the operations they underwent if they had an explanation about their illness, the surgical procedures which were to be performed on them and the expected outcome of the operation they had undergone.[23]

One method which could be used to prevent delay in seeking medical care by the expectant mothers with

the history of immediate previous caesarean section could be achieved by informing them to come to hospital to await trial of labour. The mothers can be told to come for hospitalisation when they are about thirty-seven (37) weeks of gestation so that when labour commences, they would be in an area having the facilities for appropriate intervention, should the need arise for a repeat caesarean section. However, normal delivery is preferred to caesarean section because:-

> Caesarean section carries a risk of maternal mortality two (2) to four (4) times that of normal delivery. Fear of maternal mortality, arising as a result of ruptured uterus due to trial of labour, are unjustified by present statistical data.[29]

Lins and Fortney agree to the above statement.[30] Expectant mothers who have had previous caesarean section should be allowed trial of labour. It should, however, be emphasized that although the natural vaginal delivery is preferred, if successful normal delivery does not occur within a reasonable length of time, the obstetrician must resort to other interventions including caesarean section before there is evidence of fetal distress.[31] Under proper conditions, caesarean section delivery is a simple, rapid and safe procedure.[32]

In recognition of the occurrence of maternal and fetal

mortality arising as the complications occuring due to delay in seeking medical care by the expectant mothers who have a history of immediate previous caesarean section, Greech, Breaters and Log in Uganda have suggested the following plans; first, to have at least one or two Obstetricians in each district. This may be made possible by:-

1. Training the local medical people who become aware and skilled, in dealing with the mothers' problems.

2. To make all the staff, from the consultant to midwife, feel that they are part of the maternal and child health care programme.

3. To educate people at all levels of the population on the need to attend prenatal clinics at the right time, and how to seek help in an emergency. The decision to refer these expectant mothers should be taken at their first visit to the prenatal clinic, since one cannot know whether they would visit the clinic again.

4. The construction of a maternity waiting area adjacent to the district hospitals can help reduce the deaths.[33] In Mbarara, Uganda, a maternity waiting area, adjacent to the District Hospital, was built on self help effort by the local people. This is where the high risk expectant mothers are made to wait until such a time that the need for admission arises. The researchers

say that this has helped a lot toward the proper use of the hospital beds.[34]

In conclusion, health workers should try to identify factors contributing to delay in seeking medical care by the expectant mothers with the history of immediate previous caesarean section. This should be done with the motive of devising ways and means of encouraging mothers to appreciate and properly utilize the hospitals for delivery.

CHAPTER 3

METHODOLOGY

1. RESEARCH DESIGN

The descriptive exploratory non-experimental research design was used to investigate the factors contributing to delay in seeking medical care by the expectant mothers with a history of immediate previous caesarean section(s). This method was thought to be most appropriate for the following reasons. Firstly, it was used to explore and assemble information regarding this phenomenon because the issue has not been investigated before in Zambia. Secondly, it was economical in terms of time and money expenditure as it did not require any introduction of a treatment (stimulus) to the mothers and therefore, the study was completed in a short period of time.

Even though this research design was regarded as the most appropriate method, some limitations were envisaged.[35] These include firstly, the validity of the mothers' accounts of their pregnancy and labour may be questionable in some instances because they relate to past events and as such, much information might have been forgotten by the mothers. In order to improve the validity of data in view of the stated limitations, the investigator firstly interviewed the mothers during the immediate postnatal period which was within six hours post delivery for normal deliveries, and between three to

to five days for the mothers who delivered by caesarean section. These periods were considered appropriate because the mothers were less distressed about labour as they were convalescing. Secondly, the researcher had access to the mothers' records which included the casenotes and prenatal cards to obtain data which the mothers were unable to recall.

2. RESEARCH SETTING

The study was conducted at the Department of Obstetrics and Gynaecology at the University Teaching Hospital, Lusaka. This department is divided into one clinic, one special observation unit (Intensive Care Unit), three gynaecological wards and ten obstetric wards. The gynaecolgical wards cater for a total of ninety five patients. The obstetric wards are designated to cater for a maximum number of 246 mothers and 128 babies.

This department is staffed by the Doctors headed by the Consultants and Nurses, clerical and auxillary staff headed by the Nursing Officer.

The routine activities conducted on these wards are medical and nursing rounds, physical examination of mothers and babies, diagnostic investigations, administration of prescribed medications, conducting deliveries and giving health education to the mothers.

Three postnatal wards were used for this study. This setting was selected rather than the mothers' homes for

the following reasons. Firstly, it was easy to gain access to the mothers as they were in these wards after delivery. Hence, less time was spent on collecting data as no travelling was required in order to reach the mothers. Secondly, the ward setting was conducive for collection of data because respondents were always available on the wards. Thirdly, the respondents would recall more vividly their experiences of pregnancy and labour since they were interviewed during the immediate postnatal period. Fourthly, this setting facilitated easy access to the respondents' records as certain information the mothers could not remember was obtained from the casenotes and the prenatal cards because that was the only time the two records were found together. In addition, it was convenient for the researcher because of the proximity to the postnatal wards and her institution of learning which made it possible for her to collect data without much difficulty even during the evenings.

The labour ward was not appropriate for collecting data because it was felt that the mothers who might have been brought in a collapsed state from home after rupture of the uterus, could have been omitted from the study because they might have been unable to participate in the study because of their poor condition.

3. SAMPLE SELECTION AND APPROACH

The target population for this study was the group of

postnatal mothers who had a history of immediate previous caesarean section(s), before the present hospital confinement. The sample comprised thirty postnatal mothers who had either normal delivery or repeat caesarean section during the period this study was conducted. The sample size of thirty (30) though small, was thought to be a reasonable size for proper analysis of data considering the limited time the researcher had to conduct the study. However, it was felt that the size was large enough to generate valuable information from such a study.

The purposive non-probability sampling technique was used to select the sample. "The purposive or judgemental sampling technique proceeds on the belief that a researcher's knowledge about the population and its elements can be used to hand pick the cases to be included in the sample."[36] The researcher deliberately selected all the postnatal mothers who had come with a history of one or more immediate previous caesarean section(s) occurring just before this last delivery. All the mothers with immediate previous caesarean section were taken because they were very few.

The mothers' condition was considered, especially their mental state, since they were expected to give rational accounts of their prenatal and intrapartum experiences.

The time lapse between the delivery and the interview did not exceed five days as it would have been difficult

for the mothers to give a very concise account of their experiences, especially that concerning this last delivery.

The data were collected during the mothers' postnatal period because the researcher anticipated the labouring women to be too anxious during their admission for delivery and the stress they had would have affected their response and the accuracy of the information given.

In order to reach the sample a letter requesting permission to administer the semi-structuredinterview schedule to the mothers on the postnatal wards was written to the Principal Nursing Officer at the University Teaching Hospital (Appendix I). Permission was granted in writing (Appendix II). In addition, the requirement by the Head of the Gynaecological and Obstetric Department was that the researcher was expected to present her research proposal, for his approval, at the Departmental Research Meeting on 2nd June, 1988. As per request, the researcher presented her research proposal to the Gynaecological and Obstetric Department on the above mentioned date, after which additional permission was granted since the research panel did not identify any ethical implications in the research proposal.

4. INSTRUMENT USED FOR DATA COLLECTION

Data were collected by use of a semi-structured interview

schedule (Appendix III) and by reference to the mothers' casenotes and prenatal cards. The semi-structured interview schedule was considered to be more appropriate primarily because the researcher wanted to probe a little deeper by asking both the closed and open ended questions. In addition, the advantages of the semi-structured interview schedule were also taken into consideration. These were; firstly, it was more economic in terms of both the material and time as every schedule was completely filled. Secondly, the researcher was able to establish rapport with the respondents while at the same time observed the respondents for any reactions that may have been demonstrated by non-verbal communication. Thirdly, the semi-structured interview method broke the barrier of confining the study to a particular group of respondents as it was used for both the illiterate as well as the literate. Fourthly, it allowed the researcher to be certain that the subjects interviewed were the intended participants. "It is quite common to have individuals who receive questionnaires pass the schedule on to a friend, relative, secretary, and so forth." [37] Fifthly, the response rate was quite high through the use of interviews as the respondents found it difficult to refuse to participate in the study. The response rate is said to be 80% to 90%. [38] In addition, it gave an opportunity for the researcher to have asked more interesting open-ended questions that people might not have taken the time to answer if a questionnaire was used.

The disadvantages of using this method of collecting data were also considered although it was found to be appropriate for the study. Firstly, it was time consuming for the researcher because she conducted the interviews alone. Secondly, the interviews might have been costly if much travelling was required. Thirdly, the respondents might have lost the trend of thought while waiting for the interviewer to finish writing, therefore, some useful information might have been lost. Fourthly, the recording of errors might have occurred as the interviewer tried to write the information in a hurry. Fifthly, the presence of the interviewer might have caused the respondents to have worried about anonymity and thus might not have responded honestly and fully. Sixthly, due to limited time in which the study had to be conducted, the interviewees might not have been provided with a choice of when the interview was to be conducted. In additon, Kwendakwema points out that "The need for translating the interview schedule in the local language may give rise to a problem of some terms not having appropriate words."[39]

To minimize the limitations of the semi-structured interview schedule method as stipulated above, anonymity and confidentiality were partially maintained by neither asking the respondents their names nor addresses. Rapport with the respondents was established by greeting them. The researcher further on gave the respondents an explanation of the purpose of the study and how they

were selected to participate in the study. They were further assured that they were not going to be affected adversely in any way by the outcome of the study. These approaches helped the respondents to feel at ease. The travel costs were cut as the respondents were interviewed while in hospital.

The second method of data collection the researcher utilized was the reference to the respondent's case-notes and prenatal cards. This was because the researcher wanted to record the exact information of the questions the respondents failed to answer; these questions were related to the antenatal visits, the date and time of the current hospital confinement, the mode of delivery and if the respondent and the baby had developed any complication arising as a result of the current intrapartum period.

The semi-structured interview schedule was divided into four sections (Appendix III). The first section had questions which were asked to elicit the demographic data. The second section had questions which were designated to obtain data regarding the mothers' past obstetric history. The third section had questions which elicited data on the mothers' prenatal period. The fourth and last section elicited responses on the current intrapartum period.

5. PILOT STUDY

The pilot study was not conducted to pretest the research

instrument before its use because of the limited time in which the research had to be submitted. The researcher, however, had the instrument checked by her research supervisor before she used it.

6. DATA COLLECTION

The data were collected between 13th April and 13th June, 1988 on the days when the opportunity arose. The researcher personally conducted the interviews. The duration of each interview ranged between fifteen and twenty minutes. This was because the researcher took into consideration that the postnatal mothers were convalescing from labour and, therefore, required ample time to rest.

CHAPTER 4

ANALYSIS AND PRESENTATION OF DATA

Analysis of data consists of putting all the individual observations into some manageable form. This is sometimes done by counting the number of times a variable occurred.

The data collected from thirty (30) respondents were analysed manually, tallied, counted and categorised according to the responses given for each variable. Descriptive statistics using frequency distribution and percentages have been used in tabulating the data. Berman and Verhomick point out that tables conserve space by presenting data in such a way that the narrative may be reduced.[40] In addition, the tabulated data are easier to remember.

Percentages from some of the data collected were rounded off in order to have whole numbers. Odall points out that a discrete variable can only assume a finite number. One would not have for example one point five (1.5) children[41]

TABLE 1: AGE DISTRIBUTION OF RESPONDENTS

AGE RANGE IN YEARS	NUMBER OF RESPONDENTS	PERCENTAGE
Unknown	5	17
15 - 19	3	10
20 - 24	10	33
25 - 29	8	27
30 - 34	3	10
35 - 39 and above	1	3
Total	30	100

This table shows that the majority ten (33%) of the mothers were aged between twenty (20) and twenty four (24) years followed by those aged between twenty five (25) and twenty nine (29) years. There was only one mother who was aged between thirty five (35) and thirty nine (39) years.

TABLE 2: MARITAL STATUS OF RESPONDENTS

MARITAL STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
Married	29	97
Single	1	3
Total	30	100

This table shows that twenty nine (97%) of the

respondents were married and only one (3) was single.

TABLE 3: OCCUPATION OF RESPONDENTS

OCCUPATION	NUMBER OF RESPONDENTS	PERCENTAGE
Housewife	22	73
Subsistent Farmer	1	3
General Farm orker	1	3
Marketeer	2	7
Typist	3	10
Broadcaster	1	3
Total	30	100

Table 3 shows that twenty two (73%) of the respondents were housewives, seconded by the typists who were three (10.). Only one (3%) mother was a broadcaster.

TABLE 4 : MODE OF DELIVERY RESPONDENTS HAD PRIOR TO THIS CURRENT CONFINEMENT

MODE OF DELIVERY	NUMBER OF RESPONDENTS	PERCENTAGE
Normal delivery and caesarean section	14	47
Caesarean section	16	53
Total	30	100

In table 4 the distribution shows that sixteen (53) of the respondents had their babies through caesarean section, and fourteen (47) had both normal and caesarean section.

TABLE 5 : SETTING WHERE RESPONDENTS HAVE HAD DELIVERIES CONDUCTED

PLACE OF DELIVERY	NUMBER OF RESPONDENTS	PERCENTAGE
Home and Hospital	4	13
Hospital	26	87
Total	30	100

This table illustrates that twenty six (87) of the respondents had delivered in hospital and four (13) had delivered in both the home and hospital settings during their previous pregnancies.

TABLE 6 : EDUCATIONAL LEVEL OF RESPONDENTS IN RELATION TO NUMBER OF PRENATAL VISITS RESPONDENTS MADE WITH THIS PREGNANCY

EDUCATIONAL LEVEL	NUMBER OF VISITS	NUMBER OF RESPONDENTS	PERCENTAGE
Illiterate	1	1	14
	4 - 6	2	29
	Above 7	4	57
Total		7	100

EDUCATIONAL LEVEL	NUMBER OF VISITS	NUMBER OF RESPONDENTS	PERCENTAGE
SEMI-ILLITERATE	1	2	14
	2	4	29
	4-6	4	29
	Above 7	4	29
Total		14	100

EDUCATIONAL LEVEL	NUMBER OF VISITS	NUMBER OF RESPONDENTS	PERCENTAGE
Educated	4-6	1	11
	Above 7	8	89
Total		9	100

Table 6 shows the breakdown of the respondents' educational level in relation to their attendance of the prenatal clinics. It shows that all the mothers had attended the prenatal clinic during this last pregnancy. It further on shows that eight out of nine (89%) of the educated respondents had made more than seven visits to the prenatal clinic. The illiterate and semi-illiterate expectant mothers had four out of seven (57%) and four out of fourteen (29%) who had made more than seven visits.

TABLE 7 : LOCATION OF PRENATAL CLINICS ATTENDED

LOCATION OF PRENATAL CLINIC	NUMBER OF RESPONDENTS	PERCENTAGE
Urban Health Centre	2	7
Rural Health Centre	2	7
Urban and Rural Health Centre	2	7
Hospital (U.T.H.)	7	23
Rural Health Centre and Hospital (U.T.H.)	3	10
Urban Health Centre and Hospital (U.T.H.)	14	47
Total	30	100

This table shows that fourteen (47%) of the respondents attended both the health centres and hospital prenatal clinics. The respondents who attended only the clinics at the health centres were only six (21%).

TABLE 8 : RESPONDENTS' GESTATIONAL PERIOD WHEN PRENATAL CARE COMMENCED

GESTATIONAL PERIOD	NUMBER OF RESPONDENTS	PERCENTAGE
12 weeks	2	7
18 weeks	2	7
20 weeks	7	23
24 weeks	6	20
28 weeks	9	30
30 weeks	2	7
36 weeks	2	7
Total	30	100

This distribution shows that only two (7%) had registered for prenatal care by the first trimester, seventeen (57%) by the second timester, twenty six (87%) by the 28th week of gestation and thirty (100%) by the third trimester of pregnancy.

TABLE 9A : ADVICE [illegible] TO RESPONDENTS AT [illegible] CLINIC

ADVICE	NUMBER OF RESPONDENTS	PERCENTAGE
To wait for labour while in Lusaka (near U.T.H.)	2	7
To undergo elective caesarean section	5	17
To undergo elective caesarean section for sterilisation.	6	20
To report to hospital for confinement before commencement of labour	1	3
To have hospital confinement.	3	10
To attend prenatal clinic at U.T.H.	1	3
No advice given	1	3
To seek medical care after commencement of labour	11	37
Total	30	100

Table 9A illustrates that eleven (37%) of the respondents were advised to seek medical care after commencement of labour. This was followed by six (20%) who were advised to undergo elective caesarean section for the purpose.

of sterilisation. There was no advice given to one (3%) of the respondents; and one (3%) of the respondents was advised to seek medical care before commencement of labour.

TABLE 9B : REASONS FOR BOOKING GIVEN BY RESPONDENTS AT THE ANTENATAL CLINIC

REASON	NUMBER OF RESPONDENTS	PERCENTAGE
Lack of theatre at nearest clinic	1	3
Unfunctional theatre at nearest hospital	1	3
Previous caesarean section	15	50
Previous caesarean section and hypertension.	2	7
Cephalo-pelvic disproportion with previous caesarean section.	4	13
Prevent rupture of the uterus.	5	17
Multiparity with previous caesarean section.	1	3
No reason given	1	3
Total	30	100

Table 9B shows that fifteen (50%) of the respondents were told to seek medical care because they had previous caesarean section. Prevention of rupture of the uterus was the reason given to five (17%) of the respondents. No reason for the advice, was given to one (3%) of the respondents.

TABLE 10 : [illegible] WHEN RESPONDENTS THOUGHT [illegible] FOR HOSPITAL CONFINEMENT

APPROPRIATE TIME FOR ADMISSION	NUMBER OF RESPONDENTS	PERCENTAGE
Before labour commenced	7	23
After labour commenced	23	77
Total	30	100

The above table indicates that twenty three (77%) of the respondents thought that it was appropriate to seek medical care after the commencement of labour, whereas seven (23%) thought that it was appropriate to seek medical care before labour had commenced.

TABLE 11 : [illegible] RESPONDENTS' [illegible] MEDICAL CARE AT THE TIME OF [illegible]

[illegible] MEDICAL CARE	NUMBER OF RESPONDENTS	PERCENTAGE
Came to prenatal clinic	4	13
Draining	3	10
Intra-uterine death (cord prolapse)	1	3
False labour	1	3
Labour	13	43
Hypovolaemic shock (ruptured uterus).	1	3
Elective caesarean section	5	17
Elective caesarean section and sterilization	2	7
Total	30	100

Table 11 shows that thirteen (43%) of the respondents sought medical care because they were in well established labour, five (17%) reported for elective caesarean section, four (13%) came for prenatal care and three

(10%) were draining. Two (7%) of the respondents sought medical care for the purpose of undergoing conservation section and sterilisation.

TABLE 12 : [illegible] IN RELATION TO [illegible] AREAS OF RESIDENCE

RESIDENCE	[illegible]	NUMBER OF RESPONDENTS	PERCENTAGE
Lusaka Urban	Below 1cm	11	37
	1 - 10cm	7	23
	Not assessed (Had P.V. bleeding).	1	3
Lusaka Rural	Below 1cm	4	13
	1 - 10cm	3	10
Central Province (Kabwe Rural)	Below 1cm	1	3
Eastern Province (Lundazi)	Below 1cm	1	3
Southern Province (Sinazongwe)	Below 1cm	1	3
	Not assessed (Admitted in hypovolaemic shock)	1	3
Total		30	100

Table 12 reveals that nineteen (63%) of the respondents came from the Lusaka Urban, and eleven (37%) came from the areas outside Lusaka urban. It also shows that four (36%) of the respondents who came from outside Lusaka urban, sought medical care late; in comparison with their [illegible] (9%) colleagues from the Lusaka urban who reported for hospital confinement at the U.T.H.

TABLE 13 : [illegible] RESPONDENTS' CERVICAL DILATATION ON ADMISSION

PARITY	CERVICAL DILATATION	NUMBER OF RESPONDENTS	PERCENTAGE
2	1 - 10cm	1	3
3	Below 1cm	6	20
3	Not assessed	1	3
3	1 - 10cm	4	13
4	Below 1cm	2	7
4	1 - 10cm	2	7
5	Below 1cm	4	13
5	1 - 10cm	2	7
6	Below 1cm	1	3
6	1 - 10cm	1	3
7	Below 1cm	2	7
7	1 - 10cm	1	3
9	Below 1cm	1	3
11	Below 1cm	1	3
14	Not assessed (Patient collapsed)	1	3
Total		30	100

Table 13 shows that fourteen (47%) of the respondents in the sample were grand-multiparous women in comparison with sixteen (53%) who were of low parity. It further reveals the distribution of the respondents' parity in relation to their cervical os dilatation on admission. It was found that nine (64%) out of the fourteen (47%) grand-multiparous women had less than 1cm cervical os dilatation, and eight out of sixteen (50%) mothers with low parity reported with the cervical dilatation of less than 1cm on admission.

TABLE 14 : REASONS FOR DELAY IN SEEKING MEDICAL TREATMENT

REASONS FOR DELAY	NUMBER OF RESPONDENTS	PERCENTAGE
Was initially admitted at Urban Health Centre	1	8
Lack of transport	1	8
Lack of knowledge as to when to report for delivery	6	50
Had no where to leave children	1	8
Fear of repeat caesarean section	3	25
Total	12	100

Table 14 shows the distribution of the factors that led to the respondents' delay in seeking medical care. Six out of twelve (50%) of the respondents attributed

their delay to lack of knowledge of the exact period when the respondents were expected to report for delivery. This was followed by three (25%) who delayed because they had fear of a repeat caesarean section. Only one (8%) of the respondents lacked transport.

TABLE 15 : [illegible]

[illegible]	NUMBER OF RESPONDENTS	PERCENTAGE
Normal delivery	3	10
Elective caesarean section.	12	40
Emergency caesarean section.	15	50
Total	30	100

This table shows that fifteen (50%) of the mothers had emergency caesarean section, twelve (40%) delivered by elective caesarean section and only three (10%) had normal delivery.

TABLE 16 : [illegible] RESPONDENTS [illegible] AS A RESULT OF THIS LAST LABOUR

COMPLICATION	NUMBER OF RESPONDENTS	PERCENTAGE
Ruptured uterus and Bladder	1	3
Ruptured uterus	1	3
Nil	28	93
Total	30	100

This table illustrates that one (3%) of the respondents had developed a ruptured uterus, and the other one (3%) had a ruptured uterus which extended to the bladder.

TABLE 17 : [illegible] TO DELIVERED LIVE BABIES

BABIES' CONDITION	NUMBER OF RESPONDENTS	PERCENTAGE
Alive	28	93
Fresh still birth	1	3
Macerated still birth	1	3
Total	30	100

This table shows that twenty eight (93%) of the respondents had live births, whereas one (3%) had a fresh still birth, and the other one (3%) had a macerated still birth.

TABLE 18 : [illegible] VIEWS ON WHAT THEY COULD [illegible] COMPLICATIONS [illegible]

[illegible]	[illegible]	[illegible]
No prevention	2	100
Total	2	100

This table shows that all the two (100%) mothers who developed some complications as a result of this lack of knowledge of the preventive measures that could have carried out in order to prevent the complications they had developed.

TABLE 19 : RESPONDENTS' VIEWS ON MATERNITY SERVICES BEING OFFERED AT HEALTH INSTITUTIONS

N = 10

VIEWS	NUMBER OF RESPONDENTS	PERCENTAGE
1. Filthy hospital linen in which babies are wrapped. 2. Short staff especially during the night. 3. Nurses' unfriendly attention to patients who are known. 4. Private patients being attended to in the U.T.H. setting.	1	10
5 Respondent was not informed where her baby was being nursed.	1	10
6. Respondent wrongly informed at Lusaka Urban prenatal clinic that she had multiple pregnancy	1	10
7. Doctor refused to perform sterilisation on respondent despite respondent and her husband's consent.	1	10
8 Happy to have undergone sterilisation.	2	20
9 Had good treatment	4	40
Total	10	100

Table 19 shows that four (40%) of the respondents were

happy with the [illegible] they received during their confinement. Two (20%) of the mothers were happy for having undergone sterilisation. However, four (40%) of the respondents were unhappy about the care [illegible] by the two hours at the prenatal clinic at one [illegible] health centres in Lusaka urban, and on the [illegible] at the U.T.H.

CHAPTER 5

DISCUSSION OF FINDINGS, NURSING IMPLICATIONS, CONCLUSION, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

1. DISCUSSION OF FINDINGS

The study was conducted for the purpose of identifying the contributing factors to delay in seeking medical care by the expectant mothers with immediate previous caesarean section, at the University Teaching Hospital.

Table 1 shows the age distribution of the respondents. The respondents' ages ranged between fifteen (15) and thirty nine (39) years. Ten (33%) of the respondents were aged between twenty (20) and twenty four (24) years. This was followed by eight (27%) who were aged between twenty five (25) and twenty nine (29) years. Five (17%) did not know their ages, and six (20%) were aged between fifteen (15) and nineteen (19) and thirty (30) and thirty four (34) years, respectively. Only one (3%) of the respondents was aged between thirty five (35) and thirty nine (39) years. This shows that twenty one (70%) of the respondents were in the less at risk period of child-bearing age, which ranges between twenty (20) and thirty four (34) years. The reduction in the number

of respondents aged between thirty five (35) and thirty nine (39) years, may be attributed to the possibility that mothers with the history of immediate previous caesarean section might have had a maximum of three (3) caesarean sections and as such might have undergone sterilisation during their last deliveries.

The distribution of the respondents' marital status indicates that twenty nine (97) were married and only one (3%) was single (Table 2). Experience has shown that the single parent clients are reluctant to utilise the hospitals for delivery, despite their history of immediate caesarean section. This may explain the small percentage of the single respondents who sought medical care during the time this study was being conducted. The single parent clients need encouragement to utilise the hospitals available for their own benefit.

Twenty two (73%) of the respondents in the sample were house-wives, three (10%) were typists, two (7%) were marketeers, one (3%) was a subsistent farmer, one (3%) was a general worker at the farm and one (3%) was a broadcaster (Table 3). The above findings suggest that expectant mothers, from all walks of life, equally appreciate the importance of seeking medical care especially if they have

had immediate previous caesarean section(s) during their last confinements.

Utilisation of the hospital for delivery by the mothers who have a history of previous caesarean section may be affected by the mode of delivery the respondents have had during their previous deliveries. Table 4 shows that sixteen (53%) of the respondents have delivered all their babies by caesarean section, and fourteen (47%) had normal deliveries and caesarean sections, during their previous deliveries. The respondents who had normal deliveries and caesarean sections might have had normal deliveries initially before they developed obstetrical complications like cephalo-pelvic disproportion during their subsequent deliveries. Such a trend of events might have led to the subsequent pregnancies being delivered by caesarean section(s).

Table 5 reveals that twenty six (87%) of the respondents have had only hospital confinements, compared to four (13%) who have had both home and hospital confinements. This may be attributed to the possibility that the respondents might have had normal deliveries during the time they delivered at home. The second possibility may be the respondents' awareness about the importance of having hospital confinements if they have had previous caesarean section(s).

Table 6 shows the respondents' educational level in relation to their attendance of the prenatal clinic. It shows that all the respondents in the sample had attended the prenatal clinics. It is said that about eighty (80%) of all the University Teaching Hospital maternity patients receive prenatal care.[42]

In view of the above findings, hypothesis number one (1) which states that there is a negative relationship between history of immediate previous caesarean section(s) and their attendance of the prenatal clinics, is rejected.

Table 6 also shows that the respondents with secondary and college education had eight (89%) of the mothers who had made more than seven visits. Their illiterate and semi-illiterate counterparts were only four (57%) and four (29%), respectively, who made more than seven visits to the prenatal clinics. One illiterate expectant mother registered during the third trimester and made that the only visit to the prenatal clinic. Mhango, Rochat and Arkutu classify such expectant mothers as having been 'unbooked'. They regard a mother as having been booked if they make at least two prenatal care visits to the health facility, before delivery.[43]

The difference between the attendance of the prenatal clinics by the educated expectant mothers and that of the illiterate and semi-illiterates, may indicate that the educated respondents appreciate the role the

prenatal clinics play in ensuring a safe delivery to a live, mature and healthy infant at the end of pregnancy.

In view of the findings revealed in this study concerning the relationship of education and the attendance of the prenatal clinics, hypothesis number two (2) which states that educated expectant mothers attend the prenatal clinics more than the illiterate and the semi-illiterate counterparts, is accepted.

Table 7 shows the location of the prenatal clinics the respondents attended. Fourteen (47%) attended the clinics at the Lusaka Urban health centres and the U.T.H., seven (23%) utilised the clinic at the U.T.H., three (10%) attended the rural and U.T.H. clinics and six (21%) utilized the ones at the urban and rural health centres. The high number of the respondents who sought prenatal care at the Lusaka urban health centres may be due to a high number of respondents who came from the Lusaka urban (Tables 7 and 12).

Two (7%) expectant mothers had registered for prenatal care by the 12th week, seventeen (57%) by the 24th week, twenty six (87%) by the 28th week and thirty (100%) by the 36th week of gestation. Goldberg and Graig in their study conducted in Cape Town, established

that 69.5% of the expectant mothers had booked for prenatal care when they were between twenty and twenty eight (28) weeks of gestation.[44] Therefore the observations in the two studies are similar. The respondents' compliance in seeking prenatal care early, might have been dictated by the immediate previous caesarean section(s) they had. This is confirmed by Pearson's findings in his study conducted in Midglamorgan, Britain, in which he observed that expectant mothers with poor obstetric history or medical disorders, such as diabetes mellitus, referred themselves promtly for prenatal and intranatal care.[45]

Tables 9A and 9B show the type of advice and the rationale for the type of advice given to the respondents during their prenatal period. Eleven (37%) respondents were advised to seek medical care after commencement of labour, six (20%) were advised to undergo caesarean section and sterilisation and five (17%) were told to undergo elective caesarean section. No advice was given to one (3%) mother (Table 9A).

The rationale for the advice given were as follows: Previous caesarean section was the reason given to fifteen (50%) respondents, prevention of rupture of the uterus was the reason given to five (17%), and cephalo-pelvic disproportion with previous caesarean section was the reason given to four (13%) respondents (Table 9B).

The advice which was given to the respondents, to report for hospital confinement when they are in labour may explain the mothers' tendency to seek medical care late after commencement of labour. This explains why twenty three (77%) respondents thought that the appropriate period for seeking medical care when one has a history of immediate previous caesarean section(s) is after the commencement of labour (Table 10). This may further explain why some mothers with a history of immediate previous caesarean section(s), especially if they come from distant homes, may appear in a moribund state at the time of their admission to the hospital labour wards. The moribund state of the patient, may be as a result of hypovolaemic shock arising as a result of rupture of the uterus. No expectant mother was advised to report to hospital for trial of labour.

As a result of the findings outlined above, hypothesis number three (3) which says that lack of explanation given to the expectant mothers with the history of immediate caesarean section(s) on the possibility of undergoing trial of labour prevents mothers from reporting early for medical care, is accepted.

Thirteen (43%) respondents sought medical care because they were in well established labour, and five (17%) and two (7%) reported for hospital confinement because

they were expected to undergo elective caesarean section, and caesarean section with sterilisation, respectively. One (3%) of the respondents had prolapse of the fetal cord which resulted in intra-uterine death, while she was at home. She had a macerated stillbirth in hospital, four (4) days after the cord had prolapsed. The reason for seeking medical care by thirteen (43%) mothers, after labour had started, may be attributed to the advice given to eleven (37%) mothers during their prenatal period. This finding, therefore, calls for the need to encourage mothers who have a history of immediate previous caesarean section(s) to seek medical care before labour commences. This can give the obstetric team ample time to plan the mothers' mode of delivery in order to ensure a safe child delivery.

Table 12 shows that nineteen (63%) respondents live in Lusaka urban where the University Teaching Hospital is situated. One would think that it would be easy for such mothers to seek medical care early since they are within easy travelling distance. One mother who reported late, through the urban health centre, did not have the stage of labour assessed, at the time of admission because she had per vaginal bleeding. However, she had a normal delivery three hours after her admission to the U.T.H. This brings the total

number of the mothers living in Lusaka who reported late for medical care to eight (42%). Only four (36%) mothers reported late from their homes outside Lusaka urban. Two (7%) respondents who had no theatre facilities at their nearest District Hospitals (in Eastern and Southern Provinces), lodged at their relatives' homes in Lusaka, while awaiting commencement of labour. This means that mothers living in rural areas are also aware of the importance of seeking medical care early. Despite the fewer number of respondents who sought medical care late from their homes which are outside Lusaka urban, one (3%) mother had ruptured uterus while at her village in Siavonga. The second respondent who came from Kafue, was found to have developed a ruptured uterus. This was identified during caesarean section which was performed at U.T.H. The duration of the rupture could not be established.

The findings outlined above lead to rejection of hypothesis number four (4) which states that expectant mothers with the history of immediate previous caesarean section(s) who live in distant homes from hospital, report late for hospital confinement.

Nine (64%) of the fourteen (100%) grande-multiparous mothers sought medical care with less than one (1) centimetre cervical os dilatation, in comparison to eight (50%) mothers with low parity (Table 13). This

means that grande-multiparous women sought medical care earlier than the low parity mothers. The findings outlined above contradict Hall's statement which says that "Many studies have shown that the high parity expectant mothers are more likely to appear late for prenatal care and default appointments until labour commences".[46] The findings of this study illustrate that the grande-multiparous women seek medical care earlier than the women with low parity when in labour There is need to educate women with low parity to utilise the hospital for delivery, so that their health and that of their fetuses, can be monitored through out the intrapartum period. In view of the findings in this study, the researcher rejects hypothesis five (5) which states that grande-multiparous expectant mothers seek medical care late.

Twelve (40%) of the respondents sought medical care late after labour had become well established (Table 14). There were four factors that led to delay in seeking medical care by the twelve (12) respondents in this study. Six (50%) of the respondents mentioned above were not told the specific time they were expected to report to the U.T.H. for delivery. Three (25%) of the respondents had fear of repeat caesarean section. Two (17%) sought medical care late because one (8%) lacked transport, and the other one (8%) had none to leave her children with, before labour

started. One (8%) respondent was initially admitted to the urban health centre, during the first stage of labour, got referred to the U.T.H. because she was bleeding per vaginum.

In Square's study, on the factors contributing to the patients' negative attitudes towards surgery at Kabwe General Hospital in Zambia, she established that patients had fear of dying, fear of being maimed and fear of the wrong operation being performed on them.[47] The respondents who were afraid of the repeat caesarean section would have been reassured if they had an explanation about their obstetric condition, the possible mode of delivery and the expected outcome of the mode of delivery they were expected to undergo.

The number of the respondents who sought medical care late was less than those who reported late (as shown in Table 14) because of the likelihood that those who were admitted through the prenatal clinic, would have also reported late. This calls for intensified health education of the expectant mothers with immediate previous caesarean section, on the importance of seeking medical care before labour commences.

There is also need for the maternity service team to give clearly stated instructions to the expectant mothers who have a history of immediate previous caesarean section(s).

Despite the reduced number of respondents who reported for elective caesarean esection (Table 11), fifteen (50%) had emergency caesarean section, twelve (40%) had elective caesarean section and only three (10%) had normal deliveries. The respondents who were admitted with well established labour, those admitted through the prenatal clinic at U.T.H., those who were draining and the one with ruptured uterus at the time of admission, may account for the increase in the number of respondents who undergent emergency caesarean section (Tables 11 and 15).

Three (10%) of the respondents, who were illiterates, sought medical care late, and exposed themselves to obstetrical complications. One out of the three respondents, attended the prenatal clinic once at Siavonga, was brought to hospital in advanced stage of labour in hypovolaemic shock, after she had developed a ruptured uterus and bladder, and intra-uterine fetal death.

She developed a vesico-vaginal fistula after undergoing a sub-total hysterectomy with bilateral salpingo-oophorectomy and repair of the bladder. The second respondent who came from Lusaka rural, had a ruptured uterus, but she was fortunate in that she had a live birth. The third (10%) respondent had a maderated stillbirth four (4) days following cord prolapse which had occurred while at her home in Lusaka urban

(Tables 16 and 17). None of the two mothers, as shown in table 18, knew what they could have done to prevent the complications they developed.

Kelsey made the same observation that women who were illiterates and lived in rural areas in Nigeria, had obstetrical complications like intra-uterine death, uterine rupture, recurrence of vesio-vaginal fistula, embrotomy, maternal and perinatal deaths.[48]

The above findings show that in addition to the expectant mothers' attendance of the prenatal clinics, they should have total acceptance of modern obstetric care in order to have compliance to early hospilisation by mothers with immediate previous caesarean section(s).

Table 19 shows the respondents' views on maternity services being offered at the health institutions in Lusaka. Four (40%) out of the ten (100%) respondents were pleased with the hospitality they received when they they came for this last delivery. They commended the hospital staff for this. Two (20%) of the respondents showed appreciation for having had undergone sterilisation after this last caesarean section. However, four (40%) of the respondents had negative views which were as follows:-

1. One (10%) of the respondents was unhappy because the doctor did not sterilize her because she was

twenty six (26) years of age; despite the written consent that she and her husband had given the U.T.H. authorities. This mother had an elective caesarean section making it a third caesarean section. She had four live children, including the baby delivered during this last confinement. This confusion would have been avoided if only the doctor had explained to this mother that it was too premature to perform sterilisation on her because she was still young. This explanation would have been given before the respondent and her husband were asked to give written consent for sterilisation.

2. The second respondent did not know where her baby was being nursed. This was on the third day post operatively.

3. The third respondent was misinformed at the Lusaka Urban Health Centre, that she had a multiple pregnancy. This mother said that she has developed mistrust in the health personnel at that health centre because she had overspent by preparing the baby layette for two babies.

4. The fourth respondent had made the following observations:

(a) The shortage of midwives especially during the night makes it difficult for the midwives

to give good care to the helpless babies and to the mothers.

(b) New-born babies are wrapped in filthy hospital linen. She said that this situation had prompted her to bring linen for her baby.

(c) She has on several occassions observed that nurses give quick attention to the expectant mother whom they know. She cited an example of an instance when she found a very long queue at the labour ward, where she was attended to promptly because nurses recognized her. She suggested that nurses should attend to patients on first come, first served basis, unless the new patient is in need of immediate intervention.

(d) She has observed that the private patients are given care within the U.T.H. setting. She added that these patients are given better care because they pay for the services rendered to them. She wondered why such medical personnel cannot go into private practice instead of using the government time, equipment and supplies for their own benefit.

The above outlined negative observations may act as barriers to respondents' early entry into the hospital delivery rooms, during their subsequent pregnancies. Salker states, "Entry into the medical care system

can be inhibited by a multitude of factors including financial barriers, physical availability of resources, limited provider hours, long waiting hours at places of service, and attitudinal barriers."[49] Raynal made a similar observation.[50] The maternity service health care team should, therefore, ensure that every expectant mother, and the labouring and postnatal mothers should be given free maternity care regardless of their race, creed or tribe.

The findings of the study show that eighteen (60%) of the respondents sought medical care early, whereas twelve (40%) reported late. Factors identified in the study, which contributed to delay in seeking medical care by the expectant mothers who had immediate previous caesarean section were lack of knowledge as to when they were expected to report for admission, fear of repeat caesarean section, lack of transport and absence of a person who would have kept the respondents' children.

2. NURSING IMPLICATIONS

For many years the health services in this country have been curative oriented, so much that even with today's trend of putting more emphasis on preventive service, most people still attach more value to curative services, than preventive services. Prenatal services, especially for the mothers who have a history of immediate caesarean section, do not seem to have much value attached to them.

Even if mothers who have obbtetric complications like previous caesarean section seek prenatal care at the clinics, they are given inadequate information regarding when they are expected to report for hospital confinement. This has resulted in mothers, including those who have attended the prenatal clinic, seeking medical care late. This problem demands that health workers determine new ways and means of attracting expectant mothers with a history of immediate previous caesarean section, to seek medical care early before commencement of labour. The community health nurses and midwives should teach mothers and the other people in the community, on the importance of early registration at the prenatal clinics and labour wards.

The health workers, through team work, should involve the community in making the expectant mothers, accept the maternity services being offered in the health institutions throughout the Republic of Zambia.

There is also need for health personnel to be taught or oriented on good human relations so as to equip them with better skills on the proper ways of handling people, in order to win their confidence. This would in turn change the expectant mothers' attitude towards seeking medical care early.

Periodic studies should be conducted on the effectiveness of the maternity services being provided especially

for the expectant mothers with immediate previous caesarean section, so as to identify problems and ways of how to go about solving or minimizing them. The studies are required for continuing development and improvement of nursing practice, nursing education and nursing administration.

3. CONCLUSION

A lot of valuable information was gathered from this study. Some of the findings were that most of the women who sought medical care late were Lusaka urban residents, mothers of low parity and who were illiterate. The study also revealed that all mothers had prenatal care, and that the woman who had ruptured uterus and bladder with intra-uterine death attended the prenatal clinic once during the third trimester.

The findings also revealed that most of the mothers had lack of knowledge on the specific time when they were expected to report for delivery, some had fear of a repeat caesarean section, one had no transport and the other one lacked a reliable person to keep her children during the period she was expected to have been hospitalized. Some respondents commended the hospital personnel for the nice hospitality they were accorded during their hospitalisation, although some were disappointed with the standard of maternity

services being provided to clients at the Lusaka urban health centres and the University Teaching Hospital.

4. RECOMMENDATIONS

1. There is need to intensify health education on the importance of seeking medical care early by the mothers with immediate previous caesarean section. This should be done at hospital level, as well as at health centre, and community levels. Community leaders should take an active role in this.
2. The health personnel should periodically undergo inservice orientation programmes, especailly on the need for giving clearly stated specific advice to the expectant mothers, so that the expectant mothers with obstetric complications, can know when to seek medical care.
3. Mobile prenatal services to be provided for expectant mothers who live far away from the health centres which provide prenatal care.
4. There is need for the government to build maternity waiting hostels where the expectant mothers coming from distant places and those with a history of immediate previous caesarean section(s) can be made to wait, until they go in labour. This can greatly cut down on the problem of hospital accommodation which prevents the admission of these mothers before labour commences.

5. There is need to educate the Lusaka community on the importance of having only the primigravida, grande-multiparous women and those with ostetrical problems seeking hospital obstetrical caré. The non-risk expectant mothers should be advised to deliver at their nearest maternity health centre.

6. A similar study should be conducted on a larger scale so that the results can be generalised.

5. LIMITATIONS OF THE STUDY

1. Lack of literature in Zambia on the factors contributing to delay in seeking medical care by expectant mothers with a history of immediate caesarean section.
2. The time in which the study had to be submitted to the Department of Post-Basic Nursing, was too short.
3. The pilot study was not done due to limited time.
4. The sample was too small, so generlization of the findings beyond the sample, could not be made.

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APPENDIX 1

Department of Post Basic Nursing
School of Medicine,
University of Zambia,
P. O. Box 50110,
LUSAKA

23rd February, 1988

The Principal Nursing Officer,
University Teaching Hospital,
P. O. Box 50001,
LUSAKA

Dear Madam,

RE: RESEARCH PROJECT

I am a fourth year student in the Department of Post-Basic Nuring and I am pursuing my studies in the Bachelor of Science Programme.

I am required to conduct a Research Project in the area of my choice in partial fulfilment of the course requirements. My study is on "The Contributing Factors to Delay in Seeking Medical Care when in labour by the Expectant Mothers with Immediate Previous Caesarean Section."

I hereby, therefore, ask for your permission to allow me to collect data by interviewing all the postnatal mothers in the Postnatal Wards at the Department of Gynaecology and Obstetrics. The duration of the research will be from 1st March to 30th June 1988.

Thanking you in anticipation of a favourable response.

Yours faithfully,

Dorothy Mushili Chikampa (Mrs)

c.c. The Head,
Department of Obstetrics & Gynaecology
University Teaching Hospital, Lusaka.

c.c. The Departmental Nursing Officer
Department of Obstetrics & Gynaecology - B-Block
University Teaching Hospital, Lusaka.

c.c. The Head,
Department of Post-Basic Nursing,
School of Medicine
UNZA.

APPENDIX 2

University Teaching Hospital
Private Bag RW 1
LUSAKA, ZAMBIA

OFFICE OF THE PRINCIPAL NURSING OFFICER

Our Ref: UTHB/PNO/05/01

Your Ref:

1st March, 1988

Ms. Dorothy Mushili Chikampa
Department of Post Basic Nursing
School of Medicine
University of Zambia
P. O. Box 50110
LUSAKA

Dear Mrs Chikampa,

RE: RESEARCH PROJECT ON MOTHERS WITH PREVIOUS CAESARIAN SECTION

I am in receipt of your correspondence of 23rd February, 1988 in which you requested for permission to collect data by interviewing the above mentioned group of mothers in our maternity department from 1st March, 1988 to 30th June, 1988. The Acting Executive Director and us have no objection but would very much appreciate if you can also liase with the Medical and Nursing Heads of Obstetric Department, in order for them to be aware of your presence and even assist you in certain areas of doubt.

Wishing you all the success in your undertaking.

Yours sincerely,

M.S. Ng'ambi (Mrs)
DEPUTY PRINCIPAL NURSING OFFICER

c.c. The Head - Department of Post Basic Nursing - UNZA

c.c. The Head - Department of Obstetrics and Gynae

c.c. Department Nursing Officer - Obstetrics and Gynaecology

wam/al

APPENDIX 3

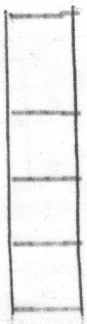
SEMI-STRUCTURED INTERVIEW SCHEDULE

STUDY SUBJECT NO: _____ CODE

1. Where do you live? 2-6

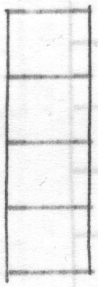
(Interviewer will classify)

1. Low residential area
2. Medium residential area
3. High residential area
4. Other; specify:_____



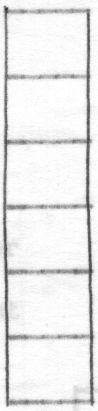
2 What is your age? 7-12

1. 15 -19 years
2. 20 - 24 years
3. 25 - 29 years
4. 30 - 34 years
5. 35 years and above



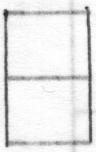
3. What educational level did you complete? 13-17

1. Grades 1 - 7
2. Grades 8 - 10
3. Grades 11 - 12
4. College
5. University
6. Other specify _____



4. What is your occupation? 18-23

1. Housewife
2. Teacher



CODE

3. Nurse
4. Self employed
5. Other specify;

5. What is your tribe?

_____ 24-37

6. What is your denomination? 38-41

_____

7. What is your marital status? 42-46

1. Single
2. Married
3. Separated
4. Divorced
5. Widowed

8. Howmmay pregnancies have you had including this last one: 47-54

_____

9 What was the type of delivery you had for the last pregnancies, excluding this last one? 55-56

1. All normal deliveries
2. Forceps/vacuum deliveris and caesarean sections
3. Normal delivery and caesarean section

10 How many pregnancies were delivered: 57-58

1. In hospital and at home?

CODE

2. In hospital? [ ] 2

11. Did you attend the prenatal clinic during this last pregnancy? 59-60 [ ]

1. Yes [ ] 1
2. No [ ] 2

12 If Yes to question 11, did you attend the clinic at: 61-65 [ ]

1. Urban Health Centre? [ ] 1
2. Rural Health Centre [ ] 2
3. Hospital [ ] 3
4. Rural Health Centre and Hospital [ ] 4
5. Urban Health Centre and Hospital [ ] 5

13. When did the aprenatal visits begin? 66-70 [ ]

1. 16 - 20 weeks [ ] 1
2. 21 - 25 weeks [ ] 2
3. 26 - 30 weeks [ ] 3
4. 31 - 35 weeks [ ] 4
5. 36 - 40 weeks [ ] 5

14. How many visits did you make to the prenatal clinic with this last pregnancy? 71-83 [ ]

_____

CODE

15. What advice related to this last pregnancy were you given and what was the reason for it?

84-92

Advice: _____

_____

Reason: _____

93-100

_____

16. What time during this last pregnancy did you think was appropriate for your admission for delivery?

101-105

1. Before labour commenced (after 36 weeks gestational period) 1

2. After commencement of labour 2

17. Where did you come from when you came for this last delivery?

106-108

_____

18 What prompted you to come at that time to seek medical care?

109-117

_____

_____

19. At which stage of labour (dilatation of the cervical os) were you when you came for this last delivery:

118-125

_____

20 For how long were you in hospital before you delivered?

126-137

_____

CODE

21. What was the method of delivery that you had for this last pregnancy? 138-14

_____

22. What problems did you develop as a result of this last labour? 141-14

_____

23. What was the condition of your baby at its delivery? 146-14

_____

24. Do you think the problems you and or your baby developed could have been prevented? 149

1. Yes _____ 1

2. No _____ 2

25. If the answer to question 24 if yes, what could you have done to prevent the problems you and your baby developed?

_____ 150

26. Is there anything you would like to share with me concerning the maternity services provided for you at this hospital and the other health centres you attended during this last pregnancy? 151-16

_____

_____

THANK YOU FOR YOUR PARTICIPATION

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