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REFERRAL COUNSELLING METHOD AND FINANCIAL COUNSELLING METHOD

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ABSTRACT: *This study sought to reappraise the study Referral counselling method and financial counselling method among mothers in Cross River State, Nigeria. The study was purely a sampling and purposive sampling technique. The questionnaire called (SMCQ) was the instrument used for data collection. The instrument was subjected to face validity by one expert in Guidance and Counselling and two experts in measurement and evaluation in the Faculty of Education, University of Calabar. The reliability estimate of the instrument was established through the Cronbach Alfa reliability method. One-way analysis of variance (ANOVA) was the statistical analysis technique adopted to test the hypotheses under study. All hypotheses were subjected to testing at a .05 level of significance. The study showed that women whose referral counselling method were low were significantly different in their safe motherhood practices among women of reproductive age from those whose referral counselling method was either moderate or high. Also, women whose referral counselling method was moderate were significantly different from those who were high in safe motherhood practices among women of reproductive age. From the data analysis, the researcher found that: referral counselling methods and financial counselling methods significantly influence safe motherhood practices among women of reproductive age. The financial counselling method had a significant influence on safe motherhood practices among women of reproductive age, a post hoc analysis was employed using Fishers' Least Significant Difference (LSD) multiple comparison analysis. Based on the findings of the study the researcher recommended among others that disrespectful treatment of mother would discourage them from taking counselling classes and practising safe motherhood and the researcher suggest that perhaps maternal referral counselling usage is low because of the delays mothers encounter in the facilities in the facilities they are referred.*

KEYWORDS: Referral counselling method and Financial counselling method, maternal Health, childbirth, Focused antenatal care

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INTRODUCTION

Counselling is the process of assisting and guiding a client, especially by a trained person, on a professional basis to resolve problems regarding choice among alternative decisions. This professional assistance is helpful in all spheres of human activities. In the area of maternal health care, counselling could help pregnant women to take useful decisions on methods to adopt to have safe delivery (Medical dictionary, 2020). Many areas of maternal health care require counselling, which can provide an important opportunity to improve maternal understanding of pregnancy, childbirth, and care of the newborn. In addition to the routine examination, screening, and treatment, the World Health Organization's focused antenatal care model recommends that counselling be provided to all pregnant women in areas related to health needs of the pregnant woman, birth and emergency preparedness, nutrition, preventing negative home practices, and support for care-seeking through danger sign recognition (Jennings, Yebadokpo and Affo, 2010).

Financial counselling is a free and confidential service offered by community organisations, community legal centres and some government agencies. Financial counsellors are skilled professionals. They listen to clients' problems and help them with things like bills and fines they are struggling to pay. In pregnant women, a low socioeconomic factor is an adverse situation in pregnancy. Low socioeconomic status (LSES) can increase the risk of adverse pregnancy outcomes. Studies have revealed that LSES is associated with pregnancy complications such as abortion, preterm delivery, preeclampsia, eclampsia and gestational diabetics. Evinced by Ronsman and Graham (2006) hinted that the majority of maternal deaths occurred at homes in rural areas, among poorer communities and during the peripartum period - the last three months of the pregnancy to the first week after the end of the pregnancy. This was buttressed by Campbell and Graham (2006) that poorer communities experience a larger number of maternal deaths. Ronsman (2006) ascertained that a peak in maternal mortality occurred during the intrapartum period around childbirth and the first day post-partum (Campbell and Graham, 2006).

Less rarefied by Filippi, Ronmans, Campbell, Graham, Mills, and Borghi (2006) in the editorial of The Lancet (2006) series on maternal survival as also reviewed in Filippi (2006) this study called for a clear strategic vision that prioritises the intrapartum period in order to reduce maternal mortality method adopted included two rounds of Benin Demographic and Health Survey (BDHS) was conducted to examine the counselling and disparities in factors of maternal health care indicators using logistic regression models. Participants were 17,794 and 16,599 women aged between15–49 years in 2006 and 2012 respectively. The results of multivariable logistic regression were used. Findings revealed that health care programmes and policies should be strengthened to enhance accessibility as well as to improve the counselling of maternal care services, especially for the disadvantaged, uneducated and those who live in hard-to-reach rural areas in Benin.

As epitomised by Sabde, Diwan, Randive, Chaturvedi, Sidney, Salazar and De Costa (2016) in a study which communicated the availability of emergency obstetric care in the context of the cash transfer programme in Madhya Pradesh, India. The result showed a total of 152 facilities were surveyed of which 118 were cash transfer programme facilities. Findings revealed that given the high proportion of births in public facilities in the state, the cash transfer programme has an opportunity to contribute to the reduction in maternal and perinatal mortality Financial costing and maternal implication as stipulated in Angèle, Abel and Jacques (2021)

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study conducted on social and economic consequences of the cost of obstetric and neonatal care in Lubumbashi, Democratic Republic of Congo (DRC). In the maternity departments of health facilities in Lubumbashi, a quantitative cross-sectional analytical study was carried out in 2019 with a population of 411 women who gave birth at 10 referral hospitals.This finding revealed that the government of the DRC should implement a mechanism for subsidizing care and associate it with a cost-sharing system. This would place the country on the path to achieving universal health coverage in improving the physical, mental and social health of mothers, their babies and their households.

In research by Kes, Ogwang and, Pande (2015) on the economic burden of maternal mortality on households: evidence from these sub-counties in rural Western Kenya (2015). Data were collected on the demographic characteristics of the deceased women; household and socioeconomic status. The result of the study posited that the health service counselling costs associated with maternal deaths were significantly higher due to more frequent service counselling as well as due to the higher cost of each visit suggesting more involved treatments and interventions were sought with these women. This finding revealed that in Kenya the process of instituting free maternity services in all public facilities would benefit mothers and that a very large number of households who seek maternal health services can be catastrophic in complicated cases without finances that would result in maternal death.

The study carried out by Arthur, (2012) was on wealth and antenatal care use: implications for maternal health care utilisation in Ghana. The study investigated the effect of wealth on maternal health care counselling in Ghana. The study is pivoted on the introduction of the free maternal health care policy in April 2005 in Ghana with the aim of reducing the financial barrier to the use of maternal health care services, to help reduce the high rate of maternal deaths. Using secondary data from the 2008 Ghana Demographic and Health survey, the result of this study revealed that wealth still has a significant influence on adequate use of antenatal care, education, age, number of living children, transportation and health insurance are other factors that were found to influence the use of Antenatal care in Ghana. Maternal financial status imparts maternal safe motherhood practices with respect to facility bills.

N'doh Ashken Sanogo, Sanni Yaya (2020) "Wealth Status, Health Insurance, and Maternal Health Care counselling in Africa: Evidence from Gabon. This study explored the wealth-related association of compulsory health insurance with maternal health care counselling in Gabon Methods. The study used the 6th round of Gabon Demographic and Health Surveys (GDHSs) 2012 data. Logistic regression and propensity scoring matching analysed associations of health insurance coverage on women's counselling of health care. The result showed the Mean (+/− SD) age of women respondents of reproductive age was 29 years (9.9). The finding revealed that a proportion of at least 4 antenatal care visits was 69.2 per cent, facility-based delivery was 84.7 per cent, and postnatal care counselling was 67.9 per cent. The analysis of data showed disparities in maternal health care services counselling among women of varied socioeconomic statuses.

Rana and Sakellariou (2020) noted that the new Sustainable Development Goals (SDGs) had the aim of reducing maternal mortality and providing equitable access to maternal healthcare. Compromised access to maternal health facilities in low-income countries, and specifically in Africa, contribute to the increased prevalence of maternal mortality. a systematic review to investigate access barriers to maternal health in low-income countries in Africa since 2015. The finding showed that the most important barriers to maternal health are transportation

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barriers to health facilities, economic factors, and cultural beliefs, in addition to lack of family support and poor quality of care. The researcher observed that maternal financial status determines her choice of facility and safe motherhood practices.

In a study carried out by Ayalneh Demissie, Alemayehu Worku and Yemane Berhane, (2020). On the "Effect of Implementing a free delivery counselling policy on women's facility-based delivery in Central Ethiopia, the study averred that access to and counselling of facility delivery services is low in Ethiopia. The method adopted data on 108-time points collected on facility-based delivery service counselling. The findings of the study revealed that the implementation of the free delivery services policy has significantly increased facility deliveries in central Ethiopia. The researcher noted that counselling mothers to utilise the free delivery service is the main key to maternal health. He noted that maternal well-being is a result of mothers adhering to the counsel of the counsellor on counselling methods and safe motherhood practices.

Nai-Peng Tey and Siow-li Lai, (2013) studied "Correlates of and barriers to the counselling of health services for delivery in South Asia and Sub-Saharan Africa" The high maternal and neonatal mortality rates in South Asia and Sub-Saharan Africa can be attributed to the lack of access and counselling of health services for delivery. From findings communicated that within each country that was adopted the poorer, less educated and rural women had a higher unmet need for maternal care services. Amsalu, Kefale and Muche (2020) on the effects of ANC follow-up on essential newborn care practices in East Africa in a systematic review. Findings revealed the situation of high maternal morbidity and mortality in Sub-Saharan Africa and that less than 80 per cent of pregnant women receive antenatal counselling and care services. (Alabi, 2019) offered that low-income Nigerians are unable to afford health services.

Research Questions

1. To what extent does the financial counselling method influence safe motherhood practices among women of reproductive age?

2. What is the influence of Referral counselling on safe motherhood practices among women of reproductive age?

Hypotheses

1. The financial counselling method does not significantly influence safe motherhood practices among women of reproductive age.

2. There is no significant influence of referral counselling methods on safe motherhood practices among women of reproductive age.

The main independent variables for this study were:

Financial counselling method;

Referral counselling method;

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METHOD

Table 1

Summary data and one-way ANOVA of the influence of referral counselling method on safe motherhood practices among women of reproductive age (N=586)

referral counselling method	N	$\bar{x}$	SD		
Low– 1	187	35.2086	3.20690		
Moderate– 2	325	36.1138	3.06654		
High – 3	74	38.5000	1.51024		
Total	586	36.1263	3.12165		
Source of variance	SS	df	Ms	F	Sig of F
Between group	574.501	2	287.251	32.669	.000
Within group	5126.154	583	8.793		
Total	5700.655	585			

* Significant at .05 level, p-value =.000, df= 2, 586.

The result in Table 1 revealed that the calculated F-value of 32.669 is higher than the p-value of .000 at a .05 level of significance with 2 and 586 degrees of freedom. With this result, the null hypothesis was rejected. This result, therefore, implied that the referral counselling methods significantly influenced safe motherhood practices among women of reproductive age. Since the referral counselling method had a significant influence on safe motherhood practices among women of reproductive age, a post hoc analysis was employed using Fishers' Least Significant Difference (LSD) multiple comparison analysis.

Table 2

Fishers' Least Significant Difference (LSD) multiple comparison analysis of the influence of referral counselling method on safe motherhood practices among women of reproductive age

LSD

(I) referral counselling method	(J) referral counselling method	Mean Difference (I-J)	Std. Error	Sig.
Low	Moderate	-.90529(*)	.27217	.001
	High	-3.29144(*)	.40724	.000
Moderate	Low	.90529(*)	.27217	.001
	High	-2.38615(*)	.38194	.000
High	Low	3.29144(*)	.40724	.000
	Moderate	2.38615(*)	.38194	.000

* The mean difference is significant at the .05 level.

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The result of the analysis in Table 2 showed that women whose referral counselling method was low were significantly different in their safe motherhood practices among women of reproductive age from those whose referral counselling method was either moderate or high. Also, women whose referral counselling method was moderate were significantly different from those who were high in safe motherhood practices among women of reproductive age.

Summary data and one-way ANOVA of the influence of financial counselling method on safe motherhood practices among women of reproductive age (N=586)

Table 3

financial counselling method	N	$\bar{x}$	SD
Low – 1	70	35.5000	2.51805
Moderate– 2	338	35.8225	3.35061
High – 3	178	36.9438	2.71992
Total	586	36.1246	3.12364

Source of variance	SS	df	Ms	F	Sig of F
Between group	177.619	2	88.809	9.362	.000
Within group	5530.287	583	9.486		
Total	5707.906	585			

* Significant at .05 level, p-value =.000, df= 2, 583.

The result in Table 24 revealed that the calculated F-value of 9.362 is higher than the p-value of .000 at a .05 level of significance with 2 and 586 degrees of freedom. With this result, the null hypothesis was rejected. This result, therefore, implied that the financial counselling method has a significant influence on safe motherhood practices among women of reproductive age. Since the financial counselling method had a significant influence on safe motherhood practices among women of reproductive age, a post hoc analysis was employed using Fishers' Least Significant Difference (LSD) multiple comparison analysis.

Fishers' Least Significant Difference (LSD) multiple comparison analysis of the influence of financial counselling method on safe motherhood practices among women of reproductive age

LSD

Table 4

(I) financial counselling method	(J) financial counselling method	Mean Difference (I-J)	Std. Error	Sig.
Low	Moderate	-.32249	.40445	.426
	High	-1.44382(*)	.43452	.001
Moderate	Low	.32249	.40445	.426
	High	-1.12134(*)	.28523	.000
High	Low	1.44382(*)	.43452	.001
	Moderate	1.12134(*)	.28523	.000

* The mean difference is significant at the .05 level.

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DISCUSSION OF FINDINGS

Referral counselling method and safe motherhood practices among women of reproductive age.

The result of the ninth hypothesis unveiled that the referral counselling method has an influence on Safe motherhood practices among women of reproductive age. The finding of this hypothesis is in line with the study of Carlstedt and Urassa (2010) who revealed that out of 1538 women referred 70 per cent were referred for demographic risks, 12 per cent for obstetric historical risks, 12 per cent for prenatal complications and 5.5 per cent for prenatal and immediate postnatal complications. The researcher noted that in the finding of Carlstedt and Urassa (2010) referral was high at 70% among women. This implies that if the facility was up to date with needed materials and skills mothers will not necessarily be referred until it is absolutely necessary. Ameyaw, Njue and Tran (2021) and finding by Carlstedt and Urassa (2010) two studies reported that women were dissatisfied due to delays in referral processes that affected their health the study also reported that women were not accompanied to receive higher levels of care, delays in referral processes, transport challenges and were given poor referral documentation. The researcher suggested that perhaps maternal referral counselling usage is low because of the delays mothers encounter in the facilities they are refereed.

The researcher observed that findings revealed that women's participation is low in counselling sessions and that this perhaps might be because of insufficient communication to the women and counselling on what to do when a referral is delayed

Financial counselling method and safe motherhood practices among women of reproductive age

The result of the tenth hypothesis showed that financial counselling method has a significant relationship with safe motherhood practices among women of reproductive age. The finding of this hypothesis is in line with the study of Ronsman and Graham (2006) who adjoined that the majority of maternal deaths occurred at homes in rural areas, among poorer communities and during the peripartum period - the last three months of the pregnancy to the first week after the end of the pregnancy the researcher noted that the poorer the communities are the larger number of maternal deaths occurred this is also supported in Campbell and Graham (2006).

In consonance with this result is Flippi (2006), the researcher discovered that the health policies should be strengthened to enhance accessibility as well as the need for improving counselling. In agreement with this finding Ayalneh Demissie, Alemayehu Worku, Yemane and Berhane, (2020) delivered that the high maternal and neonatal mortality rates in South Asia and Sub-Saharan Africa can be attributed to the lack of access and counselling services. The researcher noted in the study of Campbell and Graham (2006) that the poorer, less educated and rural women had a higher unmet need for maternal care services. In **Azuh, Ogundipe and Ogundipe (2019),** the researcher noted that a mother's decision on where to give birth was based on education level and social affluence.

Be that as it may, some findings have shown that counselling plays a major role in women taking part in safe motherhood practices. The ten variables of the study have a significant impact on reducing maternal deaths. However, from multiple studies, the factors that limit the women from participating in safe mother are likewise numerous such as lack of information counselling, poor usage of the antenatal facilities, lack of good counsellors or the non-availability, financial hardship on the women and their inability to take decisions in the face of

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emergency and in determining what number of children to produce. Due to the low level of exposure to counselling, most women wallow in pain, and despair and some die or are permanently injured from lack of counselling and safe motherhood practices.

RECOMMENDATION AND CONCLUSION

The researcher reported that women were not accompanied to receive a higher level of care, delays in referral processes, transport challenges and were given poor referral documentation. The researcher noted in the study of Campbell and Graham (2006) that the poorer less educated and rural women had a higher unmet need for maternal care services. Be it as it may, findings have shown that counselling plays a major role in women taking part in safe motherhood practices. The researcher informed that due to the low level of exposure to counselling, most women wallow in pain and despair, and some die or are permanently injured from lack of counselling and safe motherhood practices.

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