ANTENATAL MOTHERS' PROBLEMS AND COPING STRATEGIES IN THREE CLINICS IN ZARIA

BY

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DECLARATION

I hereby declare that this thesis is a record of my own research work. It has not been presented partially or wholly anywhere in any previous application for a higher degree.

All quotations are indicated by quotation marks or indentation and the source of information are duly acknowledged by means of references.

Salman Abdulwahab Adisa

CERTIFICATION

This thesis, entitled "ANTENATAL MOTHERS' PROBLEMS AND COPING STRATEGIES IN THREE CLINICS IN ZARIA", by Salman Abdulwahab Adisa, meets the regulations governing the award of degree of Master of Education (Guidance and Counselling) of Ahmadu Bello University, and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This work is dedicated to my parents Alhaji Alao Idris Salman and Madam Rabi Ajoke Alao who took the pains in seeing me through this course both morally and financially.

Also to Almighty Allah for his blessings and guidance throughout my course.

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ABSTRACT

The study was concerned with antenatal mothers' problems and their coping strategies in some selected hospitals in Zaria. The main objectives of the study was to find out the antenatal problems and possible coping techniques of the expectant mothers in order to establish a base for counsellors to provide counselling services in the medical setting.

Three major research questions were posed and answered. In addition, the following null hypotheses were stated and tested at 0.05 level of significance.

1. There is no significant differences in the strategies recommended to the expectant mothers by nursing sisters in Ahmadu Hello University Teaching Hospital, Tudun wada, Sick Bay Antenatal Clinic and Kofan kayan Hospital in Zaria City.
2. There is no significance difference between coping strategies of expectant mothers and strategies recommended by the nursing sisters and midwives in antenatal clinics in Zaria.
3. There is no significant difference between the literate and illiterate expectant mothers' problems.
4. There is no significant difference in the recommended coping strategies by the married and single nursing sisters and midwives to the expectant mothers in Zaria.

5. There Is no significant difference in the coping strategies of the illiterate and literate expectant mothers[1] problems.

The sample size for the study was 287 randomly selected subjects of which 236 were expectant mothers and 51 were nursing sisters and midlives in the three antenatal clinics used for the study in Zaria.

The main instruments used for the data collection were the questionnaire and the interview guide which were both designed by the researcher. Analysis of Variance (ANOVA) and T-test statistical techniques were used to analyse the data and all hypotheses were tested at 0.05 level of significance. Three of the above stated hypotheses (1, 3 and 4) were retained and two of them (2 and 5) were rejected.

The study revealed the following as the major findings:-

1. Abnormal frequency of urination during pregnancy, backache, nausea and vomiting, and constant day dreaming constitute the mot serious problems of expectant mothers.
2. The mean scores for general cleanliness, attending antenatal clinic, abiding by nurses advice, taking balanced diets, prayers, sleeping and resting ranked very high in the areas of coping strategies.

From these results the fallowing major recommendations were made:-

a) That group counselling involving the guidance counsellor and other medical personnel at the antenatal clinics be organised for the expectant mothers.

b) That the government as a matter of urgency should set up counselling unit within the premises of hospitals where by guidance counsellor will be posted to work hand in hand with medical personnel for improving the well being of expectant mothers.

c) Guidance and counselling should be incorporated into nurses and midwives curriculum so that they can get proper orientation of the basic concepts in guidance and counselling.

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LIST OF ABBREVATIONS

A.B.U.	Ahmadu Bello University
A.B.U.T.H.	Ahmadu Bello University Teaching Hospital
DF	Degree of Freedom
MS	Mean Square
N	Number
OS	Osutein
P	Properbility
SD	Standard Deviation
SE	Standard Error
SS	Sum of Squares

DEFINITION OF TERMS

In this study the terms used frequently are defined which limited the meaning to the study alone. They are as follows:-

Antenatal	-	Conditions of pregnant woman before delivery.
Antenatal Mothers	-	Expectant mothers or pregnant women.
Gynaecology	-	A branch of medicine which deals with the diseases peculiar to women.
Labour	-	The process where the products of conception are expelled through the birth canal after the nine months of pregnancy.
Obstetrics	-	A branch of medicine and surgery connected with childbirth.
Teenagers	-	Refers to young people in their teens of ages (between the range of 13 - 17 years old) but adult status or complete materity not yet achieved.
Trimesters	-	First three months of pregnancy.
Primigravidae	-	A woman who is pregnant for the first time.

Multigravidae - A woman who has been pregnant several times.

Multiple Pregnancy - That is more than one baby pregnancy which could either be twins, triplets (3), quadruplets (4) etc.

Areola - Smooth surface around the nipples or before the nipples of the breast.

Falous - Number of children a pregnant woman has had, say 2,3,4 children, etc.

Quickening - Is the kicking of the baby or movement of the baby felt by the mother for the primigravidae movement is felt at the 20th week of the pregnancy and for the multigravidae at the 16th week of the pregnancy.

Dilatation - Is the opening up of the cervix for the baby to come out during the labour period.

Chapter 1

THE PROBLEM

1.1 Introduction

Pregnancy and childbirth are another period of transition for a woman. It has always been a time of conflicts and feelings of inadequacy, fears and anxieties. During this period women do experience some pleasant and unpleasant periods in their lives. This is taking place in their bodies physically, psychologically, physiologically and at times socially.

Expectant mothers are faced with various problems such as constipation, nausea and vomiting, heartburn, abdominal discomfort, haemorhoids and skin irritation, varicose veins, hypertension, vasico vaginal tistuala, anaemia in pregnancy (Townsend 1978). These problems are both biological and psychological in nature, some affect expectant mothers right from the time of conception, or at first trimester of pregnancy, and in others it manifest at a later period. In the past, health care facilities available to such expectant mothers are often minimal and mostly found in urban areas to the neglect of the rural areas. Hence majority of expectant mothers in the rural areas depend on local dispensaries or traditional midwives.

With the rapid changes and development in the country today, antenatal health care has lessen the problems

encountered by pregnant mothers during pregnancy. This has been achieved through the help of trained nurses and midwives. Lawson (1983:7) said that an experience midwife is the person who performs subsequent routine examinations and gives the patient the necessary advice. So also the expectant mothers need assistance from other professional bodies such as the guidance counsellors, who can counsel the expectant mother on how to solve her problems which are psychological, physical, cultural as well as social in nature. Counselling is simply referred to as the helping relationship between two persons or individuals. While Rogers (1961) opined that counselling offer assistance and changes attitudes and behaviours.

On the basis of the above statement the study primarily investigated problems of pregnant mothers and recommended coping strategies by nurses and midwives.

1.2 Statement of the Problem

Pregnancy and childbirth stand to be a remarkable experience in the life of any pregnant mother. It requires the assistance of the husband, relations, religious organisations, schools and government who are expected to play an important role in educating and guiding pregnant

women in respect of their health and attitude towards their antenatal life. The prevailing increase in the health problems of expectant mothers in the country today has motivated the researcher to embark on this study. The investigation of Okon (1988) shows that the antenatal problems has not been adequately taking care of and that enough research has not been conducted by researchers.

In view of the above, this study therefore investigated the problems of expectant mothers and the recommended coping strategies by nursing sisters and midwives. A research into such area becomes necessary in order to assist the pregnant women to become more confident in themselves during the period of pregnancy as self-confidence enhances safe delivery. However the kind of relationship that expectant mothers need to enhance their self-confidence may be lacking. Thus Kolo (1988:1) observed that:

> Helping the expectant mothers working through childbirth is a very important and delicate task. To help a woman through it implies sharing a mystery and a miracle which demands some empathic understanding of such woman feelings, anxieties, fears and the attendant joy after the normal delivery.

The study is therefore undertaken to seek answers to the following questions:-

1. What are the major problems of antenatal mothers during pregnancy?
2. How do the pregnant mothers cope with such problems?
3. What are the recommended coping strategies by the nursing sisters to help pregnant mothers in coping with these problems?

1.3 Objectives of the Study

The main objectives of this study are:-

1. To identify the problems of expectant mothers during pregnancy period in antenatal clinics in Zaria.
2. To find out how the expectant mothers cope with such problems on their parts.
3. To identify the strategies the nursing sisters are using to help the expectant mothers cope with the pregnancy problems.
4. To suggest areas which counselling strategies can play to compliment the assistance of the nurses so that the expectant mothers could efficiently handle pregnancy problems.

1.4 Hypotheses

The study intends to test the following hypotheses:-

1. There is no significant difference in the strategies recommended to expectant mothers by nursing sisters in Ahmadu Bello University Teaching Hospital, Sick Bay antenatal clinic and Kofan Gayan antenatal clinic in Zaria.
2. There is no significant difference between coping techniques of expectant mother and strategies recommended by the nursing sisters in antenatal clinics in Zaria.
3. There is no significant difference between the literate and illiterate antenatal mothers problems.
4. There is no significant difference in the recommended coping strategies by the married and single nursing sisters to the expectant mothers in Zaria.
5. There is no significant difference in the coping strategies of the illiterate and literate expectant mothers.

1.5 Basic Assumptions

The assumptions that form the basis for this study are:-

1. That there are some problems that expectant mothers face which are psychological in nature during the period of pregnancy.

2. That such problems can be identified.
3. That the antenatal mothers use self-coping methods with their problems.
4. That the nursing sisters are much more concerned with the medical problems of the expectant mothers.
5. That it is possible to identify guidance and counselling strategies of helping pregnant mothers to solve these problems.

1.6 Significance of the Study

Since much have not been done in the area of this study, the researcher hopes that the findings of this research if made use of would be of great significance to the expectant mothers on how well they could be helped, in order to cope with their problems which are psychological emotional, social and cultural in nature, for successful childbirth.

The research work will be of great importance to the guidance counsellors in that it will help them know about the problems of the expectant mothers; their coping behaviours and the recommended strategies by nursing sisters. This will give them opportunities on how to help such mothers resolve their problems when they come for counselling.

It is also hoped that the findings of this research work will be used as guiding tools to the medical personnel in assisting antenatal mothers in antenatal clinics more empathetically.

In addition the study will provide basis for recommendations to the parents, relations, schools and government on how to assist expectant women during antenatal period.

1.7 Delimitation of the Study

The study is delimited to antenatal clinics in the Sick Bay of the Main Campus, Samaru, Ahmadu Bello University Teaching Hospital Tudun Wada, Zaria and Kofan Gayan Hospital, Zaria City. It also involved only the nursing sisters and antenatal patients in those clinics. The three clinics were chosen because they have experienced nursing sisters and treat antenatal patients from different parts of the country and from different socio-economic classes.

These three hospitals are chosen because of the large numbers of antenatal patients they receive and familiarity of the researcher with the environment which has made the research less problematic in terms of data collection.

1.8 Summary

The study investigated on the problems affecting expectant mothers in our society, which are psychological, phisological, emotional as well as social in nature and recommended coping strategies by nursing sisters and midwives. The chapter has discussed among other things, the introduction, problem, objectives, assumption, hypotheses, significance and delimitation of the study.

Chapter 2

REVIEW OF RELATED LITERATURE

2.1 Introduction

This study deals with antenatal mothers problems and recommended coping strategies used by nursing sisters in antenatal clinics in Zaria. The topic looked to the aid of antenatal mothers in Zaria who are found to be comforted with pregnancy, labour and childbirth problems. Also of importance is the recommended coping strategies to pregnant mothers by nursing sisters was reckoned in the study. In the context of this research therefore, pregnancy and childbirth is consisdered as the transition period from conception to birth which is characterized by physical and social changes of a female. While conception implies the fertilization of female egg (ovum) by the male sperm cell in the womb of a woman which later develop into a baby expected to be delivered after the nine months of pregnancy and labour period.

Thus, this chapter . reviewed related literature in the following areas:-

2.2 Antenatal and antenatal problems

2.3 Theoretical Background on Antenal Problems

2.3.1 The pregnancy period.

2.3.2 The labour period.

2.4 Manifestation of antenatal problems.

2.5 The roles of nurses in antenatal clinic

2.6 Coping strategies used by nurses with pregnant mothers.

2.7 Summary.

2.2 Antenatal and Antenatal Problems

a) Antenatal

The concept "antenatal" in English is derived from the latain words "ante" meaning "before" and "natal", - "birth" respectively.

However, various meaning have been given to it by various people Peter (1972) and williams (1974) defined it as "the condition occuring or existing before the birth of the individuel". While Garland (1966) simply put it as "before birth of the baby".

Therefore from the above meanings we can view antenatal as a period between conception and birth, used with reference to both the mother and the child. That is the condition of an expectant woman which starts from the conception through the period of pregnancy and labour and ends with childbirth.

Antenatal Problems

Antenatal problem is the difficulties of a pregnant woman during the pregnancy and labour periods. Anderson (1979:23) referred to it as disorders of pregnancy and obstetric abnormalities. This illness or disorders could be psychological, medical and social in nature as it affects the expectant mother. The problems can be classified into minor and major antenatal problems. Anderson (1979) pointed out that many mothers complained of one or more minor problems such as constipation morning sickness, abdominal discomfort, vaginal discharge, skin irritation while the major ones are anaemia of pregnancy,

antepartumhaemorrhage, hypertension and pre-eclamptic toxaemia. These conditions are unhealthy and unpleasant to the expectant mothers. They are also closely related to her anxieties doubts and several concerns which accompany physical, social and psychological changes. As Walter (1929) observed that most pregnant women develop fears, concerns and anxiety symptoms during pregnancy which can be very distressing and disturbing.

It is therefore believed that antenatal problems which are abnormalities during pregnancy affects expectant mothers psychologically and socially.

2.3 Theoretical Background on Antenatal Problems

A theory is a practical means or a framework for making systematic observations and explaining phenomena. Therefore theories of antenatal problems are attempts to explain the conditions of expectant mother during the antenatal period which will be discussed under the following sub-headings:-

i) Pregnancy period; and

ii) Labour period.

2.3.1 The Pregnancy Period

Pregnancy is not just a state of nine months of waiting, but a life crisis when a woman's identity is challenged and likely changed. It is a psychological and physiological condition involving emotional, psychological, financial and domestic effects. Bibring (1959) introduced the concept of

pregnancy as a maturational crisis when a woman observed severe psychological disturbances and Olaosebikan (1992) stated that "it is a state of conception when a woman is expecting a baby", Jones, Acosta; and Andrews (1983) defined it as a condition when one or more potential offspring are attached to the lining of the uterus.

Pregnancy can therefore mean the fertilization of a female egg by the male sperm cell in the womb of the lady which later develops into a baby to be delivered after nine months.

2.3.1.1 Symptoms and Signs of Pregnancy

Symptoms and signs of pregnancy can be classified into possible, probable (presumptive) and positive (certain) symptoms and signs.

Aderson (1979:796) give the possible signs as amenorrhea, breast changes, skin changes, appetite changes, the presumptive symptoms as nausea and vomiting, quickening, while the positive symptoms are only determined through medical diagnosis such as fetal heart, fetal movements, abdominal changes and cutaneous changes.

According to Olaosebikan (1992:5) the signs of pregnancy can be seen on the woman from her down, such as looking full and dull or sometimes pale from blood shortage, frequent spitting of saliva, darkening of the face, nose and checks, bigger breast and varicose - veins, general tirdness and dizziness. Each of these symptoms are briefly explained below.

Amenorrhoea

Amenorrhoea as the first symptom of early pregnancy is usually when the menstural period fails to occur on the expected date (when pregnant woman misses her menstruation) that is when the monthly period fails to occur within four weeks, which will make the women suspects that she is pregnant. Sometimes however, decidual bleeding may occur for the first three months at the time of the missed periods.

But sometimes a woman may missed period and still not be pregnant, for example, during the period of changes of environment or climate, mental disturbance and general diseases, such as anaemia and tuberculosis so also due to use of contraceptives.

Breast Changes

Breast changes as symptom of pregnancy are a response to the hormonal influences of pregnancy; with a prickling or tingling sensation felt almost as soon as the first period has been missed. In the first four weeks of pregnancy the patient may notice some tenderness of the breast and some fullness. After the second month the symptom persists and increased nipple become more pronounced, the areola becomes darker and the veins under the skin becomes more transparent. As the pregnancy advances the fullness become larger and darker, the area around the nipple (areola) also becomes larger, darker and swollen. The swollen is caused by osetrogen which stimulates the growth granduala tissues.

Quickening

Quickening as a symptom of early pregnancy means the woman feeling the fetus movement in her uterus. For the parous (woman who had a baby before) it begins at the 16th - 18th week, and in the multiparous (woman who has never had a baby) later, at the 18th - 20th week. The differences between them is because the multiparous does not know what to expect.

The movement of the fatus will become strong and more frequent as pregnancy advances and the mother may notice that her baby has period of activity and periods of rest. That is the movement will make the mother be aware that the baby is alive or okay, and fail to feel this she will go to antenatal clinic for medical check up.

Morning Sickness

Morning sickness, with nausea, vomiting and often dazziness is a common early symptom of pregnancy present in about fifty percent (50%) of pregnancies. The symptom occurs from the 4th - 14th week of pregnancy. As the woman wake up in the morning she has a feeling of nausea and may vomit. While some women may vomit severely throughout the day and some in the evening only. Generally morning sickness is worse in multiple pregnancies because twin pregnancy is more complicated than a woman having one baby in the uterus. Morning sickness could also be caused by other conditions like malaria, and hepatitis.

Skin Changes

During the pregnancy the skin shows an accentuation of pigmentation around the nipples, down the middle of the abdomen below the umbilicus, and sometimes particularly on the face. That is during pregnancy the patient may notice many changes in the skin such as straie, gravidarum and linea nigra of the abdomen and the chloasma.

Linea nigra of the abdomen is the darkening of the line between the umbilicus and the symphysis pubis, straie gravidarum is the reddish stretch marks occurs on the abdomen, thighs and breasts while the chloasma (mask of pregnancy) is the pigmentation of the face mainly on the forehead or checks; that is irregular darkly pigmented areas on the face. Other changes include the primary and secondary areolae of the breast. They are all caused by the hormonal changes.

Vaginal Discharge

Vaginal discharge as a symptom of pregnancy is increase cervical secretion and vaginal from sudation produced a noticeable mucous discherge from about the 14th week onward. The increase is caused because of the hormal changes. So also there is disturbances of urination which is often marked during the first few weeks of pregnancy due to the enlarged uterus pressing on the bladder.

Appetite Changes

As soon as some women are pregnant, they develop carving for some foods and an aversion for others; or some might loos appetite till when the pregnancy get to six weeks. It is more pronounced with an experienced multipare. And at times at the existence of the pregnancy, the woman may begin to eat in excess, that is taken more quantity of food than, how she ate before pregnancy.

Enlargement of the Abdomen

Englargement of the abdomen as a sign and symptom of pregnancy occurs after the third month as the growing uterus moves up into the abdominal cavity. That is a condition when a woman feeling abdominal fullness or swolling at a stage when the uterus is not much enlarged. As the pregnancy advances the uterine enlargement becomes more developed and evidents with the additional gain of about five kilogrames (5kg).

Changes in Internal Organs

Changes in internal organs as a sign of pregnancy include changes in the vaginal size, vulva and vestibule; so also small increase in the size of the uterus which is due to increased in vascularity. Anderson (1979:198) said that the most important uterine changes is "Hegar's sign and Goodell's sign". Hegar's sign is a softening of the isthmus of the uterus which occurs at the sixth week of pregnancy and Goodell's sign is a softening of the cervix, occurs about the beginning of the second month of pregnancy.

Other important signs and symptoms of pregnancy include the positive signs which are foetal heart sounds, foetal movements and foetal parts.

Foetal heart sound is the hearing of the fetal heart which is usually audible after the 18th - 20th week of pregnancy. By the stethoscope at the rate range normally from 120 - 160. When the heart is heard it is not only proves that the patient is pregnant but also that the child is alive.

Foetal movements: This is feeling the movement of the foetus, after the 20th week of pregnancy. The movement can be felt by the hand on the abdomen, over the uterus. The feeling may also be visible or audible.

Ballottment: This occurs between the fourth and fifth months of pregnancy; the small fetus, suspended in a relatively large volume of amniotic fluid, will rebound when the uterus is sharply tapped by the finger of the examiner.

Duration of Pregnancy

It is generally accepted that pregnancy lasts for about 280 days, which is 10 lunar months or 40 weeks calculated from the first day of the last menstrual period, but in exceptional cases there may be considerate variations. The shortest duration of normal pregnancy is 240 days and the longest duration of 313 days. Clayton (1976:53) pointed that if pregnancy followed a single coitus the average duration of pregnancy from the date of intercourse is 266 days and if the calculation is made from the first day of last menstrual period the average is 280 days.

Anderson (1979) said that "the duration of pregnancy is calculated by adding 7 days to the date of the onset of the last menstrual period and counting forwards nine months or back three months". For the purpose of simple practical method of calculation is to count forwards nine calender months (or backward three calender months) from the first day of the last period and add 7 days which will then give an average of 280 days.

Stages of Pregnancy

The stages of pregnancy are classified according to the major developmental characteristics of the fetus through trimesters. Trimesters are classified into three stages. The first stage - first trimester is the first three months of pregnancy. The second stage - second trimester is the middle trimester which is 4 - 6 months of pregnancy and the third stage - as the third trimester or last trimester is 7 - 9 months of pregnancy. According to Whelan (1978) the stages are classified as:-

- Just a little bit pregnant referred to as growing - (month 1 and 2).
- The middle trimester - (months of 4, 5, and 6) and the gentle art of infanticipating as (months of 7, 8, and 9).

While Anderson (1979) simply gave the stages as the first trimester, second trimester and third trimester. He goes further to elaborate that:-

> the first trimester is the period from the time of the last menstrual period through the twelfth week of gestation, the second trimester as the period from the twelfth week through the twenty-fourth week (12th - 24th week) of gestation and the third trimester as the beginning at the twenty-fourth week and ending at the fortieth week (24th - 40th week of gestitation. (pp. 160 - 162).

2.3.2 Labour pPeriod

Labour is the process whereby the products of conception are expelled through the birth canal after the 28th week of pregnancy. Pearce (1957) defined it "as the process of child birth". That is the entire process of bringing a baby into the world. A normal labour is one in which a mature fetus presents by the flexed is born spontaneously within 24 hours and without complication. While abnormal labour is the delay in labour where the first stage last for more than 24 hours. It may also be an earlier expulsion of pregnancy through abortion (miscarriage) meaning the interuption of pregnancy before the 28th week.

2.3.2.2 Symptoms and Signs of Labour

Symptoms and signs of labour are:-

1. Painful contractions
2. The shortening and dilatation of the cervix
3. The show; and
4. Lightening.

Painful Contractions

Painful contractions is the painless contractions which pass over the uterus during pregnancy which are now felt by the woman as tightening and actual pain. That is during this condition labour is recognised by the changes which take place in contractions as they become regular and painful to distract the patient from her normal activities. It commences in the lower part of the back and extends around the thigh and the lower abdomen. It increases in intensity to a maximum, then diminishes. At initial stage it lasts for about 30 seconds and occur at regular intervals of about 15 - 20 minutes.

Shortening and Dilatation of the Cervix

This is the stage of dilation of the os which lasts from the onset of true labour to full dilation of the os. That is when the labour begins the contraction and retraction of the upper uterine segment stretches the lower uterine segment and the upper part of the cervix, while the lower part of carvixal canal remains at first unaltered. As it starts from full dilation of the carvical os and last until the birth of the baby.

The Show

The show is when mucous discharge from the cervix mixed with a little blood. That is the passage of small amount of blood - tinged, sticky mucous from the vagina.

As the internal os is pulled open, the membranes are separated from the lower uterine segment, and a variable amount of ozzing of blood results.

Stages of Labour

Labour is divided into three main stages which are:-

1. First stage or stage of dilation.
2. Second stage or stage of expulsion; and
3. Third stage or stage of delivery of the secondines.

According to Townsend (1978) the first stage or stage of dilation lasts from the onset of the true labour pains until the osutein is fully dilated. That is dilatation of the neck of the womb to permit the subsequence descent of the child.

The second stage as the stage of expulsion of the child, lasts from the full dilatation of the osutein until the child is born. This is the stage during which the child's head followed by the body and limbs, descends through the boxy grindle of the vagina to the exterion. The third stage last from the birth of the child until the placenta and membranes are delivered and the uterus has retracted firmly to compress the uterine blood sinues.

Duration of Labour

In primigravidae (woman who is pregnant for the first time) the average duration of labour is 14 hours and 8 hours in the multigravidae (woman who has been pregnant several times), reason for differences is that the uterus act less efficiently in the first labour than in the second subsequent labours and the internal passages are more resistant.

However Townsend (1978:107) and Ajayi (1988) gave the average duration in both primigravidae and multigravidae as follows:-

Primigravidae		Multigravidae	
First stage	14 hours	First stage	7 hours
Second stage	1-- 2 hours	Second stage	½ hours
Third stage	¼ - ½ hours	Third stage	¼ - ½ hours
Total	16½ hours	Total	8 hours

2.4 Manifestation of Antenatal Problems

Pregnancy and childbirth brings for many expectant mothers a marvellous feelings of well-being and enhance psychological strength. So also from time to time most expectant mothers going through pregnancy experience distressing, fears and concerns, worries about the harm coming to the fetus. They also have fear for their own attractiveness, having an abnormal childbirth and myriad of fears, concerns and anxiety symptoms. Some fears about pregnancy or childbirth are related to previous unpleasant pregnancy experiences, miscarriage (abortion) or complicated delivery, distressing pregnancy and delivery experiences reported by friends.

Other manifestation of antenatal problems are those that are classified into minor and major disorders during pregnancy and these include varicose veins, backache, nausea or vomiting cramps, heartburn, abnormal frequency of urination. Others are haemorrhage, pre-eclampsia and eclampsia, sleeplessness and constipation.

Each of these symptoms are briefly explained below:-

Varicose Veins

The complaint produced by varicose veins range from cosmetic blemishes to severe pains; which may develop in the legs or in vulva and appear either as enlarged warm-like tubes beneath the skin, or as spider varicosities around the ankles and behind the knees. The legs feel heavy, look ugly which can be painful or swollen.

The veins can appear at any time during pregnancy but on the whole it tends to enlarge and become more obvious in the later months of the pregnancy. As Jones (1982:22) said that the complaints occurs in the first 12 weeks of pregnancy, and usually disappearing at the end of this time, and sometimes occuring in late pregnancy. The varicosities of the veins in the lower extremities and around the vulva are quite common in women who have had children before; than those who had not have children previously.

Backache

Backache is a common complaint during the pregnancy, which may be early sign of labour for the pregnant woman. The backache increases during the day and is felt most towards evening, and at night when it may prevent sleep.

The pain is usually felt low in the back or over the sacro-iliac joint. It is common with a multiparous women, because of lax abdominal muscles which make her tend to put her shoulder back to support the uterus and to keep her balance.

Nausea or Vomiting

Nausea or vomiting occurs in almost 50% of women in early pregnancy and more frequent in primigravidae than in multiparae.

That is vomiting is a common complaint among most pregnant women, which occurs in the early first three months of pregnancy, and very frequency among those women who have been given birth before, than those who are given birth for the first time. And as it occurs it shows the signs of dry skin, loss of weight, raise in temperature level above the normal level and others. As Clayton (1976:7) pointed out that from the 6th to the 14th week nausea or vomiting in early morning is very common. It usually disappear at the end of first trimester and sometimes recuring in late pregnancy.

Cramps

Cramps are painful muscles of the legs, which mostly occur at night. There is also cramps in the abdominal wall, back and calf which are common in the later part of pregnancy. Lack of calcium, vitamin B1 and D and temporary circulating changes in the leg have been suggested as the cause.

Heart Burn

This is common complaint in the last 12 weeks of pregnancy. That is a common problems among the expectant mothers in their last three months of child delivery. The symptom usually occur when the patient is lying down or bending over. It is due to the regurgitation of gastic content into the lower oasophagus secondary to relaxation of the cardiac. That is due to the passage of small amounts of stomach content into the lower part

of the tube (esophgus) which leads from the mouth to the stomach.

In pregnancy it occurs because the valve sourading the entrance to the stomach relaxes.

Abnormal Frequency of Urination

Abnormal frequency of urination as a complaint during pregnancy is a condition where the pregnant mother tends to urinate frequently more than before, throughout the pregnancy, due to hormonal changes and the vascular engorgement of the pelvis. It may cease after the 12th week and to reappear in the last week of pregnancy. In the late pregnancy the symptom is due to the pressure of the baby's head on the bladder, and can be quite disturbing especially at night.

Haemorrhage

Haemorrhage is a condition where there is a bleeding from the genital tracts after 28th week of pregnancy. This is bleeding from the vagina occuring at any time after the 28th week of pregnancy up to the delivery of the child.

Pre-Eclampsia and Eclampsia

Pre-eclampsia is a condition whereby the expectant woman has an increase in weight, blood presure, and there is also protein in the urine. It tends to occur at any time after the 24th week of pregnancy and more common after the 30th week. It is mostly common with people having birth at late age of about 30 - 35 years, or those marrying at late ages. That is common among the primigravidae in general.

Anameia

Anameia is the reduction of the normal hemoglobin (blood) in circulation; the complaint during the pregnancy is due to lack of blood circulation in the pregnant woman, especially those with multiple pregnancy, and also among some of the pregnant women with low income.

Other manifestations of antenatal problems are those that are related to social and psychological problems and changes of a pregnant woman; especially among the underprivileged and primigravidae women. Psychologically there is feeling of anxieties and fears in the pregnant woman right from the beginning of the pregnancy till the end of pregnancy, the woman will be thinking on how to cope with the pregnancy, especially the primigravidae who will be thinking if she can care for the pregnancy till the end of 9th month. While most of the anxieties are that; may be the baby will die in the uterus or will not be normal or healthy and fear that drug taken during pregnancy will cause bad effects.

Psychological Problems

As the pregnancy develops from one state to another women increases anxieties and fears. They are now concerned with the realities of becoming a mother and the changes in marital and family relationships. They are also concerned about the process of labour and the difficulties they may experience with delivery, especially if they had a previous experience or fantasy, about the process.

The sex and health of the infant and possibilities of death or injury to mother or child preoccupy a woman during pregnancy often cause sleepless and restless period in the last trimester.

So also during the pregnancy expectant mother experience fears and anxieties about the hospital procedures and their relationships with the medical personnels in the hospital.

Kitzinger (1977:100) said that expectant mothers taught in the year 1974, eighty-seven of them reported some incident which had produced anxiety, frustration or hostility and many experienced repeated situation in when they felt unable to communicate with doctors or midwives. That is a situation where most of the pregnant mothers will find it extremly difficult to communicate to the doctors or nurses, about the conditions of their pregnancy and health generally, and thereby tend to develop fears, aggressiveness nerviousness and hostility to nurses.

In addition, these changes are influenced by the general outlook of the woman. A woman's psychological or emotional tendencies and general outlook of life may affect her mental reaction to pregnancy.

Apart from minor discomfort associated with pregnancy examples of which are early morning sickness, dyspesic, frequency urination etc which may distress a woman. Ojo (1978) has listed some adverse emotional problems of pregnancy which include:-

1. Poor socio-economic status, that is lack of financial support this could also lead to distress and anxiety on the part of the woman.
2. Poor relationship with the husband. i.e. to say that some women may be abondened by their husbands.
3. Anxiety over normality of the baby to be born.
4. Poor environmental or living conditions.
5. Fear of the unknown based on supertitions and old wives tales.

The above changes are often seen in most cases of unhappy marriage, previous unsuccessful child-bearing experience, unmarried women and very dependant woman.

A social medical worker's assistance could be sought in cases where the anxiety or distress is due to unfavourable socio-economic factors. A friendly and understanding attitude of the midwife with encouragement from the guidance counsellor can go a long way to calm the patient.

The role of the guidance counsellor therefore is to assist the pregnant women to plan, prepare and adapt their behaviour to the changing circumstances of child birth and also to equip them face the task which life presents. Mild hypnotic could be given in cases of insomma and patients should be referred to a medical doctor if the symptoms persist.

Helping a woman by a counsellor towards accquiring techniques for handling her pregnancy and labour is for her

to have the minimum pain and the maximum confident understanding and feeling of well-being. By giving this counselling techniques with the help of doctor during pregnancy she acquires the feeling of partnership through which they can plan together for a safe and happy delivery. The counsellor's relationship with the expectant mother can assist her to speak frankly about her hopes, fears and doubts knowing that she will be heard with sympathetic understanding.

The counsellor can use this opportunity to assist the midwife in demonstrating the techniques of handling of labour in the clinic. Also a series of one to three days seminars on antenatal care could be organised and when possible with the pregnant mothers to teach the skills and the right sort of health care for happy and successful delivery.

Physiological Changes

Physiologically no expectant mother can exist on exactly the terms with her body as before the pregnancy, but she is taken over with many changes such as changes determined by weight gain of about 0.05kg every week due to general changes such as water retention, deposit of fats gain in the weight of the foetus, uterus, placenta and aminiotic fluid and those changes due to human chorionic gouadtropic horuone. This is the unique hormours of pregnancy formed from the phoblast, and can be seen at earlier day of pregnancy. About 100% of it

is executed in the urine, and manifested during the period of oregnancy because it regulates oestrogen production by placenta.

Other remarkable physical changes occuring are the profound respiratory modification, with an increased tides volume of air, the woman's oxygen consumption also raised by approximate of 20% and her lower ribs flame out as the uterus rises and presses against them.

2.5 The Role of Nurses in Antenatal Clinic

Nurses in the antenatal clinic play major roles which include educating and teaching of pregnant mothers, organise seminars and talks in the clinic, act as liason between the expectant mother and medical doctors, and provide emotional supports to the mothers.

Lewis (1983:313) and Ajayi (1983:187) gave the roles of nurses in antenatal clinics as; to detect abnormalities in pregnancy or labour, to refer patients who develop problems to a doctor, provides for all mothers and their new babies the special nursing care they require, advice and discuss with expectant mothers.

Antenatal Care

Provision of antenatal care for the expectant mother patient is one of the major roles of nurses in antenatal clinic. This involves given care to a woman during pregnancy and before delivery. In doing this the nurses has to think of the social, economic and psychological background of the

patient during this period, so that the patient will gain midwive knowledge.

The aims include to promote and maintain good mental and physical health during pregnancy, to ensure a mature healthy infant which includes the prevention of congental abnormality, to prepare the woman for labour, lactation and subsequent care of a child from physical, psychological social and educational point of view. It also aim to detect easy and treat appropriate risk conditions, medical or obstetrical that endanger the life of the mother or the baby.

History Taking

At first visit nurses in the antenatal clinic take detail history and carried out full examination of the expectant mother patient. This include her name, medical history and social environment, personal details - full name; address, date of birth, date of marriage, date of last menstrual period, others include occupation, religion, husband's occupation, obstetric history and present pregnancy and file them properly in the antenatal notes.

Teaching of the Expectant Mothers

Classes are arranged in antenatal clinic by nurses for expectant mother, for general instruction on pregnancy, labour and child delivery. There are many subjects on which instruction are useful to mothers such as the preparation of the baby's clothes and the advantages of breast feeding. It also involves a detail explanation of the stages of pregnancy and labour which are given to the patients, so that they may know what to expect during these stages.

Patients are also given a course of instruction in antenatal exercises. The exercises are directed more to the patients' posture and general physique.

Coordination of Activities

Nurses in the antenatal clinic play major roles of coordinating many activities of the various specialists, and provide good communication among them, such activities include the activity of medical consultants, social workers, who may be asked to help with social problems that arise frequently in the care of mother and their new born baby.

Other domicilary roles include, assisting the physician to keep records that may be useful to other personnel; participating in the total care and be aware of the unique needs of the individual patient. Managing the normal pregnant mother during the maternity cycle, acting as consultant, and supervisor.

Gives Guidance and Counsel Roles

Nurses in the clinic gives guidance and counselling roles to the expectant mother patients. That is the nurses assist the patients to the appropriate places, such as to the examination room; labour ward, dressing area where she may undress and put on an examination gown. Counsel the patients on the procedures involved in the examination and discussion with the patient the value and technique of labour, self breast examination.

2.6 Coping Strategies Used By Nurses with Pregnant Mothers

From the literature these are the methods the nurses use in helping pregnant mothers in coping with their problems; advice technique, referral technique, counselling technique, support and reassuranced technique.

Advice Technique

Advice by nurses to pregnant mother as a technique of coping with strategies include advice on exercise, diets, work, rest and sleep, bathing and breast care.

Exercise

Antenatal exercises are recommended by nurses to expectant mothers in order to promote their physical well-being, to teach the patients how to relax, breathe, exercise of the muscles, and pelvis.

At first trimester expectant mothers are adviced to engage an exercise such as lying on side ways and their back, and then change position and not to lie with their abdominal.

Short Walking

Nurses encourage expectant mothers to go on strolling in the evening hours when the sun is down with fresh air at least for 30 minutes to an hour strolling; which aids in the development of their muscles, and also help circulation of blood that is fress movement of blood within their body.

Deep Breathing

Advice expectant mothers to always practice breathing exercises; that is to sit on a chair or mat and breath in and out while they close their mouths.

Heardman (1982:5) give that "with mouth closed, breath gently in and out, keeping quite loose and letting the abdominal rise up with the indrawn breath and drop down with the outgoing one". The exercise is to expand the lunge and abdominal walls.

It should be practice everyday, so that on the day of labour they would not have much difficulty.

Exercise of the feet

This involve strenthing of legs and arms. Tell the pregnant mothers to sit on a chair supported with stool or a low chair, or lying down, then bend and stretch the angles, toes, and roll the feet round the circles in both directions. The exercise should be done as often as possible .

Pelvic Exercise

Pelvic exercise involve telling the women to lie on her back with her kneel bent and the feet flat unbent, with the head being supported with one or two pillows, tell to tighten the muscles on the uterus and gradually draw round the abdominal walls, pressing the back firmly on the bed, and gradually relax both muscles and contract the lower back muscles to make a tunnel under them.

The exercise is to make the muscles of the heeps in preparation for labour.

Balanced Diet

Nurses advice the expectant mothers on the importance of balance diets, which should be taken adequately. It should contain much proteins, vitamins, minerals which are very

essential to their health with less carbohydrate foods at middle trimester and much of it at the last trimester, so that they have much energy to undergo the strength of labour.

In the morning patients are adviced to take tea with baked beans or pap with cake, or tea with bread and egg. In the afternoon to take rice, plantain with either fish or meat, and in the evening to take gari (eba) or either tuwo or amala and vegetable soup with fish or meat. The food taken by the expectant mothers should be in quantity and quality diets.

Work

As a method of coping during the pregnancy expectant mothers are adviced to continue with her ordinary daily duties but to avoid heavy work which requires much energy, especially after the fourth month of pregnancy, and if the job involves much standing such as hair dressing, a two hour rest period in the middle of the working day must be observed. If her work is hard one, she is encouraged to take three months maternity leave, which should be three weeks before her expected date of delivery.

Rest and Sleep

Expectant mother patients are adviced to keep regular hours sleep and go to bed early. Eight hours of sleep is recommended in bed each night, a rest after lunch should be taken in the later half of the pregnancy. In early labour patients are encouraged to sleep with the use of appropriate hypnotic and analgestic drugs in order to maintain a normal physiological state of her body.

Bathing and Breast

Daily bath with warm water, and careful washing of breast and nipples are also encouraged with the expectant mothers during pregnancy and even after delivery.

Clothing

Expectant mothers are adviced to always wear light clothing with allowances, no bands around the breasts and abdomen. They are also adviced to wear comfortable low level shoes and avoid high heels.

Abnormal Symptoms

As a technique of coping during the pregnancy expectant mother patients are adviced verbally, as well as by printed instructions, to report at once any symptoms and signs of disease or illness, such as severe headaches, pains in the abdomen, shortness of breath, dimness of vision, flashes of light, swolling of legs or faces, haemorrhage and persistent vomiting.

Patients are also adviced to attend the instruction classes, to have booklet of advice and information about the labour and pregnancy and about social services available to them.

Referral

If the expectant mothers illness is distressing she is referred immediately to medical doctor for the meaningful medication and proper management in order to get relief from the problems. That is, nurses refers to the physicians any pregnant woman who show evidence of obstetrical or medical

disorders. So also if the problem is psychological or social in nature the patient is referred to the appropriate place such as to the social workers, guidance counsellors where the patient can be helped on how to solve the problems.

Educational Technique

Educational techniques as a means of helping pregnant mothers in coping during pregnancy involves providing information about the philosophy and subjective experiences of pregnancy and childbirth. For the woman with morbid or irrational fears and anxiety factual information related to those fears and anxiety are provided in detail which can bring considerable relief. Brown (1979:27) said that the woman who is terribly frightened about labour and delivery may benefit from detailed explanation of the philosophy of labour and delivery which include drawings and graphs. In educational class; preparation for labour involving group education techniques during which various methods of relaxation and psychotherapeutic training are discussed, so that fears are dispelled and acceptable methods of relaxation and self-hypnosis are also introduced.

Counselling Technique

Nurses organises counselling method with expectant mothers as a strategy of helping them during pregnancy and for successful childbirth. The approach can be either individual or group counselling, but with more emphasis on group counselling in the antenatal clinic as it have some advantages over the individual counselling. Kolo (1988) "pointed out that group

counselling enables the mothers pass from one stage of life that is being a bride to another stage of life. Goes further to say that counselling in group fulfils a vital need in the preparation for childbirth which individual counselling may not be able to do".

The essence of it is that it enables the expectant mothers having similar problems fears; and anxieties to express and convert together with each other together with the nurse which may not be possible in the individual counselling situation.

Support

Support and encouragement are used as a means of coping strategies with expectant mothers who is experiencing anxiety or morbid fears during pregnancy and labour.

Such support and encouragement are in a inform of given a word of encouragement as regards to the condition of her pregnancy and also during the labour stage. When such mother will find it useful to have additional contact with people, especially with the health professional personnel. It can also be interm of appointment cards or written appointments which serve as concrete body representation to the patients, because patients undergoing distress, and looking at the appointment card will gain some assurance from it that health professional is available to her.

Reassurance

Reassurance as one of the techniques nurses use with expectant mother patients have sense of confidence, and feeling of security to the patient at both physiological and psychological changes in pregnancy. For instance the nurse can tell the expectant mother that: "keep cool, we are going to try and find out the solution to the problem" or 'Don't worry, everything is going to be okay'. Such statements and others will then give the patient a sense of relief from stress and assurance that she will over come her problem.

2.7 Summary

In this chapter meaning of concept antenatal and anatenatal problem are discussed as conditions of pregnant women before birth and disorders and difficulties during pregnancy and labour respectively. Review of related literature is made on the theories of antenatal problems which include the pregnancy and labour periods.

Brief discussion is made on antenatal problems, roles of nurses in the antenatal clinic and coping strategies being used by nurses on pregnant mothers to over come their problems.

Chapter 3

METHODOLOGY AND PROCEDURE

3.1 Introduction

Methodology in research is a systematic process in carrying out a given task. Afolabi (1991) defined it as "the operational blue-print which the researcher plans to employ in accomplishing the objectives of the study". In view of the above this chapter describes in details the methods and procedures that were employed in carrying out the study on the antrenatal mothers' problems and coping strategies. The areas discussed are the research design, the population, the subjects; instrumentation, the administration of the instrument, the statistical techniques for data analysis and the limitation of the study.

3.2 Research Design

The research method adopted for this study was the descriptive survey. Afolabi (1991) said the method involves sampling from the target population of the study and generalizing the finding obtained from analysis of the sampled data. The method was adopted as it have the advantage of affording the opportunity for through and detailed examination and ensure efficiency in the result findings.

3.3 Population

The population for the study was all the expectant mothers. The population also contained all the nursing sisters and midwives in the three clinics in Zaria.

Information from Sick Bay Main Campus revealed that there were about 1,000 expectant mothers attending antenatal clinic with about 11 nursing sisters and midwives, while those expectant mothers attending antenatal clinic in Ahmadu Bello University Teaching Hospital Tudun Wada numbered about 2,100 with 26 nursing sisters and midwives by the statistics of pregnant mothers attendance list. The expectant mothers attendance list for Kofan Kayan Hospital showed about 1,150 with 14 nursing sisters and midwives.

3.4 Sample

Expectant mothers, nursing sisters and midwives were sampled from the three clinics - Sick Bay Main Campus, Ahmadu Bello University Teaching Hospital and Kofan Kayan Hospital Zaria. A total of 287 respondents were selected from the target population which was made up of 236 expectant mothers and 51 nursing sisters and midwives. Krejcie and Morgan (1970) agreed that out of a total population of about 3,000, 341 samples is the maximum required sample size that is why the 287 sample size chosen at three clinics is considered adequate.

3.5 Instrumentation

Questionnaire and an interview guide designed by the researcher and validated by specialist in guidance and counselling were used as the instruments to collect data from the respondents. The questionnaire contains three main sections. The first section (Section A) sought for personal data about the respondents like - age, educational qualification, marital status, number of children. The other two sections (Section B and C) contain items related to the pregnancy problems and coping strategies which the respondents reacted to.

The second instrument which is structured interview was conducted to those expectant mothers who cannot read nor write. The researcher interviewed them using the items in the questionnaire. Assistance of the nursing sisters, midwives and interpreters were sought for the interpretation in a situation where the researcher was unable to speak the language understood by the respondents.

3.6 Administration of the Instrument

For data collection the researcher visited the three antenatal clinics personally and administered copies of questionnaire to the respondents randomly; and also conducted interview to the expectant mothers who cannot read nor write. Administration copies of questionnaire and interview was

carried out on the day of antenatal care for each clinic respectively when the researcher was able to meet the respondents in the clinic. Where personal administration become difficult the researcher seeked the assistance of the nursing sisters, midwives, helpers and interpreters to assist in the distribution, interpretation and collection of the instrument. The data collection exercise lasted for about two months during the period of study.

3.7 Data Analysis

A number of statistical techniques were used for the data analysis in this study. Among them are the frequency counts and simple percentages were used for analysing the biodata information of the respondents. Also analysis of variance (ANOVA) and T-test statistics were used in analysing the data for testing the hypotheses. The two types of statistical tools were used because all the stated null hypotheses were comparing means to find out if there were significant differences between the groups used in the study. The ANOVA was used in cases where means scores of groups were more than two groups.

3.8 Limitation of the Study

Any study done has to face some problems. One of the obvious limitations this study faced was that some respondents failed to filled the personal data information which are very

necessary for accurate analysis of the data collected, such information include age, religion and educational qualification.

Another limitation was that 300 copies of questionnaire were distributed but the researcher was able to recollect 287 only.

3.9 Summary

The chapter highlighted the methodology and research procedure. The chapter discussed the research design, the population and sample size. The instrumentation for data collection, data analysis and the limitation of the study were also discussed. The study mainly focused on the antenatal mothers' problems and coping strategies for the antenatal mothers in Zaria.

Chapter 4

4.1 Introduction

This chapter presents the results and discussion of the data collected. The Analysis of Variance (ANOVA) and T-test techniques were employed to test the null hypotheses formulated for investigation in the study. A significance level of 0.05 is adopted as the basis for rejection or acceptance of the hypothesis.

4.2 Demographic Data

This section analyses the characteristics of the respondents. The demographic data include groups, age, marital status, educational qualification, religion, number of children and clinics of respondents.

Table 4.1: Distribution of Respondents based on Group of Respondents.

Group of Respondent	Frequency	Percentage
Expectant mothers	236	82.23
Nurses and midwives	51	17.77
Total	287	100.00

Table 4.1 reveals that all the respondents are in two groups from which 82.23% are expectant mothers and the remaining 17.77% were nurses and midwives from three antenatal clinics.

Table 4.2(a): Age Distribution of Expectant Mothers

Age	Frequency	Percentage
Under 18 years	14	5.93
18 - 23 years	64	27.12
24 - 29 years	70	29.66
30 - 35 years	63	26.69
36 and above years	23	9.75
No responses	2	0.85
Total	236	100.00

The table indicates that the largest respondents 70 (29.66%) were from age range of 24 - 29 years, followed by 64 (27.12%), and 63 (26.69%) of the respondents of age range 18 - 23 years and 30 - 25 years respectively. While 23 (9.75%) of age range 30 and above and 14 (5.93%) were from age range of under 18 years, and 2 (0.85%) of the respondents did not indicate their ages.

Table 4.2(b): Age Distribution of Nurses and Midwives

Age	Frequency	Percentage
18 - 23 years	12	23.53
24-29 years	15	29.41
30 - 35 years	13	25.49
36 and above years	11	21.57
Total	51	100.00

Table 4.2(b) shows that the largest respondents 15(29.41%) were from age range of 24 - 29 years. While 13(25.49%) were from age range of 30 - 35 years, 12(23.53%) and 11(21.57%) were from age range 18 - 23 years and 36 and above years respectively.

Table 4.3(a): Marital Status of Expectant Mothers

Marital Status	Frequency	Percentage
Single	22	8.46
Married	202	25.59
Divorced	14	5.95
Total	236	100.00

Concerning marital status of the respondents table 4.3(a) shows that 22 (8.46%) were single expectant mothers, while 202 (25.59%) were married and 14 (5.95%) were divorced.

Table 4.3(b): Marital Status of Respondent Nurses and Midwives.

Marital Status	Frequency	Percentage
Single	8	15.69
Married	42	82.35
Divorced	1	1.96
Total	51	100.00

Table 4.3(b) shows that the largest respondents 42 (82.35%) were married, while 8 (15.69%) were single and 1 (1.96%) was from divorced.

Table 4.4(a): Education Qualification of the Expectant Mothers

Educational Level	Frequency	Percentage
Primary School Certificate	55	23.30
Post Primary Certificate	56	23.73
N.C.E.	32	13.56
Graduate and Above	37	15.68
Illiterates	50	21.19
No Responses	6	2.54
Total	236	100.00

Table 4.4(a) reveals that most of the respondents 56 (23.73%) had post primary school certificate. This is followed by 55 (23.30%) of those who had primary school certificate only. The third largest group of 50 (21.19%) were illiterates and 37 (15.68%) of the respondents had Nigerian Certificate of Education (N.C.E.) 6 of the respondents represents 2.54% did not indicate their educational qualification.

Table 4.4(b): Educational Qualification of the Respondent Nurses and Midwives.

Educational Level	Frequency	Percentage
Post Primary School Certificate	15	29.41
Degree Graduate and Above	31	60.78
No Responses	5	9.81
Total	51	100.00

As regards information on the education qualification of the nurses and midwives the findings shown in table 4.4(b) indicates that the largest respondents represented by 60.70% were holders of degree certificate and above. 29.41% of the respondents were holders post primary certificate, and 9.81% did not indicate their educational qualification.

Table 4.5(a): Religious of Expectant Mothers

Religion	Frequency	Percentage
Christianity	111	47.03
Islam	113	47.88
Traditional	4	1.69
Others	2	0.85
No Responses	6	2.54
Total	236	100.00

Concerning religious distribution of the respondents table 4.5(a) shows that 47.03% were Christians while 47.88% were from Muslims. Also 1.69% were of traditional beliefs and 0.85% were from other religious not specified by them while 2.54% of the respondents did not indicate their religion.

Table 4.5(b): Religious Distribution of Nurses and Midwives.

Religion	Frequency	Percentage
Christianity	34	66.67
Islam	16	31.37
Traditional	-	-
No Responses	1	1.96
Total	51	100.00

As regard information on the religion of the respondent nurses and midwives, table 4.5(b) indicates that 66.67% were Christains, 31.37% were Muslims, while one represents 1.96% of the respondents did not indicate her religion.

Table 4.6: Number of Children per the Expectant Mother

Number of Children	Frequency	Percentage
One child	49	20.76
Two children	48	20.34
Three children	46	19.40
Four children	36	15.25
More than four children	35	14.93
No Responses	22	9.32
Total	236	100.00

The summary of the number of children of the respondents is presented in table 4.6. The table shows that the largest respondents 49 (20.76%) were from those with one child, 48 (20.34%) for those with two children. While 46 (19.40%) and 36 (15.25%) were from those with four children and more than four children respectively. And 22 of the respondents represents 9.32% did not indicate their number of children.

Table 4.7(a): Distribution of Respondents by Clinic (Expectant Mothers)

Clinic	Frequency	Percentage
Sick Bay	69	29.24
Ahmadu Bello University Teaching Hospital	92	38.98
Kofan Kayan Hospital	75	31.78
Total	236	100.00

Table 4.7(a) shows that 69 (29.24%) of the respondents were from Sick Bay Main Campus, while 92 (38.98%) were from Ahmadu Bello University Teaching Hospital Tudun Wada and 75 represents by 31.78% from the Koyan Kayan Hospital Zaria City.

Table 4.7(b): Distribution of the Respondents by Clinic (Nurses and Midwives)

Clinic	Frequency	Percentage
Sick Bay Main Campus	11	21.57
Ahmadu Bello University Teaching Hospital	26	50.98
Kofan Kayan Hospital	14	27.45
Total	51	100.00

Concerning clinic distribution of the respondents table 4.7(b) shows that 11 (21.57%) were from Sick Bay Main Campus, while 26 (50.98%) were from Ahmadu Bello University Teaching Hospital Tudun Wada and 14 (27.45%) were from Kofan Kayan Hospital Zaria City.

4.3 Research Question

The main research questions of this study seeks to find the answers to what are the problems and coping strategies of antenatal mothers in Zaria. To answer these questions the mean scores and standard deviation of respondents in all the three clinics of the study are presented in table 4.8.

Table 4.8: Means and Standard Deviation of Respondents

S/No	Source of Problems	N	X	SD
1.	Abnormal frequency of urination	236	2.4746	1.0815
2.	Anxiety	236	2.3771	1.1288
3.	Back ache	236	2.2797	1.0387
4.	Nausea and vomiting	236	2.2034	1.0111
5.	Constant day dreaming causing fear during pregnancy	236	2.1229	1.0009
6.	Pre-eclampsia and eclampsia	236	2.1144	1.0677
7.	Unassertive	236	2.1102	1.0501
8.	Getting angry easily	236	2.1017	1.0829
9.	Insomnia (couldN*t sleep well)	236	2.0890	0.9917
10.	Restlessness (unable to be at peace most of the time)	236	2.0720	0.9266

Table 4.8 (Cont'd.)

S/No	Source of Problems	N	X	SD
11.	Heartburn (hotness of the chest)	236	2.0551	1.0237
12.	Varginal discharge	236	2.0000	1.0231
13.	Depressed	236	1.9280	0.9931
14.	Lowered self pride	236	1.8983	0.9927
15.	Resentful (disagree with others to pregnancy and antenatal care)	236	1.8941	0.9279
16.	Fear of antenatal clinic Nursing Sisters and Doctors	236	1.8771	0.9967
17.	Feeling shy of being Pregnant	236	1.8771	1.0547
18.	Varisco veins (swollen veins on the leg, vulva)	236	1.8517	0.9358
19.	Feeling of isolation due to pregnancy	236	1.8771	1.0547
20.	Creates feelings of hatread for others during pregnancy	236	1.7415	0.9920
21.	Haemorrhage (bleeding from gential tract)	236	1.5636	0.9190

Table 4.8 indicates in decending order of magnitude the most frequently occuring problems that expectant mothers in the sample have expressed during pregnancy. The top ten problems are: abnormal frequency of urination, anxiety, back ache, nausea and vomiting and constant day dreaming causing fear during pregnancy; preeclampsia and e-clampsia that is increase in weight with high blood pressure, unassertive, getting angry easily insomnia (couldn't sheep well), restlessness which is unable to be at peace most of the time, and heart burn (hotness of the chest).

The lower five problems in accending order are: haemorrhage (bleeding from gential tract) create feelings of hatred for others during pregnancy, feeling of isolation as a result of pregnancy, varicose veins (swollen veins on the leg(vulva) and feeling shy of being pregnancy.

Table 4.9: Means and Standard Deviation of Coping Strategies of the Expectant Mothers

S/No	Coping Strategies	N	X	SD
1.	General cleanliness	236	3.4534	1.463
2.	Prayers	236	3.1653	1.341
3.	Attending antenatal clinic	236	3.1144	1.319
4.	Sleep and rest	236	3.0636	1.298
5.	Taking balanced diets	236	3.0466	1.290
6.	Abide withnurses' advice	236	2.8856	1.122
7.	Taking a medicates	236	2.7203	1.152
8.	Working	236	2.5508	1.080
9.	Self positive statements	236	2.5297	1.071
10.	Engaged in discussion with others	236	2.5127	1.064
11.	Supports (Moral and Financial Supports)	236	2.5127	1.064
12.	Exercises such as walking and dancing	236	2.5085	1.062
13.	Reading religious books or novels	236	2.1059	0.053
14.	Having intercourse during pregnancy	236	2.1059	0.892
15.	Reading books or pamphlets on pregnancy	236	2.0212	0.856

The following are the main five coping strategies by the expectant mothers: general cleanliness, prayers, attending antenatal clinic, sleeping and resting and taking balance diets. The lower five coping strategies in accending order are: reading

religious books or pamphlets on pregnancy, having intercourse during pregnancy, reading religious books or novels, engaged in doing. exercises such as dancing and walking, and getting supports interm of financial and moral supports.

Table 4.9 above shows that the most coping strategies by the sample expectant mothers was general cleanliness with the highest mean score of 3.4534. This is followed by prayers with a mean score of 3.1653. Attending antenatal clinic was the next coping strategy area. This area had a mean score of 3.1144. The next coping strategy area was sleep and rest. This had a mean score of 3.0636. Taking balanced diets was the next coping strategy area with a mean score of 3.0466.

Table 4.10: Mean and Standard Deviation of Recommended Coping Strategies by the Nurses and Midvies Midwives to the Expectant Mothers

S/No	Coping Strategies	N	X	SD
1.	General cleanliness	51	3.7647	0.4284
2.	Abide with nurses' advice	51	3.6667	0.5538
3.	Attending antenatal clinic	51	3.6471	0.4826
4.	Taking balanced diets	51	3.4902	0.587
5.	Sleep and rest	51	3.3137	0.5474
6.	Prayers	51	3.118	0.739
7.	Exercises (dancing and walking)	51	3.000	0.748
8.	Taking medicates	51	2.9412	0.5445
9.	Self positve statements	51	2.784	0.932
10.	Supports (Financial and moral supports).	51	2.7647	0.6193
11.	Reading religious books or novels.	51	2.725	0.777
12.	Working	51	2.5490	0.6104
13.	Reading books or pamphlets on pregnancy	51	2.529	0.758
14.	Engaged in discussion with other	51	2.451	0.730
15.	Having intercourse	51	2.373	0.720

Results in table 4.10 shows that general cleanliness, abiding with nurses' advice and attending antenatal clinic ranked highest of the coping strategies recommended by the nurses and midwives. From the table, it also evident that having intercourse during pregnancy, engaged in discussion with others and reading books or pamphlets on pregnancy have the lowest meanscores of responses by the respondents as strategies they recommended to expectant mothers when experiencing pregnancy problems.

4.4 Testing of Hypotheses

In testing the hypotheses formulated for this study, Analysis of Variance (ANOVA) and T-test statistics techniques were used. Five hypotheses were tested.

Hypothesis 1

The first hypothesis states that there is no significant difference in the strategies recommended to the expectant mothers by nursing sisters in Ahmadu Bello University Teaching Hospital Tudun Wada, Sick Bay antenatal clinic and Kofan Kayan Hospital in Zaria City. To test this hypothesis one way Analysis of Variance (ANOVA) statistics was used to analyse the result of the data. Table 4.11 presents the result of the analysis.

Table 4.11: Recommended Coping Strategies of the Nurses and Midwives in the three Clinics

Source of Variation	Df	SS	MS	F-value	P
Between groups	2	67.886	33.943		
Within groups	233	13541.640	58.119	0.584	NS
Total	235	13609.525			

P .05
NS = No significant difference.

Examination of table 4.11 above shows no significant difference in the strategies recommended to the expectant mothers by nursing sisters in all the three antenatal clinics used in this study. Based on this the hypothesis is therefore retained.

Hypothesis 2

The second hypothesis states that there is no significant difference between coping strategies of expectant mothers and strategies recommended by the nursing sisters and midwives in antenatal clinics in Zaria. To test this hypothesis a t-test statistics technique was adopted to analyse the data.

Table 4.12: Responses of Respondents based on Coping Strategies

Group	N	$\bar{X}$	SD	SE	DF	T-value	P
Expectant Mothers	236	40.68	7.61	0.50	176	-6.49	0.0000
Nurses and Midwives	51	45.12	3.37	0.47			

S = Significant at 0.05.

Table 4.12 revealed that there was a significant difference in the coping strategies of the expectant mothers and the recommended strategies by the nursing sisters and midwives. The mean scores of 45.12 for nursing sisters and midwives in antenatal clinics was higher than the mean scores 40.68 for the expectant mothers. Thus the earlier stated null hypothesis is then rejected at 0.05 significant level based on the t-test result in table 4.12.

Hypothesis 3

This hypothesis states that there is no significant difference between the literate and illiterate expectant mothers' problems. A t-test statistics was applied to test this hypothesis.

Table 4.13: Analyse of Respondents According to Literacy Level

Groups	N	$\bar{X}$	SD	SE	DF	T-value	p
Illiterate Expectant Mothers	56	40.5	12.2	1.6	82	-1.40	0.17
Literate Expectant Mothers	180	43.0	10.6	0.29			NS

NS = Not significant at 0.05 level.

The results as shown in the table 4.13 indicated that there was no significant difference between the illiterate and literate expectant mothers' problems. The mean scores of 40.5 for illiterate expectant mothers and 43.0 for the literate expectant mothers, and the standard deviation 12.2 and 10.6 respectively show very insignificant difference. This means that both illiterate and literate expectant mothers do experience the same antenatal problems. Thus the null hypothesis was retained.

Hypothesis 4

The fourth hypothesis states that there is no significant difference in the recommended coping strategies by the married and single nursing sisters to the expectant mothers in Zaria. To test this hypothesis a t-test statistics was used. The result of the test was presented in table 4.14 below:

Table 4.14: Recommended Strategies by Nursing Sisters and Midwives based on Marital Status

Groups	N	$\bar{X}$	SD	SE	DF	T-value	P
Married Nurses & Midwives	42	45.33	3.40	0.53		1.03	0.32
Single Nurses & Midwives	9	44.11	3.18	1.1	12		NS

NS = Not significant at 0.05 level.

The result as shown in table 4.14 indicated that there was no significant difference in the recommended coping strategies by the married and single nursing sisters and midwives to the expectant mothers. The mean scores of married nursing sisters showed 45.33 and 44.11 for the single nursing sisters. The table also revealed standard deviation of 3.40 for the married nursing sisters and 3.18 for single nursing sisters, which shows that married and single nursing sisters for the study did not differ significantly in their recommended strategies to the expectant mothers. Therefore earlier stated null hypothesis was retained at 0.05 significant level.

Hypothesis 5

The hypothesis states that there is no significant difference in the coping strategies of the illiterate and literate expectant mothers. To test the hypothesis a t-test statistics was adopted. The result is presented in table 4.15 below.

Table 4. 15: Coping Strategies of Expectant Mothers Based on Literacy Level

Groups	N	$\bar{X}$	SD	SE	DF	T-value	P
Illiterate Expectant Mothers	50	36.25	9.90	1.3	69	-4.15	0.0001
Literate Expectant Mothers	186	42.06	6.15	0.46			S

S = Significant at 0.05 level.

Table 4.15 shows that there was a significant difference in the coping strategies of the illiterate and literate expectant mothers in antenatal clinics in Zaria. The mean scores of 42.06 for the literate expectant mothers was higher than the mean scores of 36.25 for the illiterate expectant mothers. This means that the literate expectant mothers used more coping strategies than the illiterate expectant mothers. The stated null hypothesis was rejected at 0.05 significant level.

4.5 Discussion

The research questions of this study which were meant to reveal what the major problems of antenatal mothers were and what the recommended coping strategies by the nursing sisters and midwives are, were answered. The result revealed that both illiterate and literate expectant mothers were similar with only a slight difference in the coping strategies

of the expectant mothers and that recommended by the nurses and midwives. This finding could possibly be attributed to the fact that the correlation of pregnancy is uniform across the expectant mothers hence similar experiences in the problems expressed by the expectant mothers during pregnancy are those that are physiological, psychological and emotional in nature, such as abnormal frequency of urination, anxiety, backache, nausea and vomiting, and constant day dreaming causing fear during pregnancy. This could be probably due to weight gain in their bodies, and as the expected date of delivery draw nearer they also develop fears and anxieties related to the well-being of the baby. Kitzinger (1977) asserted that in an antenatal class with antenatal mothers, about 87% of them reported some incident which had produced anxiety, frustration, hostility and many experienced a situation which they felt unable to communicate with Doctors, nurses or midwives.

A possible explanation for the different in the coping strategies of the expectant mothers and those often recommended by the nurses and midwives could be related to the ignorance of the expectant mothers on which method best suit them, while the nurses through training and experience have acquired the most beneficial coping strategies.

Hypothesis one states that, there is no significant difference in the strategies recommended to the expectant mothers by nursing sisters in Ahmadu Bello University Teaching Hospital, Tudun Wada, Sick Bay Main Campus antenatal clinic

and Kofan Kayan antenatal clinic in Zaria. This hypothesis was retained. This means that both nursing sisters and midwives in the three antenatal clinics do recommend similar coping techniques to the expectant mother patients as revealed in table 4.11. This can possible be explained by proving that the nursing sisters and midwives in all the hospitals have the same orientation in training and practical experiences in handling expectant mothers problems.

The second hypothesis that states there is no significant difference in coping techniques of expectant mothers and strategies recommended by the nursing sisters in antenatal clinics in Zaria was rejected (table 4.12).

This is possibly due to the fact that the nursing sisters are experts, more educated in the field hence; are better disposed to know better than the expectant mothers of the useful coping strategies. It could also be that many of the nurses are mothers and so their personal experiences during pregnancy would have equiped them with the practical working coping strategies more than the expectant mothers many who are semi illiterate or literates.

Another possible explanation could be that the expectant mothers are more concerned with the problems of pregnancy than the coping strategies. Also it might be that the expectant mothers due to their historical background and also education background rely much on what traditional believers tell them on how to cope with such problems. Such a background and reliance

might have made the difference exist between them and the nurses and midwives. This is why Anderson (1979) asserted that nurses are directly and more intensively exposed to the many modern psychological and medical techniques of coping with the presented problems of their clients. This situation therefore provides nurses the unique challenge and responsibility to abstract, synthesise and unify the modern knowledge, skills and experiences of coping with pregnancy problems.

Hypothesis three which states that; there is no significant difference between the literate and illiterate antenatal mothers' problems. The result in table 4.13 revealed that there were no significant differences between the literate and illiterate antenatal mothers' problems respondents used for the study. The hypothesis is therefore retained. This is an indication that both literate and illiterate antenatal mothers used for this study experienced similar problems of pregnancy in respect of their educational qualification level. As earlier explained the pregnancy conditions which give rise to problems is a physiological development in human body. This physiological condition could have led to the expectant mothers either literate or otherwise responses to problems of pregnancy similar.

Hypothesis four states that; there is no significant difference in the recommended coping strategies by the married and single nursing sisters to the expectant mothers in Zaria. The result in table 4.14 shows that both the married and single

nursing sisters respondents did not differ significantly in their recommended coping strategies to the expectant mothers. This therefore retains the hypothesis. A possible explanation for this finding is that, both the married and single nursing sisters and midwives in the antenatal clinics acquired the same orientation in training and practical experiences of handling problems related to pregnancy of the expectant mothers.

Hypothesis five which states that; there is no significant difference in coping strategies of illiterate and literate expectant mothers respondents in this study was rejected (table 4.15).

This result may due to the fact that literate expectant mothers acquired more skills and knowledge on how to cope with antenatal problems than the illiterate expectant mothers. There is also an assumption that the literate expectant mothers were exposed more to techniques of coping with antenatal problems. This is because they can read and write and because of their literacy level; they could also read other techniques in books, pamphlet or poster in the hospitals.

4.6 Implication for Counsellors

The result of this study shows that antenatal mothers experience a lot of psychological problems during pregnancy and such problems could only be treated psychologically hence counsellors have a lot of functions in antenatal clinics. Also the result of this study reveals that educational level of the respondents (expectant mothers) significantly

influenced their coping techniques during the antenatal period. So there is need for the guidance counsellors to render some educational and antisipatory guidance in order to help the expectant mothers whose educational level has inhibit them to read more about effective coping strategies to become aware of such strategies in order to cope more effectively. One of the techniques that could be effectively used to educate mothers is anticipatory guidance and group counselling.

Education and anticipatory guidance technique involve organising antenatal teaching class for the expectant mothers and provide them with information about the physiology and experiences of pregnancy and childbirth. The techniques begins with interview. Education and anticipatory process that encourage the woman to moblize her resources so as to adopt to the changes of pregnancy and childbirth. It involves rehearsal and preparation for what she is about to experience because a pregnant woman needs to have factual information about what to expect interms of both physical and psychological changes that are to come in the next few weeks, Brown (1979) asserted that woman who is teribly frightened about labour and delivery may benefit from detailed information of the physiology of labour and delivery. Also education and anticipatory guidance is important in helping the expectant mothers prepare for the demands of infant care, and also beneficial in helping her adjust to the physical, emotional and psychological changes of early pregnancy.

In the case of group counselling with the expectant mothers; it is a way by which such groups of people are assisted to form a supporting peer group through which they can explore the emotional aspects of pregnancy and child-bearing. Denga (1985) said group counselling consists human group made of individuals with homogenous or hetrogenous needs, characteristics and problems. It is therefore necessary for the counsellor to organise group counselling for the expectant mothers on the topics related to their pregnancy problems, since it will provide a fourm for a group of individuals to share their experiences, problems and issues with each other. Kolo (1988:2) asserted that counselling in the antenatal clinics should focus on the members ability to respond to the stress inherent in pregnancy, to prepare for the childbirth emotionally, as well as physically, and to gain understanding of some of changes that occur with parenthood.

He further said that:

> Counselling in the context of antenatal simply means that one is 'helping the mind' and, in some cases, because of interacting with others, the group members can become aware of themselves and betterable to come to terms with inner needs and the demands of outer reality and are able share in a process of emotional healing (pp.2 - 3).

The counsellor is therefore to perform reassurance function to the expectant mothers and give support by accepting the reality of the pregnant woman's condition and probleme. The

counsellor must help the expectant mothers relate themselves closely with their husbands, this is essential because the awareness of childbirth is part of the psychological life of a woman, thus the counsellor must be prepare to listen and wait patiently for the expectant mothers concerns and feelings.

4.7 Summary

The chapter focusses on the presentation of results and the discussion of the results. All results to answer the research questions and to test the five main hypotheses are presented in tables 4.8 to 4.15. In the five hypotheses three were retained hypotheses (one, three and four) and two were rejected (hypotheses two and five) at 0.05 level of significant.

Chapter 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter contains a summary of the research on the antenatal mothers' problems and recommended coping strategies for the antenatal mothers in Zaria. It also presents the conclusions drawn from the study as well as recommendations based on the results.

5.2 Summary

The transitional period of pregnancy and childbirth involves wide spread psychological, emotional and physiological changes predicated upon several socio-economic variables including health, marital status, age relationships with peers, medical personnel and social workers for successful child delivery. This study was designed to investigate the problems of antenatal mothers' and their coping strategies in addition to the recommended techniques by the nursing sisters in antenatal clinics in Zaria.

The review of literature was done under the following five main headings:-

a) Meaning of antenatal and antenatal problems.

b) Theoretical Background on Antenal Problem

c) Manifestation of antenatal problems.

d) The roles of nurses in antenatal clinic.

e) Coping strategies used by nurses with pregnant mothers.

The research was delimited to a sample size of 287 respondents comprising 236 expectant mothers respondents and 51 nursing sisters and midwives respondents. It was also delimited to Ahmadu Bello University Teaching Hospital Tudun Wada, Sick Bay Main Campus antenatal clinic and Kofan Kayan Hospital Zaria City only.

Three research questions and five null hypotheses were formulated and were tested at 0.05 level significance. Analysis of Variance (ANOVA) and T-test statistical techniques were used to analysees the data.

From the analysis, the following main findings and conclusions are made:-

5.3 Main Findings and Conclusions

The following are the main findings and conclusions arising from the study:-

a) That abnormal frequency of urination during pregnancy, anxiety and backache constitute the most serious problems of expectant mothers.

b) That nausea and vomiting, and constant day dreaming causing fear are also disturbing problems expressed by expectant mothers.

c) That the mean scores for general cleanliness, prayers and attending antenatal clinic ranked very high in the areas of coping strategies by the expectant mothers.

d) Also the mean scores for general cleanliness, abiding by nurses' advice, attending antenatal clinic, taking balanced diets and sleeping and resting ranked very high in the areas of recommended coping strategies by the nursing sisters and midwives to the expectant mothers.

e) The educational level has no significant effects on the problems of antenatal mothers. That is to say that both illiterate and literate expectant mothers did experience similar problems during pregnancy.

f) That marital status is not important factor to nursing sisters and midwives when they recommend coping techniques to the expectant mothers. That is both married and single nursing sisters and midwives did recommend similar coping techniques to the expectant mothers in the antenatal clinics in Zaria.

g) That the nurses and midwives in the three clinics of study- Ahmadu Bello University Teaching Hospital Tudun Wada Sick Bay Main Campus and Mofan Kayan Hospital Zaria did recommend the same coping strategies to the expectant mothers.

h) That differences exist in the coping strategies by the expectant mothers and the recommended coping techniques by the nursing sisters and midwives to the expectant mothers in Zaria.

Based on these findings it can generally be concluded that the expectant mothers do experience some problems which are both physiological social, emotional and psychological in nature and have ways of coping with such problems; and that nursing sisters do recommend certain coping techniques to the expectant mothers in coping with their problems.

5.4 Recommendations

In the light of the findings in this study, the following recommendations are made:-

a) That guidance counsellors in conjunction with the medical personnel; especially nursing sisters and midwives; should work in alliance with the expectant mothers so that counsellors could be allowed to handle some of the psychological, social and emotional problems of the expectant mothers.

b) That the counsellors in training institutions should as a matter of urgency introduce some basic courses of nursing system to guidance and counselling, as to enable counsellors have some elementary knowledge about nursing that will aid them to work effectively with the expectant mothers.

c) Expectant mothers should be given proper guidance on how to cope more effectively with pregnancy problems, by guidance counsellors.

d) Nursing sisters, midwives, medical Doctors and others personnel in the antenatal clinics should act to eliminate some of the fears expressed by the expectant mothers particularly the fear of approaching the medical personnel.

e) That counsellors should be posted to the antenatal clinics to improve medical delivery to the expectant mothers. And this can be done through organising educational talk and group guidance constantly on childbirth delivery system involving stages of pregnancy and techniques of labour.

f) That group counselling involving the hospital counsellor and other medical personnel at the antenatal clinic be organised for the expectant mothers.

g) The expectant mothers should be encouraged by the government at all levels to attend clinic by providing them with free medical services to further improve their health condition.

h) Government as a matter of urgency should set up counselling unit within the premises of hospital whereby counsellors will be posted to work hand in hand with medical personnel for more clearity with antenatal problems.

i) That more practicuum students from counselling be sent into hospitals, espacially antenatal clinics to handle some psychological and emotional problems connected with pregnancy and childbirth.

j) Finally it is suggested that an indebth research study should be carried on this topic in other higher institutions, school of nursing and midwivery in the country.

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QUESTIONNAIRE ON ANTENATAL MOTHERS PROBLEMS' AND COPING STRATEGIES IN THREE CLINICS IN [illegible]

Dear Respondents,

The researcher is an M.Ed. candidate who is trying to make a case for assisting expectant mothers in solving their problems with guidance and counselling strategies, to compliment the assistance of nurses for efficiency handling of pregnancy problems. Kindly give your responses as honestly as possible. Be assured that your responses will be treated as confidential.

Instruction

Please do not write your name on the questionnaire, you are required to tick ( ) in the column that expresses your opinion.

SECTION A PERSONAL DATA

1. Sex: (a) Male ( ) (b) Female ( )
2. Age: (a) Under 18 years ( ) (b) 18 - 23 years ( )
   (c) 24 - 29 years ( ) (d) 30 - 35 years ( )
3. Marital Status: (a) Married ( ) (b) Single ( )
   (c) Divorced ( )
4. Educational Qualification: (a) Primary ( )
   (b) Post Primary ( ) (c) N.C.E. ( )
   (d) Graduate and above ( )
   (e) None of the above: .....

5. Religion:

(a) Christianity ( )

(b) Islam ( )

(c) Traditional ( )

(d) Other, specify: .....

.....

6. Number of children, if an expectant mother:

(a) One ( )

(b) Two ( )

(c) Three ( )

(d) Four ( )

(e) More than four ( )

Section B PREGNANCY PROBLEMS

Below is a list of pregnancy problems. Please rate the frequency at which each of the problems is experienced by you as an expectant mother and the frequency at which such problem is reported to you as a nursing sister dealing with pregnant mothers.

Note: VF stands for very frequent

F stands for frequent

NF stands for not frequent.

PROBLEMS OF PREGNANCY

	VF	F	NF	NA
1. Nausea and vomiting				
2. Varisco veins (swollen veins on the leg, vulva).				
3. Heart burn (hotness of the chest).				
4. Varginal discharge.				
5. Abnormal frequency of urination.				
6. Fear of antenatal clinic nursing sisters and Doctors.				
7. Back ache.				
8. Constant day dreaming causing fear.				
9. Haemorrhage (bleeding from genital track).				
10. Pre-eclampsia and eclampsia (increasing weight with high blood pressure).				
11. Lowered self-pride.				
12. Anxiety.				
13. Creates feelings of hatred for others.				
14. Feelings of isolation due to pregnancy.				
15. Get angry easily.				
16. Feeling shy of being pregnant				

Section C

Instruction

If you are an expectant mother, rate the coping strategies you use with the problem of pregnancy. If you are a nursing sister or a midwive, rate the ones you suggest to the expectant patient.

Note: VF - Very frequent
F - Frequent
NF - Not frequent
NA - Not at all

	VF	F	NF	NA
1. General cleanliness				
2. Sleep and rest				
3. Taking balence diets.				
4. Attending antenatal clinic				
5. Having intercourse				
6. Working				
7. Exercises				
8. Supports				
9. Taking of medicates				
10. Abide with nurses' advices				
11. Self positive statements				
12. Prayers				
13. Reading religious books or novels.				
14. Engage in discussion with others.				
15. Reading books or pamphlets on pregnancy.				

AHMADU BELLO UNIVERSITY, ZARIA - NIGERIA.

DEPARTMENT OF EDUCATION 80

Vice-Chancellor Professor Daniel I. Saror,
B.Sc., D.V.M. (A.S.U.) M.Sc. (Missouri) Ph.D. (A.B.U.)

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Our Ref: _____

Your Ref: _____

Telephone: 069/3292
Telegarms: UNIBELLO ZARIA

Date 15th July, 1992

Sir,

COLLECTION OF RESEARCH DATA

The bearer SALMAN A. ADISA is conducting research in ANTENATAL MOTHERS' PROBLEMS AND COPING STRATEGIES IN THREE CLINICS IN ZARIA

for the degree of M.ED. (GUIDANCE AND COUNSELLING)

The Faculty of Education will be grateful if you could permit Him/Her to conduct classroom experimentation/collect data at _____

Thank you for your continued cooperation with us.

Yours sincerely

F. O. Ogunlade
Post Graduate Studies Secretary