

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

TITLE: A STUDY TO DETERMINE THE KNOWLEDGE, ATTITUDE AND PRACTICE OF MEN TOWARDS THEIR INVOLVEMENT IN POSTNATAL CARE OF THEIR SPOUSES IN NDOLA URBAN

BY

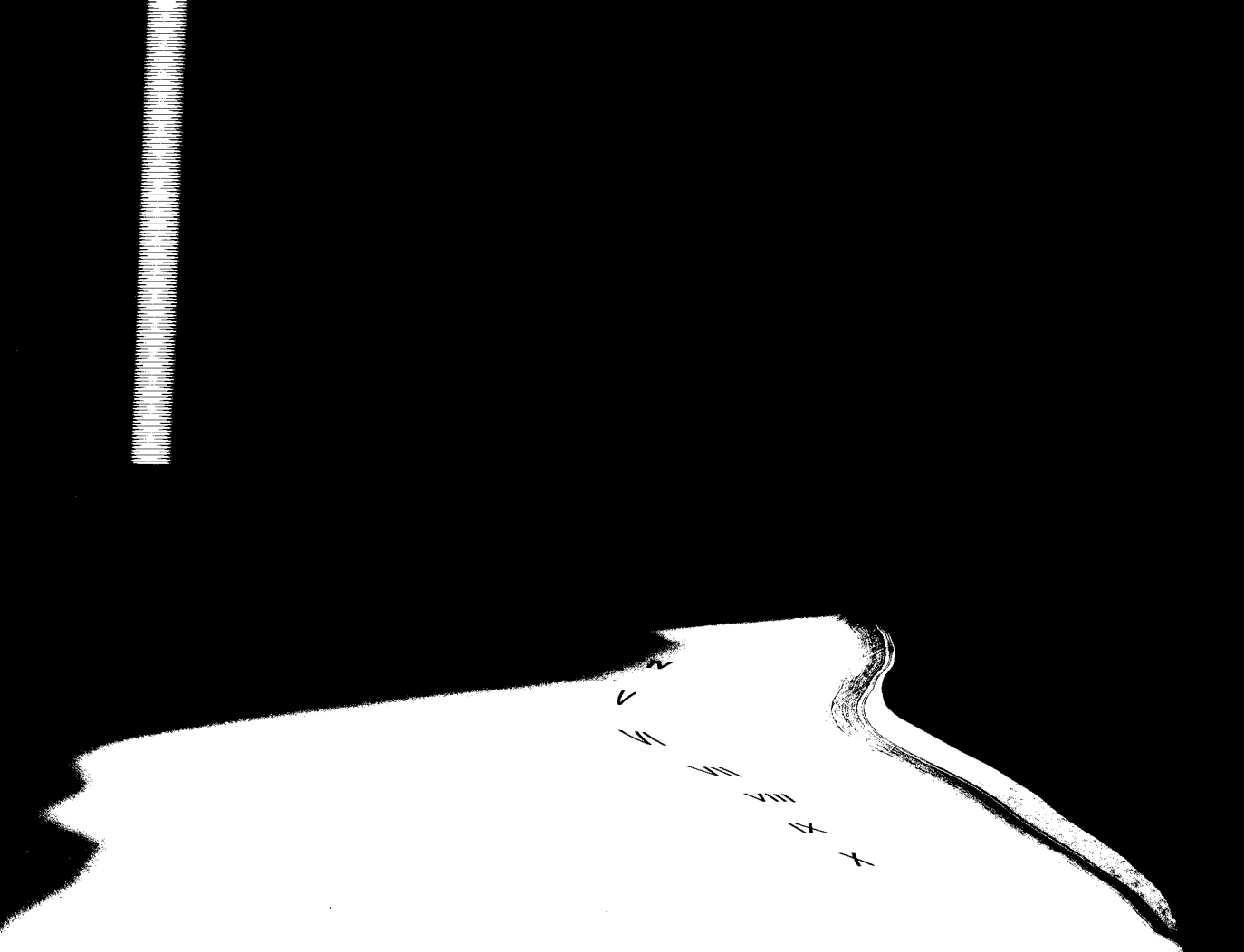
FREDRICK. C. CHAMA

ZRN - 1986 (KITWE)
ZRM - 1990 (UTH)

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LUSAKA, ZAMBIA



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ABBREVIATIONS

AIDS -	Acquired Immunal Deficiency Syndrome
DHMT -	District Health Management Team
HIV -	Human Immunal Virus
IMR -	Infant Mortality Rate
MMR -	Maternal Mortality Rate
UNDP -	United Nations Development Programme
UNICEF -	United Nations International Children Emergency Fund
UTH -	University Teaching Hospital
WHO -	World Health Organisation
ZDHS -	Zambia Demographic Health Survey

ACKNOWLEDGMENT

A number of individuals and organisations contributed to the successful completion of this study. My study would be incomplete if I did not express my appreciation for the assistance and support rendered.

I wish to thank my sponsors - Directorate of Human Resource Development, my supervisor lecturer Mrs. L. Jumbe (Whose encouragement and guidance made this study a success), Ndola District Health Management team, the 80 study respondents and research assistants, Richard Makungu and Finbarr Kabwela for their co-operation and support during data collection.

A special note of appreciation goes to Mildred Mwaba Chama who provided secretarial services, she helped turn this work from a mere dream to reality.

My gratitude goes to my; daughter, nieces and nephew, sisters and brothers, mother and Clare Ntinda for their encouragement and spiritual support .

Lastly and not the least my thanks to fellow students, especially William Mukuma, Monica Mapenzi and Nana Kambole who encouraged me to persevere when things seemed tough.

To them all I say, may God bless you.

DECLARATION

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

Signed: *hmg*

Date: 27/04/99

CANDIDATE

Approved: *R. S. S. S.*

SUPERVISING LECTURER



STATEMENT

I hereby certify that this study is entirely the outcome of my own independent investigation . The various sources to which I am indebted are clearly acknowledged in the text and references.

Signed: *hmy*

Date: *27/04/99*

CANDIDATE

DEDICATION

This work is dedicated to the Almighty God for the grace accorded to me.

My affectionate dedication to my daughter Precious who endured my absence at the time we lost my dearest wife and mother (Switbertha Bwalya Chinondo Chama)

I profoundly dedicate this work to my elder sister Exildah , My mother Angelina, my brothers and Sisters without whose love, inspiration, understanding, support and encouragement this work would never have been a reality.

To my beloved friend Clare whose great encouragement was a profound inspiration in building the determination in achieving this work.

ABSTRACT

The aim of the study was to determine the knowledge, attitude and practice of men towards their involvement in postnatal care of their spouses in Ndola urban.

It was hoped that factors influencing men's involvement in postnatal care would be determined , an approach to enhance family participation be developed so as to make community perceive postnatal care not as institutional based but rather community oriented. It was hoped that gaps in the provision of postnatal care would be identified and recommendations made to Ndola Urban District Health Management Team.

The study was done in Ndola urban on a sample size of eight (80) male respondents who were randomly selected for the study. A non experimental descriptive research design was undertaken . Respondents were taken from 4 selected residential areas namely , Twapia, Kabushi, Ndeke, and Kansenshi. Therefore, 20 respondents were picked from each of the 4 residential areas. A multi stage sampling method was used in the study to select the residential areas and respondents randomly selected. The data was collected by the use of a structured questionnaire and focus group discussions.

The study revealed that educational level and sources of information on postnatal care and parental craft have probable influence on the knowledge, attitude and practice men have on their involvement in postnatal care of their spouses. However knowledge on Postnatal care did not correspond with the social support given to spouses.

The utilisation of family planning services was found to be almost half the number of respondents 41 (51%) and only female contraceptive method is used. This was attributed to peer and traditional teaching.

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The study findings also revealed that very few respondents (21%) learnt about postnatal care through health institutions. It was also evident that men knew very little about exclusive breastfeeding as revealed in the focus group discussions. As a result men did not support exclusive breastfeeding.

Generally, the study has revealed that reproductive health programs have marginalised men. The issue of gender and reproductive health has not been enhanced.

CHAPTER ONE

1. INTRODUCTION

1.1 BACK GROUND INFORMATION

Maternal and child care mortality rates continue to be high in developing countries.

The trend is the same in Zambia as indicated by the 1996 demographic health survey (ZDHS). The projected population of Zambia is 9,453,894 (1998) out of which Women of child bearing is (15 - 49) are 2,079,857 (22%), children under one year 472,695 (5%) and children under 5 years 1,890,779 (20%). Maternal and child mortality rates are as follows :

_ Maternal mortality rate (MMR) = 649 per 100,000

_ Infant mortality rate (IMR) =104 per 1,000

_ Under 5 mortality rate = 197 per 1,000

Apparently Women and children who constitute two thirds of the population are vulnerable to having health problems. The magnitude of mortality and morbidity among mothers and children is of great concern to the Zambian government, hence maternal and child health has been given a priority. In order to address the risks faced by Mothers when going through pregnancy, delivery and postpartum, W.H.O/ UNICEF developed the safe motherhood initiative approach which is aimed at reducing mortality and morbidity among mothers and infants. Safe motherhood encompasses more than cause and consequences of maternal illness and death. It aims at bringing improvements in Women's overall status and improvement in the health services that are a key component of primary health care and addresses the particular needs of a Woman in her reproductive age group. Reproductive health of a Woman is of cardinal importance to human life.

"Reproductive health is the ability of the Woman to, live from adolescence or marriage which ever comes first , to death, with reproductive choice, dignity and successful childbearing and to be reasonably be free from gynecological disease and risk. " Evans, Et al 1987 (Quoted in Koblisky, M. Et al 1991 page 35).

The postpartum period is a crucial time for the health and well-being of the mother and child. Infact, most maternal deaths occur in the postpartum period. According to Global Review of maternal mortality research (1996), haemorrhage, hypertensive disorders and infections are major causes of postnatal maternal mortality in developing countries. These findings underscore the importance of postnatal care. It is however regretable that postnatal services are under utilised the world-over. Only 35% of Women all over the world utilise postnatal services (WHO, 1987). The trend is worse in Zambia. In Ndola for instance, 56,034 mothers attended Antenatal care while only 3,274 (5.8%) attended postnatal clinic in 1997 (Ndola District Health Information Report).

Although, there are very few studies from community and Hospital based surveys in Zambia done to determine factors influencing maternal morbidity and mortality in Zambia, it can be assumed that health service factor is not a major cause. The Zambia Demographic Health Survey (ZDHS, 1996) report indicates that 96% of mothers utilised Antenatal attendance and only 47% delivered from health institutions. Equally important is the family planning service utilisation. Only 26% of married Women used family planning method (ZDHS, 1996). Despite the low family planning utilisation, 98% of the married women and men know at least one method of family planning. This evidence suggests that most women are reasonably informed about maternal health services.

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The government's effort in improving the quality life for Zambians especially that of the mother and child need to be complimented by the Zambian community at large. Postnatal care is not only institution based, it extends into the community thus calls for family participation to which men are the closest care providers.

1.2 STATEMENT OF THE PROBLEM

The first dimension to the problem is that, despite good communication network and accessible health services to the population of Ndola urban, maternal and child health status indicators denote health problems among mothers and children. The 1997 Ndola Information report, health indicators are as follows:

- _ Infant mortality rate =68.9 per 1,000
- _ Under 5 mortality rate =114 per 1,000
- _ Family planning utilisation = Women 41,643 of child bearing age
= Men 4,409
- _ Utilisation of antenatal clinic =67%
- _ Utilisation of postnatal clinic =5.8%

The above health indicators signifies the magnitude of health problems in the community. Zambia Demographic Health Survey (ZDHS, 1996) report for the country highlighted similar health indicators.

- _ Infant mortality rate =104 per 1,000
- _Under 5 mortality rate =197 per 1,000
- _ Family planning service utilisation =26% among married women
- Utilisation of antenatal clinic =96%

on of maternity delivery services =47%

the health indicators for Ndola and the country points towards more health problems for women and children especially in rural areas.

Ndola town is the provincial headquarters of the copperbelt province of Zambia with a 1998 population of 417,104. The population is serviced by 20 government health centres, 24 private surgeries and 9 company clinics. All government health centres provide maternal and child health services. The under utilisation of postnatal clinic does not have a direct bearing on accessibility to health services. This might be due to women's attitudes towards their health. It can as well be as a result of non supportive environment hence mothers have more workload.

Urbanisation coupled with government's economic policy has contributed to poor standards of living among most of the population, hence poor health status of mothers and children. Environmental degradation too, often hits women first and hardest especially those who are constantly occupied in undertaking various chores. Reduction in fresh water availability, depletion of soil fertility and deforestation of fuelwood stocks are trends common in developing regions. According to Ofosu, A. (1991), the depletion of these resources, the labour women expend to meet basic needs increases dramatically, further compromising women's health. Economic and material support is essential to women. Men need to be forefront in providing the support. However this might not be the case due to different perception of issues and subsequently prioritising of needs is affected.

Decision making in most homes is male dominated. Subsequently family expenditure

Utilisation of maternity delivery services =47%

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Decision making in most homes is male dominated. Subsequently family expenditure

in most cases is determined solely by men. Since men are financial providers, they consider their decisions to be supreme. This has a consequence on family nutritional status as men may dictate the food to buy with little nutrition consideration. Due to insufficient and poor quality food, mothers and children's health are adversely affected. Economic constraints also affects the family needs. In order, to supplement family income women spend most of their time in productive ventures. In most incidences mothers in the peuperium are not excluded from income generating activities. Consequently, mothers do not take adequate rest, good nutrition and have little time for good personal hygiene. This compromises mothers and their babies health status. Society therefore has got a challenge of recognising a woman's social realities and biological roles to reproduction and child nuturing.

Domestic equality and reproductive rights until recently were male dominated. Uncontrolled fertility aggravates many of the women's health problems. Empowerment of women to health is essential in addressing women's health status. More fundamentally, however real improvement in Women's health status will require far reaching socio-economic and cultural changes extending beyond the health care system. Empowerment of women to health should start in a home setting. The question is how much empowerment is given to women in crucial moments like reproductive period? Cousin, O. (1991) stated that there can be no true and valid discussion of women's health until they first address the issue of empowerment. Men in many households are reluctant to give full recognition of a woman's right. This is for fear of sharing authority and responsibilities. Traditional and cultural practices in developing regions consider women as second class citizens. The reproductive role of a woman becomes compromised and problematic when man decides for her when to become

pregnant, what foods to eat, when to attend health services and generally the things to do. The woman's special needs are essential. It is for this reason that spouses have an obligation in meeting the woman's special needs and above all let them be partners in the decision making.

Postnatal promotions measures according to the integrated technical guidelines for frontline health workers (1997) should focus on the following elements:

Adequate rest and diet

Breastfeeding

Personal and perineal hygiene

Family planning and child spacing

Resumption of sexual activity

STD/HIV/AIDS prevention

Immunisation

The knowledge, attitude and practices of women and their spouses is cardinal in the promotion of postnatal care. Man and woman should be core partners in ensuring optimal health of women. The post natal health promotion measures should be supported by all men. It is important that men recognise women as competent partners in household decisions. Discrimination is an overlooked stressor in the lives of many women. Sharing of domestic tasks is neglected in most homes. The family health international (1998) reported that almost without exception, women around the world report difficulty in balancing reproductive roles and family responsibilities. Therefore the involvement of men is essential in reproductive health programmes.

The involvement of men in postnatal care of their spouses should include; the provision of an environment conducive for adequate rest, sufficient and quality food, enough physical and emotional support and adequate resources for maintenance of good personal and perineal hygiene. A mutual decision making policy in homes, especially on family planning and child spacing is cardinal. It is however regrettable that most Zambian men consider the woman's health as an individual responsibility and that of the health personnel. The negative attitude by men may be attributed by the traditional and cultural practices. It may as well be due to ignorance on their roles. The attitude of health personnel and other advocates to women's health may sideline men in their approach.

Involvement of men in the provision of postnatal care to their spouses is not enhanced in Zambia. Maternal care do not target men in the most of its approaches. This trend will continue unless postnatal care becomes community oriented. It is therefore important to ascertain factors influencing the involvement of men in the care of their spouses in the postpartum period.

1.3 STUDY JUSTIFICATION

Human reproduction is a biological responsibility of both men and women. It is obvious that men should participate in providing care to their spouses at all levels of the reproductive process. Reproductive health is an issue of gender concern and men need to be sensitive on their role in the promotion of safe motherhood.

Factors that influence or inhibit men's involvement in postnatal care of their spouses need be determined so as to develop an approach that will make the community perceive postnatal care as not institutional based but rather community based.

1.5 OPERATIONAL DEFINITIONS AND CUTOFF POINTS

1.5.1 OPERATIONAL DEFINITION

Puerperium- Period from delivery of the baby up to six weeks post delivery (puerperium synonymous with postnatal period)

Postnatal clinic- Clinic which is held to check on the health of mothers and babies at first and sixth week after delivery

Morbidity-Refers to disease and illness in a population.

Mortality- Refers to death occurring in a population.

Infant Mortality Rate- Is the number of death to infants under one year of age per 1000 live births in a given year.

Maternal Mortality Rate- Is the number of women who die as a result of the childbearing in a given year per 100,000 births in a year.

1.5.2 STUDY VARIABLE

1. Source of information on parental craft.
2. Educational level.
3. Economic status.
4. Domestic equality.
5. Attitude towards postnatal care.
6. Interaction between father and baby.

5.3 FRAMEWORK FOR DEFINING VARIABLES

CONCEPTUAL DEFINITION OF VARIABLES	INDICATORS	MEASUREMENT (cut off points)
Sources of information on parental craft	<ul style="list-style-type: none">. Health institutions. Church. Traditional gatherings. Friends	NORMAL 1. Formal institution 2 .Informal institution
2 Levels of knowledge on post natal care	2.1 Able to mention activities that take place at MCH <ul style="list-style-type: none">. Postnatal examination.Immunisation.Family planning services.Promotive practices	ORDINAL very good
	2.2 Able to mention promotive practices like : <ul style="list-style-type: none">. Postnatal review. Personal hygiene. Good nutrition. Adequate rest	Good
	2.3 associated postnatal care to curative services and those with no knowledge at all.	Poor
3 Attitudes towards post natal care	<ul style="list-style-type: none">-Encourage spouse to attend postnatal review-Escort spouse and child to MCH clinic-Provide assistance in household chores-Encourage spouse to breast feed-Interact with the baby	ORDINAL 4-5 points= very good 2-3 points= good 0-1 points= poor
4 Socio-economic factors influencing men's participation	4.1 Family breadwinner	NORMINAL -Male/female
	4.2 Source of family income	- Formal / Informal
	4.3 Family characteristics mention number of wives	NORMINAL -Monogamy -Polygamy

OF VARIABLES

CONCEPTUAL DEFINITION OF VARIABLES	INDICATORS	SCALE OF MEASUREMENT (cut off points)
	4.4 Social affiliation and interaction - No social affiliation - Social affiliation but no gender interaction - Social affiliation with gender interaction among men and women	ORDINAL 1= Poor 2=Fair 3=Good
	4.5 Income towards households expenditure approximately per month	Interval scale (K) 1.00-50.000=low 51.000-100,000=medium 101,000 and more=high
	4.6 Educational level mention type of educational institution last attended	ORDINAL None/ primary=low Secondary=medium College/University=high
5 Domestic equality	Support on household chores -assist spouse in household chores (washing, cooking, gardening, shopping, maintaining cleanness in the house	Good
	-rarely assist the spouse with house hold chores	Fair
	-household chores are a woman's responsibility	Poor
6 Interaction between father and the baby	Contact between father the and baby . hold the baby while mother is in hospital . carried the baby on discharge . stay with baby for more than 30 minutes a day . Hold the baby first time at home . Hold the baby when the mother is very busy	5-6 points=very good 3=4 points=good 1-2 popints=poor

CHAPTER TWO

LITERATURE REVIEW

PREAMBLE

The researcher had limited literature from the African region and the country Zambia. This had been due to the fact that the study had not been researched before in Zambia and many countries in Africa. This made the researcher make references to studies done in other regions of the world.

LITERATURE REVIEW

There are about 700 million women of reproductive age group (15 to 49 years) in the developing world. Half a million of these women die every year from largely preventable conditions caused by complications of pregnancy, abortion and childbirth, leaving at least 1 million motherless infants, (W.H.O, 1983).

Women in Sub-Saharan Africa have 1 in 21 lifetime risks of dying from pregnancy related causes as compared to 1 in 71, 1 in 131 and 1 in 2288 lifetime risks in Asia, Latin America and Europe respectively, (W.H.O, 1993). The following are maternal death estimates in Africa by W.H.O;

270 per 100 000 -Southern Africa

760 per 100,000 - Western Africa

600 per 100,000 - Sub-Sahara Africa

680 per 100,000 - Eastern Africa

620 per 100,000 - Malawi

Quoted from Nsemukila G. 1994)

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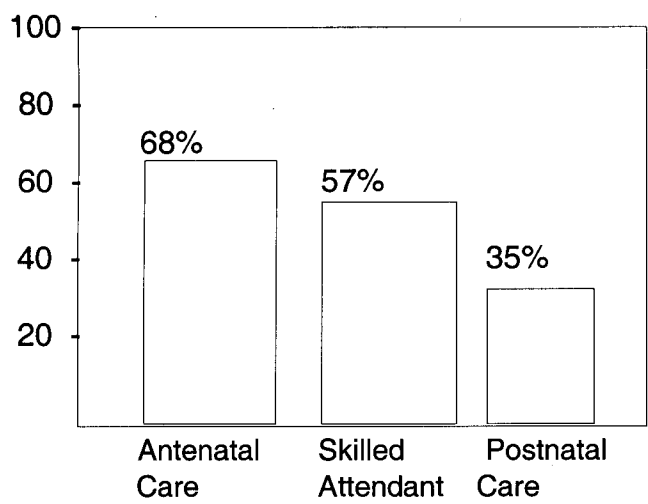
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620 per 100,000 - Malawi

(Quoted from Nsemukila G. 1994)

Most of maternal deaths occur during the postpartum period. The postpartum is a time when each mother has to adjust to physical changes and new emotional demands. Postpartum care is a crucial part of the reproductive process, but unfortunately it has been given a low priority in many maternity units. Estimates of coverage of postpartum care according to, (W.H.O, 1997), revealed that, only 35% of mothers world wide received it, compared with nearly 7 out of 10 who receive antenatal care and almost 6 in 10 who have skilled attendants present at delivery. In developing countries only 3 in 10 mothers receive postnatal care.

GLOBAL COVERAGE OF MATERNITY CARE



Source: Safe Motherhood Newsletter Issue 24 1997 (2).

The under utilisation of postpartum services especially in developing countries may explain the high maternal mortality. Maternal mortality should be looked upon as just the tip of an iceberg of maternal morbidity, suffering and ill health.

Socio-economic conditions greatly affect the health status of women and children. According to Soysa, P. (1987), 2 out of 3 women around the world presently suffer from most

planning as a men's domain (Family health international,1998). Although women bear the physical burden and pain on child bearing and are primarily responsible for child care, men say that their role as financial provider gives them authority to decide on how many children the family can afford. Studies by Lundgren, R. and Valmana, D. (1996) revealed that in Jakata, 56 percent of the 400 women said their husbands wishes prevailed, yet in Ujuna Pandana, Asia nearly 77 percent of 360 women interviewed said that they would make a decision with their husbands to have another child.

Scientists who worked on family health international's women studies project (1998) concluded that involvement of men is essential in reproductive health programmes. Health programmes should include counseling to help women and men improve communication skills and conduct education campaigns to inform men about the roles they can play in family health. In Bolivia Gynaecologists concluded that, " We've seen that working only with women doesn't solve the problems related to reproductive health." Quoted from family health international (1998). The director General (WHO) 1985, emphasised in his report that relationship between men and women as regards to reproductive health and behaviour is cardinal to promoting the health status of a woman and child. It is important from the above statement that men need accurate information about what constitute the best care possible in post partum period in the Promotion of maternal and child health.

An intimate confiding relationship between woman and their spouses is essential if men have to provide physical, social and emotional support to their spouses. This relationship can be greatly promoted by health care provider. Mrs. Ng'andu, I. of Simamalima health centre, Sinazongwe, Zambia reafirms how health workers initiate the participation of men in reprodu-

ctive health. In her report to the reproductive newsletter, March 1998, she revealed the positive support women received from their spouses after attending maternal care clinics. Gender awareness is important as it does not only help couples to analyse and improve their relationship, but enhances relationship between client and health professionals. A trustworthy relationship is cardinal especially in utilisation of family planning methods. In Zambia, the contraception rate utilisation is 26% as reported by the ZDHS (1996). Despite the low rate, awareness about family planning method among men and women is 98%.

Social support encompasses both physical and emotional support. Oakely, A. (1988) pointed out in a literature review, that there is strong evidence that social support can benefit the health of both mothers and babies. Breast feeding mothers need a lot of support from their partners, because breast feeding is best done in a peaceful and quiet environment free from worries because it is time and energy consuming. Adverse reaction and conflicting opinions can lead to feeding problems which can in turn cause the mother a lot of distress. Fathers shouldn't be excluded from breastfeeding activities.

Postpartum depression is to a great extent contributed by spouses. Payker, E.S. (1986) found out that, lack of help from the partner was associated with postpartum depression. Husbands of depressed women did significantly less in the way of household chores, shopping and sharing the care of other children, than those of undepressed women. Paykey's findings confirmed with those of Gordon Et al (1965) who stated that, women who were encouraged during pregnancy to confide in their husbands and enlist his practical help did get more help are more less likely to be depressed after child birth. In emphasising the social support, Comport, M. (1987) stated that isolation is the biggest barrier to recovery. It must be realised

that a depressed person has depressed immune function. From the above mentioned , it is evident that intimate confiding relationship is essential in the promotion of optimal emotional status.

Parental infant attachment greatly affects child's development. Affectionate relationship which develop between mother and child, father and child or other family members endures through out. Liptak, G.S. Et al (1983) in his study said that childhood problem of behaviour, emotional deprivation, child abuse and neglect are thought to be related to problems of parenting and are responsible for a great proportion of, morbidity in children. He concluded that interventions which increase competence of parents and improve their sensitivity to their children can be expected to decrease the occurrence of those problems. Paternal contact and attachment with infants is important for emotional and general development of a child. A study by Keller, W.D Et al (1985) found that fathers who were given four hours extra contact with their infants during neonatal period were more positive about father infant relationship than fathers who had not experienced extra contact this time.

There has been a focus on how to improve postpartum care coverage worldwide. From a number of researches done, it is evident that women have had adequate knowledge on maternal health vis-a-vis postpartum care. A study by Katongo, P. (1997) revealed that even in rural areas of Zambia like Serenje, 86% of women had adequate knowledge about postpartum care, however, only 46% attended postnatal clinics. Nsofu, S. (1988) in her study also revealed that of 6,878 antenatal attendants, only 76 mothers attended postnatal clinic.

These results challenge the notion of inaccessible health services. Multiple roles of women are some of the factors leading to low utilisation of maternal health services. Women have multiple roles to fulfil within their family and community. They have the major biological role in the process of reproduction frequently spending a large proportion of their reproductive years pregnant and /or breastfeeding. Additionally, the social roles of women often result in very heavy workloads for women living in poverty. The frequent combination of these roles creates major challenges for women. The social roles of women generally include major responsibilities in the family, involving care for other members, household management, food preparation, cleaning duties, use of health care and education and supervision of children. The long hours of work and multiple roles of women create a social vulnerability to problems of malnutrition and hygiene, particularly during the reproductive years.

Studies on reproductive health have done little to ascertain the influence a woman's spouse has on health status of mother and infant in Zambia. The cultural influence related to postpartum health of women has not been fully addressed. Involvement of partner in the postpartum care is ideal and a logical approach. A challenge to health professionals is the extent of men's involvement in the postpartum care and strategies to employ. Postpartum care is not the responsibility solely of the health worker. During the postpartum period mothers have little contact with the health care providers. The reduced contact may be due to the woman's multiple roles and distance with formal health care system.

CHAPTER THREE

METHODOLOGY

3.1 RESEARCH DESIGN

The research study was aimed at determining the knowledge, attitude and practices of men towards their involvement in postnatal care of their spouses in Ndola urban.

There has been unresearched speculations as to why men in Zambia are not actively involved in providing the expected care to their spouses during postpartum period. It is for this reason that the researcher sought to explore and discover factors influencing men's involvement in the postnatal care of their spouses. A non experimental descriptive research design was chosen.

The study involved both qualitative and quantitative research methods. The qualitative method involved systematic collection and analysis of more subjective narrative information whilst quantitative method involved systematic collection of numerical information and analysis of this information using statistic method.

3.2 RESEARCH SETTING

The study was conducted in Ndola urban. Four residential areas were randomly selected, namely Kabushi, Kanseshi, Ndeke and Twapia. The reason for conducting the research in Ndola is that the researcher resides there.

3.3 SAMPLE SELECTION

3.3.1 STUDY POPULATION- The study population consisted of only men whose spouses had their last delivery not more than four years ago. The subject selection criteria was to

measure current trends in the knowledge, attitude and practice men had on their involvement in post natal care of their spouses and also considered was the ability to remember events.

3.3.2 SAMPLE SIZE-A total of eighty (80) men were interviewed. Twenty (20) men from each of the four randomly selected areas constituted the sample size.

3.3.3 SAMPLING METHOD- A probability sampling method was used. The researcher employed multi- stage sampling method. Four residential areas were randomly selected from the list of all residential areas in Ndola urban. In each of the selected residential areas, two sections were selected using simple random sampling. 10 household were selected from each section using systematic random sampling. Households were picked at an interval number of 5. The sampling methods used were advantageous in that every study unit was afforded a chance to be selected and participate in the study. The probability sampling method eliminated biasness and enabled the researcher make a generalisation.

3.4 DATA COLLECTION TECHNIQUE

Two methods were used to collect data. A structured interview using a questionnaire and two focus group discussions. The major data collection tool was the questionnaire which was designed and constructed in such a manner that it enabled the researcher solicit appropriate information pertaining to the study. The questionnaire had both closed and open questions. The interview was conducted with a guide of a questionnaire and responses written on the questionnaire by the researcher and his two research assistants. To complement the information collected through a questionnaire, the researcher conducted two focus group discussions at Masala and Lubuto clinics.

To control for constraints of the interview schedules, the researcher explained the

significancy of the study. This assisted the respondents to feel free and appreciate the purpose of the interview. For the same reason the researcher introduced himself.

3.5 DATA COLLECTION

Data collection was done for 12 days, 10 days for interviews and 2 days for focus group discussions. The interviews were conducted by the researcher and two (2) research assistants. At the end of each day, the researcher and research assistants sorted out and edited collected data for completeness, consistency and accuracy.

Focus group discussions were conducted by the researcher and the two research assistants. Each discussion group comprised of 10 men. The researcher directed the discussion and recorded the significant issues relevant to the study.

3.6 ETHICAL CONSIDERATION

Permission to conduct the research was sought from Ndola District Health Management Team (DHMT). The DHMT in turn informed the health centre In-charges of Masala and Lubuto and the Health Neighbourhood committees of the four selected areas about the study and introduced the researcher. The selected respondents were informed by the researcher/assistants why the study was being conducted and their consent sought. This enable respondents to provide information freely as the study was to benefit the health of the community. Information collected was treated highly confidential. No names of respondents appeared on the questionnaire.

3.7 PILOT STUDY AND PRE-TESTING

A pilot study was conducted on the 4th and 8th July 1998, in Hillcrest (residential

area), involving 10 respondents. This served as a trial run that allowed the research team to identify potential problems in the study. Pre-testing ensured clarity of questions and consistency in method of questioning and data collection procedures. The process also helped to modify some unclear questions and construction of some extra ones as well as estimate the data collection period.

3.9 DATA ANALYSIS

Collected data was sorted out and edited for completeness, consistency and accuracy. Data was analysed by ordering, categorising and coding the researched questions. Data is presented in summary form of frequency table, cross tabulation and graphics to which a brief description is made. Data was processed manually using data master sheets and a scientific calculator.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION OF FINDINGS

Data from 80 respondents was collected using a structured interview questionnaire. To supplement this data, two focus group discussions were conducted. Both focus group discussion comprised of 10 male participants in each group.

The structured interview questionnaires were checked for accuracy, completeness and consistency in responses. Responses from open ended questions were categorised, coded and entered on the master sheet. A focus group discussion guide was used during the discussions.

Data presentation was by descriptive statistics using frequency distribution and percentages. Single and cross tabulated tables were used for easy interpretation and for the purpose of drawing meaningful inferences. Questions to certain variable were cross tabulated to show relationship between particular variables.

The sequence of data presentation starts with tables and graphics and lastly focus group discussion key statements.

TABLE 1. AGE DISTRIBUTION OF RESPONDENTS

AGE GROUP	FREQUENCY	PERCENTAGE
20-30	21	26%
31-40	30	38%
41-50	19	24%
50 and above	10	12%
TOTAL	80	100%

Table 1 shows that majority of respondents 30 (38%) were aged between 31 and 40 years. The least number of respondents 10 (12%) were aged 50 years and above.

TABLE 2. MARITAL STATUS OF RESPONDENTS

MARITAL STATUS	FREQUENCY	PERCENTAGE
SINGLE	0	-
MARRIED	76	95%
DIVORCED	1	1%
WIDOWED	3	4%
TOTAL	80	100%

76 (95%) of respondents were married, 1 (1%) divorced, 3 (4%) widowed and none was single.

TABLE 3. EDUCATIONAL LEVEL OF RESPONDENTS

LEVEL OF EDUCATION	FREQUENCY	PERCENTAGE
NONE	2	3%
PRIMARY	18	22%
SECONDARY	43	54%
COLLEGE/UNIVERSITY	17	21%
TOTAL	80	100%

Table 3 shows majority 43 (54%) of respondents attained secondary school education. 2 (3%) respondents did not attend formal education.

TABLE 4. EMPLOYMENT STATUS OF RESPONDENTS

EMPLOYMENT STATUS	FREQUENCY	PERCENTAGE
UNEMPLOYED	10	13%
INFORMAL EMPLOYMENT	34	42%
FORMAL EMPLOYMENT	36	45%
TOTAL	80	100 %

The majority of respondents 36 (45%) were formally employed, 34 (42%) were in informal employment and 10 (13%) were not employed.

TABLE 5. RESPONDENTS LEVEL OF EDUCATION IN RELATION TO THEIR KNOWLEDGE ON POSTNATAL CARE.

KNOWLEDGE ON POSTNATAL CARE	EDUCATIONAL LEVEL				
	NONE	PRIMARY	SECONDARY	COLLEGE UNIVERSITY	TOTAL
GOOD	0	3 (4%)	1 (1%)	3 (4%)	7 (9%)
MODERATE	1 (1.25%)	10 (13%)	26 (32.5%)	11 (14%)	48 (60%)
POOR	1 (1.25%)	5 (6%)	16 (20%)	3 (4%)	25 (31%)
TOTAL	2 (2.5%)	18 (23%)	43 (53%)	17 (22%)	80 (100%)

Respondents who attended college or university and primary school had 3 (4%) highly percentage of having good knowledge on postnatal care while those with secondary education 16% (20 %) exhibited the highest percentage with poor knowledge.

TABLE 6 : RELATIONSHIP BETWEEN TYPE OF MARRIAGE AND KNOWLEDGE ON POSTNATAL CARE.

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KNOWLEDGE ON POSTNATAL CARE	TYPE OF MARRIAGE			
	CHURCH	TRADITIONAL	CIVIC	TOTAL
GOOD	2 (3%)	4 (5%)	1 (1%)	7 (9%)
MODERATE	6 (7%)	39 (49%)	3 (4%)	48 (60%)
POOR	5 (6%)	19 (24%)	1 (1%)	25 (31%)
TOTAL	13 (16%)	62 (78%	5 (6%)	80 (100%)

Majority 62 (78%) of total respondents had tradition marriage out of which 4 (5%) had adequate knowledge. Respondents with traditional marriage had 19 (24%) represent ing highest with poor knowledge whilst those with civic type of marriage had 1 (1%) ad equate knowledge; representing the least group with good knowledge.

TABLE 7. SOURCES OF INFORMATION ON PARENTALCRAFT

SOURCE OF INFORMATION ON PARENTAL CRAFT	FREQUENCY	PERCENTAGE
SPOUSES	7	9%
CHURCH	13	16%
HEALTH CENTRE	17	21%
FRIENDS	9	11%
TRADITIONAL	34	43%
TOTAL	80	100%

Majority of respondents 34 (43%) learnt how to care for their children through tradi tion teaching whilst the least 7 (9%) learnt through their spouses.

TABLE 8. RESPONDENTS LEVEL OF KNOWLEDGE ON POSTNATAL CARE IN
RELATION TO SOURCE OF INFORMATION ON PARENTALCRAFT.

KNOWLEDGE ON POSTNATAL	SOURCE ON INFORMATION ON PARENTALCRAFT					
	SPOUSE	CHURCH	HEALTH CENTRE	FRIEND	TRADITIONAL	TOTAL
GOOD	1 (1%)	1 (1%)	3 (4%)	1 (1%)	1 (1%)	7 (9%)
MODERATE	5 (6%)	8 (10%)	12 (15%)	3 (4%)	20 (25%)	48 (60%)
POOR	1 (1 %)	4 (5%)	2 (3%)	5 (6%)	13 (16%)	25(31%)
TOTAL	7 (8%)	13 (16%)	17 (22%)	9 (11%)	34 (43%)	80 (100%)

Respondents whose source of information was through health centre 3 (4%) were more knowledgeable whilst those whose source of information was through traditional teaching 13 (16%) were least knowledgeable.

TABLE 9. RELATIONSHIP BETWEEN LEVEL OF EDUCATION AND ASSISTANCE
GIVEN TO SPOUSES ON HOUSEHOLD CHORES.

ASSISTANCE ON HOUSEHOLD CHORES	TYPE OF EDUCATION				
	NONE	PRIMARY	SECONDARY	COLLEGE/ UNIVERSITY	TOTAL
YES	1(1%)	12 (!15%)	33 (42%)	12 (15%)	58 (72%)
RARELY	1 (1%)	5 (6%)	6(8%)	-	12 (15%)
NO	-	1 (1%)	4 (5%)	5 (6%)	10 (13%)
TOTAL	2 (2.5%)	18 (22%)	43 (55%)	17 (21%)	80 (100%)

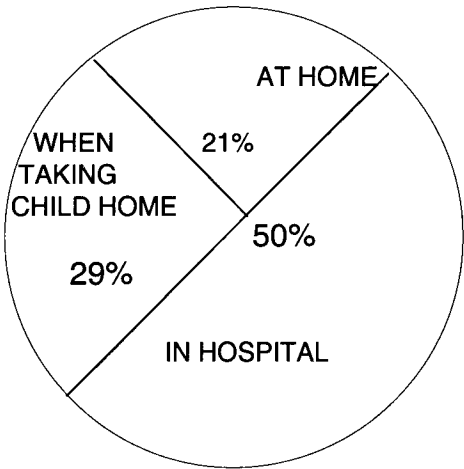
Respondents who attained secondary school level 33 (42%) were supportive to their spouse with household whilst those with college or university attainment were least supportive 5 (6%).

TABLE 10. RELATIONSHIP BETWEEN TYPE OF MARRIAGE AND ASSISTANCE GIVEN TO SPOUSES ON HOUSEHOLD CHORES.

ASSISTANCE ON HOUSEHOLD CHORES	TYPE OF MARRIAGE			TOTAL
	CHURCH	TRADITIONAL	CIVIC	
YES	10 (13%)	44 (55%)	4 (5%)	58 (73%)
RARELY	2 (3%)	9 (11%)	1 (1%)	12 (15%)
NO	1 (1%)	9 (11%)	-	10 (12%)
TOTAL	13 (17 %)	62 (77%)	5 (6%)	80 (100%)

Table 10 shows that 44 (55%) of respondents who had traditional marriage assisted their spouses with household chores. The same respondents with traditional marriage 9 (11%) didnot assist their spouses, representing the highest category with negative response.

FIGURE 1. FIRST CONTACT BETWEEN CHILD AND FATHER.



40 (50%) respondents hold their babies whislit in hospital, 23 (29 %) at discharge and 17 (21%) at home.

TABLE 11. RELATIONSHIP BETWEEN FIRST TIME OF CONTACT BETWEEN CHILD AND FATHER AND TIME FATHER SPEND WITH THEIR BABIES.

TIME SPENT WITH CHILD	FIRST CONTACT WITH BABY			TOTAL
	IN HOSPITAL	AT DISCHARGE	AT HOME	
AT LEAST 30 MINUTES EVERYDAY	38 (48%)	21 (26%)	14 (17%)	73 (91%)
WHEN MOTHER IS BUSY	2 (2.5%)	2 (2.5%)	2 (2.5%)	6 (8%)
RARELY	-	-	1 (1%)	1 (1%)
TOTAL	40 (50.5%)	23 (29%)	17 (20.5%)	80 (100%)

34 (48%) respondents who had first contact with their babies in hospital, spent at least 30 minutes with the babies and respondents who had first contact at home 1 (6%) rarely held the babies.

TABLE 12. RELATIONSHIP BETWEEN TIME OF CONTACT WITH BABY AND CHANG-ING NAPKINS PRACTICE.

CHANGING NAPKINS	TIME OF FIRST CONTACT WITH BABY			
	IN HOSPITAL	AT DISCHARGE	AT HOME	TOTAL
YES	26 (33%)	15 (19%)	12 (15%)	53 (66%)
NO	14 (17%)	8 (10%)	5 (6%)	27 (34%)
TOTAL	40 (50%)	23 (29%)	17 (21%)	80 (100%)

53 (66%) of respondents changed napkins of their babies out of which 26 (33%) were those who had first contact with the babies in hospital. The findings also revealed that 27 (34%) did not change napkins. The highest negative practice was among those with first contact with babies in hospital 14 (17%).

TABLE 13 . RESPONDENTS SOURCE OF INFORMATION ON POSTNATAL CARE
IN RELATION TO THEIR INVOLVEMENT IN ESCORTING THEIR SPOUSES FOR POST
NATAL REVIEW.

ESCORTING SPOUSE FOR POSTNATAL REVIEW	SOURCE OF INFORMATION ON POSTNATAL CARE					
	SPOUSE	HEALTH PERSONNEL	FRIENDS	MEDIA	NONE	TOTAL
YES	9 (11%)	14 (18%)	2 (3%)	5 (6%)	-	30 (38%)
NO	28 (35%)	8 (10%)	4 (5%)	6 (8%)	4 (5%)	50 (62%)
TOTAL	37(46%)	22 (27%)	6 (8%)	11(14 %)	4 (5%)	80 (100%)

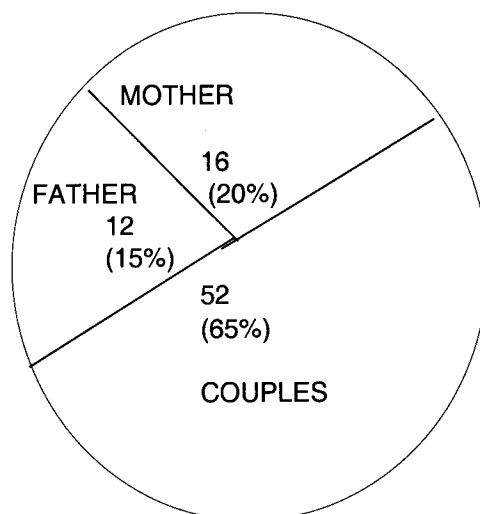
The majority of respondents 37 (46%) heard about postnatal care through their spouses, however, only 9 (11%) escorted their spouses for postnatal review. 14 (18%) out of 30 (38%) respondents who escorted their spouses heard about postnatal care through health personnel.

TABLE 14. RESPONDENTS TYPE OF MARRIAGE IN RELATION TO HOW FREE
TIME IS SPENT.

SPENDING OF FREE TIME	TYPE OF MARRIAGE			
	CHURCH	TRADITIONAL	CIVIC	TOTAL
HOME AND FAMILY SUPPORT ACTIVITIES	6 (7.5%)	19 (24%)	3 (4%)	28 (35%)
INCOME GENERATION	1 (1%)	4 (5%)	-	5 (6%)
LEISURE	6 (75%)	39 (49%)	2 (2.5%)	47 (59%)
TOTAL	13 (16%)	62 (78%)	5 (6%)	80 (100%)

39 (49%) respondents with traditional marriage spend their free time on leisure out of the total 47 (57%) respondents spending free time on leisure. The church marriage has 6 (7.5%) respondents spending time at home on family support activities and leisure respectively

FIGURE 2. DECISION MAKING ON WEANING BABIES



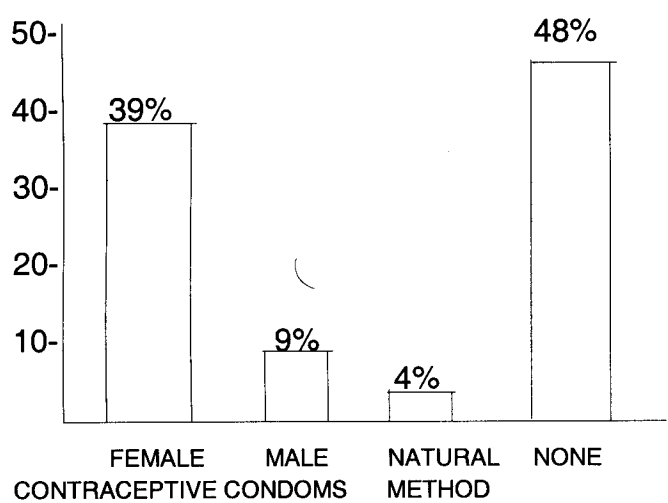
52 (65%) of respondents make mutual decision with their spouses when to wean the baby, 16 (20%) decision is made by mother whilst 12 (15%) decision is made by father.

TABLE 15. RESPONDENTS EDUCATIONAL LEVEL AND FAMILY PLANNING PRACTICE.

FAMILY PLANNING PRACTICE	EDUCATIONAL LEVEL				TOTAL
	NONE	PRIMARY	SECONDARY	COLLEGE/ UNIVERSITY	
YES	1 (1.3 %)	5 (6%)	22 (28%)	13 (16%)	41 (51%)
NO	1 (1.3 %)	13 (16%)	21 (26%)	4 (5%)	39 (49%)
TOTAL	2 (3 %)	18 (22%)	43 (54%)	17 (21%)	80 (100%)

41 (51%) of the respondents practiced practical family planning method whilst 39 (49%) did not. 22 (28%) of the total respondents who attained secondary school level practiced family planning.

FIGURE 3. FAMILY PLANNING METHODS



The majority 31 (39%) respondents used female contraceptive as family planning method whilst 7 (9%) used male family planning method and 3 (4%) used natural method.

TABLE 16. RELATIONSHIP BETWEEN AGE OF RESPONDENTS AND FAMILY PLANNING PRACTICE.

FAMILY PLANNING PRACTICE	AGE OF RESPONDENTS				
	20-30	31-40	41-50	ABOVE 50	TOTAL
YES	10 (13%)	20 (25%)	7 (8%)	4 (5%)	41 (51%)
NO	11 (14%)	10 (13%)	10 (13%)	6 (7%)	39 (49%)
TOTAL	21 (27%)	30 (38%)	19 (23%)	10 (12%)	80 (100%)

20 (25%) of respondents aged 31- 40 practiced family planning whilst those aged above 50, only 4 (5%) practiced family planning. Respondents with college/university attainment had the lowest ratio of negative response on family planning

FOCUS GROUP DISCUSSION REPORT

This is a summarised report based on two focus group discussions held with 10 men at each of the discussion. The responses below were given by the majority of the participants.

1. Do you assist your spouse with domestic work during peuperium?

. All respondents said they did especially with

- washig clothes

-cooking

- sweeping the bedrooms

-drawing water

2. What are the advantages of breastfeeding?

-Provides nutrition for babies

-Promotes baby mother contact

3. Would you encourage your spouse to feed the baby on breastmilk only for the first six months and why?

-All participants said they would not encourage it.

-Breastmilk is not adequate for proper growth of the baby.

-It demands much time of the mother at the expense of other domestic work.

-Women will demand a lot of food.

4. When do you resume sexual relations with your spouse?

-when the baby is three (3) months or more.

5. Do you practice family planning?

-Half of the participants did practice.

6. (a) What family planning methods do you use?

-Contraceptive pill (women).

(b) Why do you prefer these methods?

-It is convenient as it does not disturb the sexual enjoyment. Using condoms when having sex with your wife is taboo.

7. Who makes major decisions at home?

-Man is the prime decision maker

-Women are at times consulted.

CHAPTER FIVE

5.1 DISCUSSION OF FINDINGS

INTRODUCTION

The main objective of this study was to determine factors that influence the knowledge, attitude and practice of men towards their involvement in postnatal care of their spouse. The findings of the research study will be discussed and appropriate health care system implications will be made. From the findings, the researcher will draw up some relevant recommendations.

SOCIO- DEMOGRAPHIC DATA

The study revealed that the majority of the respondents 30 (38%) were aged between 31 and 40 years. This suggests that there are more married men in the age group of 31 to 40 years. This age group is assumed to be more productive economically other than those below 30 years and those above 50 years.

The majority of the respondents 43 (54%) attained secondary school education. This entails that most men can read and write as well as be able to interpret issues rationally. 2 (3%) respondents had no formal education. The literacy rate among the respondents is thus assumed to be high.

The study findings revealed that 10 (13%) were unemployed. 34 (42%) and 36 (45%) were informally and formally employed respectively. Therefore, 87% had a stable source of income.

KNOWLEDGE, ATTITUDE AND PRACTICE

The finding from the study revealed that 7 (9%) men had adequate knowledge on postnatal care. Respondents with college or University education attainment, 3 (4%) had the highest score on knowledge. However, those with secondary school education attainment 16 (20%) exhibited the highest score with poor knowledge. The knowledge acquisition may be as a result of the socialisation process at schools. Socialisation in college and university fosters a sense of discovery on issues affecting the opposite sex than it is at lower levels. The inception of reproductive health concept came with the integrative approach of teaching family health programs to school going adolescents. This must be encouraged. Sarrel, P. M (1990) in her study on the promotion of reproductive health, recommended that education on family planning and responsible parenting should be incorporated into school curriculum of Adolescents. This was based on the good social interaction that takes place between male and female students.

Respondents with traditional marriages had the least knowledge on postnatal care 19 (24%). They also had 4 (11%), the highest negative attitude towards assisting their spouses with household chores. The study also revealed that men with traditional marriage, 39 (49%), spent their free time on leisure, away from their families. This may imply that there is little emphasis made on social support a man is supposed to give his spouse. In many Zambian cultures, assisting spouses with domestic chores is viewed as a weakness and compromises a man's authority in a family. It is for this reason that traditional teaching ill prepare men for their social supportive role. This study results confirms with the study by Wolkind, S. (1980) where it was alluded that men are not given appropriate information on

the social support to their spouses in puerperium period, hence they do not understand the need for emotional support to their spouses. During the focus group discussions, it was evident that men relied more on relatives to assist their spouses with domestic chores post delivery.

The result of the study revealed that health personnel provided parentalcraft information to 17 (22%) of the respondents as compared to 36 (43%) through traditional teaching. Despite the low coverage by health institutions, the respondents score highest 3 (4%) with adequate knowledge on postnatal care. It is important to note 14 (18%) of the same respondents escorted their spouses for postnatal reviews. The results clearly indicate that there is positive responsiveness by men if they are well informed about their role in the promotion of reproductive health of women. It seems most health personnel target women in reproductive health issues. Dr Lourdes Uriona, a Bolivian Gynaecologist conceded at the Family Health International Conference that, working only with women does not solve the problems related to reproductive health. The researcher feels that gender to reproductive health can only be achieved if experts reach out to men. The other issue why reproductive health information is not reaching men is because health personnel are used to static services than community integration.

The study revealed that 41(51%) respondents utilised Family Planning Services. These findings are above the national utilisation coverage which is 26% (ZDHS 1996). Despite the 51% utilisation rate, no male family planning method is used. The focus group discussions revealed that it was convenient for married couples to use non barrier method and use of condoms was considered a taboo. Participants had insufficient knowledge about side effects of female contraceptives. This entails that either their spouses or health personnel have not skillfully communicated to men on family planning methods. These findings confirm the report given at the Family Health International

38.

Conference, 1998, where studies undertaken in Madagascar and Bangladesh revealed that men were less worried about side effects of contraception methods women used as they were not involved in the method of choice. The researcher feels the empowerment of women to reproductive health has marginalised men.

Although the study revealed good father interaction, there is delayed physical contact (50%) of respondents come into contact with their babies upon or after leaving the hospital health centre. The delayed contact might be due to non realisation of the importance of this interaction by both parents and health personnel. It has been evident from this study that 38 (48%) fathers who had contact with their babies in hospital, spent more time with the babies at home. This reaffirms the study by Keller, W. D. et al (1985) who stated that fathers who were given time for extra contact with the infants during neonatal period (in hospital) were more positive about their father-infant relationship than fathers who had not experienced extra contact time.

During the focus group discussion it was revealed that men had a positive attitude towards breastfeeding. However, the participants did not support exclusive breastfeeding as they thought breastmilk alone was not sufficient. They were further concerned about extra food the mother would require if she exclusively breastfed. It was also evident that the majority of the men have not heard about exclusive breast-feeding. These findings clearly indicate that certain health programs exclude men's involvement.

The findings of the focus group discussions revealed that resumption of sexual relation with spouses commenced three (3) months post delivery. Men acquired this information from friends and traditional teaching. These findings in essence entails that certain traditional practices are promotive to reproductive health.

5.2 HEALTH CARE SYSTEM IMPLICATIONS

The study revealed that men have insufficient knowledge about postnatal care. This is mainly attributed to health personnel not providing the rightful information about men's involvement in the postnatal care to their spouses. Although most respondents went through formal education, their knowledge on postnatal is limited. It follows therefore, that the integration of family health education in the school curriculum is not emphasised. Utilisation of family planning services continue to be low and worse still men feel it is only women who should use family planning methods. It seems men do not have an informed choice or they do not just care. This means that the health personnel need to intensify the education campaign on reproductive health. Consequently, women will continue using female contraceptive methods even when their health is compromised.

The findings revealed that majority of the respondents had traditional marriages. At the same time, it can be assumed that this type of marriage institution taught little about social support a man is supposed to give his spouse in the puerperium. The challenge to health care system is to collaborate its reproductive health programs with marriage institutions namely, church, traditional organisations and civic leadership.

The findings imply that there is need to work out better strategies to educate men on their role in promoting the reproductive health of women. Health personnel also need to collaborate with advocates on gender so that their efforts are complemented by other agencies like non governmental organisations.

CHAPTER SIX

6.1 CONCLUSION

The study sought to determine the knowledge, attitude and practice of men towards their involvement in postnatal care of their spouses in Ndola Urban.

The study revealed that men had insufficient knowledge about postnatal care. However, almost half of the men had a positive attitude towards providing social support to their spouses during postpartum period. Generally, the level of knowledge one had in postnatal care and parental craft did not correlate with the social support given to their spouses. It is for this reason that strategies to promoting the involvement of men should aim at cultivating a positive attitude.

Education institutions, marriage institutions and other social organisations are cardinal in enhancing the promotive practices to reproductive health. These organisations need to be integrated into the provision of information, education and communication to men on reproductive health. In fact very few men, received information on postnatal care and parental craft through health institutions. The capacity of health institutions can be complemented by other social institutions.

It has been evident that most health programs do not target men in their approaches. Exclusion of men in reproductive health has negative impact on the health of women and children. There is need for the health care system to develop better strategies in involving men in reproductive health programs.

6.2 RECOMMENDATIONS

In view of the findings of the study, the researcher would like to make the following recommendations:

1. Health institutions policy, should include guidelines on how to enhance father-baby interaction. Father-baby hospital friendly initiatives must be encouraged. Health personnel should discuss parental craft and reproductive health principles with fathers before discharge of their spouses/babies.
2. Reproductive health education should be intensified in learning institutions with emphasis on men's involvement in psycho social support of their spouses during the human reproduction process. Reproductive health advocates should penetrate male dominated working environments and also intensify media coverage on gender and reproductive health.
3. Marriage institutions namely churches, civic authorities and traditional institutions must be involved in parental craft and postnatal teaching.
4. There is need for further studies on factors influencing men's involvement in the postnatal care of their spouses.

6.3 LIMITATIONS TO THE STUDY

1. The study was an academic exercise and needed to be completed within a specified period of time. Therefore, the sample size was limited as such the findings could not be generalised to other towns in the country.
2. The study has not been researched before in Zambia and many countries in the region. This made the researcher to make reference to studies made in other regions. At the same time it was difficult to have adequate literature on the study.
3. Inadequate funding and lack of computer accessibility made the data analysis process difficult.

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THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING

INTERVIEW SCHEDULE FOR DATA COLLECTION ON A STUDY TO DETERMINE THE
KNOWLEDGE, ATTITUDE AND PRACTICE OF MEN TOWARDS THEIR INVOLVEMENT
IN POSTNATAL CARE OF THEIR SPOUSE IN NDOLA URBAN

QUESTIONNAIRE NO.....

DATE OF INTERVIEW.....

NAME OF COMPOUND.....

INSTRUCTIONS

1. Self Introduction
2. Explain purpose of Study
3. Explain assurance of Confidentiality so that respondents are free to give accurate information to the best of their knowledge
4. Obtain Consent from respondents
5. Tick the appropriate response in the box provided
6. For Questions that require written response, write in the space provided

DEMOGRAPHIC DATA

OFFICIAL USE

1. How old are you? ()
 - (a) 20 - 30 ()
 - (b) 31 - 40 ()
 - (c) 41 - 50 ()
 - (d) 51 and above ()
2. What is your Marital Status? ()
 - (a) Single ()
 - (b) Married ()
 - (c) Divorced ()
 - (d) Widowed ()
3. What is your Religion? ()
 - (a) Christian ()
 - (b) Muslem ()
 - (c) Hindu ()
 - (d) None ()
4. Who is the breadwinner?
 - (a) Myself ()
 - (b) Spouse ()
5. What is your Occupation?
 - (a) Unemployed ()
 - (b) Informal employment ()
 - (c) Formal employment ()
6. What is your approximate monthly Family expenditure
 - (a) Less than K50,000 ()
 - (b) K51,000 to K100,000 ()
 - (c) K101,000 to K150,000 ()
 - (d) K151,000 and more ()
7. How many wives do you have?
 - (a) One ()
 - (b) Two ()
 - (c) More than two ()
8. How many children do you have?
 - (a) 1 to 3 ()
 - (b) 4 to 6 ()
 - (c) More than 7 ()

9. How many rooms are in your house?

- | | |
|--------------------|-----------|
| (a) One | () |
| (b) Two | () |
| (c) Three | () |
| (d) Four and above | () |

10. Do you keep extended family members?

- | | |
|---------|-----------|
| (a) Yes | () |
| (b) No | () |

11. What is your education level?

- | | |
|------------------------|-----------|
| (a) None | () |
| (b) Primary | () |
| (c) Secondary | () |
| (d) College/University | () |

SOCIO-CULTURAL FACTORS

12. Are you a member of any Social Service Club/Organisation

- | | |
|---------|-----------|
| (a) Yes | () |
| (b) No | () |

13. If yes which organisation/club do you belong?

.....
.....

14. Does your organisation/club enrol female members

- | | |
|---------|-----------|
| (a) Yes | () |
| (b) No | () |

If yes answer No. 15

15. Do you discuss issues concerning Women's affairs

- | | |
|---------|-----------|
| (a) Yes | () |
| (b) No | () |

If yes answer No. 16

16. What do you discuss?

.....
.....

17. What type of Marriage do you have?

(a) Church

(b) Traditional

(c) Civic

()

()

()

18. Where do you learn how to care for children?

(a) Spouse

(b) Church

(c) Health Centre

(d) Friends

(e) Traditional gatherings

()

()

()

()

()

19. How do you spend your free time

.....

.....

KNOWLEDGE AND ATTITUDE

20. Have you ever heard of Postnatal Care?

(a) Yes

(b) No

()

()

If yes answer No. 21

21. Where did you hear of Postnatal Care?

(a) My spouse

(b) Health Personnel

(c) Friends

(d) Media

()

()

()

()

22. What do you understand by Postnatal care?

.....

.....

23. What activities are involved in Postnatal Care?

(a) Postnatal Examination

(b) Immunisation

(c) Family Planning

(d) Good Nutrition

(e) Adequate rest and good hygiene

(f) Treatment of Mother and Child

(g) I do not know

()

()

()

()

()

()

()

24. Have you ever escorted your spouse to Postnatal Clinic?

- (a) Yes ()
(b) No. ()

25. Have you ever taken your children to children's Clinic

- (a) Yes ()
(b) No ()

26. Do you assist your spouse with with some house work especially in the First 2 months after delivery?

- (a) Yes ()
(b) Rarely ()
(c) No ()

27. In what area do you assist your wife

.....
.....

28. If no to No. 26 WHY?

- (a) I am too busy ()
(b) Other family members do assist ()
(c) Housework is a woman's responsibility ()

BABY FATHER INTERACTION

29. Have you witnessed the birth of your Child?

- (a) Yes ()
(b) No ()

30. Would you like to witness the delivery/ another and why

No.....

Yes.....

31. When did you hold you last child for the First time?

- (a) In hospital ()
(b) When taking him/her home ()
(c) At home ()

32. How often do you hold the baby?

- (a) At least for 30 Minutes everyday ()
(b) Only when the mother is very busy ()
(c) I rarely hold the bay ()

33. Do you change the baby's napkins

(a) Yes

(b) No

()
()

34. If no to No. 33 WHY?

.....

.....

35. When do you wean your Children

.....

.....

36. Who decides when to wean the baby?

(a) Myself

(b) Mother

(c) Both

()
()
()

37. Do you use Family Planning methods to
space your children

(a) Yes

(b) No

()
()

38. If yes what Family Planning Method
do you use

.....

THANK RESPONDENT FOR PARTICIPATING IN THE INTERVIEW

THE UNIVERSITY OF ZAMBIA
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DEPARTMENT OF POST BASIC NURSING

FOCUS GROUP DISCUSSION GUIDE

STUDY TOPIC: A Study to Determine the Knowledge, Attitude and Practice of Men Towards their Investment in Postnatal Care of their Spouses in Ndola Urban.

INSTRUCTIONS

1. Self introduction of research
2. Explain purpose of discussion
3. Explain assurance of confidentiality so that participants are free to contribute in the discussion
4. Obtain verbal consent from the participants
5. Discussion should not exceed 30 minutes
6. Thank the participants at the end of discussion

FOCUS GROUP

DISCUSSION GUIDING QUESTIONS

1. What do you know about the care mothers receive from health centres/hospitals after delivery?
2. In what ways do men assist their spouses after delivery?
3. From your experiences, discuss how babies are fed and what role you as fathers perform?
4. How do you prevent frequent pregnancies?
5. Who makes decisions on issues affecting the daily living of the family.
6. Do you think issues affecting the health of Women are adequately discussed with men?

