



DRUG INTAKE AND FAMILY PLANNING COUNSELLING METHODS AMONG MOTHERS IN CROSS RIVER STATE, NIGERIA

Olufowoke M. Oyeyipo

Faculty of Education, University of Calabar, Cross River.

Email: olufowokeyeyipo@gmail.com

Cite this article:

Olufowoke M. Oyeyipo (2023), Drug Intake and Family Planning Counselling Methods Among Mothers in Cross River State, Nigeria. British Journal of Contemporary Education 3(1), 87-100. DOI: 10.52589/BJCE-PET49HGL

Manuscript History

Received: 10 March 2023

Accepted: 25 May 2023

Published: 26 June 2023

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ABSTRACT: *This study was undertaken to consider drug intake counselling and nutritional counselling methods among mothers in Cross River state, Nigeria. Two research questions and two null hypotheses were drawn to direct the variables under study; relevant literature was reviewed in line with the research objectives with most of the reviewed study supporting the theoretical framework. Ex-post facto design was adopted for the study. The selection was done through the sampling and purposive sampling technique. The reliability estimate was established through sampling and purposive sampling technique. The reliability estimate of the instrument was established through the Cronbach Alpha reliability method. One way analysis of variance (ANOVA) was the statistical analysis technique adopted to test the hypotheses under study. All hypotheses were tested using .05 levels of significance. From the data analysis, the researcher investigated the study and offered in agreement that drug intake counselling and nutritional counselling afford mothers a better birth outcome and well being. The researcher in agreement with the study of Leste, Andreozzi and Appiaihm (2004) adjoined that maternal smoking during pregnancy produces adverse effects for the foetus through several pathways. The researcher likewise agrees with the opinion of Kamuhabwa and Jalal (2011) that more than 90% of pregnant women take prescription or non-prescription drugs at some point in time during their pregnancy that are harmful to their foetus.*

KEYWORDS: Counselling, Drug Intake, Family Planning Counselling.



INTRODUCTION

The World Health Organisation (2006) defines health as a state of complete physical, mental and social well-being of an individual and not merely the absence of disease or infirmity. Health counselling as defined by WHO (2012) is the procedure by which nurses, teachers, physicians, guidance and counselling personnel and other safe motherhood vendors explain to students and parents the nature of health problems and aid in formulating a plan of action to solve the problem. Health counselling provides supportive measures to help orient women on the merit of health counselling which has an outcome on their pregnancy (WHO, 2005).

What constitutes health counselling is one-on-one counselling on ante-natal counselling, hygiene counselling, nutrition counselling, rest and recreational counselling, drug intake counselling and family planning counselling. Education is the determinant, which changes an individual's perspective of life, as well as the status and reproductive behaviour. A person's outlook or psychological set, influences a person's readiness to respond in a particular way mentally, emotionally, and attitudinally.

The researcher's attention was drawn to the increasing number of morbidity (disease, maladies, and associated medical conditions in pregnancies and childbirth and mortality) due to the inadequate health facilities and the lack of awareness of the benefits of health counselling. These drew the researcher's attention to observe the increase in the death of mothers and injuries sustained during and after delivery of children which was on the increase amongst mothers in the researcher's locality. It was based on these pathetic and unpleasant experiences that inspired the researcher to embark on this modest research work.

Research studies carried out by Mosher (2012) and Goodburn (2001) showed that poverty, malnutrition and substance abuse contribute to impaired cognitive motor and behavioural problems across childhood. Goodburn (2001) and Mosher (2012) also buttressed the statement that the environment in which the mother provides for the embryo/foetus is critical to its wellbeing, well after gestation and birth. Non-prescription drugs can potentially cause a birth defect or negatively alter cognitive and behavioural outcomes. Genetic susceptibility and time of exposure are all factors that influence the extent of the effect of a teratogen on a foetus.

The Centre for Diseases Control (2015) defined ethyl alcohol or ethanol as an intoxicating ingredient found in beer, wine and liquor. Alcohol is produced by the fermentation of yeast, sugars, and starches. CDC (2015) added that alcohol affects every organ in the body. It is a central nervous system depressant that is rapidly absorbed from the stomach and small intestine into the bloodstream. Alcohol is metabolised in the liver by enzymes; however the liver can only metabolise a small amount of alcohol at a time, leaving the excess alcohol to circulate throughout the body. CDC (2015) further stressed that the intensity of the alcohol on the body is directly related to the amount consumed. Frequency of use of over 9 months of pregnancy is also necessary to produce a child with foetal alcohol syndrome disease (May, 2002; Viljoen, 2005). These scholars further stated that for foetal and partial alcohol syndromes to occur, the mother must have been involved in binge drinking every weekend. Moreso, Viljeon (2005) observed that women whose frequency of consuming alcohol and quantity consumed are sufficient to produce very high rates of foetal alcohol syndrome.

Department of Health and Human Services (2005) posited that there is no safe level of alcohol use during pregnancy. Women who are pregnant or plan on becoming pregnant should refrain



from alcohol. DHHS (2005) further admitted that several conditions, including Foetal Alcohol Spectrum Disorders, have been linked to alcohol use during pregnancy. Women of child bearing age should also avoid binge drinking to reduce the risk of unintended pregnancy and potential exposure of a developing foetus to alcohol. To further buttress CDC (2015), it is stated that no amount of alcohol can be considered safe during pregnancy. Alcohol can damage a foetus at any stage of pregnancy. Damage can occur in the earliest weeks of pregnancy, even before a woman knows that she is pregnant. Alcohol syndrome and related birth defects are completely preventable. According to WHO (2004), smoking substantially increases the risk of death from lung and other cancers, heart diseases, stroke, and chronic respiratory disease.

In a study carried out by Almazron et al. (2014) in a cross sectional study in an out-patient pharmacy waiting area in several tertiary hospitals and primary clinics in Riyadh, Saudi Arabia, 575 Saudi Arabian women were approached for interview. This study was designed to assess Saudi mothers' experiences with measuring cups, syringes, and droppers for oral liquid medications and to educate pharmacists on dosage accuracy. The result revealed that 58% of participants measured an accurate dose of paracetamol using the oral dosing syringe.

The data were entered into Microsoft Excel, and the results of the survey were evaluated using strata multilinear logistic regression to determine the effects of participants' demographics on dosage error for device. For all analysis, two tailed $P > 0.05$ was considered statistically significant. Of the 575 mothers studied, 46% were in the age category of 26-35 years. Furthermore, 29% of the mothers had secondary education and 36% had completed University or postgraduate education. Similarly, of the participants, 82% had two or more children aged 12 years old or younger. In general, participants measured more than the intended dose with the dosing cup and less than the intended dose with the dropper. It was revealed that age and pharmacist counselling did not affect dosing errors. In contrast, education status did have an effect; dosing accuracy for each type of instrument was significantly influenced by Saudi mothers' education status.

Overdosing with dosing cups and syringes was much more prevalent in mothers who were illiterates and had elementary education compared with high school and college graduates ($P < 0.001$). Whereas, under-dosing using a dropper was more common in the latter population ($P < 0.5$). Goler (2008) averred that the obstetric provider and health counsellor are in key positions for the screening, early diagnosis, counselling and initiating treatment of pregnant women who use illicit drugs such as marijuana, hashish, hallucinogens and inhalant prescription psychotherapeutics drugs. The pregnant woman and her foetus benefit from factual non-judgmental information about the maternal and foetal risks of substance use from counselling the counsellor would provide (Heil, 2011).

Maternal prenatal substance abuse is defined as the chronic use of alcohol and or other drugs. Similarly, Mutihir (2012) observed that substance use in Nigeria, among pregnant women is a recent phenomenon as our women embrace western culture. He further stated that in more recent findings, there is the show of a "safe" level of alcohol consumption without adverse effects to the foetus. About 2.6 million women who deliver each year use alcohol at some point during their pregnancy and about 1 million children each year are exposed to alcohol, tobacco and illegal drugs during gestation. Maier and West (2001) posited that the surgeon-general warned that any woman who drank a substantial amount of alcohol during pregnancy could produce a child with foetal alcohol syndrome. Warren and Li (2004) equally stated that there is likely to be differential vulnerability for the development of foetal alcohol syndrome disease



(FASD), which might likely be the result of genetic and epigenetic factors in the mother and/or her foetus. Lesper (2001) and Lozano (2007) showed that maternal self-report of drug use is problematic because of the fear of the consequences of admitting to the use of drug such as the involvement of child protection services (CPS); the threat of child removal from mother and more importantly in our environment is socially unacceptable.

Lester, Andreozzi and Appiahm (2004) noted that maternal smoking during pregnancy produces adverse effects for the foetus through several pathways. Stating that first, cigarette smoke interferes with normal placenta function as metabolites of cigarette smoke pass uterine blood flow by up to 38%. The foetus is deprived of nutrients and oxygen resulting in episodic foetal hypoxia and malnutrition. Furthermore, this is the basis for the foetal intrauterine growth retardation seen in many infants born to smoking mothers. They observed that smoking is responsible for 20-30% of infants' low birth weight, and that infants born to smoking mothers weigh an average of 150-250 grams less than infants born to non-smoking mothers. They also added that nicotine interfered with foetal development, specifically in the nervous system. In utero exposure due to smoking during pregnancy may increase the risk of both diabetes and obesity through foetal malnutrition or toxicity. Also, smoking during pregnancy may represent another important determinant of metabolic dysregulation and type 2 diabetes in offspring and that smoking in pregnancy should be discouraged (Montgomery & Anders 2002). Substance use during pregnancy is a major public health issue and a social policy concern (Kandall, 2007). Komnare (2005) noted that the majority of drug addicts in developed countries are women. Fride (2002) adjoined that mothers on prescription drugs, such as cannabinoids used to enhance appetite in cancer and AIDS patients when present in mothers' breast milk causes indigestion of mothers milk. Thus, neonates do not gain weight and die within the first week of life; it is further proposed that cannabis-based medicines should be developed to benefit infants due to infants' failure to thrive on some of these prescriptive drugs. There is a prevalence of women drinking alcohol during pregnancy in the developed world (Andersons, 2006).

Kamuhabwa and Jalal (2011) stated that more than 90% of pregnant women take prescription or non-prescription drugs at some point in time during their pregnancy. They posited that unless absolutely necessary, drugs should not be used during pregnancy because many of them are harmful to the foetus, concluding that appropriate dispensing is one of the steps for rational drug use. Kamuhabwa and Jalah (2011) carried out in Dar es Salaam in Tanzania in a cross sectional descriptive study involving women who visit the private retail community pharmacy, and interviewing pregnant women at the antenatal clinics in the municipal hospital in Dar es Salaam. In total, 200 pharmacies were visited. Out of 200 drug dispensers, 78 (38%) were pharmacists, 17 (8.6%) were pharmaceutical technicians, 59 (29.6%) were nurse assistants and 46 (23%) sales persons without a formal pharmaceutical training.



Family Planning Counselling

World Bank (2013) and WHO (2013) posited that most of the countries with lowest rates of contraceptive use, highest maternal, infant and child mortality rates and higher fertility rates are in Africa. The researchers averred that 30% of reproductive age women use birth control. Stating further that over half of all African women would like to use birth control if it was available (WHO, 2012). Family planning is amongst the most cost effective of all health interventions (Tsui, 2010). The cost of saving items from a reduction of unintended pregnancy, as well as a reduction in transmission of sexually transmitted infections including HIV was high. Family planning is defined by the World Health Organisation in Zafar, Samia and Muhammad (2014) as a mode of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples in order to promote the health and welfare of family groups and thus contribute effectively to the social development of the country.

Omo-Aghoja (2008) observed that based on available data, Nigeria has one of the highest rates of maternal mortality in the world. Sedge (2006) averred that Nigeria's contraceptive prevalence rate is less than 13% and that the situation is further compounded by the persisting challenge of high fertility rate of about 5.8% and an annual growth rate of 2.8% in the face of a large population of about 140 million people. In recent decades, fertility has declined only slightly from a Total Fertility Rate (TFR) of 6.3 births per woman in 1981-82, to 6.0 in 1990 and 5.7 in both 2003 and 2008, according to findings of the Demographic and Health Surveys (DHS) (National Population Census, 2004). Family planning counselling is important because it allows women more control over their childbearing and helps them achieve their desired birth spacing and family sizes (Sonfield, 2011). Sonfield (2011) further opined that the use of family planning services is estimated to prevent 1.6 million unintended pregnancies each year. Logan (2007) stated that in addition, the use of family planning counselling and other related medical services may facilitate access to other reproductive health services. The problems that prevent access to family planning are poor health care services, spousal disapproval, religious concerns and misinformation about the effects of birth control among others.

According to Maine (2001) and Shehu (2006), studies in Nigeria have reported that by the very way contraception is perceived, community involvement and participation is the gold standard to the initiation of an effective family planning program. Acceptance of the programme is aimed at reducing maternal mortality (Gutmacher, 2009). Institute of Medicine (2012) opined that the last three decades have seen an increase in the time between when women first have sexual intercourse and when they get married or have their first child. Institute of Medicine (2011) equally stated that the use of family planning counselling and related medical services during this period of increased risk can play an important role in reducing unintended pregnancies and allowing women to time their fertility better. Macaluso (2010) averred that family planning counselling and other services include medical services related to pregnancy such as pregnancy tests, prenatal care, and postnatal care. Related services also include preventive reproductive health care such as screening for cervical and breast cancer.

A study by Omo-Aghoja et al. (2009) revealed a high level of contraceptive awareness but with a low self reporting prevalence rate and a poor knowledge of the categories of people that should use contraceptives. They further revealed that effective educational and counselling interventions are likely to improve providers and consumers' knowledge and subsequent uptake of contraceptive usage, increasing institutional delivery among antenatal clients.



Dieudonne, Soubeuga, Drissa sia and Gauvin (2013) carried out in two districts of Burkina Faso, Kampala and Dori in the centre-East and Sahel regions respectively. A minimum sample size of 416 participants was needed. This was a retrospective cohort study. The data were obtained from surveys of women registered on prenatal lists in rural settings. Two level sampling was involved CSPSs by drawing lots and then selected women who are users of these centers. A random sample size of 512 women was drawn. The data were collected through structured interviews with the women. Pilot survey was pretested at five CSPSs to validate the questionnaire. Among the 512 women selected from the prenatal lists, 404 (91%) were successfully enrolled and interviewed. The women not enrolled had either moved outside the study districts (n=15) or were reported as unknown by the resources person (n=33).

WHO (2008) defined family planning as the ability of individuals and couples to anticipate and attain their desired number of children, spacing and timing of their births. It is achieved through the use of contraceptive methods and the treatment of involuntary infertility. WHO (2008) further suggests that family planning services promote health and human service goals, including increasing the availability and accessibility of health care services, preventing the spread of infectious diseases (through testing for sexually transmitted diseases), promoting social wellbeing of individuals and families, encouraging preventive health care and fostering economic independence.

Sedgh (2006) posited that despite intense programmatic efforts by the Nigerian Government and various non-governmental agencies to reverse the trend, there has been little evidence to suggest a systematic improvement in these indicators. Primary prevention, based on reducing the numbers of at-risk pregnancies through effective contraceptive, is an important approach to resolving the problem. WHO (2004) adjoined that the non-usage and usage of ineffective contraception increase the risk of unintended pregnancy and its consequences, including unsafe abortions. Furthermore, the risk of abortion related complications is proportional to the risk of unsafe abortion. Also, unplanned pregnancy is responsible for 30% of the disease burden associated with maternal conditions and around 90% of unsafe abortion globally.

The National Population Commission and Owners Risk of Chaffing Macro (2004) stated that 13 percent of sexually active Nigerian women currently practice effective contraception. They further asserted that part of the reasons for the use of contraception in Nigeria include the persisting pronatalist culture of the people and religious views which discourage the use of contraception, poor availability and distribution of contraceptives and women's fear of contraceptive side effects. Orji (2002) and Ozumba (2005) opined that the perception that contraception could lead to infertility in later life is one reason that Nigerian women have always preferred non-usage of effective contraception (Otoide, 2001). Maine (2001) and Shehu (2006) buttressed that community practices and cultural beliefs play significant roles in decision making vital to women's reproductive health. Maine (2001) opined that there is a belief that women who use modern family planning methods cut short the number of children God has in stock for them and as such may be punished with infertility on re-incarnation.

Empirical research evidence by Khanal, Joshi, Neupane and Karkee (2011) showed the main reason for abortion include complete family size and the knowledge of modern contraceptive. The findings also revealed that side effects were the main reason for discontinuation of contraceptives. Intention to use some modern family planning methods after the abortion was expressed as well. The major enabling factor for continued contraceptive use was the absence of side effects. The family planning counselling was acceptable to 91% of client, understudy.



Practice, acceptance of contraception and counselling service and intention to use family planning measures were highly considered by the participants. There is a need to provide skills on adapting with the adverse effects of family planning through continuous education and reinforcement. The study also showed that health professionals played a major role in providing contraceptive counselling as a positive attitude was shown by the majority of the women. Majority were self motivated and played an important role in personal decision making.

Ziyani, Phil, Unisa, Elvers and King (2003) in a quantitative descriptive study among Swazi women in Swaziland using structured interviews to identify factors/barriers impacting on the use of contraceptives by Swazi women. Face to face structure interviews were conducted with the selected participants. Interviews were conducted by the researcher and two research assistants. The instrument was developed in such a way that data would be easily quantifiable. This information was gathered in order to contextualize the research results against the background information about the respondents, including their ages, economic and educational status as their marital status. The ages of the 205 respondents ranged from 19 to 41 years. The majority of women (73.2%) were single, whilst 55(26.8%) were married 89% were married 26%(6) were married according to the western type marriage. All respondents adhered to the Christian religion of the respondents 57% resided in rural 30% in semi-urban and 13.0% in urban areas. As many as 68% (139) had secondary/high school education. 6% were University Scholars, 21% had primary education 5% had no formal education. 69.8% were unemployed, 14.1% were in tertiary education, 15.6% were wage earners. Out of the 201 women who indicated the number of children they had, only 4.5% (9) had five or more children, but 16.5% (33) had 3-4 children.

Broad range of studies by Vamos (2008), Stidham (2011) and Barero (2000) have found that inadequate use of family planning counselling and other related services is associated with Sexually Transmitted Diseases, cervical cancer rates, higher morbidity and mortality rates for mothers and infants. Also, usage of family planning counselling and related medical services is found to be lower among women from lower-income households (Frost, 2008; Foster, 2011; Chandra, 2005). This usage may be due to inaccessibility to counsellors and inability to pay for some services (Institute of Medicine, 2009).

Research Question

1. What is the influence of mothers' perception of drug intake counselling on safe motherhood practices?
2. To what extent does mothers' perception of family planning counselling influences safe motherhood practices?

Hypotheses

1. Mothers' perception of drug intake counselling does not significantly influence safe motherhood practices.
2. Mothers' perception of family planning counselling does not significantly influence safe motherhood practices.



DATA PRESENTATION AND ANALYSIS

Table 1: Summary of independent t-test for the influence of mothers' perception of drug intake counselling on safe motherhood practices

S/No	Safe Motherhood Practice	Perception of Drug intake Counselling	N	X	SD	T	P
1	Drug Intake Habit	Negative	45	13.96	2.86	0.630	.529
		Positive	266	14.24	2.22		
2	Food Consumption Pattern	Negative	45	8.87	2.29	3.363*	.001
		Positive	266	9.96	1.97		
3	Rest Pattern	Negative	45	10.11	2.90	2.035*	.043
		Positive	266	10.88	2.24		
4	Exercise Routine	Negative	45	10.20	2.37	6.410*	.000
		Positive	266	12.33	2.00		
5.	Overall Safe Motherhood Practice	Negative	45	43.42	5.98	4.683*	.000
		Positive	266	47.13	4.71		

P < .05 level of significance; df = 309; critical t = 1.9

Results of data analysis showed that the calculated t-values for mothers' perception of drug intake counselling and safe motherhood practices in terms of food consumption pattern (3.363), rest pattern (2.035), exercise routine (6.410), and in terms of overall safe motherhood practices (4.683) were each greater than the critical t-value of 1.96 at .05 level of significance using 309 degrees of freedom. These results mean that mothers' perception of drug intake counselling significantly influences safe motherhood practices in terms of the sub-variables and in terms of overall practices. Results of mean values revealed that, it was mothers with positive perceptions toward drug intake counselling ($\bar{X}=47.13$) that exhibited better safe motherhood practices than their counterparts with negative perceptions ($\bar{X}=43.42$). The results however showed that the comparison between mothers' perception of drug intake counselling and drug intake habit yielded no significant influence. Since the result on overall safe motherhood practices was significant, the null hypothesis is rejected.

Hypothesis 1

Mothers' perception of family planning counselling significantly influences their safe motherhood practices.

The independent variable in this hypothesis is mothers' perception of family planning counselling (classified into positive and negative perceptions), while the dependent variable is safe motherhood practices among women. The classification of the women into groups of positive and negative perceptions was done using the score range of 18 (24-6=18), the lowest and highest scores for this sub-variable as shown in the respective tables. Scorers from 6-15 points were considered as having negative perceptions, while scorers from 16-24 points were considered as having positive perceptions towards family planning counselling. Independent t-



test statistical technique was employed in testing the hypothesis. Results of the analysis are presented in Table 2.

Table 2: Summary of independent t-test for the influence of mothers' perception of family planning counselling on safe motherhood practices

S/No	Safe Motherhood Practice	Perception of Family Planning Counselling	N	X	SD	T	P
1	Drug Intake Habit	Negative	33	14.61	2.32	1.32	.529
		Positive	278	13.93	2.82		
2	Food Consumption Pattern	Negative	33	8.73	2.52	3.23*	.001
		Positive	278	9.93	1.96		
3	Rest Pattern	Negative	33	9.30	2.80	3.87*	.043
		Positive	278	10.94	2.24		
4	Exercise Routine	Negative	33	10.18	2.73	5.32*	.000
		Positive	278	12.24	2.01		
5.	Overall Safe Motherhood Practice	Negative	33	42.82	5.89	4.67*	.000
		Positive	278	47.04	4.79		

$P < .05$ level of significance; $df = 309$; critical $t = 1.96$

Results of data analysis in Table 2 showed that the calculated t-values for mothers' perception of family planning counselling and safe motherhood practices in terms of food consumption pattern (3.23), rest pattern (3.87), exercise routine (5.32), and in terms of overall safe motherhood practices (4.67) were each greater than the critical t-value of 1.96 at .05 level of significance using 309 degrees of freedom. These results mean that mothers' perception of family counselling significantly influences safe motherhood practices in terms of the sub-variables and in terms of overall practices. Results of mean values revealed that, it was mothers with positive perception toward family planning counselling ($\bar{X}=47.04$) that exhibited better safe motherhood practices than their counterparts with negative perceptions ($\bar{X}=42.82$). The results however showed that the comparison between mothers' perception of family planning counselling and drug intake habit yielded no significant influence. Since the result on overall safe motherhood practice was significant, the null hypothesis is rejected.

DISCUSSION OF FINDINGS

Mothers' perception of drug intake counselling significantly influence safe motherhood practices

This result showed that mothers' perception of drug intake counselling significantly influences safe motherhood practices in terms of food consumption pattern (3.363), exercise routine pattern (6.410), rest and recreation pattern (2.035), overall safe motherhood practices (4.683) were each greater than the critical value of (1.96) at 0.05 level of significance using 3.09 degrees of freedom. In addition to the mothers' positive perception towards drug intake counselling in Riyadh, Saudi Arabia, the result showed that 58% of participants measured an accurate dose of paracetamol using the oral dosing syringe. Mothers with positive perception



were able to mention some harmful drugs, and also the effects of such drugs on the foetus. Mothers were more reluctant to use non-prescribed drugs purchased from pharmacies, having fear that such drugs may be harmful. Mothers went to visit better pharmaceuticals for care than those in the rural areas. They thought it was best to consult medical doctors before taking medications during pregnancy.

In support of this result, Mutihir (2012) opined that women with positive perception are aware of some essential drugs used for chronic treatment of disease even in pregnancy. Total avoidance of drugs is not possible and may be dangerous because some women become pregnant with medical conditions that required ongoing and episodic treatment. Therefore, drugs are sometimes essential for the health of the pregnant woman and the foetus in such situation. However, mothers with better perception of family planning counselling have control over their childbearing. They also are able to have their desired birth spacing and family size. Omo-Agboja (2008) observed that mothers with positive perception also have access to other reproductive health services and are able to prevent unintended pregnancy.

Mothers were well informed on the type of family planning type available and types most suitable for each individual. Furthermore, mothers with better and safer motherhood perception indicated absence of side effects, husband's willingness towards wife's participation. Thus, mothers with positive perception took the decision to participate in family planning as their individual responsibility. Health professionals played a major role in providing contraceptive counselling; women were self-motivated, and they also had the benefit of timing their fertility better. In addition, women are happier because they have no side effects. World Bank (2013) and WHO (2013) posited that most of the countries with lowest rates of contraception usage have the highest rates of maternal, foetal, infant and child mortality and morbidity rates in the world. Family planning services also afford these mothers with a positive perception opportunity to prenatal care, postnatal care, preventive reproductive health care such as screening for cancer and breast cancer. It also includes the benefit of pregnancy tests. Mothers were satisfied with the roles of professionals who provided counselling.

Furthermore, this result is in consonance with that of Khanal, Joshi, Neupane and Karkee (2011) and Nepal (2010) that women with positive perception are the literate women who are happier with family planning services. They are willing to use contraceptives as they have freedom from the tension of pregnancy. Thus, they use family planning for economic reasons. It relieves them from the pain and stress endured during abortion procedure and they claimed they had no side effects from family planning and have access to counselling. Majority of the clients were happier with the desired numbers of children. Women with negative perception however were not happy with the outcome: they lack access to family planning counsellors and claim the distance to the nearest family planning clinic as a barrier. Mothers who do not practise family planning claimed that the failure of the methods they adopted was one of the reasons for their resistance. Inability to pay for some services and fear of infertility as a side effect were other reasons. These mothers have low self-reporting prevalence rate and poor knowledge of the usage of contraceptives,

The researcher in line with this finding observed that the women who practised antenatal, hygiene, nutrition, rest and recreation, drug intake and family planning counselling have more positive impact than mothers who did not practise antenatal care, hygiene, nutrition, rest and recreation, drug intake and family planning counselling. The women who practised safe



motherhood had better pregnancy outcomes in the study and were happier even after delivery and the post-partum period.

Educational Implication

Maternal drug intake and family planning counselling ensure that mothers make the right choice when required to do so. Abstaining from non-prescriptive drugs and harmful food practices guarantee safe motherhood. Family planning ensures that child spacing for qualitative childbearing takes place; implication of non-counselling will lead to poor outcome in pregnancy and perhaps the death of the mother and her foetus. The implication on the education system is that severe drug intake would have negative effect on the unborn foetus sometimes leading to addiction and short life span. Poor family planning can also lead to death and maternal mortality and birthing of offspring with poor cognition.

CONCLUSION

Maternal drug intake counselling and family planning ensure that mothers who practise safe motherhood counselling are enlightened and are likely to engage in positive practice when faced with the decision to abstain from narcotics, cocaine and such vices. Likewise, family planning ensures that with a well-spaced family other amenities of life become readily available to the mother and child.

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