COMPLIANCE TO COUNSELLING SERVICES BY PREGNANT WOMEN DURING ANTENATAL IN SELECTED GOVERNMENT CLINICS IN LUSAKA, ZAMBIA

BY

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LUSAKA

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DECLARATION

I, Chiiya Linda, do declare that this is my own piece of work and that the work of other person (s) in this dissertation has been acknowledged. To the best of my knowledge, this piece of work has not been presented at university of Zambia or at any other higher institutions of learning for similar purposes.

Signature Date

…….. ……

APPROVAL

This dissertation by Chiiya Linda is approved as a partial fulfilment of the requirement for the requirements for the award of Master of Science in Counselling of the University of Zambia.

Signed…….. Date…….

DEDICATION

To all the lovely people that have made an impact in my life, particularly my father and friends.

To my husband Steve Namooya, my sons Steve and Smith and my daughter Mary I am invaluably indebted to all for the support and encouragement.

LIST OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
FP	Family planning
GDP	Gross domestic product
HIV	Human immunodeficiency virus
MCH	Mother and child health
MDG	Millennium development goal
MOH	Ministry of Health
PMTCT	Prevention from mother to child transmission
STD	Sexually transmitted diseases
STI	Sexually transmitted infections
TB	Tuberculosis
UN	United Nations
UTH	University Teaching Hospital
UNDP	United Nations Development Program
VCT	Voluntary counselling and testing
WHO	World Health Organization

ABSTRACT

The aim of the study was to assess the levels of compliance to counselling services among pregnant women during antenatal in selected clinics of Lusaka, Zambia.

The study was guided by the following objectives to: investigate the compliance to counselling services by pregnant women during antenatal in selected clinics in Lusaka, Zambia; establish whether the counselling health education mothers receive from antenatal clinic increases their health seeking behavior in both prenatal and maternal health states; find out if the counselling health education in antenatal clinics teaches mothers on infant feeding practices and Mother-Child transmission of HIV; and establish if the counselling services received during the antenatal visits are adhered to by the pregnant women.

Data was collected using a combination of quantitative and qualitative methodologies. The tools that were used for data collection were questionnaires. Data was collected from antenatal care clients, antenatal care providers and women who were in their first to fourth trimester.

The target population was that of pregnant mothers visiting antenatal clinics at Kabwata clinics. Thus, antenatal mothers were interviewed; mothers who have visited the antenatal clinics for more than two times are the ones who was included in the study.

The conclusions of the study were that; the intervention measures in place to improve women access and utilization of antenatal care services mainly address the supply side and ignore the demand side which makes the whole process fail to improve the situation on ground.

The study recommended that, to improve the level of antenatal care utilization in Lusaka, there is need to train health workers on service delivery, community sensitization on the values of antenatal care, reduction on hospital/clinic charges, equipping and stocking of enough drugs.

ACKNOWLEDGEMENTS

Compiling this work has not been an easy work: it has been a work of combined efforts from a number of individuals and institutions. Special thanks is given to the lord for his strength and blessings he gave me to pursue and reach this far in my life. I acknowledge the invaluable assistance rendered to me by Dr. Daniel Ndhlovu my supervisor for his, patience, academic and professional advice that facilitated the completion of this study. Heartfelt gratitude to all my lecturers, classmates and people I interacted with during the study.

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CHAPTER ONE

INTRODUCTION

1.0 Overview

This chapter contains introductory concepts that will show the importance of carrying out a study on the stated topic. The following are the subtitles contained in this chapter: background to the study; statement of the problem; purpose of the study; study questions; significance of the study; limitations of the study and definitions of term used in this study.

1.1 Background

Globally, all clinics and hospitals in all the countries have evolved and been mandated to provide Health education counselling in both prenatal, neonatal and antenatal stages of pregnant women. Clinics and hospitals are essentially there to provide a systematic medical supervision including examination and advice to a pregnant woman with the aim to ensure that every wanted pregnancy culminates in the delivery of a healthy baby without impairing the health of the mother. Ideally this care should begin soon after conception and continue throughout the pregnancy and after pregnancy (Rathore, 1993). In the quest to combat infant mortality rate among pregnant women, most of the counselling have been directed at addressing the predicaments of antenatal health care.

Counselling began as a social service in Paris in 1788 for women who were both pregnant and destitute. In 1901, Ballentyne expressed concern for malformed babies and still births. He was of the opinion that such mishaps could be prevented by instituting good antenatal care. He was a great visionary and his point has been proved beyond doubt with the development of fetal medicine. Thus began the medical and scientific interest in antenatal care health education leading subsequently to organized antenatal care in Europe and USA.

Antenatal care has been routinely practiced throughout the world since early in the 20th Century. It refers to pregnancy related health care provided by a doctor or a health worker in a health facility or home (Srilatha et al., 2002). Antenatal care-related expectations of pregnant women fall into four main categories: the wish to be provided with enough information, emotional support, general support in relation with representation of their interests, and the wish to be provided with professional care (Douglas et al., 2007).

Antenatal care (antenatal care) is the care that a woman receives throughout her pregnancy and some week post-partum. The rationale for providing antenatal care is to screen predominantly

healthy pregnant women to detect early signs of, or risk factors for, abnormal conditions or disease and to follow this detection with effective and timely intervention (Lumbiganon et al., 2004). Good antenatal care does more than just deal with the complications of pregnancy. It provides an opportunity to establish a birth plan (WHO, 2002), promotes a healthy lifestyle that improves long-term health outcomes for the woman, her unborn child and possibly her family (Glasier et al., 1996). Good antenatal care also informs women and their families about the possibility of unexpected events, how to deal with them and seek help when appropriate (Whitford & Hillan, 1998; Pasinlioglu, 2004).

Women and their families can also learn how to improve their health, and equally importantly, how to take care of the new-born child (Pasinlioglu, 2004). In that way, antenatal care also contributes to improving the care and health of new-borns and children in the future (Zuniga de Nuncio et al., 2003). In short, antenatal care helps to build a healthy family environment that is responsive to the mother's and the child's needs.

Antenatal care, in theory, should reduce maternal and perinatal morbidity and mortality directly through the detection and treatment of pregnancy-related illness or indirectly through the detection of women at increased risk of complications of delivery (Carroli et al., 2001). Effective and appropriate antenatal care should be offered to all pregnant women. However, what is considered "routine antenatal care" varies from country to country. Some interventions still provided to women with normal pregnancies have not been proved effective, and many of them have not been evaluated (HEN, 2006). The traditional approach to antenatal care, which was based on European models developed in the early 1900s, assumed that frequent visits were important when caring for pregnant women. Many low-income countries have adopted the traditional approach without adjusting the intervention to meet the particular needs of their population, without taking into account their country's available resources, and without evaluating the scientific basis for specific practices (Villar et al., 1997). In 1996, the World Health Organisation (WHO) launched a randomised trial in Argentina, Cuba, Saudi Arabia and Thailand on antenatal care, focusing on providing effective care through fewer but goal-oriented visits. The new focussed antenatal care had no negative effects on the maternal and perinatal outcomes and it could be implemented without major resistance from women and providers and could reduce cost (Villar et al., 2001). The new model has come to be known as the "four-visit or focussed antenatal care model", ideally having the first visit when the pregnancy is less than 16 weeks, then at 26 weeks, 32 weeks and 36 weeks. The major goal is to help women maintain normal pregnancy through the following practices: identification of

pre-existing health conditions, early detection of complications arising during the pregnancy, health promotion and disease prevention and birth preparedness and complication readiness planning (WHO, 2002). Antenatal care is also a platform for other programs that improve public health, such as prevention and intervention of HIV/AIDS, sexually transmitted infections (STI) and tuberculosis (TB).

This approach will strengthen the link between women and health services during and after childbirth and may promote breastfeeding and a healthy lifestyle (WHO, 2005). The proportion of women visiting a health facility at least four times during pregnancy is used as an indicator to monitor progress towards achievement of the Millennium Development Goal (MDG) number five.

Quality of Antenatal Health Counselling is an important determinant of pregnancy outcome and has been designated as one of the four Pillars of Safe Motherhood, along with clean and safe delivery, essential obstetric care and family planning which could contribute to reduction of maternal mortality. Poor antenatal care is considered the second most important preventable factor in maternal mortality after substandard obstetric care (Campbell et al., 2005).

The aim of the antenatal counselling is patient satisfaction. Patient satisfaction with quality of care is the degree to which the patient's desired expectations, goals and or preferences are met by the health care provider and or service. Satisfaction and dissatisfaction indicate patients' judgment about the strengths and weaknesses, respectively, of the service. Also women perception with care often determines clients' willingness to comply and continue with the service. Some studies have reported women satisfaction with antenatal care (Dyah and Rizal, 2002), specifically in these studies women were satisfied with the care received, interpersonal relationship and the infrastructures for providing the care.

Antenatal care counselling coverage is a success story in Africa, since over two-thirds of pregnant women have at least one Antenatal Care contact. However, to achieve the full life-saving potential antenatal care promises for women and babies, four visits providing essential evidence based interventions, a package often called focused antenatal care is required (World Health Organization, 2005). Antenatal services comprise complete health supervision of the pregnant women in order to maintain, protect and promote health and wellbeing of the mother and the foetus. These services are rendered to a pregnant woman at monthly intervals, up to 28 weeks of gestation, then fortnightly until 36 weeks and finally weekly visit until the birth of the baby.

Similarly, Adesokan (2010) describes antenatal counselling services as the attention, education, supervision and treatment given to the pregnant women from the time conception is confirmed until the beginning of labour, in order to ensure safe pregnancy, labour and puerperium. Qualitative antenatal services are care given to pregnant women by a skilled or trained health provider to promote the health and survival of mother and child (Adesokan, 2010).

Conventionally, antenatal care for pregnant women provides opportunities for health education and counselling on many pregnancy-related topics including HIV and prevention of mother to child transmission. This is also an opportune time to offer HIV testing within the health facility allowing pregnant women and even couples to know their HIV status. It serves as an entry point into prevention of mother to child transmission services and to establish connections into the antiretroviral programmes. However, the acceptance of prevention of mother to child transmission services varies from place to place, with differing levels of awareness amongst pregnant women regarding AIDS and HIV transmission and prevention amongst pregnant women.

Voluntary Counselling (VCT) has proven to be feasible and acceptable in antenatal clinics throughout Africa and the strides made in increasing the availability of prevention of mother to child transmission to pregnant women are encouraging. However, VCT for partners, a critical component in the prevention of HIV in both mother and child, is not as readily available and remains a missing link. VCT has been shown to reduce HIV risk among couples, and partner participation has been suggested as a potential factor to leverage prevention of mother to child transmission programmes. Given that the majority of antenatal patients have partners, offering CVCT at antenatal clinics, along with providing prevention of mother to child transmission services to the HIV-positive women, could be a solution. The combination of the two interventions would mutually reinforce prevention of horizontal and vertical transmission. Compliance to antenatal counselling services by pregnant women is therefore necessary antenatal however it is not known if the pregnant women comply to the counselling services.

1.2 Statement of the Problem

Although health education dates back as far as independence, improvements in prenatal and maternal counselling practices have not been substantial. Evidence shows that only 35% of mothers in Zambia exclusively breastfeed their babies for the first two months of life. While infant and under five mortality rates are still very high (70 and 119 respectively) as of the 2007

ZDHS. It has however been observed that diseases that contribute to such high rates are preventable. E.g. malaria, diarrheal diseases, malnutrition and respiratory tract infections. Amongst these the last three are mainly preventable with successful breastfeeding. Diarrhoeal diseases and acute respiratory infections contribute to 30% of infant deaths while malnutrition is responsible for 40% of paediatrics death in Zambia (National Food and Nutrition commission 1998). A study at UTH in the paediatrics section showed that of the children who are admitted for malnutrition 32% were readmitted for the 2nd time and 8% for the 3rd time (1985). The question is therefore, to what extent do pregnant women comply to the antenatal counselling services that they receive?

1.3 Purpose of the study

The aim of this study was to explore compliance to counselling services by pregnant women during antenatal in selected clinics in Lusaka, Zambia.

1.4 Objectives of the study

1.4.1 General Objective

Was to investigate the compliance to counselling services by pregnant women during antenatal in selected clinics in Lusaka, Zambia.

1.4.2 Specific Objectives

1. Establish the extent to which pregnant women comply to counselling services received during antenatal.
2. Determine how traditional beliefs, influence pregnant women during antenatal clinic.
3. Assess how counselling health education received by pregnant women increases their seeking behaviour.

1.5 Research Questions

1. To what extent do pregnant women adhere to counselling services received during antenatal?

2. Do traditional beliefs influence antenatal practices?

3. Does counselling health education received by pregnant women, increase their health seeking behaviour?

1.6 Significance of the study

At a time when the extent of the compliance to antenatal counselling services by pregnant women in the selected clinics was not known the result of this study may be significant. It was hoped that the results of this study may help to understand the extent to which expecting mothers comply to counselling services they receive. In addition, it may be known how traditional beliefs influence prenatal and maternal practices in the expecting mothers.

1.7 Delimitation and Limitations

The study was conducted at kabwata and chilenje clinics. The clinics were selected purposively due to the population and prominence of counselling services. It was also convenient on the part of the researcher to access the counselling facilities

1.8 Delimitations to the Study

This study was conducted at Kabwata and Chilenje Clinics of Lusaka. Chilenje clinic has been upgraded to a hospital and has a good population of antenatal counselling service providers. Kabwata is also well staffed, enabling the collection of sufficient data.

1.9 Limitations of the Study

The study only focused on two clinics out of the many in Lusaka this situation poses a limitation to generalisation of its findings

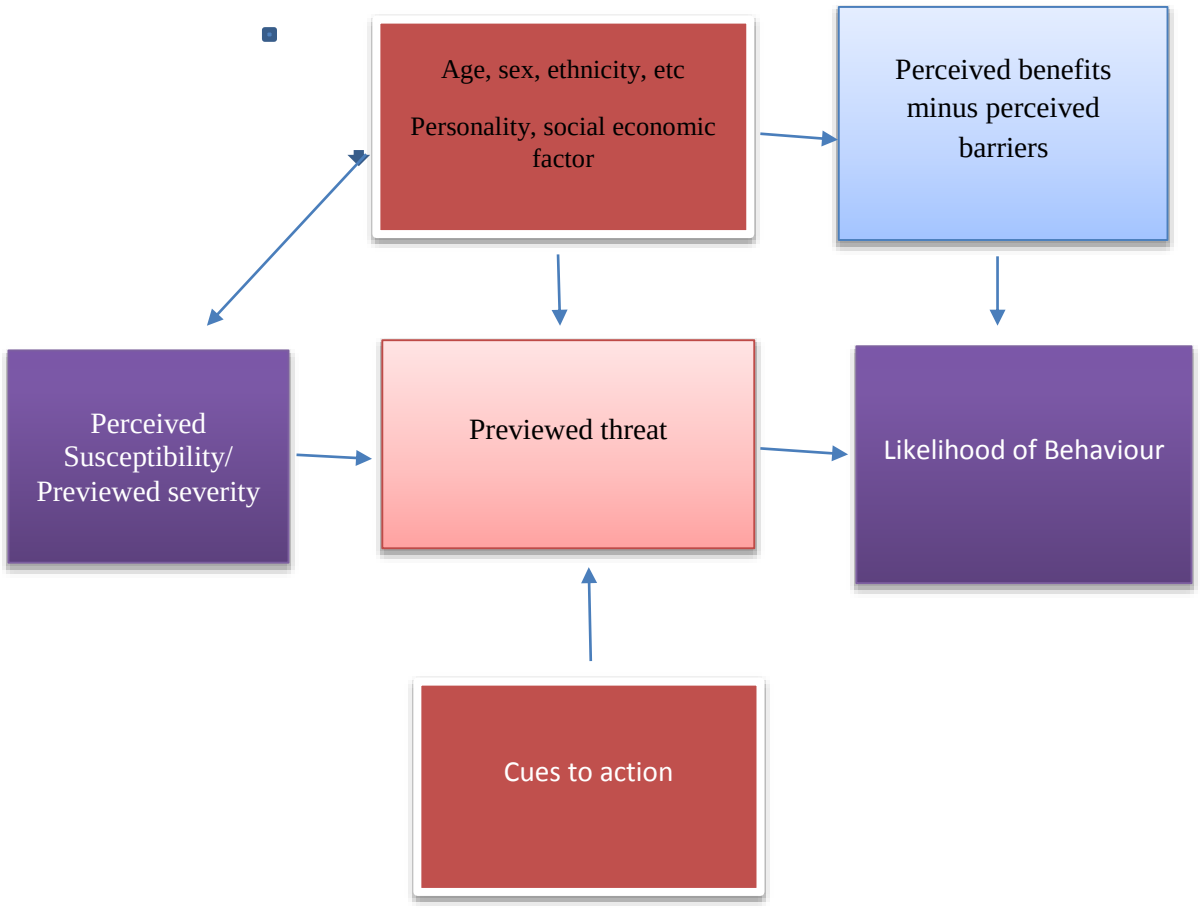
1.9 Conceptual Framework

Conceptual framework refers to a set of concepts that are linked and described by broad generalizations which are formulated by an individual for a purpose (Rosenstock 1974).

This study was based on Health Belief Model, a modification of Becker and Maiman (1974) and Rosenstock (1974). Health Belief Model was adopted in this study to explain the concepts pinned in the study, because quantitative studies need to be based on existing body of knowledge or theory.

Factors influencing the utilization of the antenatal services

Individual Perceptions Modifying Factor likelihood Action



Source: Stretcher, V, &Rosen stock I.M. (1997).The Health Belief Model in Glanz K et al)

The Health belief model emanated from a foundation of cognitive theories of behaviour. Theorists of cognitive belief believe that behaviour is contingent upon; the value that an individual place on a desired outcome, and the belief that behaviour, if performed well, will result in the desired outcome, (Bandura 1977). Furthermore, the model explains that a range of health behaviours can be predicted based on information from determinants such as perceived susceptibility, perceived severity, perceived benefits/barriers and modifying factors associated with engaging in a behaviour. The application of the model in this study has been outlined in subsequent paragraphs below, illustrating the inability of pregnant women with labor complications to access available health facilities when need arises. This is due to lack of inadequate community support, timely means of transport or resources to pay for it, long

distances poor roads and communication while poverty at household level also limits decision making to seek health care. The model indicates that Initial access /personal factors, awareness and acceptance of pregnancy can affect utilization of Anti-natal thus the ability of rural women to first identify and then accept their pregnancy. Young women are likely to delay Anti-natal counselling until late in second trimester because they are not aware of the typically indicators of pregnancy. The recognition of unplanned pregnancy can be devastating, fears relating to parental and partner disapproval and concerns about being stigmatized by peer group members can lead to delaying accessing Antenatal counselling services.

In instances where pregnancy is recognized accepted and wanted there may still be reluctance to seek counselling services if there is no belief that it might be beneficial. In addition, some cultural practices restrict women from seeking health care, reliance on traditional and cultural beliefs among some women who seek advice and support from community elders than health professionals. Initial and sustaining access may lead to delayed and failure to seek Anti-natal counselling services. Social factors personal costs incurred by travelling to and from the health facility may put a strain on the limited resources of women from rural areas. This may diminish the potential of women to access Anti-natal counselling early and regularly. Need to value women‘s time. Some women find themselves frustrated by the time they spend at the health facilities waiting for consultation. In many cases this has detrimental effects on future visit.

Perceived severity: Perceived severity refers to the subjective evaluation of the likelihood that a problem/ illness or disability, if contracted or left untreated, will have severe consequences such as pain, death, handicap, or reduced quality of life in general, (Backer and Maiman 1977). In the context of this study, willingness of pregnant mother to utilize antenatal counselling services would depend also on personal evaluation of the seriousness of the consequences associated with pregnancy complications for example, death of the foetus.

Perceived benefits/barriers: Individuals choice of behavioural options depends on their perception of benefits and barriers. Therefore, a cost benefit analysis allows an individual to evaluate the outcome expectations and assess whether the expected benefit of a behaviour outweigh the perceived expenditure incurred by engaging in the behaviour, (Rosenstock 1974).

Compliance with recommended health seeking behaviour is impeded to the extent that perceived barriers outweigh perceived benefits that would result from engaging in the health behaviour (Rosenstock 1974). For example, inconveniences such as long waiting time at antenatal clinic, distance to the health facility would act as barriers to utilization of antenatal

care. A pregnant woman would opt not to go to the clinic if she sees no benefit in doing so. Furthermore, health care worker's negative attitude towards focused antenatal care, inadequate resources both material and human, inadequate equipment and supplies, lack of knowledge regarding benefits of Antenatal care would also impede utilization of Antenatal care (Simkhada et al.2008).

Perceived susceptibility: Perceived susceptibility refers to an individual's judgment of their risk of contracting a health problem. The likelihood of seeking health interventions increases as the level of perceived susceptibility increases, (Rosenstock 1974). For instance, pregnant women would be more likely to seek medical attention in this case antenatal services if they believe that they are susceptible of developing pregnancy complications.

Modifying factors: These may include socio-cultural factors as well as demographic aspects such as age, parity, religion, educational status, social values, beliefs and practices of pregnant woman in relation to utilization of antenatal counselling (Chivonivoni et al. 2008).

1.10 Definition of Key Terms

Antenatal Care-Antenatal care is the clinical assessment of mother and foetus during pregnancy, for the purpose of obtaining the best possible outcome for the mother and child.

HIV and AIDS- is a disease caused by a virus called HIV. Both the virus and the disease are often referred to together as HIV and AIDS. People with HIV have what is called HIV infection. As a result, some will then develop AIDS.

Mother-to-Child Transmission- It is possible for an HIV-infected mother to pass the virus directly before or during birth, or through breast milk.

Prevention of mother to child transmission- Refers to a four-pronged strategy for stopping new HIV infections in children and keeping mothers alive and families healthy.

Breastfeeding - The process by which a child has receives breast milk direct from the breast or expressed.

Health education - a process based upon the scientific principle which employs planned learning opportunities to enable individuals, acting separately or collectively, to make and act upon informed decisions about things affecting their health (Simmonds, 1978).

CHAPTER TWO

LITERATURE REVIEW

2.0 Overview

This chapter is a review of the various literature presented by global scholars on the perspective of the title of the study, which is compliance to counselling services by pregnant women during antenatal in selected clinics in Lusaka. This is for the sole purpose of giving clarity to what the research is all about. The literature to be reviewed is particularly linked to the study objectives on this study and order of presentation is as such. The following are the various literature presented in relation to the title of this study.

2.1 Description of antenatal care

Lee et al. (2009) in a study conducted in Taiwan also found that mother in laws and spouse, heavily influence decision about where and whether to go for antenatal care. Engaging men as partners is a critical component of antenatal care, but their involvement has been low and there's hence a need to encourage male participation to promote the uptake of antenatal counselling services by pregnant women. The influence of male involvement on utilization of antenatal care would then be established from qualitative studies which may be designed to investigate the direction of the influence (Mullick et al. 2005).

Counselling helps in the breastfeeding of the infant. Augustine, et al (1994) conducted a retrospective study titled "Early neonatal morbidity and mortality pattern among hospitalized children". The aim of the study was to examine the association between infant feeding modes and mortality among infants admitted to the hospital in the first 7 days of life. The methodological setting was hospital based and its design a retrospective review of medical records of new-borns. The findings were that; exclusive breastfeeding was associated with the lowest rate of mortality of 29% compared with infants not yet fed of 64% or those receiving sugar water or cow's milk with or without breastfeeding represented by 43%. The study has its stronghold in the fact that the importance of having good health knowledge on breastfeeding and it association to infant mortality is stressed.

In a study conducted in Mexico by Coria-Soto et al. (1996), inadequate number of visits was associated with 63 per cent higher risk of intra uterine growth retardation. Similar results were reported in a Bangladeshi study where birth weight was positively correlated with the frequency of visits at antenatal clinics (Ahmed and Das 1992). All these results point to the important role of antenatal care counselling in identifying and mitigating the potential

complications during pregnancy. Moreover, a study conducted in Canada by Heaman et al. (2008) on inadequate prenatal care and association with adverse pregnancy outcome indicated that preterm birth, low birth weight, small-for age gestational and increased mortality rate were associated with inadequate prenatal care. Raatikainen et al. (2007) showed similar findings in a study conducted in Finland, where an increase in low birth weight infants, more fetal deaths, and more neonatal deaths were common among those under attending antenatal care.

There are different reasons which make pregnant women not to comply with the counselling services. One of the reasons is cultural beliefs. Some cultural beliefs have also been found to influence utilization of antenatal care services. The study conducted by Simkhada et al. (2010) in Nepal found that mother in laws negatively influenced utilization of antenatal care education received by their daughter in-laws. In this study Simkhada et al. (2010) found that mother in laws tend to persuade their daughter in laws to fulfil household duties instead of visiting antenatal care.

African Perspective.

In Africa, developing countries still face a challenge of poorly implemented antenatal care programs with irregular clinical visits and long waiting times plus poor feedback to the women. A study in Hadiya zone, Ethiopia found that majority of the mothers who attended antenatal care did not receive adequate number of visits and initiated the visits later than recommended by the World Health Organization.

Countries with good indicators in maternal and infant mortality have pregnancy related complications identified and managed early, however according to UBOS the overall onetime antenatal attendance in Uganda was found at 94% with women in rural areas being twice less likely to attend antenatal care than the urban women.

According to the report only 8% of rural women in Uganda received antenatal care from a doctor. Regionally South West African women were more likely to receive skilled care (20%), than Eastern women (3%), while only 2% of the women in Karamoja were reported to seek the same. It was reported that women in Uganda tend to seek antenatal care very late—37% attending for the first time at 6 months or more.

In another study done in 1999 in the nearby Malawi by Manda titled “Birth intervals, breastfeeding and determinants of childhood mortality in Malawi”. The study aimed to

determine the association between selected variables and infant and child mortality. The setting of the study was a nationwide and a retrospective study design using the 1992 Malawi Demographic and Health Survey data of 4,838 singleton births of 2,911women aged 15-49 years. Results were that children who had never been breastfed or had stopped breastfeeding because of illness theirs or their mothers' were 4.3 times more likely to experience infant mortality than children who continued to breastfeed. Stopping breastfeeding because of weaning or maternal pregnancy during the subject's first 12 months significantly increased infant mortality by a factor of 8.26. Nearly all infants were breastfed during the first year, unless they died or were ill depending on the type of illness. This produces an almost perfect correlation between breastfeeding and child survival, especially during infancy.

In Malawi provision of antenatal care is integrated with under-five clinics, family planning, post-natal care and other reproductive health services. MDHS (2010) demonstrates that 73% of the antenatal care services are provided at primary health facilities which includes health centres, dispensaries, maternity units on daily basis while 27% are provided at secondary and tertiary health delivery levels (district hospitals and central hospitals). The same MDHS Report (2010) indicates that 9% of the pregnant women in Malawi start utilising antenatal care in the first trimester ranging from 4% in Chiradzulu district to 27% in Rumphi district. Ministry of Health report (2007) illustrates that Malawi adopted use of WHO guidelines that recommends use of antenatal care services in 2003. The reports further argue that an average three visits are made per pregnancy against the recommended of at least four visits. In Malawi, the overall implementation of antenatal care is above WHO standards, while, the process of delivery of services in terms of performance is below WHO standards (Lungu et al. 2011).

A similar study done in Nigerian teaching hospital found that Nigerian women tended to obtain care late in pregnancy, and about one third the care was inadequate with almost half (47 percent) of women attending the antenatal care clinic in the third trimester.

Another study done in Ibadan, Nigeria revealed that Women who were Muslims or other religions were more than 2 times likely to attend antenatal care clinic than women who were Christians. The same study showed that Women who were 25 years and older utilized antenatal care more than women who were below 25 years of age which agrees with study made in Bangladesh.

A study done in rural Local Government Area in Ogun State, Nigeria, identified that women preferred TBAs for various reasons which included: cheap easily accessible culturally

acceptable services and more compassionate care than orthodox health workers, and for some it was the only maternity they knew. However, some respondents acknowledged that complications could arise from TBA care.

In many countries, TBAs are an important source of social and cultural support to women during childbirth and due to economic constraints, and the difficulty in posting trained professionals to rural areas; many women continue to deliver with TBAs.

Furthermore, in Zimbabwe Mathole et al. (2004), found that the early period of pregnancy was the most vulnerable to Witchcraft associated fears, which was the reason for pregnant women not attending antenatal care in first trimester. A study conducted in Malawi by Chiwaula (2011) also demonstrated that cultural beliefs negatively influence utilization on antenatal care compliance and attendance of pregnant women's. Health care workers compliance, perception and attitude play a crucial role as regards to utilization of antenatal care. Mathole et al. (2004) explains that poor attitude of health care providers towards pregnant women contributes to low utilization of antenatal care services in Zimbabwe. He further contends that many of these mothers prefer to deliver with unskilled birth attendants in the villages.

The antenatal care Service utilization in Ethiopia was significantly influenced by maternal age, where mothers aged between 25 – 29 years were less likely to utilize antenatal care service than women who were 35 years and older. Positive husband attitude towards antenatal care was also significantly related to antenatal care service utilization.

Mothers' level of education influenced the use of antenatal care for which Mothers with primary educational level were more likely to attend antenatal care than women who are unable to read and write. This study further revealed that availability of women's time is important as women spend more time on their multiple responsibilities for care of children, collecting water or fuel, cooking, cleaning, and trade than on their own health. In Hadiya; Ethiopia, Family size was a strong determinant of antenatal care service utilization with greater household size limiting the use of antenatal care service.

A study done by Simkhada B., *et al.* also included maternal education, husband's education, marital status, availability, cost, household income, women's employment, media exposure and having a history of obstetric complications. But not leaving out Cultural beliefs, Parity and ideas about pregnancy. Whilst women of higher parity tend to use antenatal care less.

A study done rural Uganda revealed antenatal care attendance being irregular with few women appreciating the fact that antenatal care attendance was to monitor both the growth of the baby and the health status of the woman. This study also identified Parity as significantly influencing antenatal care attendance, but level of education, religion and marital status did not.

Several factors influenced Ugandan women antenatal care seeking behavior which included: perceived high cost of (antenatal care services, conducting a delivery and treatment), and perceived inadequacy of services provided by the formal health system. Another study in India economic disparity along with cultural belief and restrictions determined care seeking behavior and utilization of health care, resulting in slow decline of child mortality rate. The recent Uganda Maternal Health review revealed that access to the basic antenatal care services has significantly declined.

The ministry of health, Uganda in adherence of WHO recommends a simplified antenatal care of four visits; First visit: occurring in the first trimester, between (10 – 20) week of pregnancy, Second visit: scheduled close to week 26 (20 – 28) of pregnancy, Third visit: occurring in or around week 32 (28 – 36) of pregnancy, and lastly Fourth visit (final visit): taking place between weeks 36 and 38 (>36) of pregnancy.

This study was set to identify the factors associated with late booking and inadequate utilization of Antenatal Care services in upcountry areas of Uganda. With specific objectives: to describe the knowledge, attitude and practices of women regarding antenatal care booking; to identify the socio-demographic, obstetric and cultural factors associated with late booking; to describe the knowledge, attitude and practices of women regarding utilization of antenatal care; to identify the socio-demographic, obstetric and cultural factors associated inadequate utilization of antenatal care services.

Zambian Perspective

Estimates of infant and under-five mortality do justify the importance of this study. As it stands infant mortality in Zambia is 70/1000 live births while under-five mortality is 119/1000 live births (ZDHS 2007). One main reason for these high rates is the unsuccessful prenatal and maternal health care practices like breastfeeding practices among mothers. Studies have shown that diseases of infancy are the major contributors to the high mortality rates. It is also suggested that these diseases can be prevented with successful antenatal counselling services by the mother and the adherence to the counselling services during and after pregnancy. It thus

suggests that mothers have not yet understood the importance of their milk and the role it has in the growth and the development of their children. This lack of understanding could be due to inadequate health education on breastfeeding by various health educational information providers which among them include antenatal clinics (which is the largest source presently in use).

When the above facts are observed, it is evident that practical results of antenatal health education are different from what they should be. Implying that, there is a big gap between information and practice. Studies on health education show that if it is done adequately, even the practical results should show positive effects, but literature review suggests that compliance to antenatal health education at antenatal clinics are low among pregnant mothers. This forms the driving force to determining the compliance to the counselling services received by the pregnant mothers during the antenatal clinics. Therefore, this study will focus on the compliance to counselling services by pregnant women during antenatal in selected clinics in Lusaka, Zambia

The antenatal care package for Zambia women's in antenatal clinics includes:

- Clinical screening and examination, monitoring of blood pressure, urinalysis and weight measurement at every visit – compulsory
- Active detection and effective treatment of STIs (RPR and Benzathine Penicillin). If RPR is done and found negative in the first trimester, repeat at 34 weeks gestation.
- Tuberculosis (TB) clinical screening in HIV infected mothers with sputum smear. If negative give INH as per policy, if diagnosed refer for appropriate TB care.
- Prevention, detection and treatment of anaemia should be strengthened in line with the Safe Motherhood Program. This should include determination of HB at baseline and subsequent HBs if need be and systematic de-worming.
- Malaria prophylactic with sulphadoxine-pyrethamine.
- Multivitamin supplementation for the prevention of low birth weight to all antenatal attendees including 50,000 IU of Vitamin A to be given once during pregnancy.
- Provision of confidential mandatory counselling and voluntary HIV testing as part of the routine service. This needs to be done at each contact point. Husband /partner should be encouraged to come for counselling and testing. Women should be encouraged and support to disclose their status to their partners.

- Psychosocial support for HIV positive mothers and HIV prevention education for negative mothers.
- Referral of positive mothers to peer support groups.

Summary

The body of evidence on global trend of antenatal care reviewed has shown great benefits for pregnant women's in developing countries. The problem of increased maternal mortality is largely compounded by poor social economic status in most developing countries. It has also been shown that there is low utilization of Focused antenatal care, and absence of quality emergency obstetric care exacerbates the situation.

Furthermore, the literature highlighted some factors associated with low utilization of antenatal care. These include inadequate knowledge of both pregnant mothers and health service providers on focused antenatal care, some social-cultural factors as well as perception of health service providers' towards antenatal care.

The literature also unveils the benefits of antenatal clinic attendance in identifying and mitigating the potential complications during pregnancy and birth that may cause both maternal and infant morbidity and mortality. The health belief model was adopted in this study to illustrate the concepts related to the utilization of antenatal care in developing countries, like Zambia. However, the knowledge gap still remained. It was not known to what extent pregnant women comply to antenatal services they received.

CHAPTER THREE

METHODOLOGY

Overview

This chapter contains various sub headings that are to give clarity to how the research process is to be carried out in terms of methods and approaches as well as the target population of people to be involved in the research. It also contains information on time variations of carrying out the research and the presumed budget for money expenses in executing the chosen research methods. The sub-headings in this chapter are research design, population, Sample, Sampling Procedure, instruments for data analysis, procedure for data collection, data analysis, ethical considerations, research schedule or time line and proposed budget.

3.1 Research Design

The study used the mixed methods design in order to address qualitative and quantitative data needs of the research as earlier mentioned. Research employed a mixed methods due to the compositions in the study at large. It is very clear that the study has a combination of qualitative and quantitative data elements, if respondents are to provide balanced data. For instance, the set of questionnaires will be administered among married women with questions specifically on age of the women in question, while focus group discussions (FGD) will carter for clinical officers who are directly linked to screening and selected nurses responsible for the administration and care of cervical cancer patients.

Evaluative research design refers to the research type were the data elements are individually checked for their values. This study shall involve the collection and analysis of data gathered from the clinical officers, cervical patients and nurses, which shall be used to make perceptions and judgments about the prevalence of cervical cancer. The design is appropriate for the study because it is recommended by Amin (2005) who qualified it for studies which involve a cross section of respondents or subjects with almost similar characteristics.

The study shall be descriptive in the sense that it will involve the bringing out of information from a sample of clinical officers and nurses. All of the participants have different, knowledge levels in terms of qualifications, work backgrounds, age, and experiences.

The study was also both qualitative and quantitative in design. It was qualitative in that it captured subjective views and challenges experienced by both trained nurses and clinical officers. However, since the study sought to establish the relationship between the dependent

variable and the independent variable, data shall be presented in diagrammatic, mathematical and tabulation illustrations.

The Descriptive and analytical research approaches are useful when carrying out quantitative research studies. The researcher collected information from a cross-section of respondents at once without repetitively visiting them, that is to say, the cross-sectional design was most appropriate on big population as it saved time and finances (Creswell, 2003).

3.2 Study population

Mugenda and Mugenda (1999) define population as a complete set of individuals, cases or objects with some observable characteristics. In this case the study population constituted two health institutions, Chilenje and Kabwata clinics respectively, with an estimated average population of 1500. The compounds were selected based on the population of health workers and population density. Being close to the trading places of the central business district, the two facilities are expected to have very active antenatal clinics. The participants were selected randomly and accommodated in a focus group discussion, while the health workers were purposively picked based for an interview based on the participation into the antenatal health services.

Further, though not mentioned above, the study will incorporate medical doctors purposively selected in order to have a situational analyses of what the case is at both national and health facility level. Specifically, the Clinical Officer will be ideal to provide data on the rate on cervical cancer prevalence in Kabwata and Chilenje, while patients will provide responses regarding the attitude of vaccination administrators. During the interaction, the participants will be engaged in a focus group discussion bordering on capacity-building and technological issues).

3.3 Sample size and Sample Selection

A total sample size of 50 health practitioners was selected to participate in the study. To arrive at the above sample size, the formula below was used. The sample shall be selected from the clinic in order to arrive at the sample size calculated above. Purposive sampling shall be used since the type of participants to be included are well known. The researchers shall go to the clinics and select nurses, clinical officers and laboratory technicians to be interviewed.

3.4 Sampling Technique

The sampling method which was used in this study is a non-probability sampling method called convenient sampling as it appropriate with regards to the study's shortfalls in both finance and time frame allocated to the study. 50 women visiting the antenatal clinics were sampled. Since the study was an exploratory one, convenient sampling was appropriate for this study because it allowed the researcher collect the information with the pregnant and mothers who were present during the visits.

3.5 Research Instruments

In the process of data collection in depth questionnaires was used. The reason for selecting this type of instruments is that the data required is more quantitative. The use of questionnaires has various advantages including the following; data can be collected from a large sample, confidentiality is ascertained, saves time when collecting and analysing data and interviewer bias is minimised since questionnaires are presented in paper form.

(a) Questionnaire is a set of questions has been prepared to collect answers from respondents relating to the research topic. A number of questions usually in printed or electronic form are to be answered by the individuals. Sets of such forms was distributed to individuals and the answers was collected relating to research topic. A questionnaire is a series of questions asked to individuals to obtain statistically useful information about a given topic. In this study, questionnaires were used to collect information from pregnant women's and antenatal mothers. The use of the questionnaire is justified on the grounds that they were administered to many people almost at the same time.

(b) Interview guide: - In this method the interviewer personally meets the informants and asks necessary questions to them regarding the subject of enquiry. Usually a set of questions is carried by him and questions are also asked according to that. The interviewer efficiently collects the data from the informants by cross examining them. This technique was used to collect data from project staff members. The researcher was efficient and tactful to get the accurate and relevant data from the staff members. The major advantages of this technique is that there are no chances of non-response as the interviewer personally collects data and allows for probing in order to get in-depth information. Further, data collected in form of interviews is so reliable since the interviewer tactfully collects the data by cross examining the responders. This allows the researcher to collect qualitative data and make follow up questions regarding in-depth components of the study.

(c) Focus Group Discussions and structured interviews - Howard (2000) defined a focus group discussion as a special kind of interview used for collecting information about a specific subject or area of concern. Therefore, a Focus Group Discussion is a type of interview involving an interviewer and a group of research participants, who are free to talk with and influence each other in the process of sharing their ideas and perceptions about defined topics (Borg et al, 1989). Delno and Tromp (2006) further posit that, a focus group is usually composed of 6 to 8 individuals who share certain characteristics, which are relevant for the study. The discussion is carefully planned and designed to obtain information on the participant's beliefs and perceptions on a defined area of interest. The method also allows the researcher collect the views of the respondents on the questions in a face to face encounter with primary sources.

Data Collection Tools

Data collection tools are the actual data collection instruments. Some of the tools that shall be used include interview guide and questionnaires. The interview guide was administered through a face-to-face interview to clinical officers and laboratory Technicians. A questionnaire was used on nurses due to having situational based work which demands attending to the patients any time conditions changes.

Validity of the Data Collection Tools

Validity determines the whether the research truly measures that which it was intended to measure or how truthful the research results are (Jopper, 2000). Others asserts that validity describes as the initial concept, notion, question or hypothesis that determines which data is to be gathered (Wainer and Braun, 1998). The aspect of validity measures how accurate he hypothesis was, causal relationships and variables under study. The Questionnaire was effective as the nurses are literate enough to supply relevant information. In case of the interview guide it was also effective because statistians answered the questions in a short period of time. This made the two instruments valid enough to be deployed in the data collection exercise in this research.

Reliability of the Data Collection Tools

In this study, the instruments were tested under a pilot study in order to measure the effectiveness of the methodology which shall be used in the research. The Interview and the questionnaire were effective in capturing data due to the privacy of not indicating the names. Some participants found the face to face interview or administering of questionnaires interrogative. This affected the quality of responses as a result fears of unknown and lack of

confidence in the researcher. Jopper (2000) explains reliability as the extent to which results over time and an accurate representation of the total population under study is affected by a similar methodology.

3.6 Data Collection procedure

In this research two different tools were used, and these are a questionnaire and an interview guide. The study used the registry book used by the clinic nurses to randomly select the respondents.

The questionnaires were administered to the women by the research assistants, the latter questionnaire was self-administered. The questionnaires were administered in an interview format because not all of the participating women may be literate (assuming) to understand the questions and that, they come from different part of the city, which can make the collection of the questionnaires very difficult for the researcher.

The questionnaire for participating mothers was designed to collect information on knowledge of antenatal care, also to assess demographic and socio-cultural factors that may contribute to low utilization of antenatal care, the hygiene and nutrition counselling compliance by the pregnant women's during the pregnancy period. The questionnaire for health workers and counsellors was designed to capture their current practices as well as their perception towards antenatal care services.

3.7 Data Analysis

Data analysis is the process of evaluating data using analytical and logical reasoning to examine each component of the data provided. It involves the process of gathering, reviewing and then analysing data from various sources to form some sort of finding or conclusion.

Data from the questionnaire was quantified by arranging similar responses into frequencies depending on the questions and responses. The qualitative data was arranged into themes and was analysed qualitatively. This allowed the researcher to analyse quantifiable data from questionnaires by means of Microsoft excel.

Qualitative data from focus group discussions was transcribed and analysed by coding them into themes and tables. Qualitative data was analysed thematically. This entailed that the recorded interviews and field notes was the main data sources, and that they were organized according to the types of responses. The interviews and data from clients was transcribed as

accurately as possible by listening to the recorded interviews and discussions again and comparing them with the transcriptions. Data analysis involved an on-going process of continual reflection about the data as well as asking analytical questions.

Eligibility Criteria

Eligibility criteria refers to the guidelines describing the characteristics that are considered for who and why they should participate in a particular study. In this research, Nurses, Laboratory technicians and Clinical Officers shall be eligible to participate in the study due to the role they play in the screening of pregnancy, and management of gynaecological complications among pregnant women.

Inclusion Criteria

Inclusion criteria refers to the set of reasons as to why the participants considered should be included in the research. Clinical Officers were selected due to their role in the screening process. They are directly in contact which the patients of cervical cancer and this makes them a strategic constitute in this research. Nurses are the primary antenatal counsellors responsible for the management of counselling services among pregnant women.

Exclusion Criteria

Since the study is being undertaken in an urban township of Kabwata and Chilenje, Health Assistants, Pharmacists, and Medical doctors shall not participate in the study due to the fact that they do not actively and directly participate in the management and administration of counselling services to pregnant women.

Sample Size Calculation

Kothari (2011) states that sample size refers to the number of items to be selected from the population. The sample size will be 50. From these 5 were Clinical Officers, 5 were laboratory Technicians, 10 were Nurses and 30 comprised of pregnant women.

3.8 Data Collection Techniques

Data Collection techniques allowed us to systematically collect information about our objects of study (people, objects, phenomena) and about the settings in which they occur. In this study, the questionnaires containing open and closed-ended questions to nurses were administered. Then the interview guide was administered to key personnel's from the statistics department while pregnant women were accommodated in a Focus Group Discussion (FDG). The FDG was ideal due to the organisation of the antenatal clinic meetings in the interest of time.

Questionnaires allow the researcher to manage the time as certain management frameworks would not allow personnel to be off their work stations for a very long time.

Ethical and Cultural Consideration

The ethical considerations encompassed several issues namely biasness to the issue being studied, favoring the most speaking during focus group discussions, confidentiality and privacy of participants to mention a few. To avoid being biased, the Researcher selected the participants without fear or favor based on matrix outlined in the preceding paragraphs, allowed each of them to contribute without intimidation, upheld the confidence of participants by assuring them that the information they were availing to me would never be disclosed to anyone and plainly showed them the questionnaire which had no bearing of a respondents names, addresses or contact numbers in any way. Preliminary preparation for this study included seeking permission from the district medical officer, police and local authority to allow the researcher visit the Health Facilities, without victimization. The study took into account all possible and potential ethical issues. Respondents were assured of high levels of confidentiality. In addition, the respondents were informed that the information gathered was purely for academic purposes and no names would be revealed or used. As rightly noted by Wimmer and Dominick (1994), the principle of confidentiality and respect are the most important ethical issues requiring compliance on the part of the researcher. The basic ethical requirements demanded that the researcher respects the rights, values and decisions of the respondents. In addition, during research, respondents' responses were neither interfered nor contested by the researcher. Informed consent was obtained and all respondents received equal treatment. In summary, the study will guarantee confidentiality of responses by assuring respondents that the responses they will provide will be purely for academic purposes. The interviews for data collection also will instruct respondents not to reveal any form of identity such as their name. Occupation authority' concerns will also be considered.

3.9 Target Population

The target population was that of all pregnant mothers visiting antenatal clinics at Kabwata and Chilenje health clinics. Thus, the mothers were driven by virtue of them having visited the antenatal clinics for more than two times.

3.10 Ethical Considerations

This study took into consideration the following ethical consideration: permission shall be sought from: The District Health Board of Lusaka District, Clinic management, all participants

and respondents before a questionnaire is administered to them. The research does have some personal sensitive elements of issues to it hence possibilities of having any implications of emotional and psychological harm are not there. Therefore, in the process of carrying out data collection procedures the study was upholding confidentiality standards required.

Confidentiality

Confidentiality is central to developing a trusting and productive participant's researchers' relationship and is also a legal as well as an ethical issue. The researcher treated all the information the client shares as confidential material. Confidentiality is both an ethical and legal problem in counselling. Researchers believe they have a right and in fact, a duty to safeguard information presented in a research interview. Clients, too, have a right to expect that information revealed to a researcher was held in strict confidence. Therefore, all the information provided was safeguarded by the researcher.

Anonymity

In order to uphold the ethical principle of anonymity, the participants in this research were not allowed to write their names and positions on the questionnaires, instead the questionnaires were assigned with serial number by the researcher.

Informed Consent

The concept of informed consent refers to specific instances where a counsellor may need to transfer information about the client to a third party such as a lawyer, teacher, doctor or even another counsellor. In case of the transferring of the information to the other interested parties, the researcher checked with the client that he/she clearly understands the implications of the reasons for and possible consequences of the disclosure. It is the researcher's duty to educate the client and safeguard his/her interests before disclosing the information gained in the counselling sessions.

Summary

This chapter has highlighted the research design which involved self-administered questionnaires and the interview guides during the research. This research will target fifty women from two clinics, namely; Chilenje and Kabwata clinics of Lusaka District. The essay used Microsoft excel for data analysis. The research upheld ethical consideration of confidentiality and seeking consent from the research participants during the research.

CHAPTER FOUR

INTRODUCTION

4.0 overview

This chapter presents the study finding as obtained from the field by the researcher. The study was guided by three research questions: To what extent do expecting mother comply to counselling services received during antenatal? How do traditional beliefs influence prenatal and maternal practices? How does counselling health education received by pregnant women, increase their health seeking behavior?

4.1 Extent to findings related to how counselling health educations received by mothers increase their healthy seeking behaviour

Figure 4.1.1: Distribution of pregnant women receiving counselling at Antenatal clinics

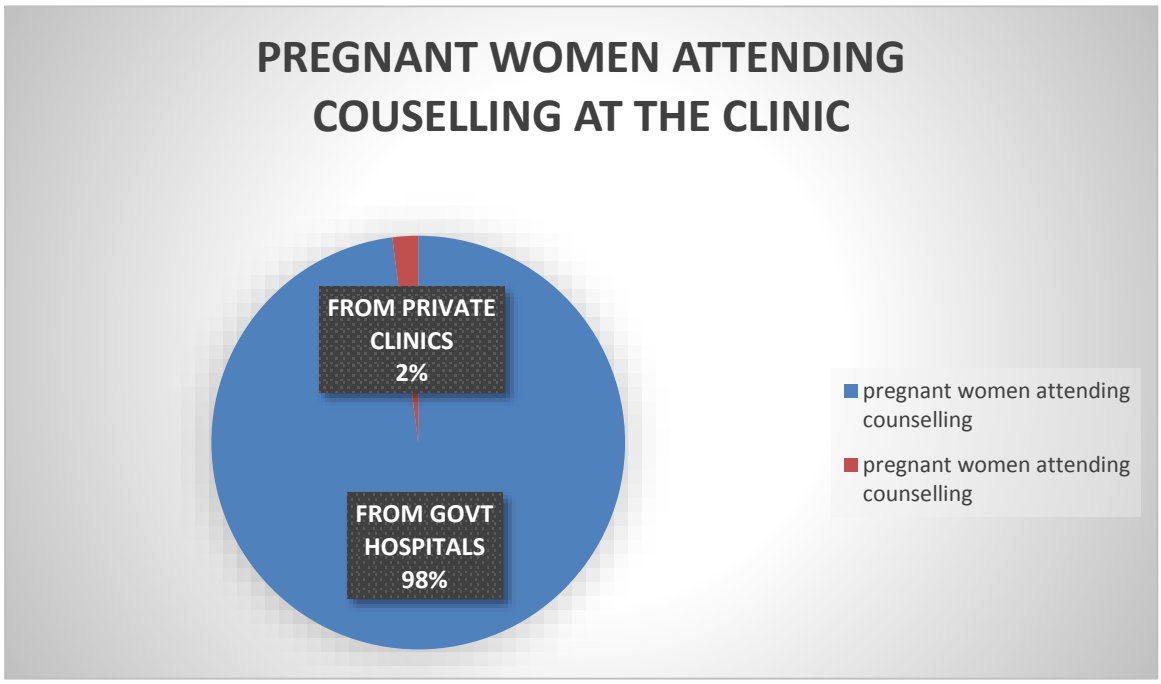


Figure 4.1.1 above shows the distribution of pregnant women that receive counselling at antenatal clinics. The majority of the respondents representing 98% were usual clients of the counselling service, while minorities representing 2% of the respondents sought counselling services from private hospitals and clinics using insurance as well as own finance. Pie chart showing respondents views on whether counselling health education increases health seeking behaviour in prenatal health.

FIGURE 4.1.2: Bar chart showing Counselling and Health Seeking Behaviour

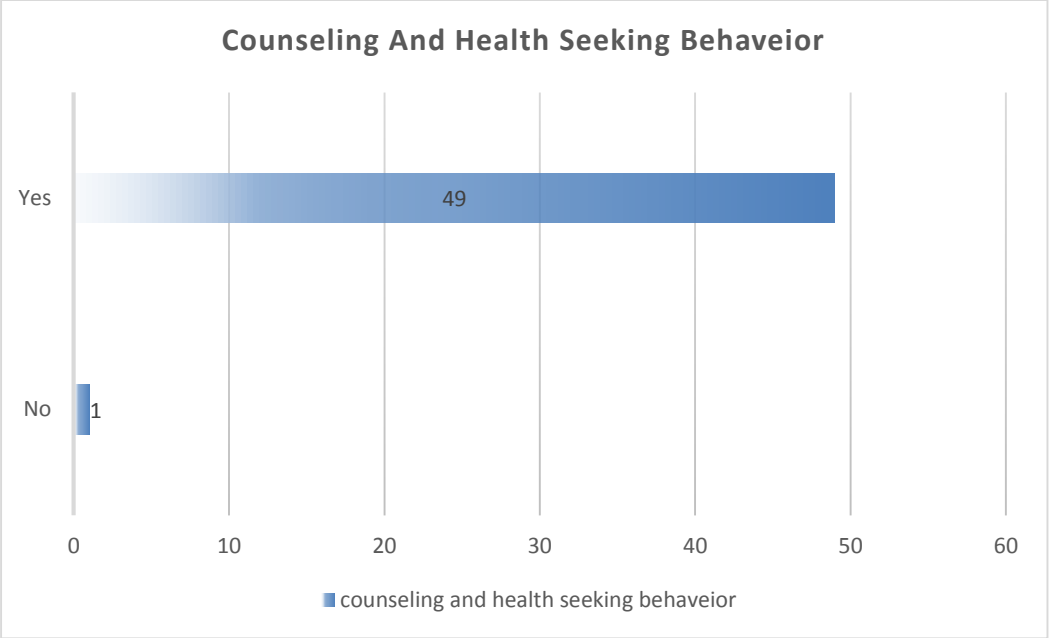


Figure 4.1.2 above shows the counselling and health seeking behaviour of the respondents. The majority of the respondents representing 49% appreciated the service of counselling while 1% didn't know. The other 50% were not sure as they attributed the need for counselling services to be an individual responsibility. Therefore, they were not sure, whether counselling services increases their health seeking behaviour or not. The bar chart below shows respondents views on whether counselling health education increases health seeking behaviour in prenatal health, forty-nine respondents agreed while one respondent disagreed.

Figure 4.1.3: The Effects of Counselling Health Education

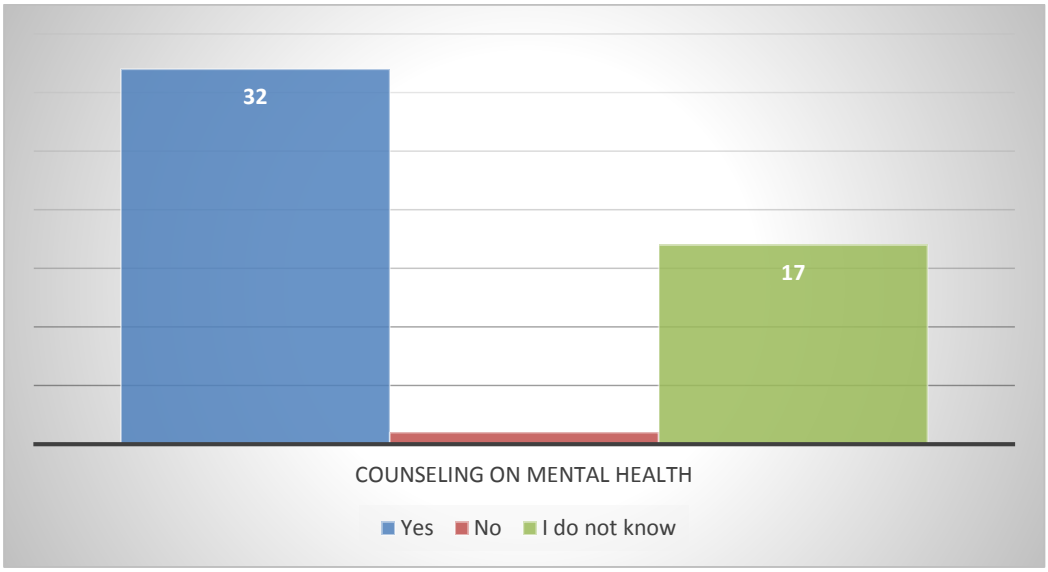
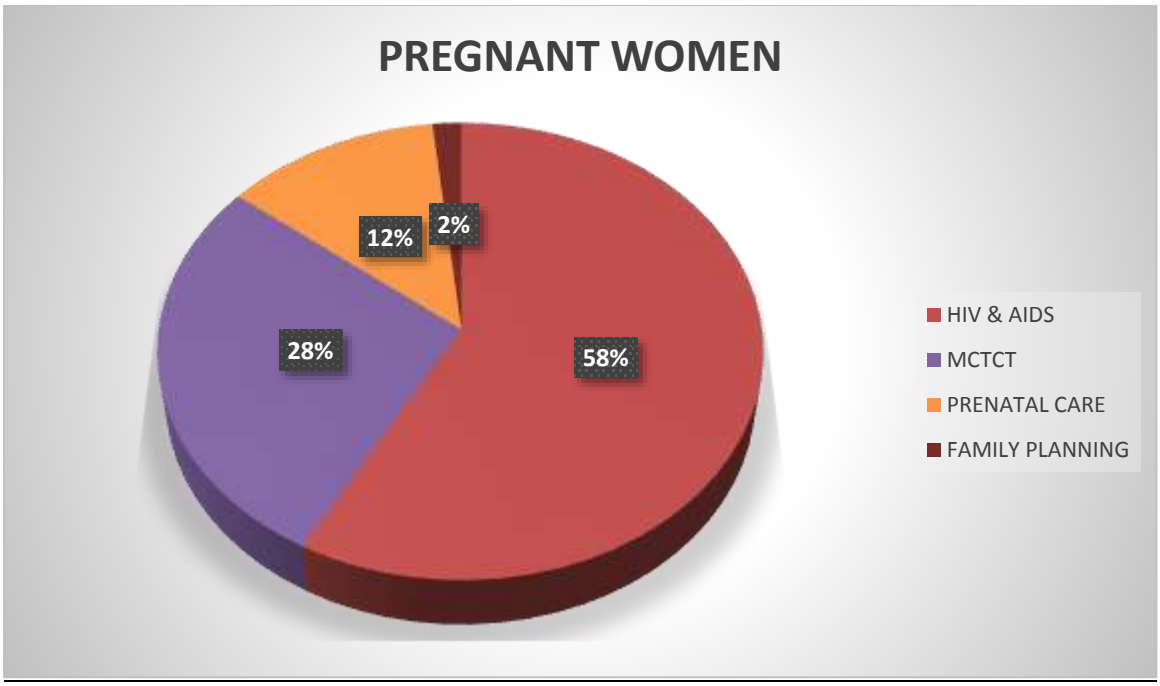


Figure 4.1.3 above shows the respondents view whether counselling health education increases your health seeking behaviour in maternal health. 32 (62%) respondents agreed, 1 (2%) respondent disagreed and the remaining 17 (34%) respondents indicated that they did not know.

Figure 4.2.4 Findings from respondents on the type of counselling services received during antenatal clinics.



Respondents provided a variety of responses on the types of counselling that at are provided at the visited centres. The following has been formulated as a result of unanimous repetition from most respondents. From the all 50 respondents 69 mentioned HIV and AIDS counselling, 43 mentioned mother and child nutritional counselling, 25 prenatal care counselling and finally 10 counselling on family planning.

Figure 4.1.5: Compliance to counselling services received during antenatal clinics

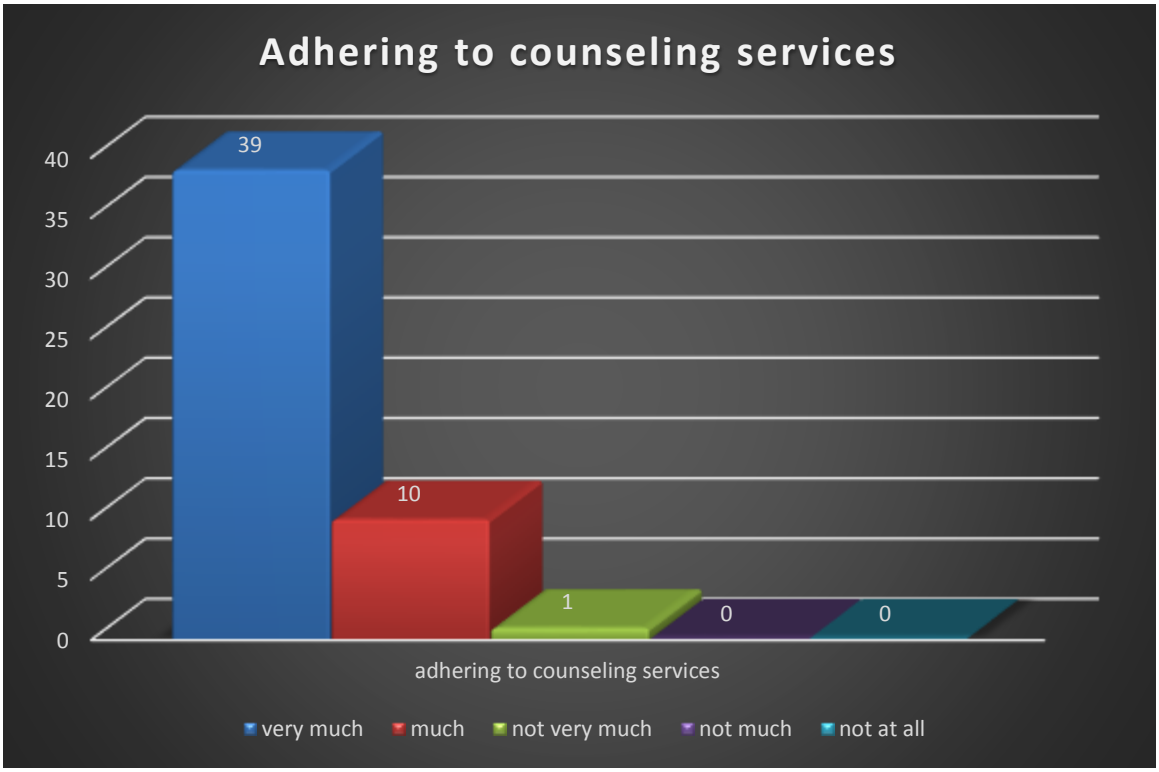


Figure 4.1.5 above shows the adherence levels among pregnant women attending antenatal clinic counselling sessions. The majority of the respondents accounting for 39% indicated high levels of complying with the counselling, while 10% indicated average adherence. 1% indicated minimal adherence, some did not know and the rest were not sure.

Reasons for responses to figure 4.1.6

Respondents provided a wide range of reasons in relation to their answer to whether they adhere to counselling services. Below are some of the responses from respondents that provide reason for the findings in figure 4.: “The counselling helps me know what to do when I am expecting, I get to know what foods to keep me healthy, the counselling helps me cope with my body changes, the counselling made me know how to take care of my wife during her pregnancy, the counselling gave me an insight on the HIV and AIDS virus and how to protect my baby, the counselling taught me how to protect myself from mosquitoes, the counselling taught me how to avoid activities that can endanger my unborn baby, the counselling prepared me mentally”

Figure 4.1.6 HIV & AIDS and PMTCT Counselling

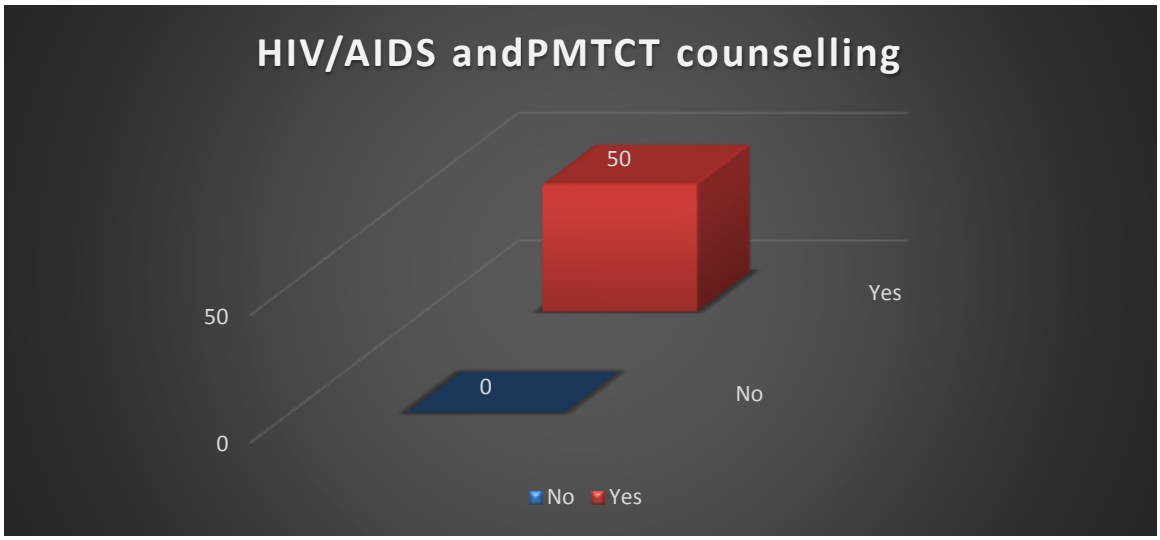


Figure 4.1.6 above illustrates the counselling of pregnant women on the prevention of HIV and AIDS as well as PMTCT. The study showed that most of the respondents had received counselling on HIV and AIDS, and PMTCT. None of the attendees had visited the clinic without being counselled during the pregnancy period.

Figure 4.1.7: Traditional beliefs influence on Antenatal life of women

Figure 4.1.8: The above pie chart shows respondents views of whether traditional belief influence on antenatal. 7 respondents indicated not influenced, 32 respondents indicated much as their response while 4 respondents each indicated not very much and not much respectively and finally 3 respondents indicated very much as their response.

Figure: 4.1.8: Bar chart showing responses on whether Traditional beliefs influence maternal practices in expecting mothers.

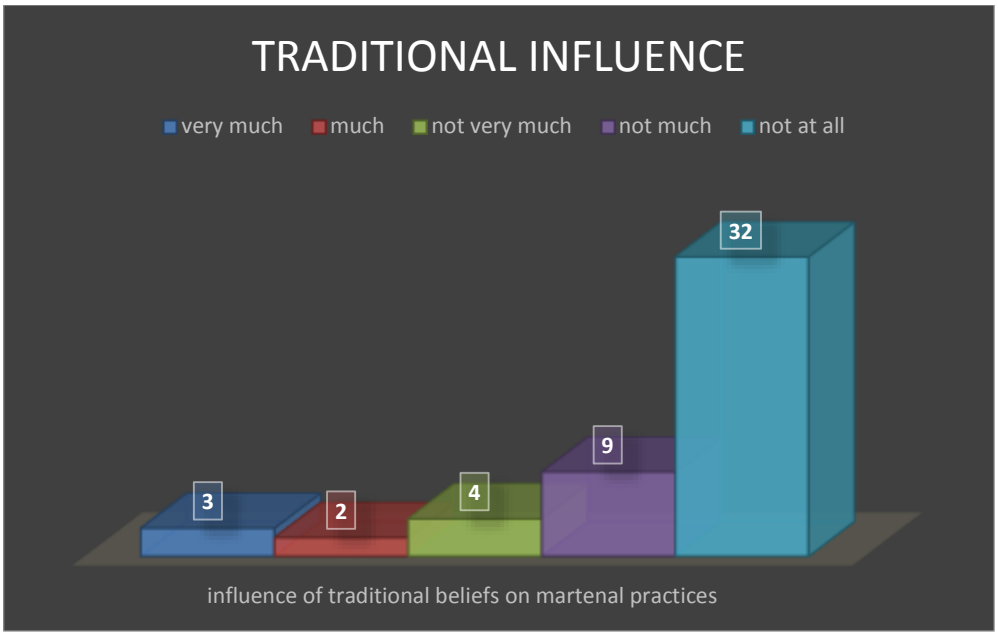


Figure 4.1.8 shows responses on whether Traditional beliefs influence maternal practices in expecting mothers. 32 respondents indicated not at all as their response, 9 respondents indicated not much, 4 respondents indicated not much, 3 respondents indicated very much and 2 respondents indicated much as their responses.

Responses that Explain how traditional beliefs influence prenatal practices.

The following responses were in relation to how traditional beliefs influence prenatal practices: 29 respondents stated that some beliefs are unrealistic, 33 respondents indicated that they did not believe in certain myths that are associated with certain traditions because they are too extreme. 19 respondents indicated that it prepares women mentally. Finally, 4 respondents discarded the beliefs stating that other beliefs are illogical as they restrict the mother to be on performing certain activates e.g. (cooking)

Respondents Suggestions of reasons as to why expecting mothers should comply with counselling services received during antenatal clinics.

Below are respondent's views and reasons as to why expecting mothers should comply with counselling services received during antenatal clinics. 47 respondents indicated that the knowledge that is provided from the services empowers and enlightens to be parents. 39 respondents indicated that it prepares parents on how to prevent and protect their unborn baby from illnesses, while 50 respondents stated that it prepares the mother and father on what to expect and finally 16 respondents indicated that it prepares the mother physically as her body begins to change.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Overview

This chapter is a discussion of findings of the study against the set out objectives, in order to answer the questions outlined; Establish the extent to which pregnant women comply to counselling services received during antenatal, Determine how traditional beliefs, influence pregnant women during antenatal clinic and Assess how counselling health education received by pregnant women increases their seeking behaviour. The objectives were answered by the following questions;

1. To what extent do pregnant women adhere to counselling services received during antenatal?
2. Do traditional beliefs influence antenatal practices?
3. Does counselling health education received by pregnant women, increase their health seeking behaviour?

The first objective of this study was to establish whether the counselling of pregnant women from antenatal clinic increased their health seeking behaviour in both prenatal and maternal health states. This objective was aimed at answering to what extent do pregnant women adhere to counselling services received during antenatal? In the questionnaire, the following findings were obtained, 32 out of 50 representing 64% respondents complied while 18 respondents representing 36% don't comply. From the above figures it can be safe to say that majority of the respondents agreed that the education that they received from the antenatal care increased their health seeking behaviour. This also means that the respondent's findings are in agreement with the literature which indicates that due to the enlightenment from the counselling sessions one begins to acquire knowledge which is useful to them.

According to Kochhar (1984), the purpose of counselling is to help people discover more effective ways of living with themselves and achieving what they need from life. It offers the opportunity to explore important issues in a safe and confidential environment. In listening without judgment, the counsellor supports the necessary process of self-discovery and understanding. Counselling helps clients achieve their personal goals, and gain greater insight into their lives. It gives individuals the tools to be the solution creator in their own life and helps them to learn how to deal with their difficulties and resolve them as quickly as possible. It is quite evident from the statistics in the findings that counselling plays a key role in

promoting the acquisition of new health knowledge leading to the reduction of morbidity and infant mortality rate. As a result, the attainment of the fourth Sustainable Development Goal being Health and well-being is slowly set on the path of being realised.

Antenatal care offers advice and information about appropriate place of delivery, depending on the woman's condition and status. It also offers opportunity to inform women about the danger signs and symptoms which require prompt attention from a health care provider. Furthermore, antenatal care may assist in abating the severity of pregnancy related complications through monitoring and prompt treatment of conditions aggravated during pregnancy, such as pregnancy induced hypertension, malaria, and anaemia which put at risk both the life of the mother and unborn baby (Bloom et al. 1999; Bhatia and Cleland 1995).

Out of the Focus Group Discussions, it was clear that the health workers in general have significantly enhanced the acquisition of antenatal knowledge thereby benefiting pregnant women. Further the women attested to the fact that counselling in most of the health areas affecting pregnancy was provided. However, low literacy levels and poverty affected the pregression of attendance of certain attendees. Some of the participants revealed that they had challenges in being consistent with attending antenatal clinic due to financial challenges. As such, it was quiet difficult in adhering to certain counselling components. One of the women had this to say in the following verbatim;

> "Most nurses teach us in English which some of us feel shy to ask especially if there are so many people who are able to express themselves….."

The second objective was to find out if the traditional beliefs influence pregnant women during prenatal and maternal practices, findings were as follows; 7 respondents indicated not as their response, 35 respondents out of 50 complied, representing 70% while 15 respondents out of 50 did not comply, representing 30%. The respondent's views revealed that many women seek antenatal care services late. Antenatal care attendees and women in the villages reported that community norms were significant constraints in planning for early antenatal care and Facility-based delivery. They commented that culture discourages them from planning for a baby who is not yet born. Prior planning is believed to bring bad lack. Some women are discouraged by relatives not to mention their pregnancy early as it would bring bad luck" (Gloria, 2000).

The fact that many women go to traditional healers and deliver from home also had influence on other women's decisions to seek antenatal care early. During the study, a certain nurse

pointed out that women in general are reluctant to go for health services unless they suspect a problem with their labour or delivery. She elaborated that the influence of culture is deeply rooted in society, which makes utilization of health services generally low among women.

The study also established that, some men do not support wives from attending antenatal due to wives having the full responsibility of fending for the family. Most of the women who attended the antenatal clinic at Chilenje were marketeers with families to feed. This hindered most of them from going to the clinic frequently. The cultural resistance to antenatal care early attendance and health facility deliveries also needs to be addressed through a variety of channels, some of which need to include men who give permission and the money to their wives for these visits.

The study also reported that, some pregnant women feel shy and do not want anybody else to look at their private parts. They will deliver outside a health facility since they have heard or experienced the fact that health workers look at and touch their private parts when they go to deliver. In the focus group discussions it was found out that there are very few times when women‘s genitals are looked at either by herself or by other people during her life time as such even those that would wish to use health services take their time thinking about that.

The final objective was to establish if the counselling services received during the antenatal visits are adhered to by the pregnant women’s. The findings in regard to that question were as follows: 39 respondents indicated very much, 10 respondents indicated much while 1 respondent indicated not much. Not much and not at all both scored nothing as they were not picked. The majority of the respondents admitted to having adhered to the counselling services offered by the clinics. These findings correlate to a study conducted in Mexico by Coria-Soto et al. (1996), inadequate number of visits was associated with 63 per cent higher risk of intra uterine growth retardation. Similar results were reported in a Bangladeshi study where birth weight was positively correlated with the frequency of visits at antenatal clinics (Ahmed and Das 1992). All these results point to the important role of antenatal care counselling in identifying and mitigating the potential complications during pregnancy. Moreover, a study conducted in Canada by Heaman et al. (2008) on inadequate prenatal care and association with adverse pregnancy outcome indicated that preterm birth, low birth weight, small-for age gestational and increased mortality rate were associated with inadequate prenatal care. Raatikainen et al. (2007) showed similar findings in a study conducted in Finland, where an

increase in low birth weight infants, more fetal deaths, and more neonatal deaths were common among those under attending antenatal care.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Overview

This chapter presents the conclusion and recommendations of the study based on the findings of the study.

6.1 Conclusions

The key findings of the study were that; a high number of respondents complied with antenatal counselling increasing health seeking behaviour in both prenatal and maternal health, the other was that traditional beliefs do influence pregnant women during prenatal and maternal practices, the study also established that most pregnant women comply with counselling services received during antenatal very much by 64% compared to the 36% who did not comply much.

6.2 Recommendations

To improve women access and utilization of antenatal care services in rural areas, there is need to establish or strengthen national policies and locally adapted guidelines to protect the rights of all women, regardless of their socioeconomic status or place of residence. There is a need for evidence-based guidelines at the national level detailing the essential minimum components of antenatal care, in line with the country epidemiological profile and country priorities and based on WHO guidelines and recommendations.

. The study established that many of the medical personnel handle their clients in an inhuman manner a sign of poor client handling Training for health workers on clinical skills, as well as on client-provider interaction, is critical to ensure high quality, professional antenatal care and delivery services.

Government should reduce on hospital/clinic charges, but also provide pregnant women with social and financial support, as well as transportation to health facilities. The need for women themselves to generate and save income for transport and delivery costs was also highlighted. One woman explained: They should have their own income generating activities to enable them have control over finances and to save money to help them in case of an emergency‖.

The study recommends an improvement in health care systems at all levels and improving maternal survival and well-being, through improving physical infrastructure, essential drugs

supplies, equipment to improve the extremely difficult working conditions for staff and enable providers to offer quality care.

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APPENDIX 1: INTERVIEW GUIDE

1. What is your occupation?
2. What is your level of qualification?
3. How long have you been working?
4. When did you start working?
5. How many years have you been working in your current position?
6. Have you attended any workshop on the compliance of pregnant women at antenatal clinics?
7. Do you think you pregnant women adequately comply to counselling at antenatal sessions?
8. Have you attended any training on compliance of pregnant women to counselling?
9. Have been left out of from the list of those required to attend a workshop?
10. How many workshops or seminars have you attended on compliance of pregnant women to counselling?
11. Are there any re-occurrence of health problems as a result of failure to comply to the counselling at the antenatal clinic?
12. What are some of the challenges that arise from lack of compliance to counselling?
13. Are there any improvements in adhering to the counselling you have offered to pregnant women?

APPENDIX 2 FOCUS GROUP DISCUSSION

The FGD accommodated the personnel's responsible for the management of statistics in order to establish current levels of compliance. The Researcher took up the role of the moderator while the Research Assistant recorded the proceedings of the discussion as secretary. Upon conferencing a meeting, the participants were sensitized in order for them to be aware of the expectations of the meeting. In order to facilitate collective participation, the researcher inducted the participants in the ground rules in order to promote equality and respect of ones contribution of views. The Focus Group Discussion was implemented in the following procedure:

Moderator: Welcome to this meeting titled, "**ASSESSMENT OF COMPLIANCE TO COUNSELLING AMONG PREGNANT WOMEN IN CLINICS"**

Discussants: Thank you

Moderator: What do the terms counselling and compliance mean?

Discussants: various answers

Moderator: Statistics indicate that Diarrhoea and Malnutrition are some of the major health problems found in the surrounding communities. What are some of the causes?

Discussants: various answers

Moderator: What are some of the challenges faced in doing what nurses tell us to do at antenatal clinic?

Discussants: responses…..

APPENDIX 3 QUESTIONNAIRE

RESEARCH TOPIC:

Compliance to counselling services by pregnant women during antenatal in selected government clinics in Lusaka, Zambia.

INSTRUCTIONS

• This questionnaire consist of two types of questions

• Questions which need a tick in the appropriate box option

• Questions which need filling or explanations

• Please kindly answer all questions correctly as instructed but you are free to skip.

• The researcher asks your maximum co-operation to make this work succeed.

A. This is not a test there is no correct or wrong answer/response.

B. All information supplied will be treated with high confidentiality

FOR ETHICAL REASONS

• Don’t write your name

• The researcher expects these questions back on or before-date.

FOR QUESTION 1-6 TICK [V] THE CORRECT OPTION IN THE BOX

PERSONAL DATA

1. Your age group

   15-24 years ( )

   25-34 years ( )

   34-45 years ( )

2. Your sex

   [i] Female ( )

   [ii] Male ( )

3. Your education level

   [i] Certificate ( )

   [ii] Diploma ( )

   [iii] Advanced Diploma ( )

   [iv] Degree ( )

4. What other responsibilities do you have?

   [i] Supervisor ( )

   [ii] Senior Clinical Officer ( )

   [iii] Acting Ward Officer ( )

5. What is marital status?

   [i] Single ( )

   [ii] Married ( )

   [iii] Separate/divorce ( )

6. What is your occupation?

   [i] Nurse ( )

   [ii] Clinical Officer ( )

   [iii] Medical Officer

FOR QUESTION 7-13 PUT THE TICK TO ONE OPTION ONLY

PROFESSIONAL DATA

7. What do you understand by the term Counselling?

……
……
……

8. What is Counselling Compliance?

……
……
……

9. Do you think the prevaslence of communicable diseases is as a result of non-compliance to counselling among pregnant women?

Yes ( )
No ( )
Not Sure ( )

10. If the answer for question 8 is YES, how did you know about it

(i) through workshop ( )
(ii) Seminar ( )
(iii) briefing( )
(iv) school topic ( )
(v) Others (mention) ( )

10. Which of the following clinical reasons do you think contributes to failure to comply to counselling?

(i) misunderstanding of instructions
(ii) lack of support from spouse
(iii) Poverty
(iv) low literacy levels
(v) others ( ) specify……..

11. Is there a code of practice for monitoring and managing compliance among pregnant women?

(i) Yes ( )

(ii) No( )

(iii) I don't know ( )

12. If yes who give this education?

(i) Health Facility assistants ( )

(ii) Community Health workers ( )

(iii) Nurses ( )

(iv) Clinical Officers ( )

Appendix 4: information sheet & consent form

THE UNIVERSITY OF ZAMBIA

SCHOOL OF EDUCATION

DEPARTMENT OF GUIDANCE AND COUNSELLING

INFORMATION SHEET & CONSENT FORM FOR CERVICAL CANCER SCREENING STUDY

Title: compliance to counselling services by pregnant women during antenatal in selected government clinics in Lusaka, Zambia

SECTION A:

I am a student of Masters Degree in Guidance and Counselling - University of Zambia. We are conducting a survey on compliance to counselling services by pregnant women during antenatal in selected government clinics in Lusaka, Zambia

It has been discovered that a lot of women in the reproductive age group are dying young due to Cervical Cancer (CC) even when their lives could be spared if they went early to the hospital for screening.

The objective of this study are to: (i) determine the knowledge and practices of clinical officers and nurses in the screening of cervical cancer and administration of HPV vaccine to children below the age of 15.

The study involves asking a series of questions from a questionnaire as well as administering an interview. The information collected will be treated as confidential and used to prepare reports after analysis without including any specific names. There are no risks involved for taking part in this study.

The results obtained in this study will (i) contribute to the understanding of why there has been low usage in the screening centers for CC and thus enhance participation (ii) help identify if there is any association between knowledge and practices in determining the actual screening to help formulate policy and influence women's willingness to be screened (iii) contribute through improved knowledge on screening among children below age of 14.

Participation in this research is voluntary. The participants are free to ask any questions and if they feel dissatisfied, they are free to decline participation without any repercussions. No officer will be charged anything to the participate in this study.

SECTION B: CONSENT FORM

The purpose of this study has been adequately explained to me and I understand the aim, benefits and confidentiality of this study. I further understand that if I agree to take part in this study, I can withdraw at any time without having to give an explanation and that taking part in this study is purely voluntarily.

If you are willing to participate in the study, please do so by signing below.

Thanking you in anticipation and for your valuable time.

Sign: ……

(Please use respondent's right thumb print for signature)

Date: ……...

Witness: ……. (I.e. a relative or interviewer)