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DEPARTMENT OF POST BASIC NURSING

HUSBANDS' AND WIVES' PERSPECTIVES ON PROVISION OF SUPPORT DURING PREGNANCY AND LABOUR IN MUFULIRA DISTRICT

BY
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A Dissertation submitted in Partial fulfillment of the requirements for the Degree of Master of Science in Nursing at the University of Zambia

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DECLARATION

I Charity Chongo, declare that this dissertation represents my own work and that all the sources I have quoted have been indicated and acknowledged by means of complete reference and that it has not previously been submitted for a Degree, Diploma or other qualifications at this or another University. It has been prepared in accordance with the guidelines for Master of Science Degree Nursing Dissertations of the University of Zambia.

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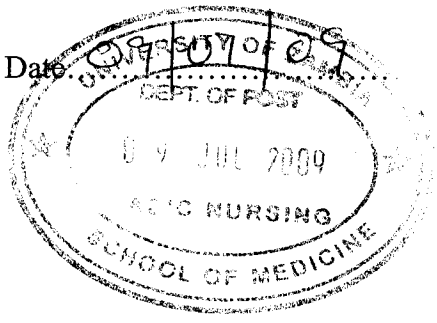

CERTIFICATE OF APPROVAL

I certify that this study on husbands' and wives' perspective on provision of support during pregnancy and labor in Mufulira District is entirely the result of my own independent investigation. Various sources to which I am indebted are clearly indicated in the context and in the references.

Signature..... Date .....

Examiner I

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Examiner II

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ABSTRACT

Since the Movement for Multi-Party Democracy came into power in Zambia, women's health concerns have been discussed in many fora and they are yet to evolve into key policy issues. One of the issues in vogue relates to pregnancy and labour and child birth and it is believed that husbands have a cardinal role to play in supporting their spouses throughout pregnancy and during labour.

The purpose of the study was to explore the husbands' and wives' perspectives on provision of support during pregnancy and labour in order to encourage their participation with the view of improving maternal health. A cross sectional descriptive study was carried out in Mufulira District. A purposive sample of 34 married expectant mothers aged 20 to 50 years participated in four focus group discussions. The focus group discussions were conducted at clinic 1 and clinic 3 in Kantashi Township. A probability sample of 385 married men aged 20 to 54 years who participated were selected using systematic sampling from the six randomly selected residential areas in Kantashi Township. The men were interviewed face to face interview using questionnaire.

The qualitative data was collected by focus group discussions between 2nd May 2007 and 6th June 2007. The four focus group discussions were recorded on a tape recorder. The field notes and transcribed interviews were written and divided into subheadings and themes. This was then deposited into appropriate categories of research issues. The information was used to formulate a standardised structure questionnaire for the husbands.

Quantitative data was collected using the standardised structure questionnaire through face to face interviews. Trained research assistants were used. Pilot test was done in the third week of June 2007. Data was collected from first week of August to first week of October 2007. Data from the field was cleaned and analysed using computer soft ware SPSS versions 11.0.

The main findings of the study were: the expectant women reported that they want their husbands to be present at home more often, to have more time to laugh together and prepare for the baby together and also to help with some house work. They also shared that they would want to have financial support that would help them have enough food and meet the stipulated requirements at the health centres. Most women reported that they would want their husbands to be present during labour, however; they had reservations on the husband being present during childbirth.

The husbands on the other hand reported that they always/ frequently (69.6%) take time to attend to the daily needs of their wives at home. The supportive behaviours that husbands exhibited were being faithful to their wives (97.1%), maintaining their wives morale (96.6%) and emphasizing behaviour according to professional advice given at the clinic by health care professionals (97.1%). However, the supportive behaviour that was least provided was helping with house work (28.6%). The men reported that they were doing more for their wives at home (98.7%).

The study findings showed that 96.6% of the husbands occasionally/ rarely/ never accompanied their wives to the antenatal care clinic though 95.3% reported that they were doing more for their wives at the antenatal care clinic. It was observed that support that was always provided at the antenatal care clinic included emphasizing professional advice give and encouraging to maintain morale. The least supportive behaviour which

the husbands exhibited was touching and soothing her to make her comfortable.

With regard to provision of support during labour the study findings showed that 53% of husbands were more likely to take time off to attend to the wife during the period of admission during labour and Only 12.5% would take time to attend to their wives during the process of delivery. The supportive behaviour that was given was maintaining their wives' morale and emphasizing behaviour according to professional advice given and providing means of transportation.

Key words: Husbands' perspective, wives' perspective, provision of support, pregnancy, labour.

DEDICATION

To the men that desire the best health for their wives in their effort to do so.

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LIST OF ABBREVIATIONS

1.	CBoH	Central Board of Health
2.	CSO	Central Statistical Office
3.	FGD	Focus Group Discussion
4.	HBM	Health Belief Model
5.	HIV	Human Immunodeficiency Virus
8.	MDGs	Millennium Development Goals
7.	MoH	Ministry of Health
9.	NHSP	National Health Strategic Plan
10.	NGOs	Non Governmental Organisations
11.	STIs	Sexually Transmitted Infections
12.	UNFPA	United Nations Population Fund Africa
13.	ZDHS	Zambia Demographic Health Survey

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Since the Movement for Multi-Party Democracy came into power in Zambia, women's health concerns have been discussed in many fora and they are yet to evolve into key policy issues. One of the issues in vogue relates to pregnancy and labour and child birth. Pregnancy, labour and childbirth are rites of passage in which both the man and his pregnant partner have their roles expand to that of parenting. Husbands have a cardinal role to play in supporting their spouses throughout pregnancy and in labour. Pregnancy, labour and childbirth worldwide are considered a state of vulnerability culturally, psychologically, physically and physiologically and are treated cautiously. On account of this, some governments have gone ahead in implementing policies that allow husband to support their spouses when they are expecting, in labour and just after delivery (ILO, 2000).

It has been observed that supporting wives during this period has positive out comes and the notable ones include: improvement of expectant mothers' access to health care including their well-being and their family (UNFPA, 2004). Where studies have been done, the type of support provided to the expectant and labouring woman has been in various categories, such as, emotional support (Kennel et al. 1991) - emotional or empathetic support, husbands accompanying the woman for antenatal clinic, being present during antenatal visits and in labour, giving encouragement, encouraging and validating behaviour according to professional advice, soothing and touching; and social support includes: providing help with house chores, as well as giving tangible support, taking care of baby-related preparations (Bryanton et al.1994 ; Oakley,1992; Corbett and Callister, 2000).

There are a battery of outcomes of such support and these may be direct or an agglomeration with other interventions and they include: having higher self esteem; better health; reduction in the duration of labour, anxiety; and operative deliveries; quick development of a more responsive and affective relations with the newborn and improvement in maternal nutrition (Kennell, 2000).

1.2 STATEMENT OF THE PROBLEM

As far back as pre independence, Zambian women have been provided with health care by the government and some Christian organizations through public health programmes. However, priorities of these public health programmes in the domain of safe mother hood and reproductive health have had minimal involvement of husbands as end beneficiaries not withstanding the fact that husbands are key decision makers in the homes (CBoH, 2002; 2003). Zambia has a very high maternal mortality ratio which has increased from 649 per 100,000 live births in 1996 to 729 per 100,000 live births in 2001-2002 (CSO, 2003). This increase is attributed to many factors and husbands' support such as, provision of transport and deciding when to seek medical help could be one of them. For instance, the Mongu maternal mortality survey (Ministry of Health (MoH), 1997) confirmed this view.

Antenatal attendance and health facility deliveries in Mufulira are low as can be seen in Table 1 below. The antenatal attendance is reported to be about 72% which is below the national coverage of 93% reported by Central Statistical Office and supervised deliveries are reported to be about 52% (Mufulira District Health Management Team 2003, 2004, 2005, 2006). This includes deliveries conducted by trained Traditional Birth Attendants in the homes. The health facility deliveries are about

40%. This implies that there is under utilization of these services. Male participation in these services has not been documented, however, it is said to be low.

Table 1: First antenatal attendance, supervised delivery and maternal deaths in Mufulira District for the period of 2003 to June 2006.

Activities	2003	2004	2005	Up to June 2006
First Antenatal attendance	5,483 (72%)	5,572 (72%)	5,420 (72%)	6,490 (72%)
Supervised delivery	3,795 (69%)	3,864 (52%)	3,772 (52%)	2,020 (66%)
Maternal death	6	6	7	2

Research in this area has not been done in Zambia and as such it is empirically not possible to ascertain the extent of health behaviour and support that husbands render to their wives. It is also not possible to say with certainty whether the perceptions of expectant mothers are in consonant or at variance from what their husbands perceive as what their roles ought to be. It is also not possible to make any assertions from a comparative perspective if the type of support rendered by husbands in the West relates with what our expectant mothers perceive husbands ought to do. The researcher cannot also ascertain the extent to which the health belief model can be applied to understand the role of perceived benefits and threats in husbands supporting their wives. Based on all these facts, it shows that the researcher had a knowledge gap on a number of variables and there was need to fill this gap.

1.3 FACTORS INFLUENCING HUSBANDS' AND WIVES' PERSPECTIVES ON PROVISON OF SUPPORT DURING PREGNANCY AND LABOUR

Health professionals and the mass media have spread the message that people need to avoid certain behaviors and adopt others as part of their daily routine if they want to maximize their life expectancy and remain healthy as long as possible. These statements are supported by ample evidence that a lack of regular screening in pregnancy may cause serious health problems and even death to both the mother and child deaths (Blair et al. 1989; Otten et al., 1990). On the positive side, there is evidence that pursuing a preventive healthy lifestyle can enhance one's health life expectancy and a safe deliver. At the center of the observed health behaviour are the following variables:

1.3.1 Demographic data

1.3.1.1 Age

Age has been noted to influence the perception of symptoms and health seeking behaviour (Andersen and Anderson, 1979) with young ones being least in responding to threats and older ones the most prompt. Younger husbands may not be familiar with the needs of a pregnant or labouring woman as well as the needed support during this period. The younger women may have unrealistic expectations from the husbands during pregnancy and labor. However older husbands and wives who may have not experienced any complication during pregnancy and labor may not be prompt in seeking medical help during pregnancy and labor.

1.3.1.2 Sex

When the extent of knowledge of symptoms of an illness is considered, it also appears that women know more about health matters than men and

take better care of than men (Feldman, 1966; Nathanson, 1975). This would be attributed to the fact that most of the health services particularly reproductive health services are targeted at women as service recipient or as care givers.

1.3.2.1 Cultural beliefs and practices

Socio cultural factors have an influence on a person's values in life. Those behaviours that seem to be approved or positively rewarded tend to be practiced more and passed on to the other generations. Therefore, any behaviour that is regarded to be right for a man whose partner is pregnant will be encouraged and practiced in order to maintain social order while performing the duty of procreation and socialization of the new child. These may include health seeking behaviours such that those health services which may be seen to cost more with little benefit will not be utilized. In most societies issues surrounding pregnancy and labour are considered to be women's domain and therefore, men are not expected to take up the carer's role.

1.3.2.2 Social networks

Suchman's (1965) study and studies by low income blacks and Mexican Americans showed that under certain conditions, close and ethnically exclusive social relationships tend to channel help- seeking behavior, at least initially, toward the group rather than professional health care delivery systems. Yet Geertsen and associates (1975) replicated Suchman's study in Salt Lake City and found an opposite trend. They observed that the Mormon community, with its strong value on good health and education and its emphasis upon family authority and tradition, demonstrated that group closeness and exclusivity can increase, rather than decrease, the likelihood of an individual responding to professional health resources.

1.3.2.3 Religion

Religious teachings play an important role in molding behaviour in the individuals. Teachings that are held as sacred are adhered to even at the expense of ones health. Therefore, those teachings that may discourage attendance by personnel of opposite sex or those that emphasize spiritual healing may put a pregnant woman and her child at risk of dying or experiencing disability. Most religions place women in subservience position which make them to rely on men such as for decision making including seeking health care services.

1.3.2.4 Socialization of boys and men

Traditional values and norms are taught to societal or community members to help adapt and ensure that there is social order. These beliefs and practices can either hinder or enhance male involvement in the care of pregnant and labouring women depending on the emphasis laid.

1.3.2.5 Lack of Community support

Community support can be in form of provision of transport in case of emergency, blood donation and elimination of discrimination and violence against women that impairs their well-being. It also includes empowering women to have access to meaningful income that can assist them have nutritious meals, and other basic items. When the community unity to work out measure to prevent or alleviate life threatening conditions for pregnant women it helps to reduce martenal and infant morbility and mortality. Lack of such concerted efforts could result in delay in seeking medical help or/ and lack of access to health care services.

1.3.3.1 Socioeconomic Status

Another major approach to the study of help seeking behavior has been its correlation with socioeconomic status. Several years ago, it was generally believed that lower-class persons tended to underutilize health services

because of the financial cost and/or culture of poverty. The culture of poverty as summarized by Thomas Rundall and John Wheeler (1979) is a phenomenon in which poverty over time, influences the development of certain social and psychological traits among those trapped within it. These traits include dependence, fatalism, inability to delay gratification, and a lower value placed on health (being sick is not especially unusual). This, in turn, tends to reinforce the poor person's disadvantaged social position. The seminal study showing how the poor had developed a different perspective concerning their interpretations of symptoms was Earl Koos's *The Health of Regionville* (1954).

Mechanic (1978:268—269) formulated a general theory of help seeking since his initial work with Volkart in the early 1960s. He suggests that whether a person will seek medical care is based on ten determinants: (1) visibility and recognition of symptoms; (2) the extent to which the symptoms are perceived as dangerous; (3) the extent to which symptoms disrupt family, work, and other social activities; (4) the frequency and persistence of symptoms; (5) amount of tolerance for the symptoms; (6) available information, knowledge, and cultural assumptions; (7) basic needs that lead to denial; (8) other needs competing with illness responses; (9) competing interpretations that can be given to symptoms once they are recognized; and (10) availability of treatment resources, physical proximity, and psychological and financial costs of taking this action. In addition to describing these ten determinants of help-seeking behaviour Mechanic explains that they operate at two distinct levels: other-defined and self defined. The other-defined level is, of course, the process by which others define an individual's symptoms as illness and call those symptoms to the attention of that person. Self-defined is where the individual defines his or her own symptoms. The ten determinants and two levels supposedly interact to influence a person to seek or not seek help for a health problem.

1.3.3.2 Men's working hours

A man's ability to provide basic needs for his family empowers him to make decisions in a family or relationship. The working hours and pay for hours worked could discourage some men from being with their partners during the antenatal clinic or labour, for fear of loss of pay which they need to support their families including paying transport fares and medical fees.

1.3.3.3 Education level

Education help broaden a person's understanding of life events and in making decisions that are healthful. It also influences a person's health care seeking behaviour. It is assumed that those with secondary level education and above are able to understand health messages and seek health care from trained health care providers. Education can also influence change of cultural beliefs and practices regarding male involvement in the care of pregnant and labouring women. For instance, the 2001 - 2002 Zambia Healthy Demographic Healthy Survey found that women who had education higher than primary school level utilized maternity services more than those with no education. This may be so for male as well as there is little difference in the level of literacy among men and women. In this instance, we can say men with such educational background would get involved in the care of their wives/ partners. Education also as a bearing on a person's economic status in that it gives a person a better placement in securing employment or being involved in economic activities.

1.3.3.4 Lack of information

Information empowers an individual to make informed decisions, as one would weigh benefits against costs. Lack of information may result in poor understanding of the effects of pregnancy and labour on the woman and the child. Lack of information would contribute to delay in making

decision or and taking action which would result in maternal or/and infant death or poor health.

1.3.4 Health related factors

1.3.4.1 Rigid antenatal clinic hours

In many health centers, antenatal clinics are conducted during the day when people are attending their normal duties. Some men who are employed may not be able to get permission to go with their partner during antenatal sessions because it will result in loss of pay.

1.3.4.2 Long waiting time

When clients have to wait for a long time for a service at a health facility they tend not to use such facility regularly. If men have to wait with their wives/partners at the antenatal clinic or indeed during labour the men may feel inconvenienced as they will lose out on work hours and hence they will not attend such services if they do not consider them to be part of their responsibility.

1.3.4.3 Providers' negative attitude towards male involvement

Some providers of antenatal and intrapartum care may not be confident in working with couples and may directly or indirectly discourage men accompanying their wives/partners.

1.3.4.4 Lack of privacy in health facilities

Provision of care during the antenatal clinic and labour involves exposure of private parts of the body. Such activities may pose embarrassment for a man to observe his partner being attended to. This is made worse if there no privacy from other clients such as adequate seclusion with curtains or walls and doors.

1.3.4.5 Inadequate health workers in the health facilities

Inadequate staffing in a health facility providing maternity care has adverse effects on the quality of care being provided. This can include inadequate information sharing with clients and their partners. When the staff experience burnout they are likely to display attitudes that will not encourage clients and their partners to use the facility.

1.3.4.6 Lack of in-service training for health workers on male involvement.

Males may not necessarily have similar needs as their partners when they attend antenatal care clinics or labour. This therefore, requires that the health provider knows how to work with males so that they can take up their role of supporting their partners. If the health provider is not competent to work with men he or she is likely to explicitly or inexplicitly discourage the men who wish to be involved.

1.4 Conceptual Model of Determinants Husbands of Supportive behaviour

We can conceptualise the research problem to be centered on the following variables:

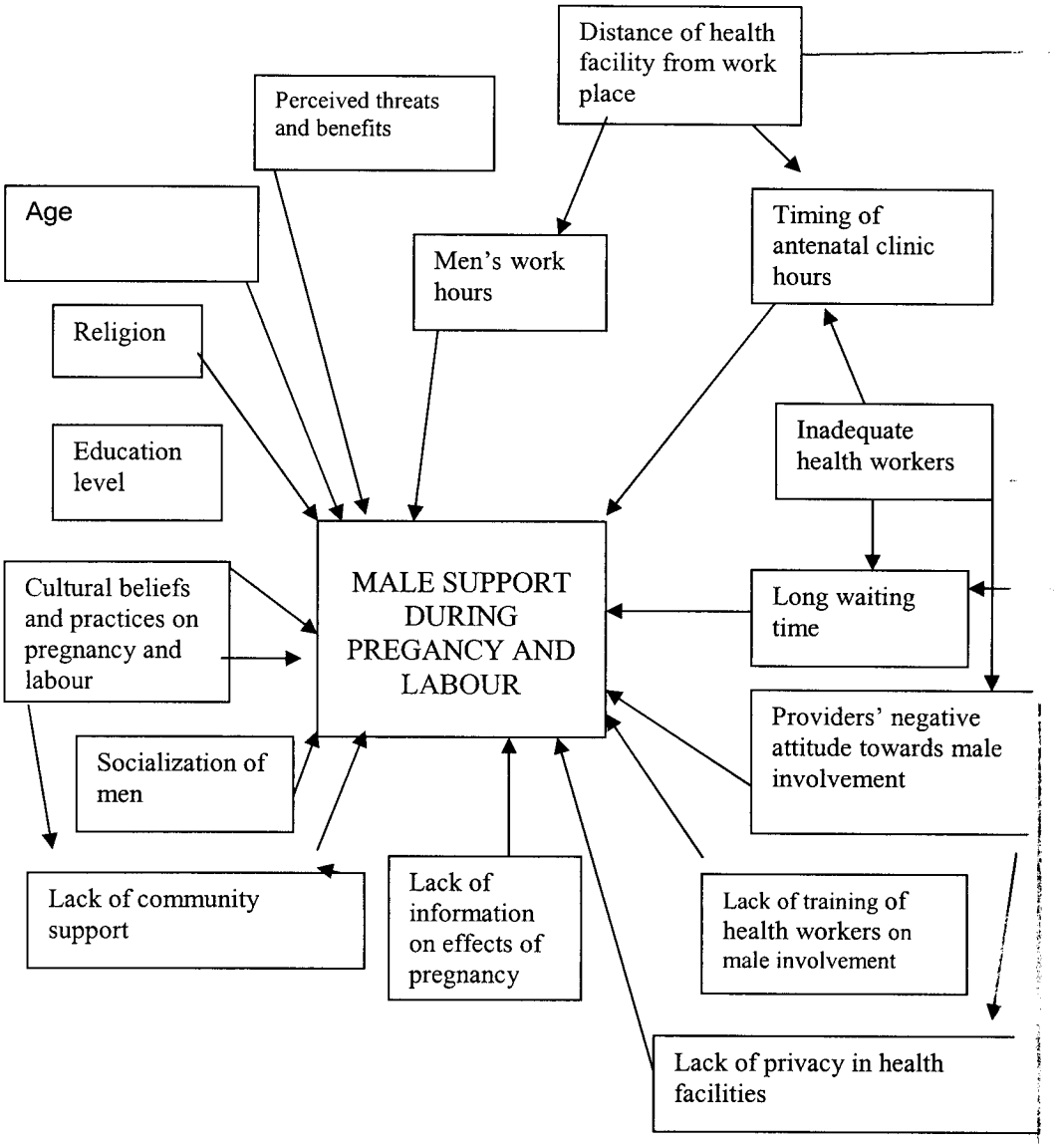

Figure 1: Conceptual Model of Determinants Husbands of Supportive behaviour

1.5 RESEARCH QUESTIONS

1. What type of support do expectant wives want from their husbands?
2. What type of support do husbands claim provide to their expectant wives?
3. What is the variation of support like between what the literature says and what expectant wives want from their husbands?
4. What is the variation of support like between what expectant wives want from their husbands and what their husbands claim they do?
5. Why do husbands do the things they do?

1.6 RESEARCH OBJECTIVES

1.6.1 General Objective

To explore the husbands' and wives' perspectives on husbands provision of support during pregnancy and labour in order to encourage them to participate in provision of reproductive health care services with the view of improving maternal health.

1.6.2 Specific Objectives

The following objectives guided this inquiry in designing the research particularly in the data collection and analytic processes and the manner of presenting of findings.

1. To explore the nature of support that expectant wives want from their husbands.
2. To explore the nature of claims husbands make in terms of support provided to their expectant wives.

3. To describe from a multiple[1] perspective as well as from a single reality perspective the extent of variation of support between what expectant wives want from their husbands and what their husbands claim they do.
4. Using the Health Belief Model, to explain[2] husbands' supportive behaviour.

1.7 HYPOTHESES

From the Health Belief Theory which has been presented later in chapter two, we have selected only two assumptions for testing and these are. From each assumption, concepts have been identified and formulated into "conceptual hypothesis". Since theories express functional relationships in affirmative terms, the deductive strategy does not espouse confirming the theoretical assumptions but aims at negating the theoretical assumptions by advancing the null hypothesis[3] — H_O (This is the statistical hypothesis that negates the thesis which is believed to be true about the parameter for the target population of interest). H_0 as a thesis represents a theory that has been put forward, either because it is believed to be true or because it is to be used as a basis for argument. We call the hypothesis that describes the remaining possible outcome(s) the alternative hypothesis — H_A, this is the statistical hypothesis that states what is assumed in the event that the null

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[1] The ontology of multiple reality is that viewpoints of many are not uniform and as such there is need to be conversant with the view points of all social actors (Goles and Hirschheim, 2000)

[1] The ontology of single reality is that viewpoints of many need to be in one voice are because reality is predetermined by the same factors to all members (Goles and Hirschheim, 2000)

3 Explaining according to Yin (2002) entails answering the "Why" type of a research question in nomothetic research this is done by testing the null hypotheses. Please see the hypotheses to be tested in chapter three.

hypothesis does not stand against the evidence and has to be considered as a plausible statement of claim that it may be so under the conditions.

Below are two hypotheses to be tested.

H_{O1}: There is no relationship between the perceived seriousness of developing a complication or of leaving it as it is (including evaluations of both medical and clinical consequences and possible social consequences) and husbands providing support to an expectant wife.

H_{A1}: There is a relationship between the perceived seriousness of developing a complication or of leaving it as it is (including evaluations of both medical and clinical consequences and possible social consequences) and husbands providing support to an expectant wife.

H_{O1}: There is no relationship between the perceived benefits being the believed effectiveness of strategies designed to reduce the threat of developing a complication/ illness in pregnancy and husbands providing support to the expectant wife.

H_{A1}: There is a relationship between the perceived benefits being the believed effectiveness of strategies designed to reduce the threat of developing a complication/ illness in pregnancy and husbands providing support to the expectant wife.

4 Using the null hypothesis is the appropriate way of testing the veracity of the theory than the alternative hypothesis. This is because the evidence that you have to collect must be used to discredit the theoretical assertions. Here the fundamental issue is what burden of truth you have to assert either way. It is a logical fallacy to affirm a consequent when a researcher sets to prove the theory right by testing the alternative hypothesis. It is a fallacy because it is not difficult to find evidence that supports the theory (Neuman, 2002:154-154).

1.8 SIGNIFICANCE OF THE STUDY

A review of literature indicated that research has been conducted on husbands supporting wives mainly in the West but no research has been conducted in Zambia. This study was therefore significant because it filled-in the literature gap on safe motherhood and reproductive health. The study will also be beneficial to women, Non-governmental Organizations and the Government because the results will augment their efforts in developing reproductive health policies and the design stage of packages. Finally, this study triangulated data collection and analytic methods and as such, it added impetus to resolving the longstanding debate of puritan quantitative and qualitative research.

1.9 VARIBLES AND CUT OFF POINTS

Table 2: Variable and scale of measurement

Variable	Operational definition	Parameters	Scale of measureme
Husbands Providing Support	Provision of physical , emotional and social support	a. I am providing encouragement during her antenatal clinic to maintain morale b. I encourage and emphasise behaviour according to professional advice that we are given c. I am providing help with house chores d. I am providing food as demanded e. I am taking care of baby-related preparations f. I am providing means of transportation to her to attend antenatal care and delivery g. I would be there to provide her with encouragement to maintain morale h. I would be there to encourage and emphasise behaviour according to professional advice i. I would be there to soothe and touch her to make her comfortable j. I would be there in the wards to give her physical support	Ordinal
Perceived seriousnes	likelihood of an expectant developing an illness/ complication during pregnancy, labor and delivery	a. That my wife may die in pregnancy and so I help out. b. That my wife may die in the process of delivering and so I help out. c. That my wife may fall ill in pregnancy or during delivery and so I help out. d. That I may have an unhealthy baby and so I help out. e. That my baby may die in pregnancy or delivery and so I help out.	Ordinal
Perceived	the believed effectiveness of strategies designed to reduce the threat of developing a complication/ illness in pregnancy, labour and labour	a. By ensuring that my wife has to be well and healthy in pregnancy. b. By ensuring that my wife has to be well and healthy during delivery. c. By ensuring that illness in my wife to be minimized and adequately managed. d. By ensuring that illness in my baby has to be minimized and adequately planned for in advance. d. By ensuring that complications in the baby during delivery being planned for in advance.	Ordinal

1.10 OPERATIONALISATION AND MEASUREMENT OF THE VARIABLES

From the null hypotheses, the following variables in table 3.2 have been identified for operationalisation and measurement.

Table 3: Dependent and independent variables

Independent Variable	Dependent variable
Perceived seriousness of developing a complication or of leaving it as it is.	Husbands providing support
Perceived benefits being the believed effectiveness of strategies designed to reduce the threat of developing a complication/ illness in pregnancy and labor	Husbands providing support

Perceived seriousness or threat is operationalised as a husband taking some preventive action on account of fear:

a. That my wife may die in pregnancy and so I help out.

b. That my wife may die in the process of delivering and so I help out.

c. That my wife may fall ill in pregnancy or during delivery and so I help out.

d. That I may have an unhealthy baby and so I help out.

e. That my baby may die in pregnancy or delivery and so I help out.

Perceived benefits are operationalised as a husband taking some preventive action of helping out on account of desiring:

a. By ensuring that my wife has to be well and healthy in pregnancy.

b. By ensuring that my wife has to be well and healthy during delivery.

c. By ensuring that illness in my wife has to be minimized and adequately managed.

d. By ensuring that illness in my baby has to be minimized and adequately planned for in advance.

e. By ensuring that complications in the baby during delivery being planned for in advance.

Husbands providing support is operationalised as provision of social, physical and emotional support by virtue of:

a. Being present during my leisure time and helping out.

b. Being present during all antenatal examinations and helping out.

c. Being present when in labour and helping out.

d. Being present during delivery and helping out.

e. I am encouraging her to maintain morale

f. I am emphasising behaviour according to professional advice that we are given at the clinic.

g. I am helping out with house work

h. I touch and sooth her to make her comfortable

i. I by her the food that she wants

j. I am taking care of baby-related preparations

k. I make sure that I have no other woman in my life to go out with.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

This chapter focused on literature on perspectives on husbands providing of support during pregnancy and labour. The literature review has been organized according to global, regional and national perspectives. The purposes of literature review are three folds:-

a) To provide a critical framework for the study.

b) To offer not a mere bibliography but an analytical and critical appraisal of the important and recent substantive and methodological development in the researcher's area of interest and indicate how the study will refine, revise, extend or transcend what is not known.

c) To inform and lend support to the researcher's assumptions operational definitions and even methodological procedures by demonstrating that the study has profiled from scholarly and scientific work that has preceded it.

The sources of literature were research studies, abstracts on provision of support during pregnancy and labour from internet and journals.

Polinski (2005) a free lance writer reports that couvade, a sympathetic pregnancy experienced by partners of pregnant wives seems to be a universal phenomenon with cases found across cultures, continents and centuries. These symptoms start near the end of the first trimester and generally stop with the birth of the child. Masoni, et al, (1994) also reported that husbands of pregnant wives experience various psychosomatic symptoms such as variations in appetite, nausea, insomnia and weight gain, changes in sexual habits, fear, anxiety and curiosity.

This shows that husbands are affected by the pregnant state of their partners hence the need to involve them in the provision of support to their pregnant partners during pregnancy and labour. Previously health programmes such as Maternal and Child health and Safe Motherhood have been targeting women only and this has not improved the health of women. The United Nations in 1999 urged Governments and their partners to involve husbands in the provision of support during pregnancy and labour in order to improve the well being of women (Ntabona, 2001). Support during pregnancy and labour is provided depending on the socio cultural and economic background of people.

2.2 GLOBAL PERSPECTIVE

Studies that have been conducted on male perspective on provision of support during pregnancy and labour have showed improved access to health services by women thereby reducing maternal mortality rate.

Draper (2002) reported that husbands expressed their desire to be involved with their partner's pregnancy but had difficulty in getting involved. However, their participation in pregnancy confirmation helped them to get involved in the care during pregnancy and shaped their early transition into fatherhood. Cooper (2005) in a study of first-time expectant father's transition to fatherhood in Britain revealed that participation in pregnancy confirmation, parent-craft classes and assistance at labour and birth helped husbands recognise their role and obligation as primary providers which when enacted could improve the welfare of mothers and children. Robertson (2002) reported that not all husbands want to help their partners during birth of their child but involving them in comprehensive prenatal education helped them participate in providing care to their expectant partners and gave them the chance to bond at birth with their child. This

implies that husbands too need support to be involved in the care of their expectant partners.

A study in Sweden by Hallgren et al (1999) revealed that husbands who participated in antenatal classes with their partners and participated in childbirth found childbirth experience more demanding than they expected and felt unprepared for the unpredictable process. However, the support provided to their partners made positive contribution to the women's welfare. In another study by Feldman at el (2000) showed that social support offered to pregnant women can significantly predict foetal growth as those that received support from their family, the baby's father and general support had better foetal outcome

Wikipedia (2006) reported that husbands may give active assistance to simply being present during their wives labour and many wives find the presence of their partners in the delivery room comforting. Cartino (1999) reported in rural Bolivia a Lilac Tent Project provided prenatal, postnatal and family information and services tailored to the local needs to both husbands and wives saw an increase in attendance by both husbands and wives. According to a study conducted by the Population Council (2005) in Bolivia, El Alto to investigate husbands' participation during pregnancy, childbirth and postpartum period in order to provide basis for developing strategies for effective participation of husbands in maternal and family health care; it was found that husbands who were actively involved in the care of their pregnant wives encouraged them to obtain antenatal care and this contributed to the improvement in the well-being of women and children. This implies that male participation has to be tailored to the individual needs for it to be beneficial to the women. This was reflected in the report by Fein (1976) which said that child birth preparation classes should be organised in such a way that it does not only

help the husbands to be involved during pregnancy, labour and childbirth but also helps them to adjust to postnatal family life.

In studies conducted by UNFPA (2004) in Guatemale it was revealed that male provision of support during pregnancy and labour resulted in positive maternal health outcomes. The social support included husbands accompanying their wives on antenatal visits, were present or nearby during births, although they were not with their wives who delivered in hospitals, and they took care of baby-related preparations.

2.3 REGIONAL PERSPECTIVE

Mullick et al. (2005), in a research study carried out in KwaZulu-Natal in South Africa entitled "Involving Men in Maternity Care: Health Service delivery issues" found that male involvement in the provision of support during pregnancy and labour increased their access to information on pregnancy and labour. This resulted in increased Antenatal Care clinic attendances among pregnant women. Early and continued antenatal care from skilled attendant helps prevent adverse outcomes of pregnancy as reported by Koblinsky (2003).

Ntabona (2001) reported that in Gambia, husbands viewed covering of financial cost of antenatal care for their multiple wives as their duty though reasons for completing the four recommended antenatal care visits were not clear to them. Though the husbands may pay for these services they may be actively involved in adhering to health advice which they may not fully understand.

In a study conducted by the Frontiers in Reproductive Health (2005) to investigate the effect of shifting the health care services during antenatal care on couples as opposed to wives alone, it was discovered that wives

who were accompanied by their husbands or partners to the antenatal clinic utilized the health services more compared to those who were not accompanied by their partners.

A study done in Zimbabwe to investigate the role of husband's involvement in antenatal care in the reduction of Human Immunodeficiency Virus (HIV) infection risk for couples showed that husbands and wives have different expectations about male involvement in pregnancy (Marindo, 2001). Wives stated that they needed emotional support from their partners while husbands reported that they needed more information on pregnancy. Husbands also cited inconvenient clinic hours and uncomfortable sitting arrangement in the waiting rooms as some of the barriers to their participation in antenatal care with their partners (Marindo, 2001).

2.4 NATIONAL PERSPECTIVE

The need for more male participation in reproductive health has been acknowledged even by policy makers. However, literature has shown that there is low participation by the men folk.

Dover (1995) in a field study in rural Zambia reported that young men not in married relationship would rather have the partner abort than accept responsibility for a pregnancy. This behaviour puts the pregnant woman at a more vulnerable position as she would be susceptible to procuring unhealthy practices that increase her risk of poor health or death.

Nsemukila et al. (1998) in "A study of factors associated with maternal mortality in Zambia" revealed that men played significant role in encouraging and approving their wives antenatal attendance and place of delivery. In this study some husbands and wives stated that husbands have

no role to play during delivery. They observed that wives whose husbands participated in their care during antenatal and Intrapartum period utilised the health services efficiently. They also observe that wives who did not attend antenatal care had a higher chance of dying due to pregnancy related complications. The low participation of husbands in antenatal and Intrapartum care could account for inefficient use of health facilities for such services by wives contributing to poor health or death from conditions that can be prevented, controlled or/and treated.

A study conducted by Mulumbwa (1999) on "Low participation of men in Family Planning services in Kasama District" showed that lack of male involvement in reproductive health was hindering wives from accessing family planning services. The UNFPA (2005) in the country update reported that in North Western Province some socio cultural beliefs and practices hinder male participation in reproductive health. Lack of male involvement who are in most instances the decision makers would hindered wives from utilizing health care services and resulted in poor maternal health.

Husbands are decision makers in the homes and as such they ought to make decisions regarding health care. The 2001-2002 Zambia Demographic Health Survey revealed that 47% of husbands made decisions alone without consulting their wives (CSO, 2003). This notion was confirmed by Ndonyo (2005). Since most decisions in the homes are made by husbands who are bread winners including decisions on seeking health care, it is most prudent that they are involved in reproductive health issues so that they understand the need to provide support to wives during pregnancy and labour in order to minimize delays in seeking health care ultimately leading to improved maternal and foetal outcome.

Delays in seeking health care could lead to more wives dying during pregnancy and delivery. Zambia has a very high maternal mortality ratio has increased from 649 per 100,000 live births in 1996 to 729 per 100,000 live births in 2001-2002 (CSO, 2003) and this could be attributed to delays in seeking health care due to lack of support provided to wives during pregnancy and labour among other factors. For instance, the Mongu maternal mortality survey (Ministry of Health (MOH), 1997) confirmed this view.

Delay in making the decision to seek care is the first of the three phases in delaying a woman receiving the needed health care that can improve her well being. In the Health Belief Model health seeking behaviours are said to be influenced by certain factors, which are, perceived susceptibility to and seriousness of the health problem, and perceived benefits of taking action and barriers to taking action (Becker and Lißmann, 1973). This implies that the decision to seek health care can be made when the presence of an abnormal condition is recognised and realised to be harmful to life and the benefits of health care out weighs the cost of procuring it. This puts the woman at cross roads in that although pregnancy, labour and childbirth is acknowledged as potentially risky they are commonly considered natural and normal events for wives and death during these phases may be considered normal and inevitable (Thaddeus and Maine, 1991). This is compounded by her not being the decision maker in such important moments.

Therefore, if husbands were enlightened on reproductive health issues, they would encourage their wives/partners to seek medical services early and also provide support during pregnancy and labour. In this way, Zambia will achieve the 6th Millennium Development Goal (reducing maternal and child morbidity and mortality.

It is therefore, imperative that the perception of both husbands and wives on husbands providing emotional and social support during pregnancy and labour be assessed so that suggestions for improvement are made.

2.5 THEORETICAL MODELS

Researchers have used various theories in studying health behaviour. The notable theories include: the biocultural model, The Health belief Model and the Biocultural Model.

2.5.1 THE BIOCULTURAL MODEL

The biocultural model of medical anthropology asserts that societies have systems of ethnomedical beliefs and knowledge which serve to reinforce cultural guidelines for health and illness behavior (Freund and McGuire, 1992; Rhodes, 1990).

Another characteristic of the biomedical system is the doctrine of specific etiology (Mishler, 1984). In this paradigm, diseases are seen as "deviations from the norm of measurable biological (somatic) variables (Mishler, 1984)." Alternative definitions are largely ignored. Diseases are diagnosed in an interaction where the patient's identification of physical symptoms is matched with physician knowledge about how specific diseases cause specific symptoms. The cause of a disease then is reduced to either a specific toxin or pathogen. Treatment is directed both at the alleviation of physical symptoms, and at the destruction of the specific causative agent. Most disorders are understood in terms of such simple cause-effect relationships.

With the extensive focus on diagnosis on treatment, preventive strategies are largely ignored. Patients continue to be concentrated in large acute care facilities. This continues despite increases in the prevalence of chronic long-term disorders. Diseases are viewed as static entities rather that dynamic processes. The information base for biomedical diagnoses is mostly quantitative, and tends to ignore more anecdotal, qualitative data.

Nearly all phases of medical care are dominated by the doctrine of specific etiology. It has been argued by Mechanic (1978) that doctors need to take more seriously the satisfaction and quality of life concerns of their patients. This model is not appropriate in this study because pregnancy is not an illness it is just a physiological state and as such preventive strategies in antenatal care are not covered.

2.5.2 THE BIOCULTURAL APPROACH

The biocultural approach presents strong challenges to the assumptions of biomedicine. The model has its history within the field of medical anthropology. As its name suggests, it is a synthesis of the approaches of cultural and biological anthropology. Many disciplines are drawn upon in the investigation of health, disease, and healing, often with the intention of improving health care delivery.

Humans are seen as holistic beings with interrelated biological and sociocultural contexts. It is seen as important to attain a comprehensive understanding of the human condition through an evaluation of a number of factors including: biology, environment, psychology, social organization, and political economy

Research using a biocultural approach is often cross-cultural and comparative. It may also be historical. Most crucial is an emphasis on participant observation and the value of qualitative data. It is recognized that the study of disease does not generally take place in a vacuum, but rather in a cultural system. The cultural bias of both the researcher and those being studied must be accounted for. An attempt must be made to identify with the concerns of patients and research participants. The biocultural approach conceptualizes biomedicine as one of the world's many ethnomedical systems. However, the biocultural approach has been criticized for taking issues of political economy too lightly. Some researchers advocate for a more critical perspective that broadens the cultural interpretive approach to include an analysis of the hegemony of

the capitalist world system. The fact that we are comparing some variables, does not qualify this theory to be used here and we are not a capitalist country to examine the consumer models.

2.5.3 THE HEALTH BELIEF MODEL

One of the most widely accepted standards for understanding health seeking behavior is the Health Belief Model (HBM) (Figure 2). The model is deserving of serious consideration in the context of this research because of its reliance on individual perceptions. One of the most influential social-psychological approaches designed to account for the ways in which healthy people seek to avoid illness is the Heath Belief Model of Irwin Rosenstock et al. (1994). The Health Belief Model (HBM) attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals when weighed against benefits and risks of taking or not taking an action. The Health Belief is based on the assumptions that people exist in a life space composed of regions with both positive and negative valences (values). A health condition would be a negative valence and would have the effect of pushing a person away from that region, unless doing so would cause the person to enter a region of even greater negative valence (for example, risking death in twin pregnancy might be more negative than failing delivering a case of placenta praevia.. While people are pushed away from regions with negative valences, they are attracted toward regions of positive valences. Thus, a person's behaviour might be viewed as seeking regions which offer the most attractive values (Kleinman, 1988).

The key variables of the HBM are as follows:

1. **Perceived Threat:** Consists of two parts: perceived susceptibility and perceived severity of a health condition.

- **Perceived Susceptibility:** One's subjective perception of the risk Threat) of contracting a health condition,
- **Perceived Severity:** Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).

2. **Perceived Benefits:** The believed effectiveness of strategies designed to reduce the threat of illness.

a. **Perceived Barriers**: The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.

b. **Cues to Action:** Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action. Cues to action are an aspect of the HBM that has not been systematically studied.

c. **Other Variables:** Diverse demographic, sociopsychological, and structural variables that affect an individual's perceptions and thus indirectly influence health-related behavior.

d. **Self-Efficacy:** The belief in being able to successfully execute the behavior required to produce the desired outcomes.

This model has general limitations of the HBM include:

(a) Most HBM-based research to date has incorporated only selected components of the HBM, thereby not testing the usefulness of the model as a whole;

(b) As a psychological model it does not take into consideration other factors, such as environmental or economic factors, that may influence health behaviors; and

(c) The model does not incorporate the influence of social norms and peer influences on people's decisions regarding their health behaviors.

However in spite of these limitations, it has a better standing and was therefore applied in this study. The study explored the husbands' supportive behaviours, their perceived benefits and perceived seriousness of the pregnant state and labour. The wives discussed what the support they expected or and were receiving from their husbands during pregnancy and labor. They also discussed what they considered to be benefits of such support and what the barriers were to the husbands providing support.

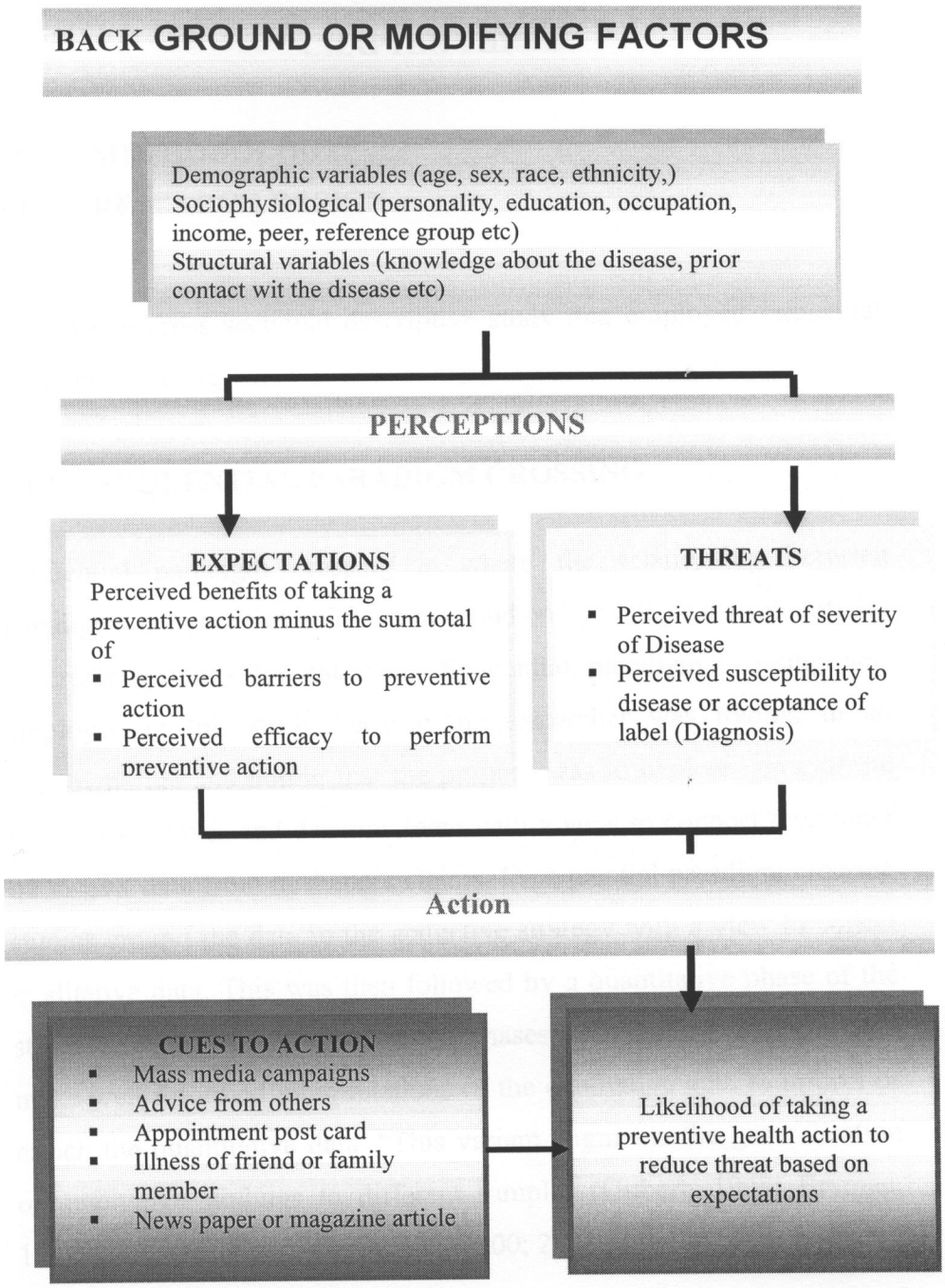

Figure 2 Health belief Model

Source: Rosenstock et al., (1994)

CHAPTER THREE

3.0 METHODOLOGY

3.1 RESEARCH DESIGN

This was a cross sectional descriptive study that employed sequential paradigm crossing.

3.1.1 SEQUENTIAL PARADIGM CROSSING

Sequential paradigm crossing is where the relationship between paradigms is linear and unidirectional and one paradigm is used initially to create grounds for the next. Sequential paradigm crossing was employed in this study because the researcher was trading in an unknown area and noting that the purpose was to explore some of the wants from wives and describe them with a view to connect them later on to new data from husband's claims. In sequential paradigm crossing studies ground the data in the abductive strategy with a view to collect qualitative data. This was then followed by a quantitative phase of the study. The idea of having these two phases was to allow the researcher make well informed interpretations of the qualitative data to inform or enrich the quantitative data. "This variant augments the generalisation of qualitative findings to different samples (Gilbert, 1993; Bryman, 1996, 2003; Goles and Hirschheim, 2000; 259).

3.1.2 CROSS SECTIONAL RESEARCH

Cross sectional research involves collection of data at one point in time so that the phenomena under study are captured during one data collection period (Polit, et al 2001). Essentially, data are collected at

only one point in time, comparing different participants at different ages (Creswell, 1994). In this study, the cross sectional design was appealing for reasons of economy of time and cost in spite the fact that the design severely limits the researcher's ability to address developmental issues or offer causal interpretations generally and more elaborately over time . It was also appealing for the participants and the researcher because there was only one period for data collection, and the researcher was not faced with the difficulty and cost of maintaining contact with subjects over a long period of time (Neuman, 2000).

3.1.3 DESCRIPTIVE RESEARCH

Descriptive research designs measure variables about its subjects only once and this is because no attempt is made to change behavior or conditions and the researcher measures things as they are. Descriptive research designs are predominantly observational, because researchers observe the subjects without otherwise intervening then documents aspects of a situation (Polit et al 2001).

3.2 RESEARCH SETTING

The study was conducted in Mufulira District. Mufulira District is situated on the northern part of the Copperbelt Province of Zambia. According to Central Statistical Office (2004), Mufulira had a population of 143,930 which is 9% of the Copperbelt province population. The male population was 72,526. There were 26,097 households in Mufulira and 82.7% of these are male headed. This therefore, put husbands in decision making position in many households.

The District has two public hospitals and twenty (20) public health centres, one private hospital and four (4) private health centres that provide antenatal care. Of these all the hospitals and ten (10) public and four private health centres provide care for women in labour. Communities that are in the outskirts of the town receive antenatal care on monthly basis through the outreach (mobile) health services by the Mufulira District Health Management Team.

The staff in these health care facilities encourage pregnant wives to come with their support persons or companion to the antenatal clinic for antenatal care and during labour and child birth. It was for this reason that the researcher had chosen Mufulira as a study site with the view of evaluating the programme or the health workers' efforts.

3.3 STUDY POPULATION

The study population consisted of married females and males in the reproductive age group (aged between 20 and 54 years for males and 20 -50 year for females) residing in urban areas of Mufulira district. The male population in the district was 72,526 and that of females was 104,784.

3.4 SAMPLE SIZE AND SELECTION

This study employed two types of sampling techniques and these were random and purposive sampling. Purposive sampling was used in selecting expectant mothers because these units are spatial, temporarily non-independent and the units are generally unknown (non pre-specifiable) *apriori* and indeterminate (Miles and Huberman, 1994:27; Manion and Cohen, 1997:86-89; Neuman, 2000:196-200). Purposive

sample sizes are usually small. The source of the sampling units were antenatal clinics. These clinics are patrolled by women some of whom may not be married. These were not the subject in this study and as such we purposively sampled those who met the inclusion criteria. It was these sampling units which were considered to be ideal because these samples needed to be studied intensively, and each one of the sample elements, typically generates a large amount of information. This should be noted because from purposive samples; rich, copious, intensive and lengthy amounts of data may emerge (Miles and Huberman, 1994:27; and Neuman, 2000:196-200). Purposive sampling is best suited for field studies, which have a prime focus on the topic than the desire to meet the population's representativeness (Bernard, 2000). The husbands were selected using systematic sampling. The men were from six randomly selected residential sections in Kantashi Township.

3.4.1. Sample of men

The probability sampling technique was the main stay to obtain men who were married and have had or have an experience with a pregnancy or birth as units of analysis. The study employed the Nether formula to calculate the sample size:

$$n = z^2 \frac{PQ}{d^2}$$

This involved:

An estimate of prevalence / proportion (p)

Desired confidence level (α)

Desired width of confidence interval (d) of an estimated proportion of an attribute that is present in the population.

The proportion of male participation in provision of support during pregnancy and labour which was used was 50% because the researcher could not identify such from any study done in Zambia.

For this formula:

Confidence level 95%

P= 50 (proportion of males involved in antenatal care and intrapartum care)

z= 1.96 at 0.05 (z value for 95% confidence level) $\propto$

Q= 100 – 50 = 50

d^2 = sample size for a coverage rate of 50%

Therefore:

$$n = z^2 \frac{PQ}{d^2}$$

$$n = \frac{1.96 \times 1.96 \times 50 \times 50}{5 \times 5}$$

$$n = \frac{9604}{25}$$

$$n = 384.16$$

Therefore, the sample size was rounded up to 385.

The sample was selected from the community, that is, Kantashi Township serviced by four health centres. The township is in the urban

and is divided in ten residential sections. Six residential sections were selected by simple random selection. Sixty-five respondents were drawn from each section using systematic sampling. The number was obtained by dividing sample size by the number (six) of residential sections. The sampling interval was calculated by dividing the number of houses in each residential section randomly selected by the sample size. The respondents were selected by first selecting the house using systematic random selection method, that is, every Kth interval, and then the male present in that house who met the selection criteria was interviewed. The first house was selected using the table of random numbers which is similar to random sampling. Sampling method was used because it could assist obtain results in a convenient and efficient manner (Polit, et al, 2001). Each house was counted as a household. Those who were not present a second visit was made the following day or by appointment before being replaced. Participation was voluntary.

3.4.2. Sample of women

The women who met the criteria were selected on basis of homogeneity for the focus group discussions. Four focus group discussions were conducted two at Clinic 1 and two at Clinic 3. Each group comprised of 5 - 11 pregnant women, a total of 34 women. Written consent to participate was obtained and they were assured of confidentiality.

3.4.3. Inclusion criteria

Only married men in the 20 and 54 years age group, who had experienced pregnancy and pregnant women aged between 20 and 50 years, and residing in Kantashi Township, Mufulira District were considered eligible for study.

3.4.4. Exclusion criteria

All males and females unmarried, those aged below and above the reproductive age group, those in the reproductive age but had not experienced pregnancy, and not residing in Kantashi Township, Mufulira District were excluded from the study.

3.5 DATA COLLECTION TOOLS

Two types of data collection tools were employed in this study and these were focus group discussion guide with expectant mothers and Researcher Administered Standard Structured Questionnaires (RASSQs) with the men. The data collection tools were developed in phases based on the psychological model of behaviour change the Health Belief Model (HBM). The Focus Group Discussion guide was set of open ended questions which the expectant women (wives) answered and discussed. The Researcher Administered standard Structured Questionnaire (RASSQs) was designed after analyzing the Focus group discussions then refined after a pilot test. Incites from literature as to how Ajzen (1988); Conner and Sparks (1995); and Godin and Kok (1996) constructed levels of measurements of their constructs from the Theory of Planned Behaviour have been used resulting in the data collection tool in the appendices. The questionnaire had closed ended questions diivided in five sections. Section A contained demographic information. Some of the variables in this section included age, educational level, employment status, family income and number of children. Section B questions that assisted in measuring support given at home and reasons for rendering support. Section C contained questions that assisted to measure the support given in relation to antenatal care clinic and the motive for providing the support. Section D contained quetions that helped to

measure the support given during labour and the reasons for providing supoort.. Section E contained questions that assisted to measure the support given during the process of delivery and the moyive for providing the support.

3.6 DATA COLLECTION TECHNIQUE

Data collection was done with the help of research assistants who were trained prior to the procedure. The logical relationship between the research question and the appropriate data collection tool is shown below.

Table 4 Data collecting technique

Research Question	Data Collection Method
1. What type of support do expectant mothers want from their husbands?	Focus Group Discussions
2. What type of support do husbands claim they provide to their expectant wives?	RASSQ
3. What is the variation of support like between what the literature says and what expectant mothers want from their husbands?	Analytic Induction of Literature and Focus Group Discussions
4. What is the variation of support like between what expectant mothers want from their husbands and what their husbands claim they do?	Analytic Induction of Focus Group Discussions and RASSQ data
5. Why do husbands do the things they do?	RASSQ using null hypotheses from the Health Belief Model

Focus group discussion is a form of group interview in which a group of persons answer and discuss questions on a given topic (Polit, et al, 2001). Focus group discussion is a group of 5 – 15 persons guided by a facilitator or moderator, during which group members talked freely and spontaneously about a topic following a written set of questions (Polit and

Hungler, 1999). Prior to the focus group[4] discussions the respondents' background information (including demographic characteristics, education level and family structure among others) before moving on to their maternity experiences were obtained. In the focus groups respondents were invited to talk about issues that are critical on the topic of husbands supporting them in pregnancy and when in labour as well as possible benefits of this support.

These discussions were recorded on the audiotapes. The researcher moderated the discussion using the Focus Group Discussion guide. The midwife was engaged as research assistant to help with recording and time keeping. Four focus groups were conducted each lasting about 45 minutes. Focus groups were chosen withstanding the fact that mothers are busy and ethnographic interviews may not be possible. Noting that people get caught up in the spirit of group discussion and this may allow more revelations than they would in the more formal interview setting. As discussants ask questions of each other, new avenues of exploration are opened. In discussions, multiple meanings are revealed as different discussants interpret topics of discussions in different ways. Interaction is the key to successful focus groups. In an interactive setting, discussants draw each other out, sparking new ideas. The reactions of each person spark ideas in others, and one person may fill in a gap left by others. One

[4] Originally developed for market research, a focus group is a group interview or discussion. The focus may be on a particular topic of interest, for example a health problem, or the group may be focused, in the sense that its members have common characteristics. The term is increasingly used to refer to any group discussion where group interaction is used to generate . Focus groups tend to be open-ended and have less structured protocols (i.e., researchers may change the data collection strategy by adding, refining, or dropping techniques or informants). They rely more heavily on iterative interviews; respondents may be interviewed several times to follow up on a particular issue, clarify concepts or check the reliability of data. They use triangulation to increase the credibility of their findings (i.e., researchers rely on multiple data collection methods to check the authenticity of their results). Their findings are not general sable to any specific population; rather each case study produces a single piece of evidence that can be used to seek general patterns among different studies of the same issue.

may even find a form of collaborative mental work, as discussants build on each other to come to a consensus that no one individual would have articulated on their own (Krueger and Casey, 2000).

Face to face interviews using structured interview questionnaire were conducted with the help of research assistants. The research assistants were trained in the use of the questionnaire to ensure uniformity of asking questions and recording responses. The answers to the question posed during the interview were recorded by writing them down during the interview. This data collecting technique helped clarify questions that were not clear to the respondents and accommodated both illiterate and literate persons. To control for the limitations of the interview method, the interviewers introduced themselves and stated the significance of the study in order for the respondents to appreciate the study and were assured of confidentiality. The respondents with some difficulties with English were interviewed in the native language, CiBemba in commonly used on the Copperbelt Province. The questionnaire was translated into ciBemba to assist the research assistant.

3.7 PILOT STUDY

This study employed a questionnaire based on the health belief Model constructed after analyzing data from the focus group discussions. The researcher used a questionnaire after the pilot test to assess the extent to which the questionnaire would grant us reliability. The researcher used an opportunity to perfect the questionnaire from the observed reactions of the respondents to the research instrument and their willingness to answer the questions. The pilot testing also helped to determine how much time would be needed to administer the questionnaire and to analyse it. The lessons learnt from the pilot tests coupled with the out

comes of the focus group discussions, the researcher enabled the researcher to develop a reliable and locally focussed questionnaire

The questionnaire was administered to a forty (40) husbands residing in Kankoyo Township after the focus group discussions with expectant wives. When the focus group discussions were done and the questionnaire had been pilot tested, the questionnaire was reviewed to see if it was consistent with our culture. From the questionnaire which had been designed to assess husbands' supportive behaviour, reliability addressed the degree to which a husband's observed scores on each item agreed with his overall or universal score (Fagan, 1989). If the item scores all agree closely with the universal score (often measured as the average score on the questionnaire. In this study a Cronbach alpha coefficient of 0.70 was selected as a measure of reliability). If the item scores agree very closely with the universal score, then they should also be very closely related to one another as well. This way of assessing reliability is referred to as internal consistency, and is the approach presented in this study. Some questions that scored below 0.75 were dropped while others were revised depending on what comes up in the focus groups. In this way, reliability was achieved. Validity is the determination of whether a measurement instrument actually measures what is purported to measure (Polit et al, 2001; Basavanthappa, 2007). To achieve this the material from Focus Group Discussions were used and senior midwives were requested to check that the questions in the questionnaire were clearly constructed to avoid ambiguity. The questionnaire was administered to husbands who met the selection criteria.

A pre-test on forty (40) husbands was done to ensure clarity, precision and consistency of questions. The pre-test sample constituted 10% of the total sample of 385. The pre-test was done in Mufulira in the fourth

week of June 2007. The respondents were selected using systematic sampling method of houses in one of the residential sections of Kankoyo Township.

Data was collected over a period of five months beginning 1st week of May 2007 to 1st week of October 2007. The four focus group discussions were conducted from the first week of May to the first week of June during the scheduled Antenatal Clinic. The structured interviews were conducted from the 2nd week of August to 1st week of October 2007.

3.8 ETHICAL CONSIDERATIONS

Since this study involved human subjects, consent was obtained from University of Zambia Research Ethics Committee. It was also research prudent to obtain informed consent prior to data collection. In this vein, letters expressing purposes, benefits and risks were sent to and consent obtained from stakeholders, the Town Clerk of Mufulira Municipal council, the In Charge of Kantashi Police station and the Director of Health for Mufulira District Health Management Team in charge of health centres in Kantashi District and Medical Superintendent for Malcom Watson Hospital). The critical ethical elements of concern in this study are set below and they appear in the drafted copies of the letters in the appendices (Appendices). Written consent was also obtained from all eligible respondents. The contents of the ethical letters have been designed to meet the standards advanced by Bailey (1996), Kvale, (1996) and Holloway (1997) as follows:

- Regarding the usage of the respondents being human subjects to yield data:

All respondents were availed with information as to how they had been selected. This helped in reducing uncertainties and questions for example, "why have they selected me and not the other person".

- What would be done to the respondent and the data?

All respondents were availed with details of what steps would be followed and that nothing would be done to them that would be injurious.

- Risk:

The respondents were informed that they may have some discomfort or some anxiety and if they felt this, they may not wish to participate in the study. They were availed with the necessary information so as to encourage their participation.

- Benefits:

All respondents were availed with information regarding direct and indirect benefits.

- Confidentiality:

Assurances was given that all information that would be provided by the respondents would be treated with utmost confidentiality. In this way respondents were satisfied with anonymity.

- Rights:

Respondents would be availed with information regarding the authority they have to quite the study anytime and to submit there complains to the

authority and even to the researcher. A grievance process would be availed to them.

3.9 LIMITATION OF THE STUDY

The limitations of this study are inherent of the research design which has been chosen. Cross sectional descriptive research is fraught with looking at cases from a narrow time span so that the measurements may be viewed as contemporaneous and it is not possible to compare different participants developmentally more elaborately over time and over a number of variables to see change and causal relationships (Creswell,1994; Babbie, 1995; Bailey, 1996; Blaikie, 2003; Neuman, 2000). The Medical Superintendent refused to give permission to conduct focus group discussions in the health centers managed by Mopani Copper Mines Plc. This meant that the views of women who utilized their services were not explored. However, this did not interfere with the selection of male respondents.

3.10 DISSEMINATION AND UTILIZATIONOF RESULTS

A report will be compiled at the end of data analysis. Printed copies will be made available to relevant authorities responsible for policy making, planning and implementing maternal /safe motherhood services, namely the Ministry of Health and Mufulira District Health Management Team. A copy will be submitted to the Department of Post Basic Nursing, School of Medicine at the University of Zambia.

CHAPTER FOUR

4..0 DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This chapter presents both qualitative data derived from the focus group discussions with pregnant women who were married and qualitative data from the structured interviews with the male respondents.

The study sample comprised 385 married men who had an experience with pregnancy and 34 pregnant women who were married. Four focus group discussions were held with the married pregnant women and the male respondents were interviewed using a structured questionnaire in a face to face interview. All the respondents were residents of Kantashi Township an urban area in Mufulira district.

Data analysis is 'the systematic organization and synthesis of research data and testing of research hypothesis using those data' (Polit et al, 2001). Both the qualitative and the quantitative data were processes. Qualitative data was summarized and in some cases quotations were used. The quantitative data was presented in tables and bar charts in order to summarize findings in a meaningful way that is easy to understand. Cross tabulation was done to show the relationship between some variables

4.2 DATA PROCESSING AND ANALYSIS

4.2.1 QUALITATIVE DATA

4.2.1.1 FOCUS GROUP DISCUSSIONS

Four focus group discussions pregnant mothers were held between 2nd May and 9th June 2007 at two health centers in Kantashi Township namely

clinic 1 and clinic 3. The first group had five participants; the second had twelve participants, the third had seven participants and the fourth group had ten participants. The discussion has been reported under the variables supportive behaviours, perceived threats and perceived benefits during pregnancy, labour and delivery. It has been presented in narrative form.

4.2.1.2 QUALITATIVE DATA ANALYSIS

The process of data analysis (content analysis of textual data), was used in this study. Content analysis refers to the quantification of narrative, qualitative material (Polit and Hungler, 1999). A basic issue when performing qualitative content analysis of qualitative textual data is to decide whether the analysis should focus on manifest or latent content (Downe, 1992). This study covered both forms of content analysis. An analysis of what the text says deals with the content aspect and describes the visible, obvious components, which are referred to as the *manifest content*. In contrast, analysis of what the text talks about deals with the relationship aspect and involves an interpretation of the underlying meaning of the text and this is referred to as the *latent content* (Downe, 1992). Both manifest and latent content deal with interpretation but the interpretations vary in depth and level of abstraction.

One of the most basic decisions when using content analysis is selecting the *unit of analysis*. A unit of analysis refers to a unit that will be used to categorise the content into meaningful groupings (Polit and Hungler, 1999). This could for example refer to, a person, a program, an organisation, a community, state or nation. Other authors have considered the unit of analysis as interviews or diaries in their entity and the amount of space allocated to a topic or an interaction under study (Downe, 1992: 313–321). They may include parts of the text that are abstracted and coded or every word or phrase written in the transcript. In this study, the units of

analysis were the written texts and these were field notes from recorded discussions.

Since the data was in textual form, the data was reduced and analysed. The data reduction process involved the combinations of steps as set forth below:

Step 1. Each recorded interview was listened to several times in order to have a picture of the general meaning of units or substantive statements. These are words, sentences or paragraphs containing aspects related to each other through their content and context.

Step 2. All field notes and transcribed interviews was written and arranged in textual units using the respondent's literal words. A textual unit is an aggregation of one respondent's data presented in form of a complete thought or a sentence.

Step 3. Each respondent had a textual unit composed of the facilitator's questions and the Focus Group Discussion members' answers. All textual units were assigned numbers.

Step 4. Each text was ascribed a pseudonym for purposes of identification.

Step 5. Each text was then read several times by the researcher in order to gain and provide a context for the emergence of demographic characteristics such as: age, education, employment status inter alias and general meaning units.

Step 6.The text was then delineated into meaning units by going over every word, phrase, sentence and paragraph. This is the process of getting at the essence of the meaning expressed in a word or phrase or sentence or

paragraph. The meaning unit sheds light on a specific explicit area of content, which is identified with little interpretation. A meaning unit can be parts of the text based on theoretical assumptions from the literature, or parts of the text that address a specific research question or topic in an interview or observation. A meaning unit or unit of analysis is the crystallization or condensation of what the social actors would have said (Polit and Hungler 1999). This is because a unit of meaning expresses a unique and coherent meaning. It is from this process that coding of themes; headers and sub headers can be created. Codes are 'tools to think with' and 'heuristic devices' since labelling a condensed meaning unit with a code allows the data to be thought about in new and different ways. A code can be assigned to, for example, discrete objects, events and other phenomena, and should be understood in relation to the context (Ghosh 1992).

Step 7.Themes were selected inductively from raw information on the basis of observed phenomena or deductively generated. Phenomena had information at a minimum to describe and organise the possible observations and at a maximum, to interpret aspects of the phenomenon. A theme is a larger and more inclusive unit of analysis such a phrase, sentence or paragraph embodying ideas or making an assertion about some topic (Polit and Hungler 1999)

Step 8. Headers were then selected to fit the themes. Creating themes is a way to link the underlying meanings together in categories.

Step 9. Sub headers were then defined considering that headers had more than one descriptive organised element.

Step 10. Essentially sub headers were linked to the questions asked.

Step 11. From the sub headings, themes, which had a relevance to answering research questions, were identified and delineated and deposited into appropriate nodes. Nodes are the main categories of research issues. Categories are the core feature of qualitative content analysis. A category is a group of content that shares a commonality. Categories must be exhaustive and mutually exclusive. This means that no data related to the purpose should be excluded due to lack of a suitable category. Furthermore, no data should fall between two categories or fit into more than one category.

Step 12. In order to ascertain inter-coder reliability between each of the coders (categorical agreement with the expert), during the theme location and the manual coding stage, the codes were worked in a rotation (round robin) whereby each one of them had an opportunity to write themes and code all responses and observations. The researcher was available throughout the themes location and the categorical coding duration to provide for reduction reliability spot checks. This covered comparing all categorized themes among all coders. This process created an incentive for attention to the task of coding and instantaneous checking.

Having done so, then the analysis became induction and deduction along the nodal trees and by doing this, it was easy to show any phenomena of interest and create typologies. From this process, it would be possible to uncover the invariant features of phenomena in order to provide a rigorous description of them by looking for common themes as well as individual variations and to generate an idiographic theory and to write a composite summary.

4.2.2 QUANTITATIVE DATA ANALYSIS

Quantitative data analysis is the main stay of nomothetic research. Quantitative data from the Researcher Administered Structured

Questionnaires was analysed with a view to show either the following or both (a) to elicit descriptive features of the inquiry and (b) to make inferences from the data to the general population.

In the early stages of the analysis, since we had descriptive objectives to be met, the researcher analysed single variables. With such analysis the aim is usually to describe the characteristics of each variable such as, the distribution

of responses and the number of (non) responses. To do this descriptive or summary statistics were used to describe or summarise the data, so that the reader can construct a mental picture of the data and the people, events or objects of the entire sample.

At the end of each day of data collection the Researcher Administered Structured Questionnaires (RASQ) were sorted out. They were edited and checked for completeness, internal consistence, legibility and accuracy. At the end of data collection the data was categorised as being nominal or ordinal then assigned numerical code (1, 2, 3, and others). The codes were then entered and analysed using SPSS version 11.0. The categories that had less than 5 items in the cells were collapsed inorder to apply the Chi-Square. In order to show the relationship between quantitative variables, the researcher applied the Chi square with the cut off point for statistical significance set at 5% and the confidence interval at 95%. Only p values of 0.05 0r less were considered statistically significant thereby rejecting the null hypothesis. The Chi-square tests the hypothesis that two variables are related only by chance. If a significant relationship is found, this is not equivalent to establishing the researcher's hypothesis that A causes B, or that B causes A. The decision rules of rejecting the hypothesis are that :

If X_{obs} is X_{crit}, < then H_o is rejected

If X_{obs} is $\geq X_{crit}$, then H_o is rejected and

This is dependent on the "***d***" the degrees of freedom at 0.05 significance. The Pearson Chi-Square was reported and for cross tabulations which had cells with less than 5 the Fisher's Exact Test was used.

4.3 PRESENTATION OT FINDINGS

4.3.1 QUALITATIVE DATA

4.3.1.1 SOCIO DEMOGRAPHIC CHARACTERISTICS FOR WIVES

Table 5: Social demographic Characteristics of wives (female respondents) (n=34)

Characteristics	Frequency	Percent
Age group (years)		
20-29	25	73
30-39	8	24
40-49	1	3
TOTAL	**34**	**100**
Educational Level		
Primary	15	44
Secondary	17	50
College	2	6
University	-	-
TOTAL	**34**	**100**
Number of children		
None	4	12
1 to 4	27	79
5 to 8	3	9
TOTAL	**34**	**100**
Religious denomination		
None	2	6
Roman Catholic	17	50
Protestants	15	44
Muslim	-	-
Others	-	-
TOTAL	**34**	**100**
Family Income		
Below K 1 million	18	53
K 1 to K 2 million	12	35
Above K 2 million	4	12
TOTAL	**34**	**100**
Employment		
Un employed	29	85.2
Self employed	2	6
Employed	3	8.8
TOTAL	**34**	**100**

Mode: 20 years Minimum age: 20 years

Maximum age: 43 years

4.3.1.2 SUPPORT DURING PREGNANCY

The women considered the supportive behaviour of their husbands to be important to their wellbeing during pregnancy. During the discussions women described some of their expectations from their husbands during pregnancy such as, being faithful, providing company, being kind and caring and providing moral support.

1. Women expressed that they expected their husbands to be faithful as one said: (Participant 2)

> *''They (husbands) should respect themselves, by not having relationships with other women. Not to be unfaithful. If they do not respect themselves and go to other women and have unprotected sex and come to you, you will be affected as they can bring STIs or HIV, then you are pregnant. You will be infected and you are pregnant. It is better he respects himself and stays at home.''*

Another participant put it this way;

> *'They (husbands) should not move around. No, they should care for us until we deliver. They should not have other women as having other women will make them not to provide good care to us their wives.''*

Yet another participant said:

> *''You can not deliver safely because of infections. There are many infections namely HIV, syphilis and other different types of infections. You can have problems when giving birth.''*

2. The presence of the husband at home was regarded as contributing to the wellbeing of the woman. This was reflected in the statements by two participants:

Participant 15:

'It feels nice to be with your husband even when nothing is hurting, you are just together laughing.''

Participant 2:

''He should be near you most of the time, not leaving you alone. He can go for work but stay home after knocking off.''

3. The husband's presence at home was perceived to be beneficial by some women because the husband could assist with house hold chores as stated by some participants:

Participant 2:

''This is the time we need them (husbands) *to be around. It is not in order that when you are in pains you go to the neighbour and ask a young person to come and assist you. This period he should be around so that he knows what happens.''*

Participant 4:

''So that he can help you with some work when you do not have enough energy''

Participant 29:

''He should stop you from carrying heavy loads and carries for you. It shows concern.''

4. The husband's presence at home also provided women time for discussion with their husbands as reported by this participant:

'' Also he can discuss with you what you were told at the hospital and you could tell him what you were told.''

5. Provision of encouragement by the husbands was expressed as a supportive behaviour that the women appreciated. This was stated by these participants:

Participant 15:

''when you are sick he should keep you company and encourage you by telling you not to worry and that you will be well soon; and that you should not get sick.''

Participant 14:

''He should cheer you up and not shout at you. He should take care of you like a child.''

Participant 4:

''He should not be impatient. Yes, he should not be impatient.''

6. Provision of food was also expressed as a way of support that women appreciated. This is reflected in the following statements by two participants:

Participant 1:

''We want our husbands to give us what we want to eat when we are pregnant. A pregnant woman needs and wants to eat different types of food. When we request for such foods our husbands should provide.''

Participant 2:

''He should look for the food, drink, fruits without giving excuses that he has no money. ''

7. Financial support was also cited as a supportive behaviour that women appreciated:

Participant 31:

''I would like him to support me financially, for example when I tell him what is needed at the antenatal he buys all that is needed and not to have difference over money.''

Participant 2:

*''They (*husbands*) should give us money to buy items for the baby''*

Participant 3:

*''They (husb*ands*) should buy all that is required at the antenatal clinic, all that is indicated on the card and all that is required at the hospital, not refusing some items.''*

8. A peaceful atmosphere created at home is appreciated by pregnant women:

Participant 7

''Let me also say this. We need to have peace. Even if he buys food or stays home and if you are not talking to each other, it is useless. Let me say, we need to make each other happy, not when you request him to stay home, he stays at home against his wishes just because you forced him to stay home.''

Participant 5:

''when you are upset and shouts he should not answer back, he should just keep quite. It makes you feel nice.

Participant 6:

''You need to get spoilt a bit when you are pregnant. When he upsets you he should just keep quiet. It makes you feel nice (laughter from the group and agreeing) when you vent your anger on him.''

9. The other supportive behaviour reported by the women was that they would want men not to beat them especially when pregnant as these two participants stated:

Participant 1:

''When we pregnant we take advantage because we know that he will not beat you. He should understand your state, the temper rises fast. He should not be impatient ''

Participant 2:

''He should not beat you when you are wrong. He should not beat you but wait for another time so that you can discuss nicely, not beating you when you are pregnant.''

Participant 3:

"In beating you you can have a miscarriage."

10. Women expected men to participate in the preparation for the new baby. Some said that they would like their husbands to buy the baby items while others did hold a different view as it is reflected in these comments:

Participant 16:

''He has a better choice.''

Participant 17:

''He knows the prices better than me because he had checked in the shops. This makes me feel good because it shows that he is happy about the new baby coming.''

Participant 15:

''Not when he is not talking about it, it looks like it is someone else's responsibility.''

When asked whether the women would like the husbands to go and buy baby's items alone they said that they would rather do it together as stated by these women:

Participant 1:

''we can assist each other. When buying the items for the baby I would rather we go to together because they do not know everything that needs to be bought.''

Participant 2:

''Sister, there are things we (women) do not like. It is not nice to go shopping with a man and he is the one getting the money and paying. It is better when you go to buy you carry the money even if you are with him. You see what to buy and you pay for it. There are things that he can bring and there are things that you should buy yourself.''

The women perceived the following as threats to husband's provision of support:

1. Some men are shy to attend antenatal clinic in a group. This was reported by these participants:

Participant 1:

''Some are shy, they consider this clinic to be for women.''

Participant 2:

''Attending the antenatal clinic would depend on various factors. For instance some men are shy to accompany their wives to the clinic while others go to work.''

Participant 3:

''There are men who are shy to attend antenatal clinic but when you get home he wants to check the card and wants to know what you were told.''

Participant 25:

''Men are afraid to attend the antenatal clinic because they move a lot and are afraid that they will be told that they are the cause of some diseases and are guilty.''

2. Some husbands beat their wives as a way of resolving conflict as stated by one participant:

''Men are different. There are men who fight when they are drunk, others fight because they have a girlfriend. Others it is just the pregnancy. Some, when you are pregnant you do not get on well and he is easily irritated by your presence and he shouts at you or beats you.''

3. Having extra marital relationships. This was reflected in this statement by this participant:

*''They (*husbands*) should not have other women (*extra marital relationships*). Having other women will make them not to provide good care to us their wives.''*

The other women agreed with her.

4. Woman may be divorced if she seems to demand more help from the husband as this woman said: (Participant 16)

''There are things a man can help with not everything, just because you are pregnant. You should be able to know what you can do and what you cannot. Then you do some activities which you are able to do. In doing such work it will be a form of exercise for you. You should be helping each

other not that he does everything. If you want to be spoilt just because you are pregnant he will find someone more active.''

Some women agreed with her.

The women perceived the following as benefits of receiving support during antenatal care clinic from husband:

1. Husband will know what takes place at the antenatal clinic as stated by this participant:

   ''At least they will know what we come to do here because they may be thinking that when we come here you just examine us. They can also be present to know what we discuss here.''

   The other women agreed with her.

2. Husband will provide the needed money to get the requirements asked for at the antenatal clinic as reported by one woman:

   ''When they attend antenatal they will know what happens at the clinic and what is required.''

   The other women agreed with her.

3. The woman will have a good feeling and she will be happy. When asked how the women would feel if their husbands attended the antenatal care clinic. They answered in a chorus that it would a good thing. One of them said:

   ''It feels good and shows concern.''

4. Couple counselling and testing for HIV can be done and the couple will know how to care for each other as stated by one woman:

   ''when you come to book for antenatal care since we have the HIV test on the first visit he should also come, we have the test at the same time. So

that we know who is infected or if both of you are infected then you can know how to take care of each other.

5. It will minimise conflicts on requirements at home and at the hospital.

One participant said:

*''If they (*husbands*) attend antenatal clinic they would know what is required to be bought for the baby and will not give excuses for not giving the wife money.''*

6. Have a healthy baby. This was reflected in statements made by the participants:

Participant 1:

''He should be concerned and should take care of the baby by taking care of the mother. Because it is the baby that makes us want what we want to eat when pregnant.''

Participant 2:

''when you have good food the baby grows well.''

4.3.1.3 SUPPORT DURING LABOUR

The women expressed that they would like their husbands to be present when labor starts but some expressed reservations for the husband to be present in the labor suite during labour and childbirth. The women reported the following as what they would consider as a husband's supportive behaviour during labour:

1. Escorting them to the clinic or hospital when in labor. This is reflected in the statements by the participants:

Participant 15:

''He should take me to the labor ward, he should be present through out even to see the baby being born''

Participant 3:

''Since labour starts at home he should be present. He should look for transport and take me to the hospital. We should start off together. He should be present.''

2. Being present during labour either at the bedside or within the labour ward. This is reflected in the statements by the participants:

Participant 1:

''he should not just leave you in the labor ward and just ask about the progress. He goes away to come back later drunk.''

Participant 4:

''If he is at work he should be released from work, come to the labor ward but not enter the labor ward.''

Participant 3:

''He should not be in the delivery room but within the hospital so that he can hear all that is happening not being absent but not in the delivery room.''

The following are the perceived benefits of husbands providing support during labor:

1. The husband will advocate for child spacing to allow the wife to rest between pregnancies as one participant said:

''....it will help to space children because some men want you to have babies frequently but when he sees how you suffered he can agree that you rest before conceiving, like resting for even four years.''

2. The midwife will not be harsh if the husband is present as stated by one woman:

''if he is present the midwife will not beat you or should at you.''

The other women hummed in agreement.

3. Give smoothing touch.

One participant said:

''He should be present to soothe you so that the pain is less'' (laughter from the group while others nod)

Another said:

''He should be there to comfort you when it is paining to touch you'' (she placed her hand on the lower back in a massaging motion. she laughed and other women joined in the laughter.)

4. Being encouraging.

She continued,

''He tells you that it will stop being painful.'' (All the women laughed in agreement.)

Another participant (Participant 20) said:

''If he is nearby, you can be brave and the pain will be less.''

5. Buy presents:

Participant 6:

''He should me a flower and nice clothes to look good when am discharged.''

The following are the perceived threats to husbands providing support during labour:

1 Women experiences difficulty labour if the husband was sexually unfaithful. One participant stated that:

*''I have heard about ''**inchila**'' from my neighbour. If the husband has extra marital affairs his wife will have problems during delivery. So it is good that the man does not have extra marital affairs and he should stay home.''*

(*''**inchila**''* *is* word in ciBemba which means difficultly labour due to the husband's extra marital relationships during pregnancy.)

2. Some men get disturbed when the wife is in labour as reflected in the participant's statement:

*''Some men when told that the wife is sick (in labo*ur) *will be disturbed and will worry a lot. He should be told when you have delivered after knocking off.''*

4.3.1.4 SUPPORT DURING DELIVERY

The women reported the following as husband's supportive behaviour during delivery:

1. Being present to provide encouragement.

One woman said: (Participant 1)

''He should show me that he is concerned by being present.''

2. Being present in the labour ward, watching what is taking place as reflected in the statements by the participants:

Participant 15:

''He should take me to the labor ward. He should be present throughout even see the baby being born.''

Participant 24:

''I want him to be present.''

Participant 13:

''He is the one who should be present.''

Participant18:

''He should be present and witness the delivery.''

3. Being present but not in the labour room

One woman said:

''.... When it is time (to give birth) *you should remain alone and he should go out to wait.''*

Another (Participant 24) said:

'Sister, at that time you just need to be alone with the sister (midwife). *There should be no witnesses.* (laughter from the women).

The following are the women's perceived benefits of husbands providing support during delivery:

1. The husband will advocate for child spacing to allow the wife to rest between pregnancies.

Participant 2:

''...What I am saying happened to my friend and her husband. The husband requested to be present. This was before they started allowing men (in the labor ward). *He was present to see his wife deliver and was doing this (*rubs the back*). The husband said that he felt sympathy for the pain his wife went through. They waited until the child was in grade 2.''*

Participant 25:

"...It can help to space the children because some want you to have babies frequently. But when he sees how you suffer he can agree that you rest before you conceive again, say for four years."

2. The midwife will be kind if the husband is present.

''The sister (midwife) will not beat or shout at you.''

3. The woman will have the courage to bear the pain and strain of labor.

Participant 14:

"If he is nearby, you can be brave and the pain will be less. Then you can be brave because you do not want to be scolded later at home if you scream or misbehave. You can not insult when he is present."

The following are the women's perceived threats to husbands providing support during delivery:

1. the couple will experience disharmony afterwards at home

One participant said:

''Before the time comes you can be together so that he can comfort you. Now when it is time to go in (to give birth) you should be alone.'' (Laughter from the group, in agreement.)

She continued

''not with him sitted there because he would come and mock you later because that hurts. He should just be present before the time to give birth. When it is time you should remain alone and he should go out to wait.''

Another participant stated that:

''He can be there during labor but *not when it comes* (during child birth*).''*

Some women agreed with her then she continued

*''Why I could not want him to be present during child birth, may be when I come home (*after delivery*) he can be telling me things such as 'did you see what you did there' and there would be misunderstanding in the home. It is better I am alone.''*

4.3.2 QUANTITATIVE DATA

4.3.2.1 SOCIO DEMOGRAPHIC CHARACTERISTICS OF HUSBANDS

Table 6: Social demographic Characteristics of husbands (n= 385)

Characteristics	Frequency	Percent
Age group (years)		
20-29	135	35.1
30-39	140	36.4
40-49	87	22.6
50-54	23	6.0
TOTAL	**385**	**100**
Educational Level		
Primary	4	1.0
Secondary	189	49.1
College	152	39.5
University	40	10.4
TOTAL	**385**	**100**
Number of children		
None	52	13.5
3 to 4	320	71.7
5 to 8	44	14.8
TOTAL	**385**	**100**
Religious denomination		
None	66	17.1
Roman Catholic	147	38.2
Protestants	78	20.3
Muslim	2	0.5
Others	92	23.9
TOTAL	**385**	**100**
Family Income		
Below K 1 million	87	22.6
K 1 to K 2 million	197	51.2
Above K 2 million	101	26.2
TOTAL	**385**	**100**
Employment		
Un employed	23	6.0
Self employed	49	12.7
Employed	313	81.3
TOTAL	**385**	**100**

Mean age: 34 years Minimum age: 20 years

Mode: 27 years Maximum age: 54 years

Age standard deviation: 8.685

Table 6 shows that the majority of the respondents 36.4% (140) were aged between 30 -39 while 6% (23) were in the age group 50 -54. The mean age was 34 years, the minimum age was 20 years and the maximum age was 54 years. The age standard deviation was 8.685.

The study showed that the higher (49.1%) number of respondents had secondary education while those with primary education were the least (1%). Most of the respondents 71.7% (320) had 1 to 4 children while those with 5 to 8 children were 14.8% (Table 6).

Table 6 also shows the respondents religious affiliation as 38.2% (147) of respondents belonged to the Roman Catholic religious denomination, 20.3% (78) were Protestants and 0.5% (2) were Muslim. The majority of the respondents (81.3%) were employed and 6% were unemployed. 51.2% of respondents had a family income between one to two million Kwacha (Table 6).

4.3.2.2 PROVISION OF SUPPORT DURING PREGANCY

4.3.2.2.1. PROVISION OF SUPPORT AT HOME

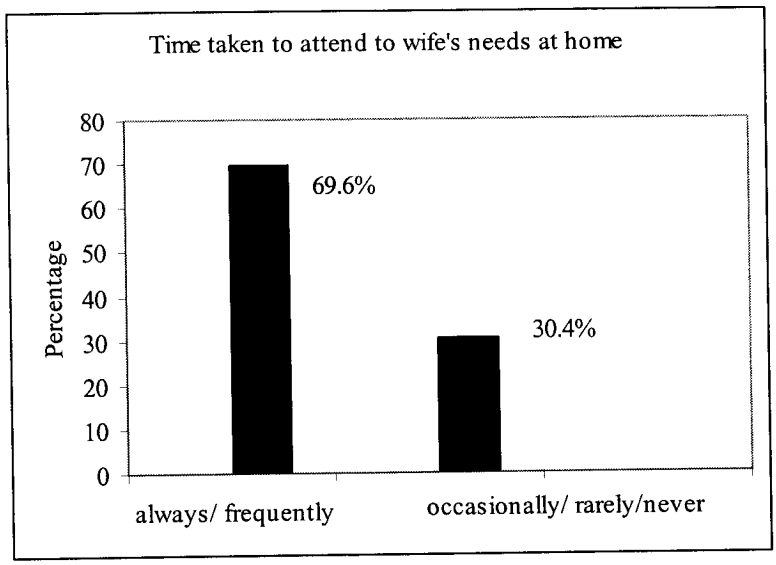

Fig 3: Time taken to provide attend to wife's daily needs at home (n=385)

Figure 3 shows that most of the respondents provided time from their leisure to attend to their wife's daily needs during pregnancy, always/ frequently provide time from their leisure time to attend to their wife's daily needs at home while 30.4% (115) reported that they occasionally/ rarely /never provided time from their leisure time to attend to

Table 7: Respondent's age group in relation to provision of time to attend to your wife's daily needs during pregnancy at home (n=385)

	Provision of time from leisure to attend to wife's daily needs during pregnancy at home		
Respondent's age group	Always/ Frequently	Occasionally Rarely/ Never	Total
20-29	24.2% (94)	10.9% (42)	35.1% (135)
30-39	27.8% (107)	8.6% (33)	36.4% (140)
40-49	15.1% (58)	7.5% (29)	22.6% (87)
50-54	2.6% (10)	2.4% (13)	6% (23)
Total	**69.6% (268)**	**30.4% (117)**	**100% (385)**

Table 7 shows that 27.8% (107) of the respondents reported that they always/ frequently provided time to attend to their wife's daily needs at home were in the age group 30 -39 years and 10.9% (42) who reported to occasionally/ rarely/ never providing time from their leisure to attend to their wives daily needs at home were in the age group 20 - 29 years. Pearson Chi-Square=10.891, df=3, p-value=0.12 (Not significant).

Table 8: Educational Level in relation to provision of time to attend to wife's daily needs during pregnancy at home (n=385)

	Provision of time from leisure to attend to wife's daily need during pregnancy at home		
Educational level	Always/ Frequently	Occasionally/ Rarely never	Total
Primary	0.5% (2)	0.5% (2)	1% (4)
Secondary	29.9% (115)	19.2% (74)	49.1% (189)
College	30.4% (117)	9.1% (35)	39.5% (152)
University	8.8% (34)	1.6% (6)	10% (40)
Total	**69.6% (268)**	**30.4% (117)**	**100% (385)**

Table 8 shows that 30.4% (117) of the respondents who always /frequently provided time to attend to their wife's daily needs during pregnancy at home had college education. 19.2% (74) of the respondents who reported that they frequently provided time to attend to their wife's daily need at home during pregnancy had secondary education. Fisher's Exact Test=25.916, p-value=0.003 (CI = 0.000, 0.008), (Significant)

Table 9: Number of Children in relation to provision of time to attend to wife's daily needs during pregnancy at home (n=385)

	Provision of time from leisure to attend to wife's daily needs during pregnancy at home		
Number of Children	Always/ Frequently	Occasionally/ rarely /never	total
None	9.4% (36)	4.2% (16)	13.5% (52)
1 to 4	52.9% (204)	18.7% (72)	48.91% (276)
5 to 8	7.1% (28)	7.6% (29)	33.4% (132)
Total	**69.9% (268)**	**30.1% (117)**	**100% (385)**

Table 9 shows that 52.7% (204) respondents with 1 to 4 children reported to have had always/ frequently provided time from their leisure time to attend to their wife's daily needs at home during pregnancy. 18.7% (72) of the respondents reported to occasionally /rarely /never providing time from their leisure time to attend to their wife's needs at home during pregnancy had 1 to 4 children.

Pearson Chi-Square=1.605, df=2, p-Value= 0.448, (Not significant).

Table 10: Employment in relation to providing time to attend to wife's daily needs during pregnancy at home (n=385)

	Provision time from leisure to attend to wife's daily needs during pregnancy at home		
Employment	Always / frequently	Occasionally /rarely /never	Total
Un employed	2.6% (10)	3.4% (13)	6% (23)
Self employed	10.4% (40)	2.3% (9)	12.7% (49)
Employed	56.6% (218)	24.7% (95)	81.3% (313)
Total	**69.6% (268)**	**28.3% (117)**	**100% (385)**

Table 10 shows that 56.6% (218) of the respondents who reported that they always/ frequently provided time to attend to wife's daily needs at home during pregnancy and 24.7% (95) of the respondents who reported that they occasionally /rarely /never provided time from leisure to attend to their wife's daily needs at home during pregnancy were the employed. Pearson Chi-Square = 10.773, df = 3, p-value = 0.005. (Significant).

Table 11: Family Income in relation to provision of time to attend to wife's daily needs during pregnancy at home (n=385)

	Provision of time from leisure to attend to wife's daily needs during pregnancy at home		
Family Income	Always	Occasionally /rarely never	total
Below K 1m	13.8% (53)	8.8% (34)	22.6% (87)
K 1m to K2m	33.8% (130)	17.6% (67)	51.2% (197)
Above K2 m	22.1% (85)	4.1% (16)	26.2% (101)
Total	**69.6% (1268)**	**30.4% (117)**	**100% (385)**

Table 11 shows that 33.8% (130) of the respondents reported that they always/ frequently provided time to attend to their wife's daily needs during pregnancy at home were those with a family income ranging from one to two million Kwacha. Pearson Chi-Square=14.432, df=2, p-value= 0.00, (Significant).

Table 12: Supportive behaviour at home (n=385)

Variable	Supportive behaviour performed		
	Always/ frequently	Occasionally /Rarely	Total
Provision of time from your leisure to attend to your wife's daily needs during pregnancy at home	69.6% (268)	30.4% (117)	100% (385)
Supportive behaviour (Encouraging to maintain morale)	96.6% (372)	3.4% (13)	100% (385)
Supportive behaviour (Emphasizing behaviour according to professional advise given at the clinic	97.1% (374)	2.9% (11)	100% (385)
Supportive behaviour (helping out in house work)	28.6% (110)	71.4% (275)	100% (385)
Supportive behaviour (Making sure that I have no other woman in life to go out with).	97.1% (374)	2.9% (11)	100% (385)
Supportive behaviour (Taking care of baby related preparations)	89.4% (344)	10.6% (41)	100% (385)
Supportive behaviour (Buying her the food that she wants)	76.6% (295)	243.% (90)	100% (385)
Supportive behaviour (Touching and soothing her to make her comfortable)	63.4% (244)	36.6% (141)	100% (385)

Table 12 shows values of supportive behaviours at home by the husbands. The majority of the respondents (97.1%) reported that they made sure that they did not go out with other women' 82.9% (319) stated that they emphasized behaviour according to professional advice given at the antenatal care clinic and 96.6% (374) stated that they encouraged their wife to maintain morale.

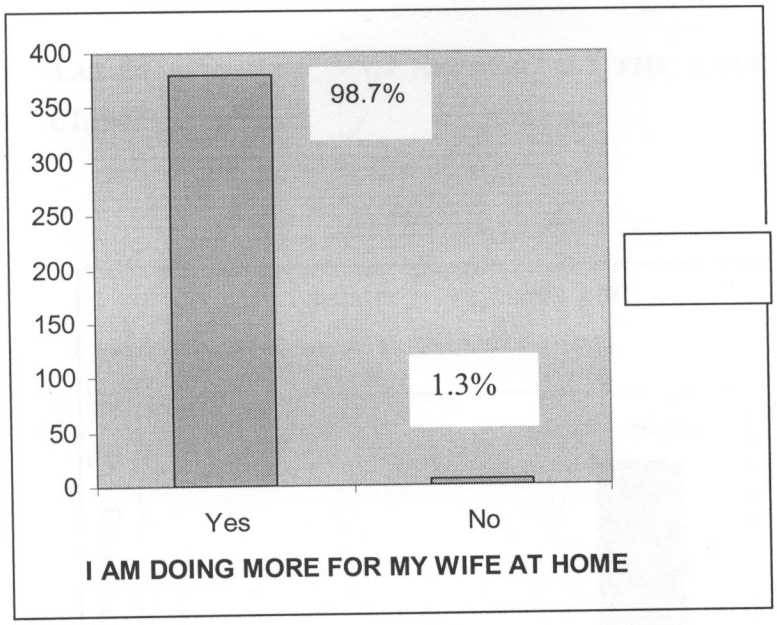

Figure 4: I am doing more for my wife at home

Figure 4 shows that 98.7% (380) of respondents reported that they were doing more in terms of providing support at home to their wives during pregnancy and 1.3% (5) reported that they were not. (n=385)

4.3.2.2.2 PROVISION OF SUPPORT AT THE ANTENATAL CARE CLINIC

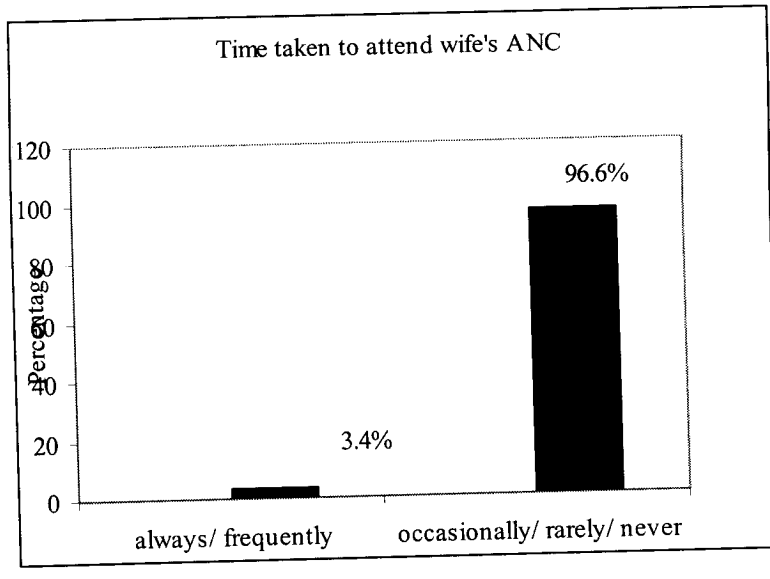

Figure 5: Time taken to attend wife's antenatal care clinic

Figure 5 shows that the majority of respondents 96.6% (372) occasionally/ rarely /never accompanied their wives to the antenatal clinic and 3.4% (13) reported to always/ frequently take time off from leisure to attend their wives antenatal clinic. (n=385)

Table 13: Respondent's age group in relation to time taken off from daily schedule to attend wife's antenatal clinic (n=385)

	Time taken from daily schedule to attend wife's antenatal care clinic		
Respondent's age group	Always/ frequently	0ccasionally/ rarely/ never	Total
20-29	1.6% (6)	33.5% (129)	35.1% (135)
30-39	0.8% (3)	35.6% (137)	36.4% (140)
40-49	0.8% (3)	21.8% (137)	22.6% (87)
50-54	0.3% (01)	5.7% (22)	6% (23)
Total	**3.4% (13)**	**96.6% (372)**	**100% 385**

Table 13 shows that the 35.5% (137) respondents occasionally/rarely/ never accompanied their wives to the antenatal care clinic were aged 30 - 39 years. 1.6% (6) of respondents reported that they took time to attend their wives to the antenatal clinic were in the age group 20 -29 years.

Table 14: Educational Level in relation to time taken off from daily schedule to attend wife's antenatal clinic (n=385)

	Time taken from daily schedule to attend wife's antenatal clinic		
Educational Level	Always /frequently	Occasionally/ rarely/ never	Total
Primary	0.3% (1)	0.8% (0)	1% (4)
Secondary	1.8% (7)	47.3% (182)	49% (189)
College	0.8% (3)	38.7% (149)	40% (152)
University	0.5% (2)	9.9% (38)	10% (40)
Total	**3.4% (13)**	**96.6 % (372)**	**100% (385)**

Table 14 shows that 47.3% (182) of the respondents occasionally/ rarely/ never took time off to accompany their wives to the antenatal clinic and 1.8% (7) of the respondents always/ frequently took time off to accompany their wives had secondary school education

Table 15: Number of Children in relation to time taken off from daily schedule to attend wife's antenatal clinic (n=385)

	Time taken from daily schedule to attend your wife's antenatal clinic		
Number of Children	Always/ frequently	Occasionally/ rarely/ never	Total
None	0.3% (1)	13.2% (51)	13.5% (52)
1 to 4	2.6% (10)	80.5% (310)	83.1% (320)
5 to 8	0.5% (2)	2.9% (11)	3.4% (13)
Total	**3.4% (13)**	**96.6% (372)**	**100% (385)**

Table 15 shows that 80.5% (310) of the respondent4 occasionally/ rarely /never took time off from their daily schedule to accompany their wives to attend antenatal clinic had 1 to 2 children.

Table 16: Employment in relation to time taken off from daily schedule to attend wife's antenatal care clinic (n=385)

	Time taken off from daily schedule to attend wife's antenatal clinic		
Employment	Always/ frequently	Occasionally	Total
Un employed	(0)	6% (23)	6% (23)
Self employed	0.8% (3)	11.9% (46)	12.7% (49)
Employed	2.6% (10)	78.7% (303)	81.3% (313)
Total	**3.4% (13)**	**96.6% (372)**	**100% (385)**

Table 16 shows that most respondents (78.7%) who were employed indicated that they 0ccasionally/ rarely/ never took time off from their daily schedule to accompany their wives to the antenatal clinic. None of the unemployed (0%) reported always/ frequently taking time off to accompany their wives to the antenatal clinic.

Table 17: Family Income in relation to time taken off from daily schedule to attend wife's antenatal clinic (n=385)

	Time taken off from daily schedule to attend wife's antenatal clinic		
Family Income	Always/ frequently	Occasionally/ rarely/ never	Total
Below K 1m	0.8% (3)	28.1% (84)	22.6% (87)
K 1m to K2m	2.1% (2)	49.1% (189)	51.2% (197)
Above K2m	0.5% (2)	25.5% (99)	26.2 (101)
Total	**3.4% (13)**	**96.6% (372)**	**100% (386)**

Table 17 shows that 49.1% (189) of the respondents with a family income between one to two million kwacha 0ccasionaaly/ rarely/ never took time off from their daily schedule to attend their wife's antenatal care clinic. 25.5% of respondents with a family income above two million kwacha indicated that they occasionally took time off to accompany their wives to the antenatal clinic.

Table 18: Support given at antenatal clinic (n=385)

Variable	Frequency supportive behaviour performed		
	Always/ frequently	Occasionally / rarely/ never	Total
Time off from daily schedule to attend wife's antenatal clinic	3.4% (13)	96.6% (372)	100% (385)
Supportive behaviour (Encouraging to maintain morale)	47% (181)	53% (204)	100% (385)
Supportive behaviour (Emphasizing behaviour according to professional advise given)	47% (181)	53% (204)	100% (385)
Supportive behaviour (Touching and soothing her to make her comfortable)	37.9% (146)	62.1% (239)	100% (385)
Supportive behaviour (I provide means of transport to attend antenatal clinic)	75.1% (289)	24.9% (96)	100% (385)

Table 18 shows that 75.1% (289) of the respondents reported that they always/ frequently provided means of transportation for their wives to attend antenatal clinic. The majority 96.6% (372) of the respondents reported that they occasionally/ rarely/ never took time of to attend their wives antenatal clinic.

Table 19: Time taken off from daily schedule to attend wife's antenatal clinic in relation to provision of encouragement at the antenatal care clinic to maintain morale(n=385)

	Supportive behaviour (I encourage her at the antenatal clinic to maintain morale)		
Time taken off your daily schedule to attend wife's antenatal clinic	Always/ frequently	Occasionally/ rarely/ never	Total
Always / frequently	3.1% (12)	o.3% (1)	3.4% (13)
Occasionally/ rarely/ never	43.9% (169)	52.7% (209)	96.6& (372)
Total	**47% (181)**	**53% (204)**	**100% (385)**

Table 19 shows that the majority of those took time off from their daily schedule to attend their wife's antenatal care clinic always/ frequently provided encouragement to maintain morale (3.1% out of 3.4%).

Table 20: Time taken off from daily schedule to attend wife's antenatal clinic in relation to provision of comfort by touching and soothing her (n=385)

	Supportive behaviour (I am there to comfort her by touching and soothing her)		
Time taken off from daily schedule to attend wife's antenatal clinic	Always/ frequently	Occasionally/ Rarely /never	Total
Always/ frequently	3.1% (12)	0.3% (1)	3.4% (13)
Occasionally/ Rarely / never	34.8% (132)	61.8% (240)	96.6% (372)
Total	**37.9% (144)**	**62.1% (241)**	**100% (385)**

Table 20 shows that of the respondents that always/frequently (3.4%) took time to attend their wife's antenatal care clinic 3.1% always/ frequently touched and soothed their wife to provide comfort.

Table 21: Time taken off from daily schedule to attend your wife's antenatal clinic in relation to provision of encouragement to her by emphasizing professional advice given (n=385)

	Supportive behaviour (I encourage her by emphasizing behaviour according to professional advise given)		
Time taken off from daily schedule to attend wife's antenatal clinic	Always/ frequently	Occasionally/ Rarely /never	Total
Always/ frequently	3.1% (12)	0.3% (1)	3.4% (13)
Occasionally/ rarely/ never	43.8% (169)	52.8 (203)	96.6% (372)
Total	**46.9% (181)**	**53.1 (204)**	**100% (385)**

Table 21 shows that of the respondents that those who always/frequently (3.4%) took time to attend their wife's antenatal care clinic always/ frequently (3.1%) encouraged their wives by emphasizing behaviour according to the antenatal clinic.

Table 22: Time taken off from daily schedule to attend wife's antenatal clinic in relation to provision of means of transportation to attend antenatal care (n=385)

	Supportive behaviour (I provide means of transport to attend antenatal care)		
Time taken off from daily schedule to attend wife's antenatal clinic	Always/ frequently	Occasionally/ rarely/ never	Total
Always/ frequently	2.6% (10)	0.3% (1)	3.9% (11)
Occasionally /rarely/ never	72.5% (279)	24.6% (93)	96.1% (374)
Total	**75.1% (289)**	**24.9% (96)**	**100% (385)**

Table 22 shows that of the respondents that always/frequently (3.4%) took time to attend their wife's antenatal care clinic, 3.1% always/ frequently provided means of transport to the antenatal clinic. However, 72.5% of the respondents that reported that they always/ frequently provided means of transport to the antenatal clinic even though they occasionally/ rarely/ never took time off to attend the wife's antenatal clinic.

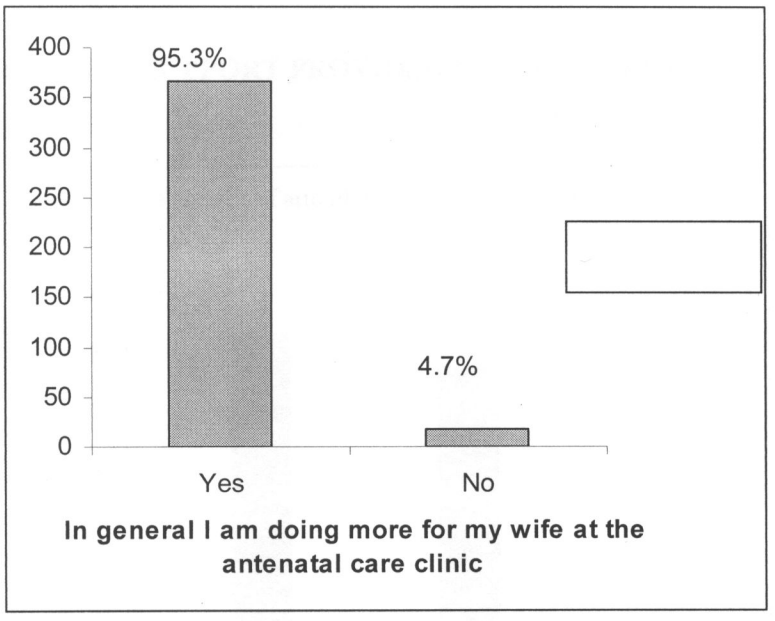

Figure 6: Doing more for my wife at the antenatal care clinic

Figure 6 shows that 95.3% (367) of respondents reported that they were doing more for their wives in terms of providing support to their wives at the antenatal care clinic and 4.7% (18) reported that they were not. (n=385)

4.3.2.3 SUPPORT PROVIDED DURING LABOUR

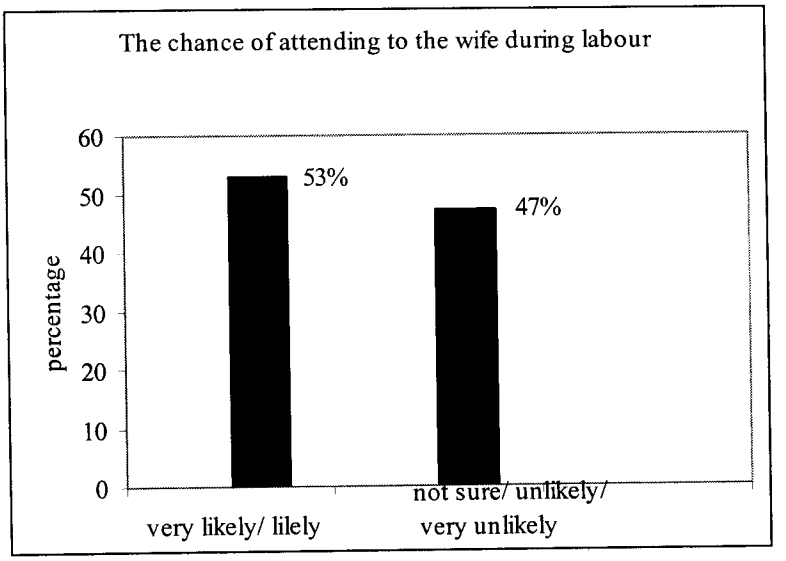

Figure 7: Chance of taking time from daily schedule to attend to the wife during the period of admission during labour

Figure 7 shows that 40.2% (155) of respondents reported that they were not sure they would attend to their wife during the period of admission during labour. 39% (150) of the respondents reported that they were likely to attend to their wife during admission during labour. 6.5% (25) of respondents reported that they were unlikely and 0.3% (1) very unlikely to attend to their wife during admission during labour. (n=385).

Table 23: Respondents' age group in relation to time taken off from daily schedule to attend to the wife during the period of admission during labour (n=385)

	Time taken off from daily schedule to attend to the wife during the period of admission during labour		
Respondent's age group	Very likely/ likely	not sure	Total
20-29	16.1% (62)	19% (73)	35.1% (135)
30-39	16.9% (65)	19.5% (75)	36.4% (140)
40-49	15.8% (61)	6.8% (26)	22.6% (87)
50-54	4.2% (16)	1.8% (7)	6% (23)
Total	**53% (204)**	**47% (181)**	**100% (385)**

Table 23 shows that 16.9% (65) of the respondents within the age group 30 -39 years reported that they were very likely/ likely to take time off from their daily schedule to attend to their wife during the period of admission during labour. And in the same age group 19.5% (75) respondents reported that they were not sure/ unlikely/ very unlikely to take time off from their daily schedule to attend to their wife during the period of admission during labour. Pearson Chi-Square = 17.903, df = 3, p-value =0.000 (Significant).

Table 24: Educational Level in relation to time taken off from daily schedule to attend to the wife during the period of admission during labour (n=385)

	Time taken off from daily schedule to attend to the wife during the period of admission during labour		
Educational Level	Very likely / Likely	not sure unlikely very unlikely	Total
Primary	0.5% (2)	o.5% (2)	1% (4)
Secondary	26% (100)	23.1% (89)	49.1% (189)
College	21.6% (83)	17.9% (69)	39.5% (152)
University	4.9% (19)	5.5% (21)	10.4% (40)
Total	**53% (204)**	**47% (182)**	**100% (385)**

Table 24 shows that 26.% (100) of the respondents with secondary school education reported that they were very likely/ likely to take time off from the daily schedule to attend to their wife during the period of admission during labour. And 17.9% (69) the respondents with secondary school education reported that they were not sure/ unlikely/ very unlikely to they would take time off from the daily schedule to attend to their wife during the period of admission during labour.

Table 26: Employment in relation to time taken off from daily schedule to attend to the wife during the period of admission during labour (n=385)

	Time off from daily schedule to attend to the wife during the period of admission during labour		
Employment	very likely likely	not sure Unlikely Very unlikely	Total
Un employed	1% (4)	2.9% (11)	6% (23)
Self employed	1.6% (6)	6% (23)	12.7% (49)
Employed	11.4% (44)	31.4% (121)	81.3% (313)
Total	**14% (54)**	**40% (155)**	**100% (385)**

Table 26 shows that of the respondents who were employed, 33.2% were likely to take time off from their daily schedule to attend to their wife's during admission during labour. 11.4% (44) were very likely to take time off from their daily schedule to attend to their wife's during admission during labour. Pearson Chi-Square=2.978, df=2, P-value= 0.228 (Not significant).

Table 27: Family Income in relation to time taken off from daily schedule to attend to the wife during the period of admission during labour (n=385)

	Time taken off from daily schedule to attend to the wife during the period of admission during labour		
Family Income	very likely likely	not sure Unlikely Very unlikely	Total
Below K 1m	12.7% (49)	9.9% (38)	22.6% (87)
K 1m to K2m	25.2% (97)	26% (100)	51.2% (197)
Above K2m	15.1% (158)	11.2% (43)	26.2% (101)
total	**53% (204)**	**47% (182)**	**100% (385)**

Table 27 shows that of the respondents with a family income of one to two million kwacha 26% (100) were not sure/ unlikely/ very unlikely they would take time off from their daily schedule to attend to their wife's during admission during. And 25.2% (97) were very likely/ likely to take time from their daily schedule off to attend to their wife's during admission during. Pearson Chi-Square=2.298, df=2, p-value= 0.317 (Not significant).

Table 28: Support in Labour (n=385)

Variable	Frequency supportive behaviour performed		
	Always/ frequently	**Occasionally/ rarely/ never**	**Total**
Supportive behaviour (Encouraging to maintain morale)	96.4% (371)	3.6% (14)	100% (385)
Supportive behaviour (Emphasizing behaviour according to professional advice given)	97.4% (375)	2.6% (10)	100% (385)
Supportive behaviour (Touching and soothing her to make her comfortable)	67% (258)	33% (127)	100% (385)
Supportive behaviour (I provide means of transport to maternity center)	75.6% (293)	24.4% (94)	100% (385)
Supportive behaviour (give her drink)	76.1% (293)	23.9% (92)	100% (385)

Table 28 shows that the majority of respondents 97.4% (375) reported that they would always/ frequently emphasize behaviour according to professional advice given during the period of admission during labour. The least (67%) supportive behaviour reported to be done always / frequently was touching and soothing the wife to make her comfortable. 10.4% (40) of the respondents reported that they would rarely touch and sooth the wife to make her comfortable.

Table 29: Time taken off from daily schedule to attend to the wife during the period of admission during labor in relation to provision of support (I am encouraging her to maintain morale) (n=385)

		Supportive behaviour(I am encouraging her to maintain morale		
Time taken off from daily schedule to attend to the wife during the period of admission during labour		Always/ frequently	Occasionally/ Rarely/ never	Total
	very likely/ likely	51.3% (198)	1.6% (6)	52.9% (204)
	not sure/ unlikely/ very unlikely	45% (173)	1.6% (8)	47.1% (181)
	Total	**96.3% (371)**	**3.7% (14)**	**100% (385)**

Table 29 shows that 51.3% (198) of the respondents who were very likely/ likely to take time off from their daily schedule to attend to their wife during the admission during labour reported that they would always/ frequently provide encouragement to maintain morale. However, even the respondents who were not sure/ unlikely/ very unlikely to take time off from their daily schedule to attend to their wife during the period of admission during labour, 45% (173) reported that they would frequently provide encouragement to the wife to maintain morale during the period of admission during labour. Pearson Chi-Square=30.525,df=16, p-value= 0.015 (Significant).

Table 30: time taken off from daily schedule to attend to the wife during the period of admission during labour in relation to provision encouragement by emphasizing behaviour according to professional advice given. (n=385)

		Supportive behaviour (I encourage her by emphasizing professional advise given)		
		Always frequently	Occasionally/ Rarely/ never	Total
time off from daily schedule to attend to the wife during the period of admission during labour	very likely/ likely	51.1% (197)	1.8% (7)	52.9% (204)
	Not sure / unlikely/ very unlikely	46.3% (178)	0.8% (3)	36.6% (181)
	Total	**86.9% (375)**	**2.6% (10)**	**100% (385)**

Table 30 shows that 51.1% (197) of the respondents reported that they were very likely/ likely to take time off from their daily schedule to attend to their wives during the period of admission during stated that they would always/ frequently provide encouragement by emphasizing behaviour according to professional advice given. 46.3% (178) of those who were not sure/ unlikely /very unlikely to take time off from their daily schedule to their wife during the period of admission during labour stated that they would always /frequently provide encouragement by emphasizing behaviour according to professional advice given.

Table 31: Are you going to take time off from your daily schedule to attend to your wife during the period of admission during labour in relation to provision of comfort by touching and soothing her (n=385)

		Supportive behaviour (I am there to comfort her by touching and soothing her)		
		Always frequently	occasionally rarely never	Total
Time taken off from daily schedule to attend to the wife during the period of admission during labour	very likely/likely	40.5% (160)	12.5% (44)	53% (204)
	not sure/ unlikely/ very unlikely	26% (98)	21% (85)	47% (181)
Total		**66.5% (258)**	**33.5% (129)**	**100% (385)**

Table 31 shows that 40.5% (160) of the respondents reported that they were very likely/ likely to take time off from their daily schedule to attend to their wives during the period of admission during stated that they would always/ frequently provide comfort to the wife by touching and soothing her. 26.% (178) of those who were not sure/ unlikely /very unlikely to take time off from their daily schedule to their wife during the period of admission during labour stated that they would always /frequently provide comfort the wife by touching and soothing her. Pearson Chi-Square=153.111, df=16, p-value= 0.000 (Significant).

Table 32: Time taken off from daily schedule to attend to the wife during the period of admission during labour in relation to provision of drink (n=385)

		Supportive behaviour(Give her drink)		
		always frequently	occasionally rare never	Total
time taken off from daily schedule to attend to the wife during the period of admission during labour	very likely/ likely	37.3% (144)	15.7% (60)	53% (204)
	not sure/ unlikely/ very unlikely	38.8% (149)	8.2% (31)	47% (181)
	Total	**76.1% (293)**	**23.9% (91)**	**100% (385)**

Table 32 shows that 38.8% (149) of the respondents who were not sure/unlikely/ very unlikely to take time off from their daily schedule to attend to their wives during the period of admission during labour stated that they would always/ frequently provide the wife a drink. Of the respondents (53%) who reported that they were likely to take time off from their daily schedule to attend to their wives during the period of admission during labour 37.3% (144) stated that they would frequently provide the wife a drink. Pearson Chi-Square=47.358, df=16, p-value= 0.000 (Significant).

Table 33: Time taken off from daily schedule to attend to wife during the period of admission during labor in relation to providing means of transportation to maternity center (n=385)

		Supportive behaviour(Providing transport to maternity center)		
Time taken off from daily schedule to attend to the wife during the period of admission during labour		Always/ Frequently	Occasionally/ Rarely/ never	Total
	very likely/ likely	41% (158)	12% (46)	53% (204)
	not sure/ unlikely/ very unlikely	36.6% (133)	10.4% (48)	47% (181)
Total		**77.6% (153)**	**22.4% (94)**	**100% (385)**

Table 33 shows that 41% (158) the respondents who reported that they were very likely/ likely to take time off from their daily schedule to attend to their wives during the period of admission during labour also reported that they always/ frequently provided transport for their wives to go to the maternity centre. 36.6% (133) of the respondents who were not sure /unlikely/ very unlikely to take time off from their daily schedule to attend to their wives during the period of admission during labour reported that they occasionally/ rarely /never provided transport for their wives to go to the maternity centre. Pearson Chi-square=42.880, df=16, p-value= 0.000 (Significant).

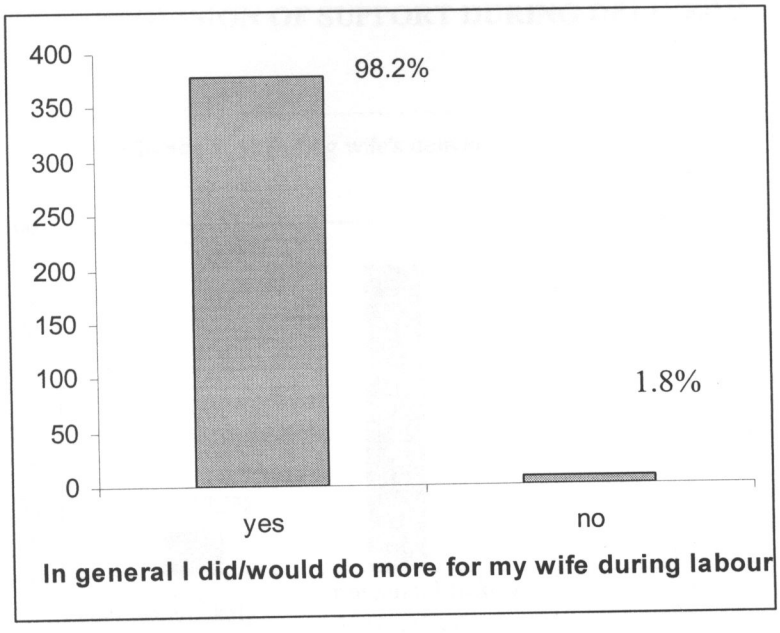

Figure 8: Did / would do more for the wife in labour

Figure 8 shows that most 98.2% (378) of the respondents reported that they did/ would do more for their wife during labor and only 1.8% (37) reported that what they did/ would do more for their wife. (n=385)

4.3.2.4 PROVISION OF SUPPORT DURING DELIVERY

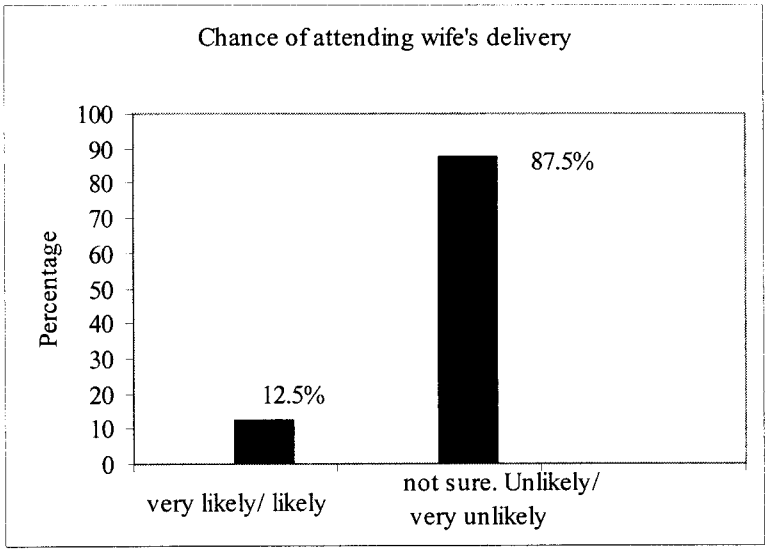

Figure 9: Chance of taking time off to attend to the wife's delivery.

Figure 9 shows the chances that husbands would take time off from daily schedule to attend the wife's delivery. The majority 40.5% (156) of husbands reported that they were not sure if they would take time off to attend to their wife during delivery. 26.5% (102) reported that they were unlikely take time off to attend to their wife during delivery. 20.5% (79) stated that they were very unlikely to take time off to attend to their wife during delivery. Only 3.6% (14) of the respondents indicated that they were very likely and 8.8% (34) stated that they were likely to take time off to attend their wife's delivery. (n=385)