# DETERMINING KNOWLEDGE, ATTITUDE AND PRACTICE OF MEN TOWARDS POSTNATAL CARE SERVICES IN MAZABUKA DISTRICT OF ZAMBIA

BY

LUNGU RABECCA

UNZA, DNS 2012

# THE UNIVERSITY OF ZAMBIA

# SCHOOL OF MEDICINE

## DEPARTMENT OF NURSING SCIENCES

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**A RESEARCH STUDY SUBMITTED TO THE SCHOOL OF MEDICINE DEPARTMENT OF NURSING SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF SCIENCE IN NURSING DEGREE**

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**ABBREVIATIONS**

| | |
|---|---|
| ANC | Antenatal |
| DHO | District Health Office |
| DHOT | District Health Office |
| DHS | Demographic health survey |
| FP | Family planning |
| HBM | Health belief model |
| ICPD | International conference on population and development |
| IEC | Information education and communication |
| JOICFP | Japanese Organisation for international cooperation for family planning |
| MCH | Maternal and child |
| MDHO | Mazabuka District Health Office |
| MiM | Men in maternity |
| MNCH | Maternal, neonatal and child health |
| MOH | Ministry of Health |
| PMTCT | Prevention of mother to child transmission of HIV |
| PNC | Post natal care |
| PPFAR | Planned Parenthood federation in Africa Region |
| RH | Reproductive Health |
| SMH | Safe motherhood |
| SPSS | Statistical Package for Social Science |
| SRH | Sexual and Reproductive health |
| TBA | Traditional Birth Attendants |
| UNFPA | United Nations Fund Population Agency |
| USAID | United States Agency for International Development |
| WHO | World Health Organisation |
| ZDHS | Zambia Demographic Health Survey |

## DECLARATION

I, *Lungu Rabecca* hereby, declare that the work presented in this study for a Bachelor of Science Degree in Nursing has not been presented either wholly or in part, for any other Degree and is not being currently submitted to any other Degree.

**Signed:** ..... **Date:** 06.06.12...

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## STATEMENT

I, ***Lungu Rabecca,*** do hereby certify that this study is entirely the result of my own independent investigations. The various sources to which I am indebted are clearly indicated in the text and reference.

**Signed:** ..... **Date:** 06:06:12

## DEDICATION

*To*

*My late Mother - Mrs Martha Tembo Lungu*

Whose support, words of wisdom and encouragements continue to ring through my mind

*To*

*My daughter - Faith Chisepo Sakala*

*To*

*My husband- Stephen, sisters and the Phiris*

For the love, encouragement and support that has made it possible for me to accomplish my ambitions. To Papa Musa for being a supportive and caring father, brother and friend throughout my training till that fateful morning of 28.01.2012 - MHSRIP

## ABSTRACT

In Zambia more than half of the women do not receive PNC services and the lowest percentage of women utilising PNC services is in southern province (ZDHS, 2007). Mazabuka district is one of the districts in southern province which has presented with low postnatal care service utilization standing at 39% in 2010. Since men are considered to be decision makers and bread winners, their decisions affect their partners' access to RH services; this study therefore was conducted with a purpose of determining knowledge, attitude and practice of men towards PNC services in Mazabuka district. This was to establish if men's involvement would improve the postnatal service utilization by women within the district. The hypothesis for the study was that the less the knowledge on postnatal care services, the poor the practice (utilisation) towards the service and that; Men with positive attitude towards PNC services are more likely to utilise the services (practice).

A non intervention descriptive cross section research design was used. Sampling was multi staged and later a purposive sampling method was applied to select fifty respondents as they came to the health facility for any service. Data was collected using a structured interview schedule on men over 17years regardless of their marital status, had a child before and residing in Mazabuka. Analysis of data was done manually on data master sheet and use of statistical package for social scientists version 16.0. Data was presented in the form of frequency tables, pie and bar charts. Cross tabulation tables were used to determine the relationship among variables.

Results from the study revealed that 100% of the respondents had a positive attitude towards PNC services, 68% of the respondents had high knowledge and 82% had good practice. Majority (75%) of the respondents, who had good practice, had high levels of knowledge, 100% of the respondents with good practice and high knowledge had positive attitude. Respondents between 28-35 years and those with fewer children and with formal education had high knowledge. Distance to the health facility also had an influence on knowledge, attitude and practice. Health workers and spouses were the major sources of information on PNC services and 48.5% of those who sought PNC services said the treatment by health service provider was excellent.

# CHAPTER ONE: INTRODUCTION

## 1.0 BACKGROUND

The postnatal period is critical to the health and survival of a mother and her new born. The most vulnerable time for both is during the first 24 hours after birth through to the first week though the whole 42 days postnatal is crucial. Lack of care during this period may result in death or disability as well as missed opportunities to promote healthy behaviours, affecting women, newborns, and children. According to the Population Reference Bureau; MNIP (2007), over 500,000 women and girls worldwide die of complications related to pregnancy and childbirth each year and over 99 percent of those deaths occur in developing countries such as Zambia. These could be the consequence of lack of knowledge and barriers to postnatal care (PNC).

According to WHO (2000), each year, 310,000 newborns would die in Africa and it has been estimated that if routine PNC and curative care in the postnatal period reached 90 percent of babies and their mothers, 10 to 27 percent of newborn deaths could be averted. This means that high PNC coverage could save up to 310,000 newborn lives a year in Africa; and yet PNC programmes are among the weakest of all reproductive and child health programmes in the sub Sahara region of Africa, Zambia inclusive. Low coverage of care in the postnatal period negatively influences other maternal, newborn, and child health (MNCH) programmes along the continuum of care. Some restrictions that keep away the mothers from accessing care during the postnatal period contribute to the delays responsible for maternal and neonatal mortality. These factors include cultural and religious beliefs that do not allow mothers to move out of their homes after delivery or even allow men to have anything to do with the baby and the mother during the postnatal period; poor socio-economic status of most families among many others could also be responsible for low utilization of PNC services.

Schuler et al., (2002), state that men play important and often dominant roles in decisions critical to women's Sexual and reproductive health (SRH) issues. They possess social power and authority, and tend to dominate decision making. This can pose serious threats to women's RH. Socially ingrained gender roles make it difficult for women and men discuss

SRH issues. Men in many societies are more likely than women to control household expenditures and decision making in the family.

When a man is the principal wage earner in a household, his health may be valued more than a woman or child's since a missed day of work for the man due to illness means missed income. Thus, families may be reluctant to use resources for RH services such as postnatal services. Furthermore, Men would often make poor decisions about seeking care during pregnancy and childbirth, in part because they may not know the availability of such services or may not understand the dangers involved in neglecting such services. Therefore, involving men and enabling them to participate in SRH activities could enhance the effectiveness and utilization of postnatal services, hence prevent and manage problems which could arise in the postnatal period for both the mother and the baby.

Women's overall status, particularly in the areas of economics, education, and decision making could affect their access to maternal health care and influence maternal health outcomes, hence, play a big role in shaping dangers associated with motherhood. Roth and Mbizvo (2001) stated that women's lack of decision-making power limit their access to health care and negatively affect maternal health outcomes. In recognising the role men play towards RH, a number of studies have been done world wide to advocate for the involvement and integration of men in SRH programmes.

A preliminary study in 2002 in Turkey by Turan et al revealed that women clients said they expected their husbands to provide financial and emotional support, but that men's responsibilities in labouring outside the home excuse them from participating in household and parenting chores. The study also found that couples rarely spoke to each other about reproductive health issues. One man in the study said, "I don't know what my wife is feeling. Nobody taught me. I didn't get any information''. This shows that men have little knowledge about their role in RH. Working with men in RH could be a viable strategy for addressing some of the countries' public health problems such as underutilisation of PNC services in Zambia.

In Indonesia, an interventional study-Involving Husband in Safe Motherhood - The Suami Siaga ("Alert Husband") Campaign was implemented in 1999/2000. The project aimed at involving men in maternal and child health (MCH) through a mass media campaign. This

was meant to contribute to improved birth outcomes in Indonesia. The results showed that men after being informed of their role and its importance and involving them in safe motherhood programmes, there was high utilization of the RH services.

In Pakistan, male involvement in reproductive health is said to have started long before the concept of a holistic approach emerged from the Cairo International Conference on Population and Development (ICPD) in 1994 due to the alarmingly high maternal mortality ratio influenced by multiple factors, including women's extremely limited freedom of action (Kamal I. 2000). Results of the surveys of men's involvement in reproductive health programs in Pakistan highlighted that men based decisions on conventional ways of managing health matters, such as an economic assessment of the situation. These studies suggested that if men were better educated and taught what to do and when, they could play a lifesaving role during pregnancy and childbirth (Population Reference Bureau, 2002: incite Piet-Pelon et al., 1999).

In Africa, The World Health Organization, Regional Office has identified reproductive health as a priority area in the delivery of health care services in the African region (Kosia A. 2011). This is in response to the persistently high levels of maternal and neonatal morbidity and mortality. The long-term vision of the Organization in the region on reproductive health is to ensure that every woman goes safely through pregnancy and childbirth and infants are born alive and healthy. In pursuance of this vision, the reproductive health strategy for the African region was developed in 1998. The strategy was aimed at assisting member states and partners to identify priorities and plan their programmes and interventions at various levels, particularly at the district level. Male involvement and participation was one of the strategic directions of the reproductive health strategy for the African region.

Most SRH efforts have in the past, focused on women because service providers assumed that women had the greatest stake and interest in protecting themselves from the risk and burdens of pregnancy and childbearing. In recent years, however as stated by UNAIDS (2000) and WHO (2001), the recognition has significantly grown that men, who are influential decision-makers in family and in communities, also must play a very important role in SRH programs. Most decisions affecting family life, politics, etc. are made by men who are not so much involved in SRH/FP programs. In addition, the prevailing social and

religious environment in some cultures does not encourage discussion of sexual matters in either formal or informal settings. This leaves the men with little knowledge on SRH/PNC.

Existing studies in the area of SRH in most African communities indicate that women are dominated by men through patriarchal power, which has been a traditional and historical privilege for men. Most countries have regarded issues of SRH such as family planning, pregnancy and childbirth as exclusively women's affairs (Agenda Special Focus, 2005).
The socio-cultural norms in Africa does not allow Men to accompany their partners to family planning, antenatal or postnatal care services and are not expected to attend the labour or birth of their children. For example when a baby is born, a man is not supposed to hold it till after two months and if a baby dies before the age of two months, no man is expected to attend such a funeral as it is considered to be 'women's affairs'.

In view of this, most African men lack information about SRH and therefore view it in a negative light. However, such practices puts the mother and baby at risk because their (men) lack of participation at family planning, antenatal and postnatal consultations means that they do not benefit from any information given by health providers, regarding the health of mother and baby, or about their role in it. This will mean that even when the mother or baby experiences a problem during the postpartum period, there will be delays in seeking care because the man may not have information on the problems that would occur after delivery and may not recognise them or could be aware yet restricted to take action because of the cultural beliefs that surround child birth. According to Agenda special focus, (2005) incite; Dallabetta et al (1997), Male participation is vital to improve women's access to reproductive health (RH) services. Since Men dominate decision making and have a unique role to play in promoting safe motherhood because in many cases, they control the cash reserves or their permission needs to be obtained for obstetric care-seeking, they should not be viewed as passive onlookers or mere obstacles but surely need to be involved fully in the available PNC services.

USAID (2003) analysed some of the Demographic and Health Surveys (DHS) and reviewed that two thirds of women in sub-Saharan Africa give birth at home, and only 13 percent of these women receive a postnatal visit within two days of birth. According to DHS data in Ethiopia, 90 percent of mothers did not receive any PNC within the first six weeks.

Of the few who did have a PNC contact, more than half gave birth in a health facility, where crowds and the practice of early discharge often hinder mothers from receiving proper PNC. In Eritrea, 92 percent of women giving birth at home received no PNC within the first six weeks. Similarly, 85 percent of women giving birth at home in Mali and 70 percent of women giving birth at home in Rwanda received no PNC at all, according to the most recent DHS country data. This situation has led to a number of studies to be done and strategies put in place to try and involve men in RH within and outside the Sub Sahara region hoping to increase utilization of RH services such as PNC.

In South Africa, a study -Involving Men in Antenatal and Postnatal Care: The Men in Maternity Project was conducted in 2003. Some of the objectives of the study was to Improve male involvement and intra-couple communication; Improved family planning knowledge and use at six months postpartum. The results however showed that men were actually willing to participate after being informed of their important roles in promoting safe motherhood.

In Nigeria, a study- Linkages between Women's Political Participation and Reproductive Health was conducted to assess the Male Influence towards PNC services. Among women with little or no education, current use of modern contraceptives was 10 times higher among those whose husbands approved of family planning (FP) than among those whose husbands did not approve. This shows that men have a great influence on the women's decision making practices in reproductive health.

Realising the common problem and concern within the region, a conference was held in 1999 in Ndola, Zambia with the support of the UNFPA which attracted several countries within the sub Sahara Africa including Zambia on Male Participation in Community-based Reproductive Health Programs. This conference led to the production of a guide for operationalizing male participation and other gender issues in community-based sexual and reproductive health programs which was meant to make an attempt to give a new dimension to male participation with gender considerations (IPPFAR and JOICFP, 2000).

### 1.1 POSTNATAL SERVICES IN ZAMBIA

According to USAID (2009), approximately 4,000 women and girls die each year due to pregnancy-related complications and another 80,000 to 120,000 Zambian women and girls will suffer from disabilities caused by complications during pregnancy and childbirth each

year. The majority of maternal deaths (62%) occur soon after birth with postpartum haemorrhage being the major cause of death (WHOSEA, 2004). This means that reducing maternal mortality and disability will depend on identifying and improving those services that are critical to the health of Zambian women and girls, including adequate postpartum care for mothers and babies.

In Zambia, PNC services are provided at six hours, six days and six weeks post delivery. This is done to detect any deviation from normal and manage appropriately. These services are offered in almost all Public (Government) health institutions and in most private health institutions at no cost and at a minimal cost respectively. PNC services are also offered in homes during home visits. Post natal services include physical examination of the mother and baby, counselling and guidance, family planning, PMTCT services, nutritional support, breast feeding support services, immunisations and investigations among many. The benefits of PNC services especially during the first 24 hours include early diagnosis of complications for both mother and her newborn, care of the newborn and mother including education on breastfeeding and family planning.

To help governments and private organisations meet their maternal health goals, safe motherhood partners from around the world met in October 1997 to identify the most efficient and cost-effective ways to improve maternal health. A comprehensive package of services for safe motherhood was made (WHO, 1996). This also was in a view to try and reduce maternal mortality and to increase the coverage for postnatal services. Zambia has adopted the safe motherhood package of services in its maternal services of which integrated postnatal care is among the list. Family centred care with an emphasis on Male involvement has been emphasised in the recent years yet still the emphasis is more on antenatal care services than the postnatal care services. To help determine the factors influencing under-utilization of PNC services in Zambia, Several studies have been done for example Choolwe N.J (2007) in Mazabuka. The results from this study show that men have a role to play such as funding the trip to the health facility, making decisions for their partners among others and that lack of male involvement is an obstacle to PNC service utilization among women.

Mazabuka District, found in the southern part of the country has equally not been spared by the low postnatal coverage and poor male involvement in reproductive health services. For

example, Post Natal attendance coverage was at 39% in 2010 from 23% in 2008 (MDHO Action plan, 2010) which is still a non impressive rise. During the SWOT analysis, poor male involvement was found to be a threat (MDHO Action plan, 2010-1011).

Involving the decision makers-the male counterpart in postnatal care services could probably increase the coverage of integrated maternal and newborn care in the postnatal period. This is because men are providers in most homes, hence, decision makers.

## 1.2 STATEMENT OF THE PROBLEM

In Mazabuka district, PNC services are provided by all the health care facilities within the district. Apparently Mazabuka District Health Office (MDHO) has one of the largest numbers of health facilities (52). However the district has continued to have low PNC coverage which is still at 39 % (DHO Action plan, 2010-1011). In 2008 the District Health Office Team (DHOT) took the following measures to improve PNC services in the district.

1. Provision of incentives to postnatal mothers at each visit such as chitenge materials and nappies to motivate them and reinforce the behaviour.
2. Training of traditional birth attendants (TBAs) to make follow ups and also provide counselling and education on child care and other support services after delivery.
3. Provision of transport for following up postnatal mothers and distributing baby packs.
4. Introduction of MCH inter-facility exchange visits to share experiences and challenges.
5. Quarterly Technical support supervision to health facilities in order to ensure that the standard in the provision of RH services are maintained.
6. Conduct refresher courses for midwives
7. Integration of postnatal Clinic to other outreach programs to ensure a wider coverage,
8. Introduction of Reach Every pregnant Mother as a strategy to ensure compliance to postnatal service
9. Advocate male involvement in about 42 health facilities within the district through the chiefs and village headmen (MDHO Action plan, 2008).

The above measures by the DHO and other stakeholders has however helped to improve the PN coverage in some way evidenced by a rise in PN coverage from 23% in 2008 to 39% in 2010. During the review of the SWOT analysis, poor male involvement was found to be amongst the greatest threats to PNC services (MDHO Action plan, 2010). This shows that

improving the accessibility and utilization of reproductive health services such as PNC should not only look at the women as service beneficiaries but also involve men because they have a strong influence on women's health and their access to care.

### 1.3 ANALYSIS OF INFLUENCING FACTORS

There are various factors that may influence the utilization of PNC services. These factors may include knowledge, attitude and the practice of men towards PN services.

In this study, the factors have been divided into service related, personal factors, socio-cultural and economic related factors.

#### 1.3.1 SERVICE RELATED FACTORS

1. **Information on PNC**: Lack of information on the existence of the service or its necessity affects the utilization of the service (Theuring et al, 2009). Families may not know the services are offered for free and that even men are welcome to utilise the PNC services such as family planning and child care.

According to Mullick (2001), this could be very common especially for families in which the woman did not attend any antenatal care session where information and education is given on different topics including PNC

2. **Distance to health facilities**: Men may have the information on PNC services and appreciate the benefits. The distance to the facility may affect them positively or negatively. The longer the distance to the facility, the less likely that people will utilise the PNC services offered at that particular service centre (Choolwe, 2007). Physical accessibility is an important variable for utilisation of postnatal health services (Eijk van MA et al 2006). Distance limits men and women's willingness and ability to seek health care particularly when appropriate transportation is not readily available and the roads are impassable.

The 2007 Zambia Demographic and Health Survey reported that women cited that one of the biggest obstacles is difficulty in getting funds from their partners to go to health centres. Such difficulties will affect accessibility of PNC services and will consequently affect their knowledge on PNC services because they may not be willing to walk a long distance on foot to the health facility.

3. **Attitude of the health service providers:** Service provider's attitude emerges as a significant barrier to male involvement (Peacock, 2003). Some health care providers may have a negative attitude towards men being present during the PN reviews. According to an observation made, a number of men have been refused to enter consultation rooms with their female partners.

4. **Infrastructure**: Infrastructure at the health facility may not support presence of the male partner attending his female partner's PNC review. There may be no privacy provided for each couple due to limited rooms making the users shun the services (Tangcharoensathien et al, 2009). This could be the case for most health institutions in Zambia especially in the rural areas where infrastructure is limited.

### 1.3.2 PERSONAL RELATED FACTORS

1. **Attitude of Men**: Men who have a good attitude towards RHS are more likely to be knowledgeable on available RH services and the benefits of PNC services to the family. Such men are likely to encourage their partners to seek and utilize the services as well as be involved in utilizing PNC services. The client's attitude can also be influenced by age, marital status, parity and cultural beliefs (Char et al, 2011).

2. **Marital status**: Single men may fail to access information and PNC services for fear of being labelled. Married men on the other hand may be free to talk about and access RH services. This influence the knowledge levels of their female counterparts because their partners will share the information with them (Char et al, 2011).

### 1.3.3 SOCIO-ECONOMIC FACTORS

According to Dhakal et al (2007), the husband's socio-economic status, occupation and education are significantly associated with the utilisation of postnatal care.

1. **Educational level**: Men who have attained higher level of education are likely to be more knowledgeable on PNC services and as such more likely to influence their partners to seek the service than men with no or lower level of education. The husband's education and occupation can represent family income and social status (Dhakal et al, 2007).

**2. Occupation:** The husband's occupation and education can also represent family income as well as social status. Occupation of the husband is an influential factor for utilisation of postnatal care services. Some men may have the knowledge and positive attitude towards PNC services yet their work demands them to work throughout the day. This may mean no extra time for them to attend RH/PNC services though they may encourage their partners to attend (Dhakal et al, 2007).

3. **Poverty:** Poverty threatens all aspects of family life. The men are more likely not to attend health services because they would rather go out to look for money. Therefore, they would not perceive PNC service as important. Low socio- economic status is likely to affect the education level

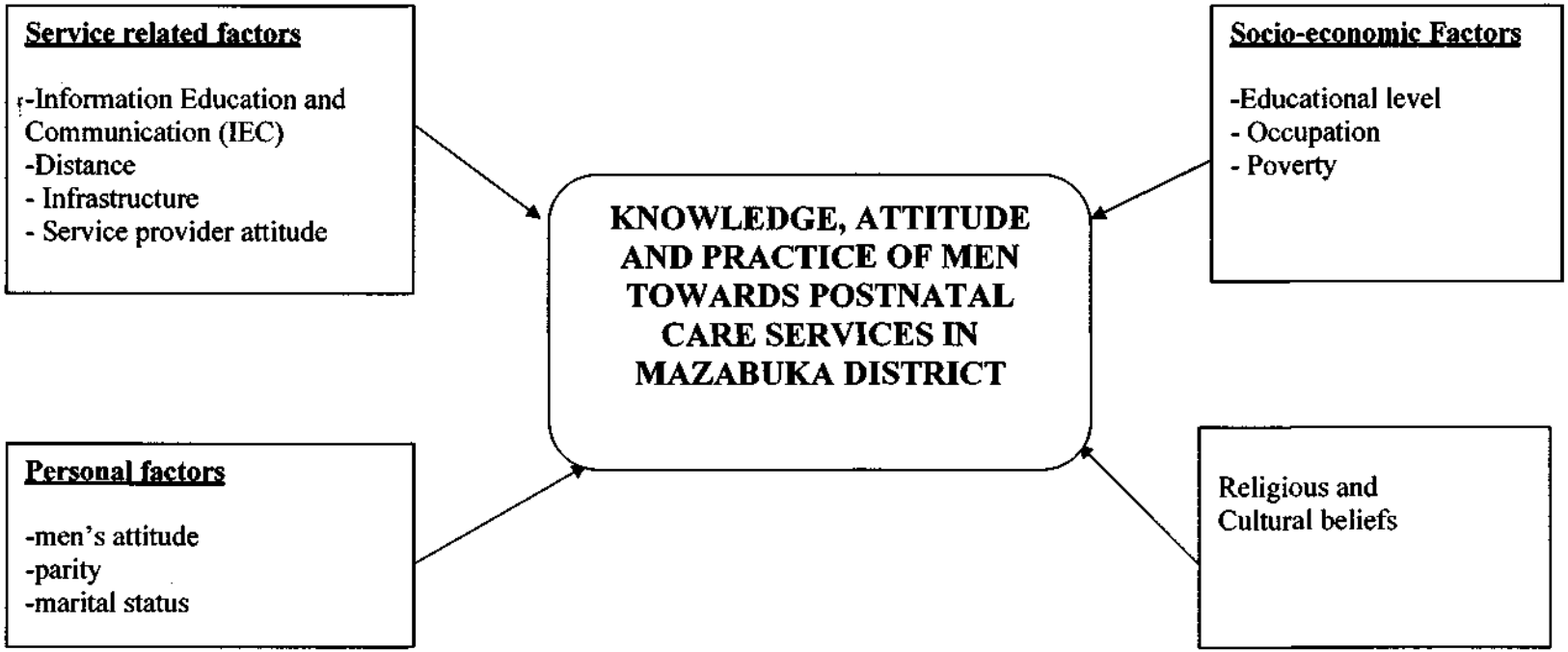
### 1.3.4. CULTURAL AND RELIGIOUS BELIEFS:

The socio-cultural practices around childbirth such as maternal seclusion after delivery and cultural beliefs in a community play a vital role in non-utilisation of postnatal care services. Religious beliefs and cultural beliefs usually have a greater influence on the perception and practice of people, men not to be left out (Walston, 2005). People would adhere to the norms and values their religion and culture advocates for. Christianity is the dominant religion in Zambia comprising of different denominations which have different views on male involvement in reproductive health. For instance, the Zion does not subscribe seeking help from health facilities for any reason. They advocate total dependence on religious beliefs and practices and these have a strong influence on men and women's utilization of health services including postnatal care.

**1.4 PROBLEM ANALYSIS DIAGRAM**

**DETERMINING KNOWLEDGE, ATTITUDE AND PRACTICE OF MEN TOWARDS POSTNATAL SERVICES IN MAZABUKA DISTRICT**

**Figure 1:1**



## 1.5 THEORETICAL / CONCEPTUAL FRAMEWORK

### 1.5.1 HEALTH BELIEF MODEL

This study was guided by the Health Belief Model (HBM). The health belief model was originally developed in the 1950s by Hochbaum and friends while working as social psychologist in the United States public health services and was inspired by a study on why people sought X-rays examinations for TB. The Health Belief Model (HBM) is a tool that scientists use to try and predict health behaviours. Lately, the HBM has been adapted to explore a variety of health behaviours including SRH behaviour (Basavanthappa, 2007).

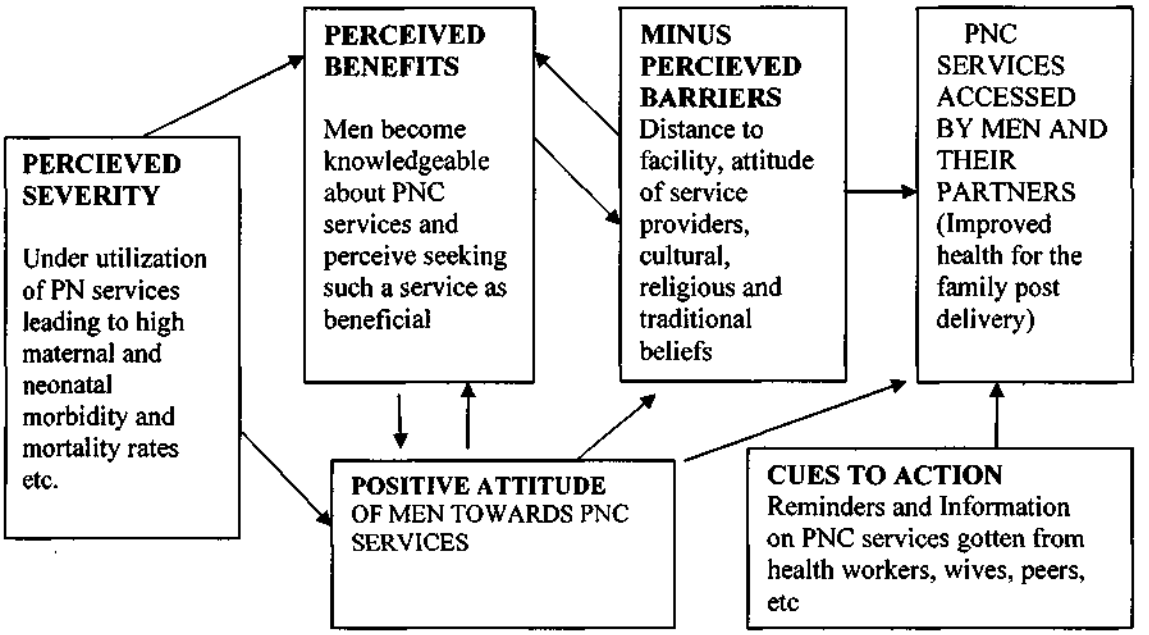
Potter and Perry (2006) state that the HBM is a popular model applied in nursing, especially in issues focusing on patient compliance and preventive health care practices. The model postulates that health-seeking behaviour is influenced by a person's perception of a threat posed by a health problem and the value associated with actions aimed at reducing the threat. It further proposes that a person's health-related behavior depends on the person's perception of four critical areas which are:

1. Perceived susceptibility: This is an individual's assessment of their risk of getting or having the condition. People will not change their health behaviours unless they believe that they are at risk.
2. Perceived severity: This is an individual's assessment of the seriousness of the condition, and its potential consequences. The probability that a person will change his or her health behaviours to avoid a consequence depends on how serious he or she considers the consequence to be.
3. Perceived benefits: This is an individual's assessment of the positive consequences of adopting the behavior. It is difficult to convince people to change behaviour if there isn't any personal gain.
4. Perceived Barriers: This is an individual's assessment of the influences that facilitate or discourage adoption of the promoted behavior. This looks at the potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.
5. 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. These actions are external events that prompt a desire to make a health change. This helps someone from wanting to make a health change to actually making the change.

6. Self efficacy: This looks at a person's belief in his or her ability to make a health related change. That is, having faith in your ability to do something has an enormous impact on one's ability to do it. When men are empowered with knowledge, they will feel confident and willing to participate.

### 1.5.2 DIAGRAM OF THEORETICAL FRAMEWORK

**Figure 1: 2**




### 1.5.3 DESCRIPTION OF THE PREDICTED RELATIONSHIPS

According to the HBM, a person's perceived vulnerability to a condition, their perceptions of the severity of the condition, perceived barriers, efficacy and benefits of any proposed action with something triggering to act can explain a change in health behaviour (Boskey, 2010).

In this study, only four constructs have been used. That is; perceived severity, perceived benefits, perceived barriers and cues to action.

1. Perceived severity: If men know or perceive the consequences of them and their partners not attending PNC services such as ill health, susceptibility to infections (if child is not immunised), early and unplanned pregnancies (no access to FP services) and deaths etc, then they will be willing to seek the service. This can only be through access to RH information by both partners.
2. Perceived benefits: If men knew the benefits and advantages of PNC services such as a better life for the family leading to increased productivity, free health services, low

death rates etc. they will access the service. This basically because it is difficult to convince people to change behaviour if there isn't any personal gain.

3. Perceived barriers: If perceived barriers to access of PNC services such as costs involved, negative staff attitude, cultural and traditional beliefs, non availability of the services etc where to be removed, then men would be willing to seek these services.
4. Cues to action: External influences promoting the desired behavior may include information provided or sought; reminders by partners or influential others, persuasive communications, and personal experiences. The staff and other stake holders need to intensify on information dissemination. The men who have been involved can also be used as role models in order to motivate other men to get involved in PNC services.

The use of this model in this study would suggest that if men became knowledgeable concerning PNC services and realise the benefits of utilising such a service such as low morbidity and mortality rates for the mother and baby, collective decision making concerning family planning, free information on child rearing, F/P services etc, these benefits would out weigh the perceived barriers such as transport costs. They would then utilize the PNC services. The improved practice towards PNC services would mean improved coverage, reduced maternal and neonatal morbidity and mortality rates.

## 1.6 JUSTIFICATION

According to literature reviewed at global, regional, national and district level, it shows that there is still underutilization of PNC services as compared to antenatal care services (WHO, 2006). A number of strategies have also been introduced such as integration of RH services and involvement of men in these services. In most countries studies have also been done on male involvement in RH with a view to find a lasting solution in preventing postpartum complications e.g. death.

In the Zambian tradition, males are considered to be decision makers and bread winners. Since the men's decisions affect their partner's access to RH services, they need to be fully involved in the PN period. Their involvement in RH would contribute tremendously to the well being of mothers and their new born and the family as a whole. Involving men would help in early detection of any problem in the mother and baby in the postnatal period; understand issues of child care, breastfeeding and family planning. The men would also be willing to support their partners in terms of finances. This could possibly increase the

postnatal coverage and eventually reduce the maternal deaths and the infant mortality occurring in the PN period which is currently a national problem.

The low utilization of PNC services in Zambia poses a great challenge to the achievement of reproductive health. Most studies have been done to identify factors that influence underutilization of PNC services by women in Zambia including Mazabuka district yet statistics still shows that utilization of the PNC services is still very low with less male involvement being a threat to the provision of PNC services.

The significance of the study lies in the fact that knowledge, attitude and other influential factors such as traditional men's beliefs in RH may be influencing the utilization of postnatal care services. Through this study the researcher hopes that men will speak out what they really know about postnatal services offered within the district, their attitude towards these services and also establish their practice towards PNC because adequate knowledge and utilisation of postnatal care can help reduce morbidity and mortality among mothers and their babies. Therefore, this study seeks to solicit information on how to increase utilization of PNC services by integrating men in PNC within the health facilities in Mazabuka district of Zambia.

## 1.7 OBJECTIVES OF THE STUDY

### 1.7.1 GENERAL OBJECTIVE

The main objective of this study is to determine Knowledge, Attitude and Practices of men towards postnatal care services in Mazabuka District.

### 1.7.2 SPECIFIC OBJECTIVES

i. To assess the level of knowledge on postnatal care services among men in Mazabuka District.
ii. To examine the attitude of men towards PNC services in Mazabuka district.
iii. To assess the practice of men towards PNC services in Mazabuka district
iv. To examine the association between knowledge, attitude and practice on men in PNC services in Mazabuka district.

## 1.8 HYPOTHESES

A hypothesis is a formal statement of expected relationships between two or more variables in a specified population (Burns and Groove, 2009).

Hypothesis for the Study include:

i. The less the knowledge on postnatal care services by men, the poorer the practice towards the service.

ii. Men with positive attitude towards PNC services are more likely to utilise the services.

## 1.9 CONCEPTUAL DEFINITIONS

A conceptual definition is the definition of a concept by a set of other concepts. It conveys the general meaning of the concept and uses words to define the properties of something.

1. Postnatal period is the first six weeks following delivery of a baby (WHO, 2002).
2. Practice: Is a way of doing something that is the usual or expected way in an organisation or situation (Oxford, 2004).
3. Knowledge means awareness, understanding and problem-solving capacity (Bennett C. 2006)
4. Men: An adult human male (Pearlsal, 2002).
5. Attitude" refers to someone's opinions or feelings about something, especially as shown by the behavior (Mayor et al. 2006)

## 1.10 VARIABLES AND CUT OFF POINTS

A variable is an attribute that varies, that is, takes on different value (Polit and Beck, 2008). It is a property or characteristics of persons, things or situations that change or vary and are manipulated, measured or controlled in research (Burns and Grove, 2005).

### 1.10.1 Dependent Variable

A dependent variable is a variable that changes as the independent variable is manipulated by the researcher: sometimes known as criterion (Basavanthappa, 2007).

The dependent variable for this study is practice

### 1.10.2 Independent Variable

This is the variable that is purposely manipulated or changed by the researcher (Basavanthappa, 2007). These variables have an effect on the dependent variable. These include Knowledge and Attitude.

**TABLE 1:1: VARIABLES, INDICATORS AND CUT OFF POINTS**

| VARIABLE | INDICATOR | CUT OFF POINTS | QUESTION NUMBERS |
|---|---|---|---|
| Dependable variable **Practice** of men towards postnatal services | 6 to 10 correct scores out of 10 marks | - Good | 21 to 30 |
| | 1 to 5correct scores out of 10 marks | - Poor | |
| Independent variable **Knowledge** of men towards postnatal services | 5 to 6 correct scores out of 5 knowledge questions. | - Highly Knowledgeable | 7-12 |
| | 3 to 4 correct scores out of 5 knowledge questions | -Moderately knowledgeable | |
| | less than 2 scores out of 5 knowledge questions | -Low knowledge | |
| **Attitude** of men towards postnatal service | 11 to 20 Correct scores out of 20 marks. | Positive attitude | 13-20 |
| | 10 or less scores out of 20 marks. | Negative attitude | |

# CHAPTER TWO: LITERATURE REVIEW

## 2.1. INTRODUCTION

Literature review refers to an extensive, exhaustive and systematic examination of publications relevant to the research project (Basavanthappa, 2007). The types of information for review of literature are conceptual and data based literature (Basavanthappa, 2007). The common sources of literature used in this study are books, Journal articles, critique reviews, abstracts published in conference proceedings, professional and government reports, and unpublished doctoral dissertations and thesis.

The general purpose of the literature review is to gain an understanding of the current state of knowledge about the research topic (Johnson and Christensen, 2004). For this study, the literature was reviewed to gain more understanding on men's involvement in SRH services with a particular interest to PN services. The review also helped the investigator to identify literature gaps supporting the choice of topic as well as refining the research problem and background information.

## 2.2 OVERVIEW OF KNOWLEDGE, ATTITUDE AND PRACTICE OF MEN TOWARDS PNC SERVICES

According to Rosen et al (2002), the benefits of involving men in women's RH services are well recognised and have been advocated for by many. Millick et al (2005) stated that with respect to obstetric care, it is often the family and not the woman alone who makes decisions. Men are the obvious target audience because in many cases, they control the cash reserves or their permission needs to be obtained for obstetric care-seeking (Millick et al, 2005; incite Dallabetta et al, 1997). Lack of involvement by men deprives women of their partners' care and support in coping with HIV infection and in making appropriate infant feeding decisions after delivery (UNICEF, 2001).

A number of international organizations have emphasized the important role of male partners in reproductive health issues following the satisfactory results of several initiatives conducted in different countries concerning the involvement and support of male partners in reproductive health (Reproductive Health Outlook 1998; Engender Health, 1998).

However, most existing literature on men's involvement in RH is about family planning, PMTCT and ANC. No much documentation has been done with regard to male involvement in providing support to woman during the maternity cycle, particularly after delivery.
In view of this, the investigator looked at related literature on male involvement in reproductive health with particular attention to the 3 variables: Knowledge, Attitude and Practice.

## 2.3 KNOWLEDGE OF MEN TOWARDS PNC SERVICES

In this study, knowledge is defined as the information or facts that men have on PNC. Globally a number of related studies have been done to determine the level of knowledge in men with regard to their involvement in RH. A study; Antenatal and Postnatal care seeking behavior in a matrilineal society: On the garo tribe of Bangladesh by Rakibul et al (2009) was conducted. The study identified that availability of services in a community did not necessarily reflect the care seeking behavior unless the awareness about the available services among potential clients was increased, Women's decision-making power regarding their health issues can improve the situation further and men's attitude towards women in a specific society or community determines the women's health care seeking behavior.

In another study; involving men in maternity care in India by Varkey et al (2004), The FRONTIERS Men in Maternity (MiM) program in India "encouraged husbands' participation in their wives' antenatal and postpartum care" as a response to the findings that men as primary household decision makers had an impact upon women's health. Populations of couples served by three dispensaries served as controls for three comparable populations which used different dispensaries. A sample survey of eligible men and women attending the MiM antenatal clinics was conducted in the clinics and then again at home when their infant was six months old to measure the effectiveness of the intervention by comparing women and their husbands to those of eligible couples from the three control clinics. Results from this study showed that the MiM intervention of involving men was able to raise awareness and use of family planning (FP) in the postpartum period, and also increased awareness of dual protection for STIs. In this case, the more people become aware and knowledgeable about the service, then they were able to utilise it can utilise the service.

In Africa, the MiM Care study was implemented in KwaZulu-Natal in South Africa by Mullick et al in 2001 and was evaluated to establish whether it was feasible to involve men in antenatal and postnatal care, and whether this would be acceptable to health care providers,

the clients and their partners. The study was also designed to establish how effective the expanded antenatal and postnatal care programme would be for improving the reproductive health of both women and the men, especially for increasing the use of postpartum family planning, increasing recognition of danger signs that could potentially lead to maternal mortality and improving partner communication and support. The study revealed that some men admitted that they lacked knowledge because their partners did not tell them what they learnt from the clinics. One commented that "women do not tell us what has been said at the clinic and they do not bother to ask us to accompany them (women) to the clinic"; while another said "they only convey what was detected to be a problem at the clinic". Men felt it was important to be informed and were willing to be involved in most aspects of maternity care. This showed that men lacked knowledge and therefore could not utilize the service.

Nationally, a related study in Mambwe District of Zambia by Desire Dinzela Tshibumbu in 2006 was conducted. The investigator looked at factors influencing men's involvement in PMTCT of HIV programmes. The reasons behind the low involvement among men in RH services particularly in PMTCT services were investigated. In this quantitative, exploratory study, the factors studied were grouped as knowledge and awareness, socio-cultural, programmatic and demographic characteristics. The major findings were that knowledge of PMTCT was the strongest factor which was positively associated with the level of men's involvement in PMTCT services before and after delivery (postnatally).

## 2.4. ATTITUDE OF MEN TOWARDS PN SERVICES

"Attitude" refers to someone's opinions or feelings about something, especially as shown by the behavior (Mayor et al. 2006). In this study attitude is defined as the way men feel, think and react towards the PNC services.

A multivariate analysis by Romero-Gutierrez et al in 2003 on postpartum contraceptive acceptance in Leon, Mexico was carried out with the aim of identifying the reasons for the acceptance or rejection of contraceptive methods among postpartum women at the Hospital. The findings revealed that one of the most prominent reasons for contraceptive refusal were husband's rejection (33.2%). The results showed that the rejection of contraceptives was mainly attributed to husbands' negative attitude about the use of the contraception.

In Nepal, a study -Barriers to and attitudes towards promoting husbands' involvement in maternal health in Katmandu, was conducted by Mullany B., (2005). This was in preparation for a male involvement in antenatal care intervention, this qualitative study specifically aimed

to understand the barriers to male involvement in maternal health and explore men's, women's, and providers' attitudes towards the promotion of male involvement in antenatal care and maternal health.

In-depth interviews were conducted and the most prominent barriers to male involvement in maternal health included low levels of knowledge, social stigma, shyness /embarrassment and job responsibilities. Though providers also foresaw some obstacles, primarily in the forms of hospital policy, manpower and space problems, providers unanimously felt the option of couples-friendly maternal health services would enhance the quality of care and understanding of health information given to pregnant women, echoing attitudes expressed by most pregnant women and their husbands. The predominantly favourable attitudes of pregnant women, husbands, and providers towards encouraging greater male involvement in maternal health in this study implied that the introduction of an option for such services would be both feasible and well accepted.

In Sub Sahara Africa, a similar study on ANC /PMTCT services was done by Byamugisha et al (2010) to determine male involvement in the prevention of mother-to-child transmission of HIV (PMTCT) programme in Mbale district, Eastern Uganda. The study was conducted using a cross-sectional survey of 388 men aged 18 years or more, whose spouses were attending antenatal care at Mbale Regional Referral Hospital. The results showed the majority (74%) had a low male involvement index and only 5% of men accompanied their spouses to the antenatal clinic. This was attributed to the men's low education levels. Men who had attained secondary education had a high male involvement index than those who had primary or no formal education. A negative attitude of some men was common, as demonstrated by the focus group discussion: "I believe it is not good to follow your wife to the antenatal clinic. Even though she exposed her privacy to you at home but when you reach the antenatal clinic it is different. So it is better she goes alone". Another one said, "If I accompanied my wife to hospital every time she goes for her antenatal check up, my friends would think I am a weakling. They would laugh at me". One of the key informants said: "Because of cultural beliefs, most men do not like to accompany their wives to the antenatal clinics. Men who accompany their wives to ANC are perceived to be weaklings by their peers".

Lack of adequate space in the antenatal clinics was cited as another factor hindering male involvement in RH. One respondent said: "The clinics are congested. There is not enough space to accommodate the women and their husbands. Men will not feel comfortable sitting

with women who are strangers to them. They would rather wait outside and if the procedures take long they would leave.

Barriers to male involvement in the PMTCT programme were related to the poor health system, socio-economic factors and cultural beliefs which have an influence on attitude and utilisation of the RH services.

Another study; male involvement in prevention of mother to child transmission of HIV (PMTCT) services in Tanzania by Theuring et al in 2009 was conducted. This study assessed male attitudes regarding partner involvement into ANC/PMTCT services in Mbeya region, Tanzania. The aim was to fill the existing gap on male focused research and to learn about men's perspectives on and experiences with ANC/PMTCT services in order to identify strategies for increasing partner participation rates in SRH services. Results from this study showed that almost all the respondents generally supported PMTCT interventions (PMTCT services are not only specific to ANC but also through to the PN period). The respondents mentioned barriers to PMTCT attendance such as lacking information/knowledge, time, neglected importance and the service representing the female domain among others. Some men said "men do not attend these clinics because it's not their role. They only do so when their wives are not feeling well" and another one said "I heard that in case you have escorted your wife to the services, you will be told to wait outside the clinic room, so why should I go and end up waiting outside?" However, other men still showed some positive attitude towards their involvement. One respondents said "When I attended PMTCT services, I felt good about it; we were counselled together and got knowledge on important issues. The providers were very polite with me". This however shows that men with a positive attitude are more likely to attend the PNC services and learn more about RH.

## 2.5. PRACTICE OF MEN TOWARDS PNC SERVICES

"Practice" means the application of rules and knowledge into action Badran IG, 1995). In this study, practice refers to making use of the available PNC/RH services.

Mullany et al (2007) looked at the impact of including husbands in antenatal health education services on maternal health practices in urban Nepal: The study was designed to test the impact of involving male partners in antenatal health education on maternal health care utilization and birth preparedness. Four hundred and forty two (442) women seeking antenatal services during second trimester of pregnancy were randomized into three groups: women who received education with their husbands, women who received education alone and

women who received no education. The education intervention consisted of two 35-minutes health education and these women were followed until after delivery.
Women who received education with husbands were more likely to make more than 3 birth preparations and also attend a post-partum visit than women who received education alone or no education. The results revealed that educating pregnant women and their male partners yielded a greater net impact on maternal health behaviours compared with educating women alone. Results from this observation study suggest that including men in reproductive health interventions can enhance positive health outcomes and increased service utilization.

Results from Yemen by Almualm Y (2007) in his study Knowledge, attitude and practice of husbands towards modern family planning in Mukalla revealed that the majority of the husbands (51.3%) agreed that husbands should also practice family planning though 43% felt that F/P should be practiced by the wife. The results also highlighted that husbands needed relevant information to participate responsibly in making decisions on F/P and that they could learn about such services by accompanying their wives on clinic days, organising transport to the clinic among others.

In Africa some related studies have also been done. For example, Soliman, M. H. (1999) carried out a study on the Impact of antenatal counselling on couples' knowledge and practice of contraception in Mansoura, Egypt. The impact of antenatal counselling on couples' knowledge and practice of contraception was investigated and the results showed that Involving husbands in family planning counselling sessions led to joint decisions being made and encouraged women's use of contraception. The majority of couples retained most of the information given. Integrating family planning counselling into antenatal care in all facilities and involving the husband are recommended. In this study men were involved right from antenatal care, therefore they gained knowledge on the importance of their involvement hence, they utilised the postpartum F/P services (the practice was good).
In the study done by Theuring et al in (2009) in Mbeye revealed that difficulties of life contribute to men having poor practices towards RH services because it is better to go and seek money for the family, instead of attending clinics which where designed for women only.

In Zambia, Susu et al (1996) carried out a study on Family planning practices before and after childbirth in Lusaka, Zambia. The respondents were recruited from the PN wards at University Teaching Hospital (UTH).

Family Planning practices before and after delivery were investigated among 376 of these women. The interviews were conducted in their homes or at the postpartum clinic at the UTH at the end of puerperium.

Thirty four percent of the women had used a family planning method before the present childbirth. Most of those (90%) had used modern methods. One year after delivery, 64% of the women were using modern or traditional family planning methods. Those who did not use any method indicated that their husbands did not allow them. Results from this study can suggest that poor practice of men has a negative influence on women's health.

In Mazabuka District, not so much has been done on the involvement of men in RH services. A study -"No sister, the breast milk alone is not enough for my baby" was done by Siziya et al in 2005. This was a qualitative assessment of potentials and barriers in the promotion of exclusive breastfeeding. From the focus group discussions, women stated that they could only get the best advice from the trained health workers i.e. nurses and doctors. The father of the child was not mentioned as a person from whom to seek advice. When the nurses were asked who had the influence on the mother, their spontaneous answer was the father. "Sometimes it is better you involve the husband as well in the health education, the one who gets paid you know. Because sometimes the husband is well paid, but maybe he drinks a lot and may not support the mother in terms of buying nutritious food which is important for the child." Results from this study showed that lack of partner support and participation has been found to be a barrier to replacement feeding for HIV infected women. Even women who choose to exclusively breast feed need partner support (Baggaley et al 2000). This could mean that poor practices towards RH by men would negatively influence the health outcomes for both the mother and baby (PMTCT is not only for ANC services).

Results from several studies show that factors associated with R/H practices by men include personal (i.e. knowledge), demographic (i.e. parity, age), socio-cultural, religious, economic, and health services. Research results have also revealed that approval of husbands is an important factor in the utilization of R/H practices (Kamal, 2000)

## 2.6. RELATIONSHIPS AMONG VARIABLES

This section looks at the relationship among knowledge, attitude and practice A related study by Senanayake et al was conducted in 2006 on Knowledge, attitudes and practices regarding postpartum contraception among 100 mother-father pairs leaving a Sri Lankan maternity hospital after childbirth. This was done in response to previous studies done which revealed that a deficiency in family planning in the postpartum period and in families with young children was present in Sri Lanka, as evidenced by the high abortion rate and reported rationales for abortions that included lack of birth spacing. Analysis of this study revealed a general lack of knowledge about post-partum education (especially in fathers), and the researchers concluded that this lack of education contributed to the high abortion rate in Sri Lanka. This could mean that people were aborting because they did not know (especially fathers) about the availability of postpartum contraception. Possibly if fathers knew, they could have influenced their partners to utilise the service as a couple.

In 2003, another study was carried out by Roudsari et al in south-west Tehran province to assess the knowledge, attitude and practices of men; Iranians and Afghan refugees regarding reproductive health. This study was conducted to assess the differences in knowledge, attitudes and practices regarding reproductive health issues in these 2 groups. The study revealed that Men in both groups had very low scores for knowledge about reproductive issues. The scores for practices were statistically significantly different between the groups, being better for Iranians, but were still quite low. Considering the very poor scores for knowledge in both groups, it is clear that the familiarity of women with family planning and their beliefs about this topic, and their determination to use contraception, together with their effectiveness in delivering the knowledge to their husbands is quite important for raising the practice scores because most of the contraceptive methods used by the clients at the health facilities actively involved women rather than men. When it came to attitudes, the second step before taking action, Iranians men had better scores; they also had higher scores for practices than Afghan refugees. This shows how attitude influenced practice. Though there were low levels of knowledge, the group which had better scores for attitude demonstrated good practice towards RH. Published reports confirmed a 70%–90% rate of acceptance of contraception and reproductive health topics, while the rate for contraception use was around 30%, around 20% of women clearly indicated the negative attitudes of their husbands as the reason for discontinuation of contraception (Roudsari et al, 2003; incite Afzali et al 1993).

The negative attitude is another obstacle to effective use of contraception, continuous attendance to service delivery sites and proper usage of RH services.

## 2.7. CONCLUSION

Susan Babirye (2011), state that fathers are central in everyday decision-making, particularly on issues of access, control and distribution of resources, movement outside the home as well as how many children to have and when to have them. In relation to making pregnancy and childbirth safer, men have a big stake in the decision to seek care when pregnancy-related complications arise. They have a say in determining when, how and where to seek medical help. It can be seen from the literature review that knowledge is important in the utilization of SRH/PNC services (Utilization in this context means practice). On the other hand, having knowledge does not necessary mean good practice because there are other factors that may hinder the good practice such as a negative attitude. Some men may seem to have a positive attitude towards the RH/PNC services yet their practice is limited due to other associated factors such as lack of knowledge, occupation, religious and cultural beliefs, availability of the service or the service providers, attitude of health service providers etc. In conclusion, we can say that attitude, knowledge and practice can influence each other spontaneously, collectively. Therefore, this study wished to investigate how each of these variables relates to each other and how they influence utilization of PN services in Mazabuka district.

# CHAPTER THREE: RESEARCH METHODOLOGY

## INTRODUCTION

Burns and Grove (2005), defines research methodology as the entire strategy for the study, from identification of the problem to final plans for data collection. It is the development, testing and evaluation of research instruments and methods used in research investigation, in which the reliability and validity of the tool used for data collection has to be ensured.

## 3.1 RESEARCH DESIGN

A research design is a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings (Burns and Groove, 2009). It involves a plan of activities which guide a researcher in collecting, analyzing, and interpreting data. This study utilised a non experimental descriptive study design. According to Basavanthappa, (2007) a non experimental study is one in which the investigator does not control or change any aspect of the situation under study as in the case of experiment, but simply describes what naturally occurs. A descriptive research design is a scientific method which involves observing and describing the behavior of a subject without influencing it in any way. Burns and Grove (2009), defines descriptive study design as a study crafted to gain more information about characteristics within a particular field of study. A non interventional, descriptive study design was used and it was chosen because no intervention was required and that more information was required to be obtained about the men's knowledge, attitude and practices towards the PN services and thereafter, the information would be used to strategise on how best to incorporate the men in SRH/PN services.

## 3.2 RESEARCH SETTING

A research setting is a physical location and condition in which data collection takes place.
It ranges from naturalistic settings to laboratories depending upon the study topic and the researcher's choice (Basavanthappa, 2007).

The study was conducted from 5 health facilities within Mazabuka District which where selected using the multi stage sampling method. Mazabuka district is found in the northern part of the southern province of Zambia, with the surface area of 6,687 kilometres. It is about 126 km away from Lusaka, the capital city of Zambia and more than 400km from Livingstone which is the provincial headquarters and the country's tourist capital.

It shares boarders with Kafue district in the north, Mumbwa district in the north western, Monze district in the south and Siavonga district in the north east. Mazabuka district has a projected population of 268,399 with a growth rate of 3.4. Common languages spoken are Tonga, Nyanja, Bemba; and English as the official language. Christianity is the main religion in the district.

## 3.3 STUDY POPULATION

According to Burns and Groove (2009) a study population includes all elements such as individuals, objects, events or substances that meet the sample criteria for inclusion in a study. The study population in this research included men from 18 years and above who had had a child before.

## 3.4 SAMPLE SELECTION

Sample selection is a process of selecting a group of people, events, behaviours or other elements that are representative of the population being studied (Burns and Grove, 2009).

Mazabuka District was conveniently selected because that is where the researcher resides. This reduced on the transport costs. Since the district is vast and has 52 health facilities, it is divided into 3 zones for administrative purposes. Therefore, a multistage sampling method was used to select the sample. Using simple random sampling; 2 zones out of the 3 in the district were selected. From the 2 zones selected, a sampling frame was made which is a list of all the names of the health facilities in the 2 zones. From the sampling frame, 5 health facilities (Magoye, kaleya, Nakambala, Mubuyu, and Research health centres) were selected using simple random sampling. Thereafter, purposive sampling was then employed to select sample units from each of the 5 health facilities. Therefore, 10 men were sampled from each health facility. The men who meet the inclusion criteria were selected as they came to the clinic to seek health care and only 5 men where selected each day from each health facility with a total of 25 men each week from the 5 health facilities.

### 3.4.1 ELIGIBILITY CRITERIA

Eligibility criteria are the list of characteristics essential for inclusion or exclusion in the target population (Burns and Groove, 2009).

### 3.4.2 Inclusion Criteria

Inclusion criteria are the characteristics that the subjects or elements must possess to be part of the target population (Burns and Groove, 2009).

Participants who where included in the study are men aged 18years and above residing in Mazabuka District. Only men who had had a child, married or not, were selected since the researcher focused on assessing the knowledge, attitude and practice of men towards PNC services.

### 3.4.3 Exclusion Criteria

Exclusion criteria are those characteristics that can cause a person or element to be excluded from the target population (Burns and Groove, 2009). The exclusion criteria included all men below 18years of age and all those who have not had a child before and coming from outside the catchment area. This is because those below 18 years may have problems understanding issues and would be considered as minors. And those who have had no child may not appreciate issues of reproductive health such as ANC, PNC, F /P. Those from outside the catchment area would give a wrong picture of what is prevailing in the district

## 3.5 SAMPLE SIZE

A sample size is the number of subjects or participants recruited and consenting to take part in the study (Burns and Groove, 2009). A sample size of 50 men was selected. The sample size of 50 respondents was given by the Nursing department. This is because of the inadequate resources to conduct the study and the short period in which the research was being conducted.

## 3.6 OPERATIONAL DEFINITIONS

**3.6.1** Knowledge towards PNC services in this study refers to the general knowledge men have on PNC services, awareness on the existence of the service in the health facilities, their benefits to the family.

**3.6.2** Attitude towards PNC services refers to inclinations to react in a certain way towards PNC services

**3.6.3** Practice towards PNC services is the application of rules and knowledge into action. This means making use of the available PNC/RH services. Practice also refers to utilisation

**3.6.4** Men refer to male counterparts, 18 years old and above and have had a child.

**3.6.5** Postnatal period refers to the period from delivery to two months.

## 3.7 DATA COLLECTION TOOL

Data collection tool is a measuring device used in gathering of information needed to address a research problem. It may take the form of questionnaire or interview schedule, checklist, focus group discussion guide, projected device or some other type of tool for eliciting information (Polit and Beck, 2008). In this study, data was collected using a questionnaire for the structured interview schedule. An interview schedule is an instrument of gathering self report information, which is formally written (Pilot & Hungler, 2007).

The instrument contained 30 open and closed ended questions. This was easier to use on both the illiterate and literate. The questionnaire was divided into the following sections: demographic, knowledge, attitude and practice data. This technique was chosen because it could be used for both the literate and the illiterate. It is also effective for obtaining opinions, attitudes, values and perceived behavior.

### 3.7.1 VALIDITY

This is a measure of the truth or accuracy of a claim (Burns and Grove, 2005). Validity simply means that the conclusions are true. In this study both internal and external validity were considered.

**Internal Validity**: Internal validity is the extent to which the effects detected in the study are a true reflection of reality, rather that the result of the extraneous variables (Burns and Grove, 2005). To reduce the impact of extraneous variables in the study and increase on internal validity, the use of random sampling techniques and selecting a particular type of the group of men making up the sample was utilized. The same questions were asked to all respondents so as to prevent biasness.

**External Validity:** External validity is the extent to which the study findings can be generalized beyond the sample used in the study (Burns and Grove, 2005). In this study, efforts to enhance external validity include the random selection of the respondents.

To ensure validity in this study, questions were made simple, concise and brief for the investigator and respondents to understand and a pilot study was conducted at Nakambala urban clinic in Mazabuka.

### 3.7.2 RELIABILITY

Burns and Grove (2007), defines reliability as a measure that denotes the consistency of measures obtained in the use of a particular instrument. This means that the instrument used has to be consistent and dependable in measuring that which it is purposed to measure.

In short, someone else using the same method in the same circumstances should be able to obtain the same findings. Reliability in this study was upheld by conducting a pilot study to ensure stability of the tool and necessary changes were made to the tool thereafter.
A standardised interview schedule was administered to all the respondents after conducting a pilot study. The questionnaire was subdivided into sections so that information could flow well and each section measured with the some variable.

### 3.8 DATA COLLECTION TECHNIQUES

Data collection technique is the actual method on how the data is going to be collected (Polit and Beck, 2008). It is the use of data collection tools to gather information needed to address a research problem. These methods are used to collect data to answer a research question. It also allows systematically collect information the people under study.
In this study, face to face structured interview schedule was used as a technique for data collection. Data was collected for a period of 10 days. Two days were allocated to each of the five facilities and five interviews were conducted per day with each interview lasting about 30 minutes.

### 3.9 PILOT STUDY

According to Basavanthappa (2007) a pilot study is a small scale dress rehearsal that proceeds as if it were the actual research; it is a replica of the main study. It is a study conducted before the major study in order to make revisions and find flaws in the methodology. The primary objective of the study was to test the elements of the research proposal in order to correct any part that did not work well. The pilot study was to help to test whether the variables defined by operational definition were actually observable and measurable.

The pilot study was done from Nakambala urban clinic were only 10% of the total sample size (5men) was interviewed. These men were purposively sampled as they come to seek health care from the clinic on this day. After the pilot study, some changes were made to the interview schedule such as rephrasing some questions which were unclear to the respondents. Later the main study was under taken.

## 3.10 ETHICAL AND CULTURAL CONSIDERATIONS

Ethical and cultural consideration is a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and obligations to the study participants (Polit and Beck, 2008). The main ethical issues most considered when conducting research include the voluntary nature of the participation, the reduction of risks for the participants while maximising benefits on the study participant, obtaining informed consent; ensuring confidentiality and privacy of participants, and institutional ethical issues, which include obtaining authority to conduct research and scientific honesty.

In this study, ethical issues were addressed by requesting permission to conduct the study from the District medical officer. The respondents were briefed about the purpose of the study and that they had the right to participate or withdraw from the study. They were also assured of confidentiality of personal information shared with the researcher after which, an informed consent was obtained from all men who were ready to participate in the study. After each interview, the completed questionnaires were separated from the consent forms and safely kept to avoid unauthorized access to the information that was obtained.

# CHAPTER 4: DATA ANALYSIS AND PRESENTATION OF FINDINGS

## 4.1 DATA ANALYSIS

Data Analysis is the systematic organization and synthesis of research data and the testing of research hypothesis using data (Polit and Beck 2008).

Data was collected from respondents using a questionnaire. Fifty (50) respondents participated in the study. The questionnaires used were counted to ensure that the correct number was obtained. They were checked for accuracy; completeness and internal consistency and entered in numeric form. The findings were presented on the data master sheet. Frequency counts, percentages, comparison and cross tabulations of variables were done to show relationships among variables.

### 4.1.1. Qualitative data

Qualitative data is the information collected in the course of a study that is narrative (Polit and Beck, 2008). Three questions were used to collect qualitative data from the respondents, two knowledge questions and one practice question. Responses for the open ended responses were read and reread to get the concepts, categorised according to similarity and then coded. Coding is the process of transforming qualitative data into numerical symbols that can be computerised (Burns and Grove 2009). The responses were then entered on a spreadsheet and analysed using the SPSS, version 16.0.

### 4.1.2 Quantitative Data

Quantitative data is information collected in the course of a study that is quantified or in numeric form (Polit and Beck, 2008). Quantitative data were entered on the data master sheet and the data set spread sheet created on SPSS version 16.0. The data was checked for completeness and consistency and entered in numeric form. The data was coded, categorized, and computed to arrive at the domain scores. The quantitative data in this study included the demographic variables, 3 closed ended questions on knowledge, 5 attitude questions and 7 practice questions on PNC services.

## 4.2. DATA PRESENTATION

Presentation of findings involves display of the results of the data collected (Polit and Beck, 2008). The findings were presented in frequency tables, figures (pie charts and bar charts) and cross tabulations.

The tables were suitable because they summarise the findings in meaningful ways, which is easy to understand. The cross tabulations were helpful in comparing the relationship between the variables from which meaningful inferences were drawn.

The pie charts and the bar charts provide a variety of ways in which to present data and thus prevent the monotony of narrative presentations.

The tables and figures were clearly numbered and carefully labelled with self explanatory headings under sections A, B, C and D.

The sections below show the findings of the study.

**SECTION A**

**4.2.1 Demographic Data**

This section consists of one table on demographic characteristics of the study respondents: Age, marital status, number of children, religious denomination, educational level and occupation. The data was presented on a frequency table.

**Table 4.1: Demographic data (n=50)**

| VARIABLES | FREQUENCY | PERCENTAGE |
|---|---|---|
| **AGE** | | |
| 18 – 27 | 13 | 26% |
| 28- 37 | 24 | 48% |
| 38 and above | 13 | 26% |
| **TOTAL** | **50** | **100%** |
| **MARITAL STATUS** | | |
| Single | 4 | 8% |
| Married | 45 | 90.% |
| Divorced | 1 | 2% |
| **TOTAL** | | **100%** |
| **No OF CHILDREN** | | |
| 1-3 | 30 | 60% |
| 4-6 | 15 | 30% |
| 7-9 | 4 | 8% |
| Above 9 | 1 | 2% |
| **TOTAL** | **50** | **100%** |
| **DENOMINATION** | | |
| Roman Catholic Church | 6 | 12% |
| Seventh Day Adventist | 24 | 48% |
| Jehovah's Witness | 5 | 10% |
| Pentecostal | 8 | 16% |
| Others(specify) | 7 | 14% |
| **TOTAL** | **50** | **100%** |
| **LEVEL OF EDUCATION** | | |
| Never been to school | 2 | 4% |
| Primary | 19 | 38% |
| Secondary | 21 | 42% |
| Tertiary | 8 | 16% |
| **TOTAL** | **50** | **100%** |
| **OCCUPATION** | | |
| Non | 5 | 10% |
| Farmer | 9 | 18% |
| Self employed | 10 | 20% |
| Formal employment | 10 | 20% |
| General worker | 16 | 32% |
| **TOTAL** | **50** | **100%** |

Table 4.1 above shows that the majority of the respondents, 24(48%) were aged between 28-37 years. More than two thirds, 45(90%) of the respondents were married. Majority of the respondents, 30(60%) had 1-3 children and only 1(2%) respondent had more than 9 children. Almost half of the respondents, 24(48%) belonged to the Seventh day Adventist church. The level of education varied from no education to tertiary education. Of the 50 respondents, 21(42%) had only secondary school level of education and only 8(16%) had tertiary education. Concerning their occupation, 16(32%) were general workers.

**SECTION B**

**4.2.2 Knowledge on PNC Services**

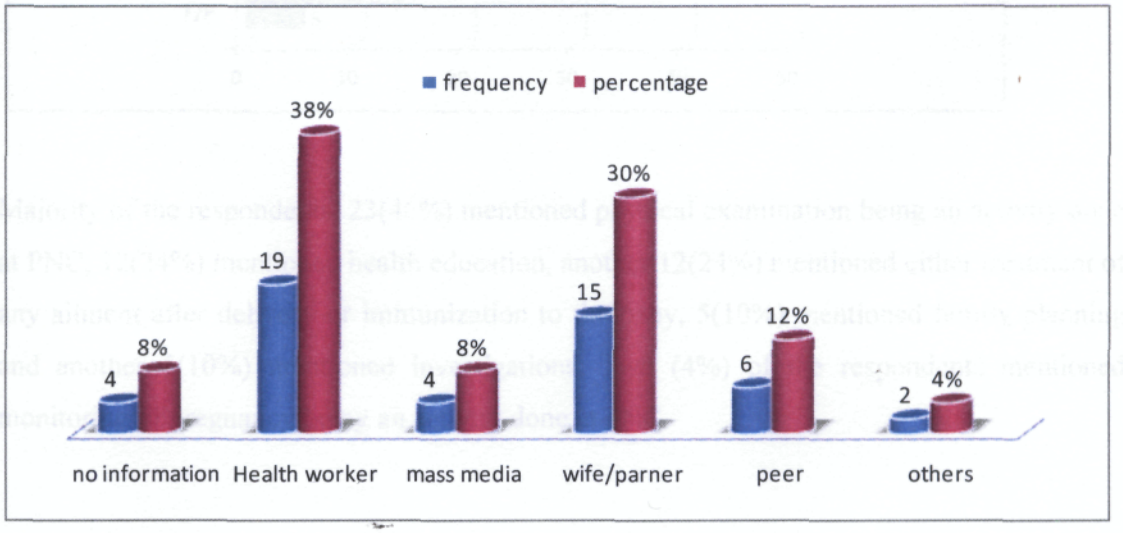
This section sought to determine knowledge of men towards PNC services. Data was presented in frequent tables and bar charts.

**Table 4.2: Awareness of PNC services available at Local health facility (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| **YES** | 40 | 80% |
| **NO** | 10 | 20% |
| **TOTAL** | 50 | 100% |

More than two thirds of the respondents, 40(80%) were aware of the availability of PNC services at their local health facility while 10(20%) where not.

**Figure 4.1: Source of information on PNC services (n=50)**



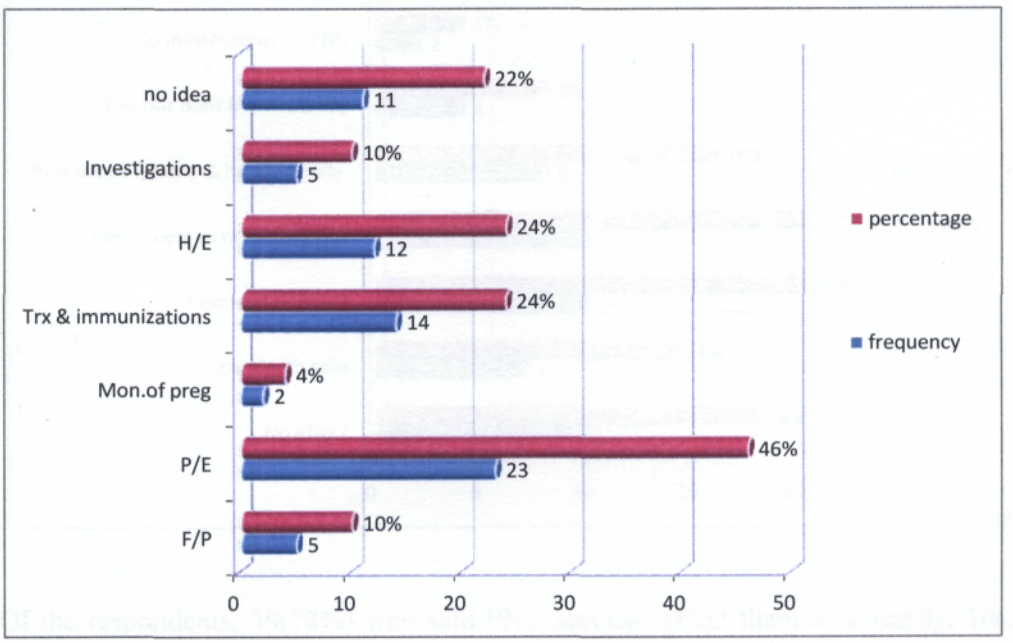
The figure above shows that 19(38%) respondents got the information from health workers, 15(30%) from their partners, 6(12%) from peers, 4(8%) from mass media and 2(4%) from other sources such as collage. Four (8%) had no information of PNC services

**Table 4:3 Knowledge of the activities done at PNC clinic (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| Yes | 39 | 78% |
| No | 11 | 22% |
| **TOTAL** | 50 | 100% |

More than half, 39(78%) of the respondents had knowledge of what happens at PNC clinic.

**Figure 4.2: At least two activities done at PNC services (n=50)**



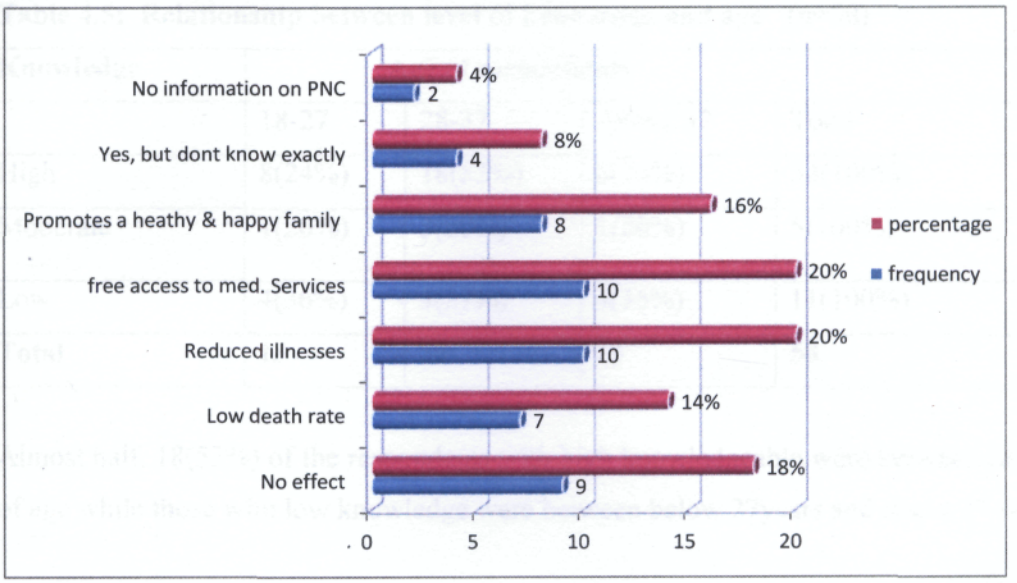

Majority of the respondents, 23(46%) mentioned physical examination being an activity done at PNC, 12(24%) mentioned health education, another 12(24%) mentioned either treatment of any ailment after delivery or immunization to the baby, 5(10%) mentioned family planning and another 5(10%) mentioned investigations. Two (4%) of the respondents mentioned monitoring of pregnancy being an activity done at PNC.

**Table 4.4 Effects of PNC on the family (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| Yes | 39 | 78.0 |
| No | 9 | 18.0 |
| Don't know | 2 | 4% |
| **TOTAL** | 50 | 100.0% |

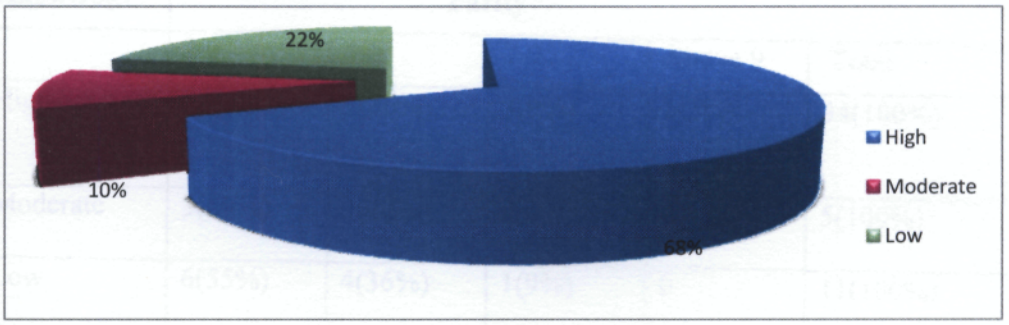
Table 4.4 shows that more than half of the respondents, 39(78%) said the PNC activities affected them as a family and gave different reasons while 9(18%) mentioned that the activities did not affect them.

**Figure 4.3: How PNC affects the family (n=50)**




Of the respondents, 39(78%) who said PNC services affect them as a family, 10(20%) said PNC services benefited the family by reducing illnesses, another 10(20%) mentioned free access to medical services. Eighteen percent said it promoted a happy family, 7(14%) associated PNC activities to reduced death rates, 4(8%) said PNC activities affected them but could not explain how while 2(4%) had no information on PNC.

**Figure 4. 4: Total knowledge Levels (n=50)**




More than half 34(68%) of the respondents reported high knowledge levels, 5(10%) had moderate knowledge while 11(22%) had low knowledge on PNC services.

**RELATIONSHIP BETWEEN KNOWLEDGE AND DEMOGRAPHIC DATA**

**Table 4.5: Relationship between level of knowledge and age (n=50)**

| **Knowledge** | **Age of respondents** | | | |
|---|---|---|---|---|
| | 18-27 | 28-37 | Above 37 | Total |
| High | 8(24%) | 18(52%) | 8(24%) | 34(100%) |
| Moderate | 1(20%) | 3(60%) | 1(20%) | 5(100%) |
| Low | 4(36%) | 3(27%) | 4(36%) | 11(100%) |
| **Total** | **13** | **24** | **13** | **50** |

Almost half, 18(52%) of the respondents with high knowledgeable were between 28-37 years of age while those with low knowledge were between below 27years and above 37 years.

**Table 4.6: Relationship between level of knowledge and marital status (n=50)**

| **Knowledge** | **Marital status** | | | |
|---|---|---|---|---|
| | Single | Married | Divorced | Total |
| High | 2(6%) | 31(91%) | 1(3%) | 34(100%) |
| Moderate | 1(20%) | 4(80%) | 0 | 5(100%) |
| Low | 1(9%) | 10(91%) | 0 | 11(100%) |
| **Total** | **4** | **45** | **1** | **50** |

The majority of the respondents, 31(91%) with high knowledge levels were married.

**Table 4.7: Relationship between level of knowledge on PNC services and parity (n=50)**

| Knowledge | Parity | | | | |
|---|---|---|---|---|---|
| | 1-3 | 4-6 | 7-9 | Above 9 | Total |
| High | 21(62%) | 9(26%) | 3(9%) | 1(3%) | 34(100%) |
| Moderate | 3(60%) | 2(40%) | 0 | 0 | 5(100%) |
| Low | 6(55%) | 4(36%) | 1(9%) | 0 | 11(100%) |
| **Total** | **30** | **15** | **4** | **1** | **50** |

The table shows that 21(62%) of the respondents with high knowledge had 1-3 children.

**Table 4.8: Relationships between knowledge on PNC services and Religion (n=50)**

| Knowledge | Religious Denomination | | | | | |
|---|---|---|---|---|---|---|
| | Roman Catholic | SDA | Jehovah's witness | Pentecostal | Others | **Total** |
| High | 4(12%) | 20(58%) | 4(12%) | 4(11%) | 2(6%) | 34(100%) |
| Moderate | 0 | 2(40%) | 1(20%) | 1(20%) | 1(20%) | 5(100%) |
| Low | 2(18%) | 2(18%) | 0 | 3(27%) | 4(36%) | 11(100%) |
| **Total** | **6** | **24** | **5** | **8** | **7** | **50** |

More than half 20(58%) of the respondents who had high knowledge were SDA while 4(36%) with low knowledge belonged to other denominations.

**Table 4.9: Relationship between knowledge on PNC services and education (n=50)**

| Knowledge | Level of education | | | | |
|---|---|---|---|---|---|
| | Never been to school | primary | Secondary | Tertiary | Total |
| High | 1(3%) | 13 (38%) | 13(38%) | 7(21%) | 34 (100%) |
| Moderate | 0 | 1(5%) | 3(14%) | 1(12%) | 5 (100%) |
| Low | 1(9%) | 5(45.5%) | 5(45.5%) | 0 | 11(100%) |
| **Total** | **2** | **19** | **21** | **8** | **50** |

Table 4.9 above shows that the majority of the respondents, 26(76%) with high knowledge had been to either primary or secondary school.

**Table:4.10: Relationship between knowledge and occupation (n=50)**

| **Knowledge** | **Occupation** | | | | | |
|---|---|---|---|---|---|---|
| | Non | Farmer | Self employed | Formally employed | General worker | Total |
| High | 4(12%) | 9(26%) | 4(12%) | 8(24%) | 9(26%) | 34(100%) |
| Moderate | 0 | 0 | 2(40%) | 2(40%) | 1(20%) | 5(100%) |
| Low | 1(9%) | 0 | 4(36%) | 0 | 6(55%) | 11(100%) |
| **Total** | **5** | **9** | **10** | **10** | **16** | **50** |

Of the respondents who presented with knowledge, 8(24%) were formerly employed and 9(26%) were general workers.

SECTION C

**4.2.3 Attitude towards PNC Services**

**Table 4.11: Decision making on seeking PNC services (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| Husband | 1 | 2.0% |
| Wife | 18 | 36.0% |
| Both | 31 | 62.0% |
| **TOTAL** | **50** | **100.0%** |

More than half, 31(62%) of the respondents made the decision to seek PNC services as a couple while 18(36%) was made by the wife and 2% was made by the husband.

**Table 4.12: Likely hood of accompanying partner to PNC services (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| Very likely | 27 | 54% |
| Somewhat likely | 15 | 30% |
| Somewhat unlikely | 2 | 4% |
| Not likely at all | 6 | 12% |
| **TOTAL** | 50 | 100% |

More than half of the respondents 27(54%) were more likely to accompany their partners to PNC reviews while 6(12%) said they were not likely at all to accompany their partners for PNC services.

**Table 4.13: The role of men in PNC services (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| A large role | 41 | 82% |
| A medium role | 3 | 6% |
| A small role | 5 | 10% |
| No role at all | 1 | 2% |
| **TOTAL** | 50 | 100% |

Majority of the respondents, 41(82%) said men had a large role in PNC services while 1(2%) said that men have no role all in PNC.

**Table 4.14: Should Men accompany partner to PNC (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| Yes | 50 | 100% |
| No | 00 | 00 |
| **TOTAL** | **50** | **100%** |

All the respondents, 50(100%) said it was okay for husbands/partners to accompany their partners for PNC reviews.

**Table 4.15: Importance of boys and men learning about RH (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| Very important | 43 | 86% |
| Somewhat important | 7 | 14% |
| **TOTAL** | **50** | **100%** |

Majority of the respondents, 43(86%) said it was very important for boys and men to learn about RH.

**Table 4.16: Men's views on the benefit of PNC services (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| Yes, beneficial | 44 | 88% |
| No, not beneficial | 6 | 12% |
| **TOTAL** | **50** | **100%** |

Majority of the respondents, 44(88%) said PNC services were beneficial to their families.

**Table 4.17: Total level of attitude**

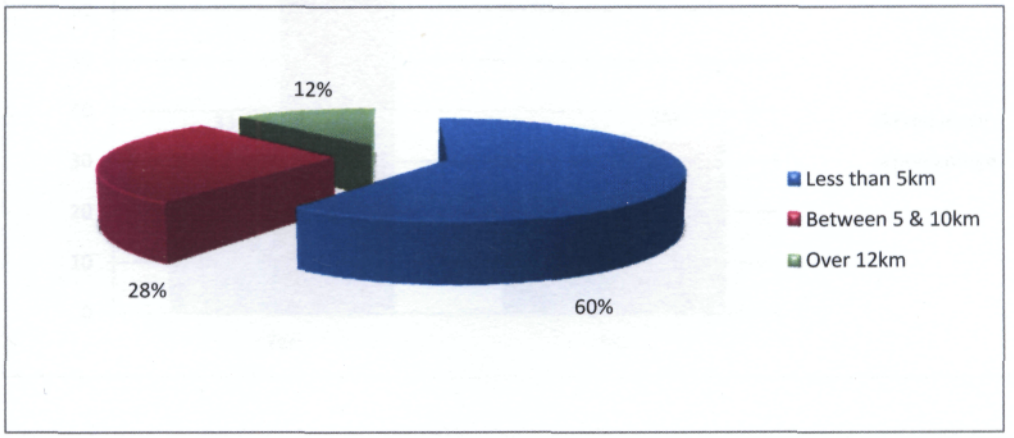
| | FREQUENCY | PERCENTAGE |
|---|---|---|
| Positive attitude | 50 | 100% |
| Negative attitude | 00 | 00% |
| **TOTAL** | **50** | **100%** |

All the respondents 50(100%) had a positive attitude towards PNC services.

**SECTION D:**

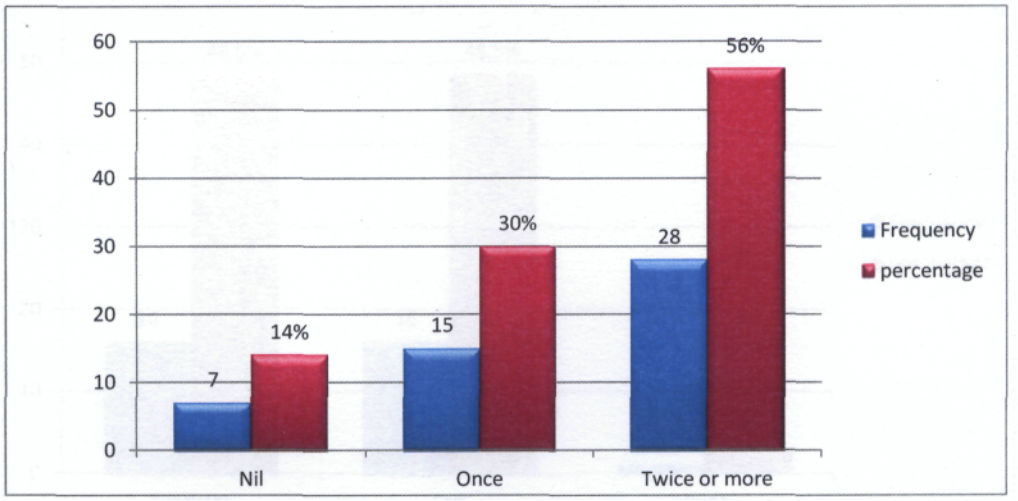
**4.2.4: Practice of Men towards PNC Services**

**Figure 4.5: Distance of house from health facility (n=50)**



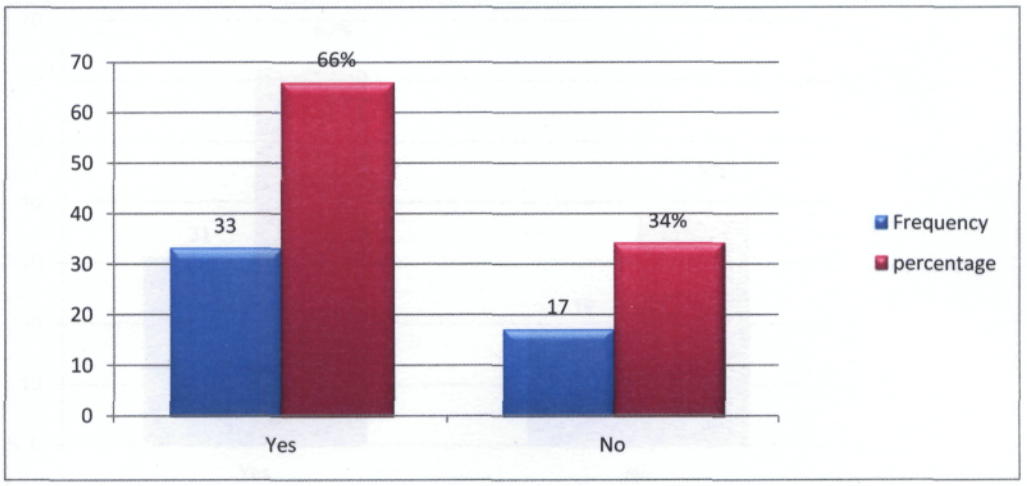

Thirty (60%) of the respondents lived within 5km radius from the health facility while only 6(12%) lived more than 12km from the health facility.

**Figure 4.6: Frequency on seeking PNC services after delivery (n=50)**



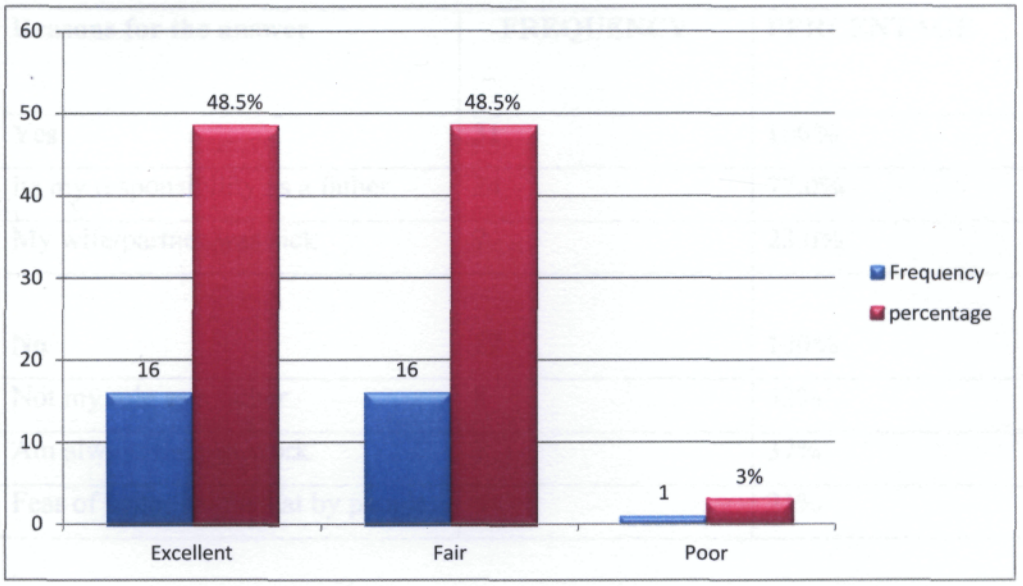

Half, 28(56%) of the respondents, reported having sought PNC services at least twice after the partner had given birth, 15(30%) said only once while 7(14% ) of the respondents never went for PNC services after birth.

**Figure 4.7: Accompanying partner for PNC (n=50)**



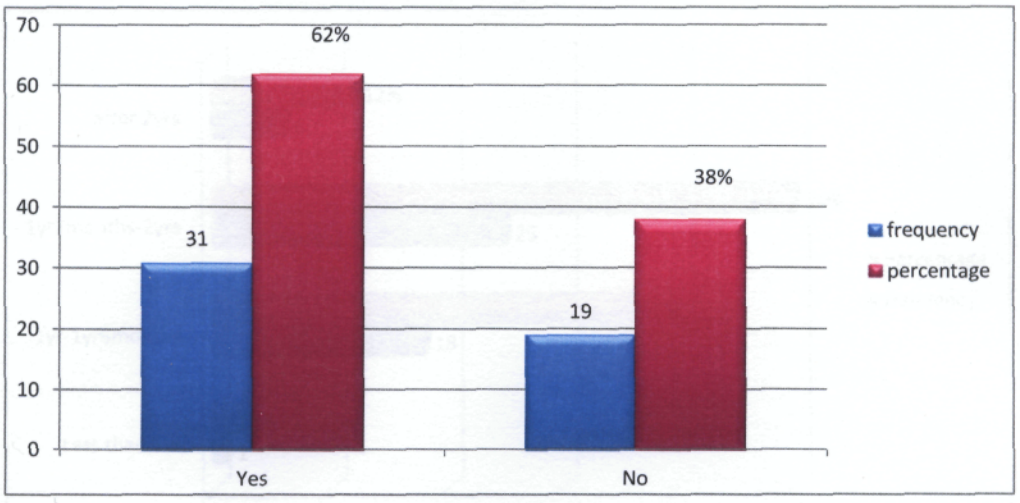

More than half, 33(66%) of the respondents indicated that they had accompanied their partners while 17(345) said they had never accompanied their partners before.

**Figure 4.8: Treatment by the health personnel (n=50)**




Almost half 16(48.5%) of the respondents who accompanied their partners indicated that they received excellent treatment from the health personnel with another 16(48.5%) saying the treatment was fair while only 1(3%) said the treatment was poor.

**Figure 4.9: Taking child for under five clinic (n=50)**



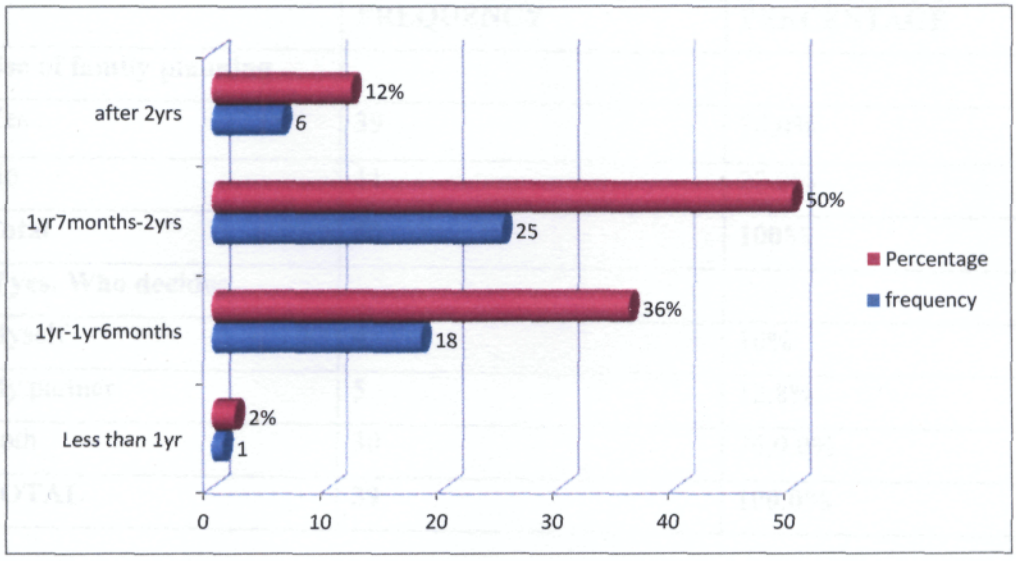

Majority of the respondents 31(62%) said they had taken their children to the under 5 clinic before.

**Table 4.18: Reasons for taking /not taking the child to under 5 clinic (n=50)**

| Reasons for the answer | FREQUENCY | PERCENTAGE |
|---|---|---|
| **Yes** | **31** | **100%** |
| Its my responsibility as a father | 24 | 77.0% |
| My wife/partner was sick | 7 | 23.0% |
| **No** | **19** | **100%** |
| Not my role as a father | 8 | 42% |
| Am always busy at work | 7 | 37% |
| Fear of being laughed at by people | 4 | 21% |

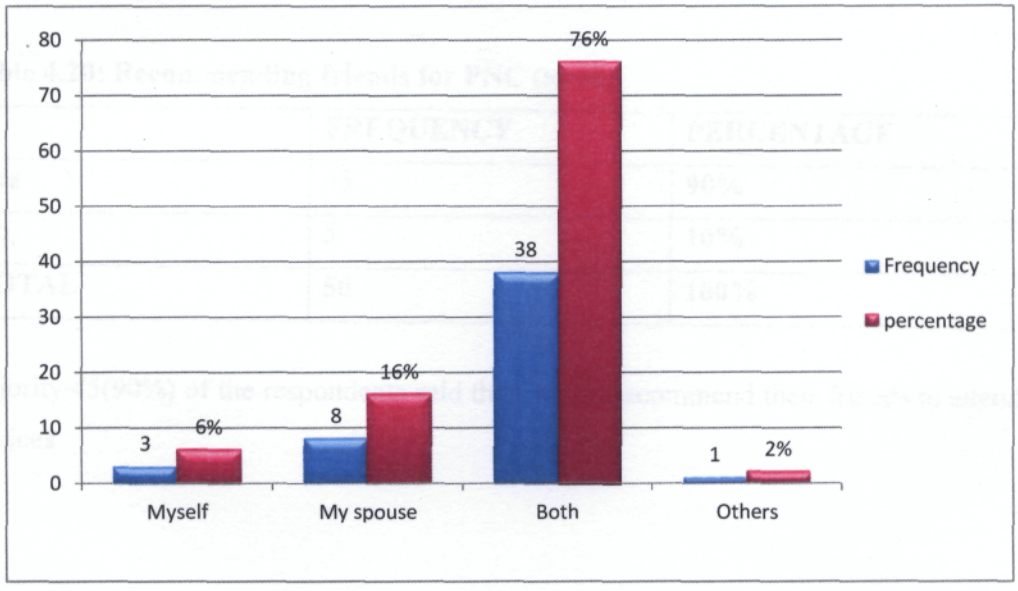
Majority of the respondents, 24(77%) who took their children for under five clinic said they did it because it was their role as fathers while of the 19(38%) respondents who never took their children, 8(42%) said it was not their role, 7(37%) said they were always busy at work while 4(21%) said they were scared of being laughed at by the people

**Figure 4.10: Time of weaning (n=50)**




Half, 25(50%) of the respondents weaned their children between 1year 7months

**Figure 4.11: Decision on when to wean the child (n=50)**




More than half of the respondents 38(76%) made the decision as a couple, 8(16%) was made by the partner, 3(6%) by the man while 1(2%) was made by others (grandmother).

**Table 4.19: Use of Family Planning (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| **Use of family planning** | | |
| Yes | 39 | 78.0% |
| No | 11 | 22.0% |
| **Total** | **50** | **100%** |
| **If yes, Who decides** | | |
| Myself | 4 | 10% |
| My partner | 5 | 12.8% |
| Both | 30 | 76.9.0% |
| **TOTAL** | **39** | **100.0%** |

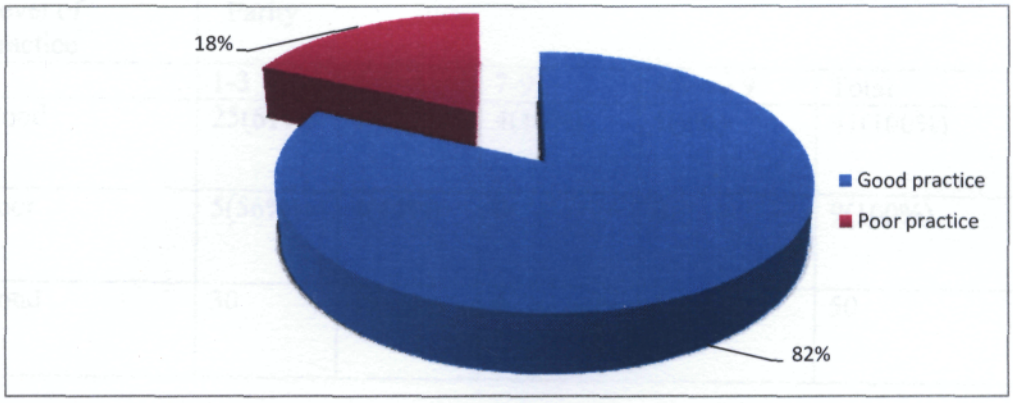
Majority of the respondents, 39(78%) utilized family planning (F/P) services while 11(22%) of the respondents did not. Of the 39(100%) respondents who used F/P, 30(77%) made a collective decision as a couple, 5(13%) was made by the partner and 4(10%) made the decisions themselves.

**Table 4.20: Recommending friends for PNC (n=50)**

| | FREQUENCY | PERCENTAGE |
|---|---|---|
| Yes | 45 | **90%** |
| No | 5 | **10%** |
| **TOTAL** | **50** | **100%** |

Majority 45(90%) of the respondents said they would recommend their friends to attend PNC services

**Figure 4.12 Total level of practice (n=50)**




Majority 41(82%) of the respondents had good practice while 9(18%) had poor practice.

## RELATIONSHIP BETWEEN PRACTICE AND DEMOGRAPHIC DATA

**Table 4.21: Relationships between Practice and age (n=50)**

| Practice | Age of respondents | | | |
|---|---|---|---|---|
| | **18-27** | **28-37** | **Above 38** | **Total** |
| **Good** | 11(27%) | 19(46%) | 11(27%) | **41(100%)** |
| **Poor** | 2(22%) | 5(56%) | 2(22%) | **9(100%)** |
| **Total** | **13** | **24** | **13** | **50** |

The majority 19(46%) of the respondents who had good practice were between ages 28 and 37years while the majority 5(56%) of those who had poor practice were in the some age group.

**Table 4.22: Relationships between level of practice and marital status (n=50)**

| Practice | Marital status | | | |
|---|---|---|---|---|
| | Single | Married | Divorced | Total |
| Good | 1(3%) | 39(95%) | 1(2%) | **41(100%)** |
| Poor | 3(33%) | 6(67%) | 0 | **9(100%)** |
| **Total** | **4** | **45** | **1** | **50** |

More than two thirds, 39(95%) of the respondents with good practice were married.

**Table 4.23: Relationship between level of practice and parity (n=50)**

| Level of Practice | Parity | | | | |
|---|---|---|---|---|---|
| | 1-3 | 4-6 | 7-9 | Above 9 | Total |
| Good | 25(61%) | 11(27%) | 4(10%) | 1(2%) | 41(100%) |
| Poor | 5(56%) | 4(44%) | 0 | 0 | 9(100%) |
| Total | 30 | 15 | 4 | 1 | 50 |

More than half, 25(61%) of the respondents who had good practice had 1-3 children

**Table 4.24: Relationships between level of practice and Religion (n=50)**

| **Practice** | **Religious Denomination** | | | | | |
|---|---|---|---|---|---|---|
| | Roman Catholic | SDA | Jehovah's witness | Pentecostal | Others | **Total** |
| Good | 4(10%) | 20(48%) | 4(10%) | 6(15%) | 7(17%) | **41(100%)** |
| Poor | 2(22%) | 4(44%) | 1(12%) | 2(22%) | 0 | **9(100%)** |
| **Total** | **6** | **24** | **5** | **8** | **7** | **50** |

Almost half 20(48%) of the respondents, who had good practice belonged to SDA church.

**Table 4.25: Relationships between level of practice and education (n=50)**

| **Practice** | **Level of education** | | | | |
|---|---|---|---|---|---|
| | Never been to school | primary | Secondary | Tertiary | **Total** |
| Good | 1(2%) | 14(34%) | 19(47%) | 7(17%) | **41(100%)** |
| Poor | 1(11%) | 5(56%) | 2(22%) | 1(11%) | **9(100%)** |
| **Total** | **2** | **19** | **21** | **8** | **50** |

The majority of the respondents, 19(47%) who had good practice had been to secondary school while 5(56%) of those who had poor practice had only gone up to primary level of their education.

**Table 4.26: Relationships between Practice and Occupation (n=50)**

**Table 4.26: Relationships between Practice and Occupation (n=50)**

| Practice | Occupation | | | | | |
|---|---|---|---|---|---|---|
| | Non | Farmer | Self employed | Formally employed | General worker | **Total** |
| Good | 4(10%) | 8(20%) | 8(20%) | 10(24%) | 11(26%) | **41(100%)** |
| Poor | 1(11%) | 1(11%) | 2(22%) | 0 | 5(56%) | **9(100%)** |
| **Total** | **5** | **9** | **10** | **10** | **16** | **50** |

Ten (24%) of those formerly employed and 11(26%) of the general workers had good practice

**Table 4.27: Relationship between Distance to health facility and Practice (n=50)**

| Level of practice | Distance from health facility | | | |
|---|---|---|---|---|
| | Less than 5km | Between 5 and 12km | Over 12km | **Total** |
| Good | 24(58%) | 11(27%) | 6(15%) | **41(100%)** |
| Poor | 6(67%) | 3(33%) | 0 | **9(100%)** |
| **Total** | 30 | 14 | 6 | **50** |

More than half, 24(58%) of the respondents with good practice lived within 5km radius

**SECTION E:**

**RELATIONSHIP BETWEEN KNOWLEDGE, ATTITUDE AND PRACTICE**

This section looks at the study variables and seeks to prove the hypotheses for the study.

**Table 4.28: Relationships between Knowledge and Practice (n=50)**

| Level of practice | Level of Knowledge | | | |
|---|---|---|---|---|
| | High | Moderate | Low | |
| Good | 31(75%) | 4(10%) | 6(15%) | **41(100%)** |
| Poor | 3(33%) | 1(11%) | 5(56%) | **9 (100%)** |
| **Total** | **34** | **5** | **11** | **50** |

Table 4.28 above show that the majority of the respondents, 31(75%) who had good practice had high levels of knowledge while 5(56%) of those who had poor practice had low knowledge levels.

**Table 4.29: Relationships between Knowledge and Attitude (n=50)**

| Level of knowledge | Level of attitude | | |
|---|---|---|---|
| | Positive | Negative | Total |
| High | 34 | 0 | **34(100%)** |
| Moderate | 5 | 0 | **5(100%)** |
| Low | 11 | 0 | **11(100%)** |
| **Total** | **50** | **0** | **50(100%)** |

All the respondents, 34(100%) who had high levels of knowledge and 11(100%) of those who had poor practice still had a positive attitudes towards PNC services.

**Table 4.30: Relationships between Practice and Attitude (n=50)**

| Level of practice | Level of attitude | | |
|---|---|---|---|
| | Positive | Negative | **Total** |
| Good | 41 | 0 | **41(100%)** |
| Poor | 9 | 0 | **9(100%)** |
| **Total** | **50** | **0** | **50** |

The above table shows that all the respondents, 41(100%) with good practice levels and 9(100%) of those who had low practice levels had a positive attitude towards PNC services.

**SECTION F: RESPONDENTS' SUGGESTIONS**

**Table 4: 31: Suggestions from respondents in relation to PNC services**

| Suggestions | Frequency | Percentage |
|---|---|---|
| Male involvement should continue | 21 | 42 |
| Improve on information dissemination so that all men can be informed on the importance of PNC | 5 | 10 |
| Health personnel should not keep men outside when they accompany their partners | 4 | 8 |
| PNC should stop as it is not beneficial because it exposes newborns to a lot of people and infections | 1 | 2 |
| Male involvement should stop | 2 | 4 |
| I prefer to have a workshop | 1 | 2 |
| No comments | 16 | 32 |
| **Total** | **50** | **100** |

Most of the respondents, 21(42%), recommended that male involvement in PNC should continue, 5(10%) said information dissemination should improve so as to sensitise more men on the importance of PNC services. Eight respondents (16%) said men should not be kept outside when they accompany their partners for PNC while 4(8%) said PNC exposes new born babies to infections and should not be encouraged while 2(4%) said male involvement should be stopped as it is not good for a men to be in the company of women, 1(2%) of the respondents said they preferred to have a workshop to talk about PNC services while 16(32%) had no comment.

# CHAPTER FIVE: DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

## Introduction

The discussion of the study is based on analysis of the data collected from a sample of fifty (50) respondents using an interview schedule. The general objective of the study was determining knowledge, attitude and practice of men towards postnatal services in Mazabuka district. The chapter also includes the implications of the findings to the health care system, recommendations drawn from the findings and the study limitations.

The research findings are discussed according to the three research objectives.

These objectives were to determine

1. The level of knowledge on postnatal care services among men in Mazabuka District.
2. The attitude of men towards PNC services in Mazabuka district.
3. The practice of men towards PNC services in Mazabuka district

## 5.1 Characteristics of the sample

This study was carried out on fifty (50) men above the age of 17 and had a child before. The key background characteristics included age, marital status, parity, religious denomination, educational level and occupation.

Forty eight percent (48%) of the respondents were aged between 28 and 37 years, 13(26%) were aged between 18 and 27 years, another 26% were above 38 years (Table 4.1). This shows that most of the respondents were young and almost similar to a study done by Islam R et al (2009) in the study Antenatal and Postnatal care seeking behavior in a matrilineal society were 70.2% of the respondents ranged between 25 and 35 years. The majority of the respondents, 45(90%) were married, 1(2%) were divorced and 4(8%) were single. This shows that the majority of the men seeking health services from the health facilities were married. More than half of the respondents, 30(60%) had 1-3 children, 15(30%) had 4 to 6 children, 4(8%) had 7-9 children and only 1(2%) had more than 9 children (Table 4.1). This could be as a result of increased access and utilization of family planning services by couples; hence, people have smaller families. All the respondents, 50(100%) were Christians and almost half, 24(48%) belonged to the seventh day Adventist church (SDA), 8(16%) were Pentecostals, 7(14%) belonged to other Christian denomination, 6(12%) were Catholics and 5(10%) belonged to the Jehovah's Witness Organisation (Table 4.1).

All the respondents, 50(100%) were Christians possibly because of the declaration of Zambia as a Christian nation and the majority belonged to SDA possibly because this denomination originated from the southern province of the country. Slightly over one third of the respondents 21(42%) attained secondary education, 19(38%) attained primary education and 8(16%) attained tertiary education while only 2(4%) had never been to school. This is similar to the study done by Islam R et al (2009) on Antenatal and Postnatal care seeking behavior in a matrilineal society in Bangladesh where most of the respondents (42.2%) had secondary education. For Zambia, this could be as a result of the increase on the number of schools especially basic schools. This result confirms the findings of ZDHS (2007), which shows that the proportion of those who have attained primary and secondary education is increasing steadily. However, the levels of those who attained tertiary education were still low. The findings further indicate that 16(32%) of the respondents were general workers, 10(20%) were self employed and another 10(20%) were in formal employment; 9(18%) were farmers and 5(10%) had no occupation (Table 4.1). Mazabuka district is surrounded by farms and this could suggest why most of the respondents were general workers in the surrounding farms.

## 5.2 Discussion of each Variable

### 5.2.1 Knowledge of men towards PNC services

This section discusses the knowledge of men towards PNC services. It includes information from the tables on knowledge about awareness of the availability of services, the source of the information, knowledge of what goes on at PNC, effect of PNC on the family and any known benefits of PNC services to the family.

The study revealed that more than half, 34(68%) of the respondents had high knowledge on PNC services and most of the respondents, 19(38%) got the information from the health workers followed by 15(30%) who got the information from their partners/wives (figure 4:1). This does not correlate with the studies: Involvement of men in reproductive health in Jammu and Kashmir, India by Varkey et al (2004) which reported that a higher proportion of men reported exposure to RH messages such as family planning through the radio and Television; And Reproductive health services for refuges by refuges in Guinea by Howard et al (2008) where despite Reproductive Health Group (RHG) facilitators being the primary source of reproductive health information for all respondents, more men than women obtained information from non-health sources, such as friends and the media. Most of the respondents who presented with high knowledge levels, 18(52%) were aged between 28 and 37 years.

While most of those with low knowledge levels were aged below 27 years and above 37 years and above (Table 4:5). This could suggest that the medium the age, the more positive influence on men's willingness to learn and be involved in PNC services.

Majority of the respondents, 31(91%) with high knowledge levels were married and almost half, 15(44%) of those with high knowledge got the information from the health workers. This could be as a result of the increased efforts by health personnel in information dissemination on SMH/SRH/PNC and this should be encouraged so as to empower more men with knowledge on PNC services. Respondents who had 1 to 3 children had high knowledge (Table 4.7). This could be attributed to the families' commitment due to limited number of children. This may also indicate that young and inexperienced couples were more willing to learn through their participation in PNC services. Generally in terms of knowledge, the study revealed that most men were knowledgeable (Figure 4:4). This contradicts the study done by Mullany B.C (2005) on Barriers to and attitudes towards promoting husbands' involvement in maternal health in Katmandu, Nepal, where most men had low levels of knowledge which was found to be one of the most prominent barriers to male involvement in maternal health.

### 5.2.2 Attitude of men towards PNC services

Traditionally, men are believed to be decision makers, hence influence the health care seeking behaviour for the whole family. However, with greater emphasis on male involvement in SRH, this notion is slowly fading out. For example in this study, all the 50(100%) respondents demonstrated a positive attitude towards PNC services (Table 4.17). Most of the respondents, 31(62%) made decisions to seek PNC services as a couple while others left the decision to be made by the wife (Table 4.11). The study further revealed that the likely hood of men accompanying their partners for PNC was very high, 27(54%), (Table 4.12) and that men, 41(82%) realised their large role in PNC services (Table 4.13). Most of the respondents, 43 (86%) admitted the importance of boys and men learning about RH/SMH (Table 4.15) and the benefits which go with it (Table 4.16).

Generally, these findings indicate a positive attitude towards PNC services. The results could be attributed to the current Government policies such as the Zambia Reproductive Health Policy (2005), in which male involvement is emphasised. This was adopted at the ICPD of 1994 which emphasised on male involvement in maternity services though this has mostly been pronounced in ANC services.

Awareness programmes on male involvement in RH have been created following the notion that opportunities have to be offered to involve men in all aspects of SRH (ZRHP, 2005). This could be a possible contributor to men's understanding of the effects of PNC services to their families such as loss of their loved ones (women and neonates) and hence the zeal to be involved in every way possible. However, this is contrary to the findings of Roudsari et al (2006) in a study; Reproductive health knowledge, attitudes and practices of Iranian and Afghan men in Tehran province and; Byamugisha et al (2010) in a study; determinants of male involvement in PMTCT programme in Mbaye district of Uganda where the qualitative data obtained revealed that attitude in both studies was low/negative among the men and a major obstacle to effective utilisation of the RH services.

### 5.2.3 Practice of men towards PNC services

This section discusses the practice of men towards PNC services. It includes information from the tables and figures on practice in relation to distance, how often the couple seeks PNC services after delivery, if the men ever accompany their partners for PNC service, if they have ever taken their children to under 5 clinic and reasons for the answer given in relation to their involvement in PNC services.

The respondents who lived within 5km radius demonstrated good practice (Table 4:26). This could be as a result of limited costs involved in terms of transport. The results further revealed that more than half, 28(56%) sought PNC services at least twice after delivery either as a couple or not (Figure 4.6) while 33(66%) accompanied their partners for PNC services (Figure 4.7). However, this does not tally with a study done by Byamugisha et al (2010) where only 5% of men accompanied their partners to ANC services. Those who accompanied their partners, 16 (48.5%) said the treatment by health personnel was excellent (Figure 4:8). The majority of the men, 31(62%) took their children to under five clinics (figure 4:9). Of those who never did, 19(36%), reasons given included; fear of being laughed at by people (shyness), not their role as fathers (cultural-social stigma) and busy working schedules (Table 4:18). These results correlate with the study done by Mullany B.C (2005) in Katmandu, Nepal, where the most prominent barriers to male involvement in maternal health included social stigma, shyness /embarrassment and job responsibilities. The results further revealed that those who had attained secondary education had good practice; this could probably be due to easy understanding of the concept of PNC services.

These findings match with those of Byamugisha et al (2010) where men who had attained secondary education had a high male involvement index than those who had primary or no formal education. The examination of the relationship between numbers of children born with male participation proved that there is higher involvement / good practice from couples with less than 3 children (Table 4.23). This is similar to the study done by Islam R et al (2009) in a study Antenatal and Postnatal Care Seeking Behavior in a Matrilineal Society in Bangladesh which revealed that respondents with 3 or more children where less likely to seek ANC and PNC services. Of the respondents with poor practice, 3(33%) where single, this shows that there is need to encourage the single fathers to seek health care services where they can get information on RH. When it came to decision making towards RH services such as weaning the child and family planning, the study revealed that most decisions where made collectively as a couple followed by partners (Figure 4:11; Table 4:19). This does not agree with the study done in Indonesia in 2009 by Vita Yulia Dewi on Factors that Influence Male Participation in Family Planning and Reproductive Health where a large percentage of men (88.4%) made decisions regarding contraceptive use by their wives.

Generally, the study revealed that majority 41(82%) of the respondent had good practice levels (figure 4:12). This could be as a result of the high levels of knowledge as seen in Figure 4.4 where 68% had high knowledge. However, there is still need to encourage men to get involved since, 9(18%) still had poor practice towards PNC services (Figure 4.12).

### 5.2.4 Relationship among variables

This section looks at the relationship that exists between the three variables in this study which include knowledge, attitude and practice of men towards PNC services. All the 50(100%) respondents had positive attitude towards PNC services (Table 4.17). Of the respondents, 41(82%) with good practice, 31(75%) had high knowledge levels (Table 4.28). All the 34(100%) respondents with high knowledge levels had a positive attitude including all the respondents, 11(100%) with low knowledge levels (Table 4.29). However, this is contrary to the study done by Islam R et al (2009) where knowledge determined attitude on health care seeking behaviour. In this study knowledge does not seem to determine attitude because the respondents who had low knowledge levels still presented with positive attitude (Table 4.29). Nine respondents, (18%) had poor practice towards PNC services despite the positive attitude (Table 4.30), this is similar to the results in a study; Involving men in maternity care in South

Africa by Mullick et al (2004) which revealed that despite some men having a positive attitude their practices were low because they did not have knowledge on the availability and importance of their involvement in maternity care services.

Therefore, in this study, adequate knowledge and a positive attitude seems to be major determining factors and a positive influence on practice/health care seeking behaviour. This shows that there is need to continue educating the communities especially men on issues of PNC services/RH and promote their practice by encouraging them to continue seeking PNC services and also recommending PNC services to their fellow men. The findings in this study may suggest that an increase in male involvement may have a positive influence on the utilisation of PNC service by both men and women in Mazabuka district.

## 5.3 IMPLICATION TO THE HEALTH CARE SYSTEM

The health care system has an important and leading role in the dissemination of information on Male involvement in SMH/SRH particularly PNC services. Men being decision makers need to be encouraged and accommodated in the RH and SMH programmes in both the private and public health institutions nation wide. Increase in the involvement of men in PNC services may determine their partners' utilization and hence increase the PNC coverage which can help reduce the maternal and neonatal morbidity and mortality rates resulting from negligence and delays in seeking health care services after delivery.

### 5.3.1 To Nursing practice

According to the findings of this study, 50(100%) of the respondents had a positive attitude towards PNC services and most, 19(38%) respondents got the information from the health workers (Figure 4:1). This means that the health workers are doing a good job and should be encouraged to continue. However, it is important for the nursing staff and other health workers including community based agents to increase efforts towards informing and educating the community on the importance of male involvement in PNC.

There is need for the health care system together with individual men to unite and help educate the men within the communities on the importance of their involvement in RH/SMH issues. It could be important to emphasis male involvement throughout the reproductive cycle so that when men are involved right from the beginning their knowledge levels would be enriched and their practice would be good.

### 5.3.2 To Nursing Research

Involving men in PNC would contribute to the healthy outcomes of women and babies after delivery and reduce complications that come with the pregnancy and birthing process and other complications that may arise after delivery. There is, therefore, need to carry out more research on how to find better ways of involving men in RH and SMH programmes. More research should also be done targeting men and their accessibility to PNC services hence improve on the PNC coverage country wide.

### 5.3.4 To Nursing Administration

Leadership is very critical in male involvement in reproductive health. Through good leadership, male involvement strategies can be improved by collaboration with both non governmental and governmental partners supporting safe motherhood while working with community influential leaders like councillors, members of parliament, chiefs and village headmen to encourage men to utilize the available RH services. It is important to deal with the challenges such as improving staffing to shorten the long waiting time in order to motivate the male clients to attend PNC.

Infrastructure for MNCH departments should be improved to increase space at PNC clinic so that each couple could have enough privacy as they are being attended to. Poor infrastructure could be one of the reasons men are asked to remain outside the examination room while their partners are being attended to (Table 4:30). There is also need to intensify integration of services so as to incorporate more men in the RH unit.

### 5.3.5 To Nursing Education

Nurses should receive education on how to incorporate men in SRH/SMH issues without making them feel uncomfortable. Men are also attracted to reproductive health clinics that offer a wider range of high quality services (including family planning, treatment of sexually transmitted infections, counselling, sex therapy, urology and general medicine). Therefore, the nursing schools should aim and ensure that they produce nurses who are competent enough to handle a variety of health issues that a couple may present with during the PNC visit and be able to provide RH information to the couple on a variety of subjects.

There is need to train more males in RH programmes. In Zambia, the nursing profession is female dominated and gender sensitivity in the delivery of services is somehow overlooked. The scarcity of male staffs at health facilities could possibly be discouraging more men from seeking the services, hence, the low practice levels in some men.

If more men are incorporated to offer RH services, men probably won't feel shy or fear to be laughed at when they seek the service seeing that some of the service providers are men just like them.

## 5.4 CONCLUSION

The study sought to determine the Knowledge, attitude and Practice of men towards PNC services in Mazabuka district. A structured interview schedule was used to collect information. The sample was drawn from fifty (50) men from 5 clinics who were purposively selected and a written consent was obtained from each respondent before they answered the questionnaire.

The objectives of this study were achieved through the findings which revealed that men had a positive attitude towards PNC services. The results further revealed that the majority of the respondents had high knowledge levels and good practice towards PNC services. However, though the majority of the respondents had a positive attitude, a few still had low knowledge levels and poor practice towards PNC services. This calls for consented efforts by all concerned personnel, senior management support through intensifying on information dissemination and education on the availability of the services as well as the benefits of PNC services not only for the men but for the family as a whole. Issues of infrastructure, staffing, outreach services among others should be considered to promote more male participation in RH/PNC services.

The study therefore accepts the hypotheses that; the less the knowledge on PNC services, the poor the practice towards the service. This is evidenced on Table 4.28 where 31(75%) of the respondents with high knowledge levels had good practice; and that Men with positive attitude towards PNC services had good practice (Table 4.30).

## 5.5 RECOMMENDATIONS

Men's participation in the care of their partners after delivery is an important strategy in improving maternal health. In order to succeed in this programme, concerted efforts are required by all co-operating Partners.

The following are the recommendations made:

### 5.5.1 To Ministry of Health

1. There is need to increase the staffing for nurses and midwives within the district to increase and improve service delivery. Therefore, MoH should consider revising the establishment for MDHO.
2. Dissemination of information through the media like Radio and Television to sensitize people on male involvement in RH/SMH with emphasis on male participation in PNC services and not only in ANC should be increased.

   The MoH; Health Education unit should also consider using local radios since majority of the community members are able to access these radio stations in most of our rural communities where the delays in seeking health services are so pronounced e.g. radio Chikuni and Radio Mazabuka.

### 5.5.2 To Mazabuka District Health Office

1. The DHO through the MCH coordinator should continue to sensitise the communities on the availability and importance of PNC services and the involvement on men in such programmes. This could be done through distributing posters, brochures and pamphlets which are male directed and IEC at every clinic e.g. ART clinic, ANC, FP clinic, Under 5 clinic, mobile ART clinic etc.
2. The DHO should improve on provision of transport to the clinics for the staff to conduct information dissemination to communities and outreach areas and offer the service to those who are in hard to reach areas where access to health services is not easy such as Namaila, cheba and Chikani communities among others.
3. A monitoring check list should be formulated to go along side the performance assessment tool to evaluate how well the information on male involvement in R/H is being disseminated to the community and if the efforts are yielding desired outcomes. Mentorship visits should continue so as to encourage those facilities which are not doing well and reinforce and motivate those facilities and staffs who are doing fine.
4. DHO should carry out a similar study in all Health Centres of the District using other selection techniques in order to obtain more accurate information and be able to generalize the findings to the entire District. More male directed researches should be conducted too. This could help identify other factors contributing to under utilisation of the PNC services in the district.

### 5.5.3 To out reach centres (The study health facilities)

1. There is need to explain everything being done to the woman and baby during the visit and portray a positive and welcoming attitude towards the couple so as to encourage them to come back and/or encourage other men to seek the PNC services.
2. Men should not be allowed to remain outside the examination room when they accompany their partners for PNC services so that they do not feel left out and not involved. This would also make them know that their role is not just escorting or transporting but that they are part of the whole PNC review and sole beneficiaries.
3. Couple counsellors and lay counsellors should be given the key messages so that they incorporate male participation in PNC when counselling couples right from ANC so that men appreciate their involvement throughout their partners' maternity circle.
4. The health centre in charges together with other staff should train Male Reproductive Health Motivators in order for them to reach out to the men in the community and work places and educate them on the importance of their participation in PNC.

## 5.6 DISSEMINATION OF FINDINGS

Dissemination of research findings is the diffusion or communication of research findings by presentation and publication to a variety of audiences, such as nurses, other health professionals, policy developers and consumers (Burns and Grove, 2005). It involves the measures that would be undertaken to make known to the relevant authorities and the study participants what the study has measured.

The researcher hopes to disseminate the information by writing reports to the relevant authorities through the Department of Nursing Sciences. These reports will go to MoH (the sponsor), Mazabuka DHO and the University of Zambia. The researcher also hopes to disseminate the research finding through the local radio station, Radio Mazabuka so that it benefits the whole community.

## 5.7 LIMITATIONS OF THE STUDY

The limitation of the study was that the sample size (50) was too small to be representative of the whole population of Mazabuka district. This was due to limited time and little resources to involve more respondents.

The other limitation was the criteria used to select the sample; purposive sampling. This meant that the respondents who came to the health facilities had the same characteristics and possibly had a positive attitude as observed in the 100% positive attitude among respondents.

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**APPENDIX I: QUESTIONNAIRE** **SN** 

**UNIVERSITY OF ZAMBIA**

**DEPARTMENT OF NURSING SCIENCES**

**STRUCTURED INTERVIEW SCHEDULE**

**TOPIC: DETERMINING KNOWLEDGE, ATTITUDE AND PRACTICE OF MEN TOWARDS POSTNATAL SERVICES IN MAZABUKA DISTRICT**

**DATE OF INTERVIEW:** .....

**PLACE OF INTERVIEW:** .....

**NAME OF INTERVIWER:** .....

**INSTRUCTIONS TO INTERVIEWER**

1. Introduce yourself to the respondent
2. Explain the purpose of the interview
3. Get written consent from the respondent and do not force them to be interviewed
4. Assure the respondent that his names and/or addresses will not be written on the interview schedule and that all responses will be held in strict confidence to ensure privacy and anonymity
5. Encourage respondents to answer all questions
6. Indicate response by ticking in the appropriate space for closed ended questions
7. Indicate response by filling in the spaces provided for open ended questions
8. Give the respondent an opportunity to ask questions at the end of the interview
9. Thank the respondent at the end of interview

**SECTION A: DEMOGRAPHIC DATA**

**FOR OFFICIAL USE**

1. How old were you on your last birthday?
   a. 18 – 27 years
   b. 28– 37 years
   c. Above 37 years
2. What is your marital status?
   a. Single
   b. Married
   c. Divorced
   d. Widowed
3. How many children do you have? _____
4. What is your Religious denomination?
   a. Roman Catholic
   b. Seventh Day Adventist
   c. Jehovah's Witness
   d. Pentecostal
   e. Others (Specify) _____
5. What is your highest level of education?
   a. Never been to school
   b. Primary
   c. Secondary
   d. Tertiary
6. What is your occupation? _____

**SECTION B: KNOWLEDGE OF PNC SERVICES**

7. Are you aware of postnatal care services offered in maternity Care at your health facility?
   a. Yes
   b. No
8. Where did you first get information about PNC
   a. Health workers
   b. Mass media
   c. wife/partner/Family members
   d. Peers
   e. Other, specify.....

9. Do you know what happens at the postnatal clinic?

   a. Yes

   b. No

10. Mention atleast 2 things/ activities done at postnatal clinic?

   a. .....

   b. .....

11. Do these PNC activities affect you as a family?

   a. Yes

   b. No

12. If yes to N° 11, specify how they affect you.

.....

.....

**SECTION C: ATTITUDE TOWARDS PNC SERVICES**

13. Whose decision should it be on when to seek PNC services?

   a. Husband
   b. Wife
   c. Both
   d. Other (specify)_____

14. How likely do you think you are to accompany your partner to PN review?

   a. Very likely
   b. Somewhat likely
   c. Somewhat unlikely
   d. Not likely at all

15. How large a role do you think the husband should have in Maternity Care and particularly postnatal care services?

   a. A large role

   b. A medium role

   c. A small role

   d. No role at all

16. Is it OK if a husband escorts his partner/wife for PN services

   a. Yes

   b. No

17. How important do you think it is that boys and men should learn about reproductive health?

    a. Very important
    b. Somewhat important
    c. Somewhat unimportant
    d. Not important at all

18. Are there any traditional / religious/ cultural beliefs that restrain Men from attending maternity / postnatal care services?

    a. Yes
    b. No

19. What is your view about the benefits of PN services to your family?
    .....

20. Kindly rate the response of men towards PNC services in your Community.

    a. Poor
    b. Good
    c. V. good

**SECTION D: PRACTICE TOWARDS PNC SERVICES**

21. How far is your house from the nearest health facility?

    a. Less than 5km
    b. Between 5 and 10km
    c. Over 12 km

22. How often do you seek postnatal services after your partner has given birth?

    a. Non
    b. Once
    c. Twice
    d. Thrice

23. Have you ever accompanied your partner for PNC services

    a. Yes
    b. No

24. If yes to Q24. How did the health personnel treat you?

    a. Excellent
    b. Fair
    c. Poor

25. Have you as the father ever taken your child to the under five clinic?

    a. Yes

    b. No

26. Give reasons to your answer to No 25.....

.....

27. When do you wean your children? .....

28. Who decides when to wean the child

    a. Myself

    b. My spouse

    c. Both

    d. Others, Specify.....

29. Do you use family planning methods as a couple?

    a. Yes

    b. No

30. If yes to N° 28, who decides when and what to use?

    a. Myself

    b. My spouse

    c. Both

31. Would you recommend your friends to attend postnatal care services?

    a. Yes

    b. No

Any comment.....

.....

**END OF INTERVIEW.**

**THANK YOU FOR YOUR PARTIPATION**

**APPENDIX II: CONSENT FORM**

Dear participant,

My name is Rabecca Lungu. I am a student at the University Of Zambia School of Medicine, Department of Nursing Sciences. I am pursuing a Bachelor of Science Degree in Nursing.

In partial fulfilment of the degree program, I am required to undertake a research project.

My study topic is **"Determining knowledge, attitude and practice of men towards postnatal services in Mazabuka district"** You have purposively been selected to participate in this study and I wish to inform you that participation in this study is voluntary and you are free to withdraw at any stage of the study if you wish to do so. You will be asked some questions about postnatal services. The information you will give me will be kept confidential and no name will be written on the questionnaire.

You will not receive direct benefits from the study or monetary gain but the information that you provide will help Mazabuka district health office and other relevant authorities in incorporating men in maternity care services such as postnatal services.

I (name).....

Of.....

On this day of...../...../2011 declared that I understand the purpose of this study and I am willing to participate.

Signature/Thumb print of respondent.....

Signature of interviewer.....

**APPENDIX III: PERMISSION LETTERS**

University of Zambia
School of Medicine, Dept of Nursing Sciences
P.O. Box 50110,
Lusaka.

14th October, 2011.

The District Medical Officer
Mazabuka District Health Office
P.O Box
Mazabuka

UFS: The Head of Department
School of Medicine, Department of Nursing Science
P. O. Box 50110
Lusaka.

Dear Madam

**RE: PERMISSION TO CONDUCT A PILOT STUDY IN MAZABUKA DISTRICT**
I am a final fourth (4th) year student pursuing a Bachelors' Degree in Nursing in the Department of Nursing Science at the University of Zambia, School of Medicine.

In partial fulfilment of the award of the Bachelor of Science Degree in Nursing, I am required to carry out a research project. My topic is "**Determining knowledge, attitude and practice of men towards postnatal services in Mazabuka district**". I therefore request for your permission to conduct interviews from 5 men from Nakambala urban clinic. The respondents will be required to answer the structured questions. I intend to carry out this exercise from 31st Oct to 1st November, 2011.

Your assistance in this regard will be highly appreciated.
Yours faithfully,

Lungu Rabecca (RN/RM)
**BSc. IV NURSING STUDENT**

University of Zambia
School of Medicine, Dept of Nursing Sciences
P.O. Box 50110,
Lusaka.

14th October, 2011.

The District Medical Officer
Mazabuka District Health Office
P.O Box
Mazabuka

UFS: The Head of Department
School of Medicine, Department of Nursing Sciences
P. O. Box 50110
Lusaka.

Dear Madam

**RE: PERMISSION TO UNDERTAKE A STUDY IN MAZABUKA DISTRICT**

I am a final fourth (4th) year student pursuing a Bachelors' Degree in Nursing in the Department of Nursing Science at the University of Zambia, School of Medicine.

In partial fulfilment of the award of the Bachelor of Science Degree in Nursing, I am required to carry out a research project. My topic is "**Determining knowledge, attitude and practice of men towards postnatal services in Mazabuka district**". I am therefore requesting for your permission to conduct interviews to the target population from 5 health facilities within the district. I intend to carry out this exercise for 10 days starting from 3rd to 16th November, 2011.

Your assistance in this regard will be highly appreciated.
Yours faithfully,

Lungu Rabecca (RN/RM)
**BSc. IV NURSING STUDENT**

# REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

Office of the District Director of Health
Mazabuka District Health Management Team
P.O. Box 670060
MAZABUKA

Tel: 30951/30624

Fax: 30532

**MH/EN/9591**

28th October. 2011

Ms Rabecca Lungu
University of Zambia
School of Medicine
**LUSAKA**

Dear Madam

**RE: REQUEST TO UNDERTAKE A STUDY IN MAZABUKA DISTRICT**

Reference is made to the above subject and to your letter dated 27th October, 2011 in which you requested permission to do a study on '**Determining knowledge, attitude and practice of men towards postnatal services**' in Mazabuka District as part of your research project.

I am pleased to inform you that management has no objection to your request and as such you are to conduct your interviews at Nakambala, Research, Magoye, Kaleya, and Mubuyu Health Centres for a period of two (2) weeks beginning 31st October 2011.

We wish you success in your study.

Ms. P. Mweni (A/HRMO)
**For/ACTING DISTRICT MEDICAL OFFICER**

Cc: The Head of Department, School of Medicine, Department of Nursing Science, UNZA, LUSAKA

**APPENDIX IV: WORK PLAN**

| TASK TO BE PERFORMED | PERSONNEL ASSIGNED TO TASK | DATES | PERSONAL DAYS REQUIRED |
|---|---|---|---|
| Literature review | Researcher & supervisor | Continuous | Continuous |
| Finalize research proposal | Researcher | 10rd Oct to 26th Oct, 2011 | 16 |
| Clearance from authority | Researcher | 13th Oct to 27th Oct 2011 | 14 |
| Pilot study | Researcher | 31st Oct to 1st Nov 2011 | 2 |
| Data collection | Researcher | 3rd to 16th Nov, 2011 | 10 |
| Data analysis | Researcher & supervisor | 28th Nov to 3rd January, 2012 | 30 |
| Report writing | Researcher | 3rd Jan to 22nd Jan 2012 | 20 |
| Submission of draft report to DNS | Researcher | 1stFeb to 25th Feb, 2012 | 25 |
| Submit corrected copy | Researcher | 11th march to 25th March, 2012 | 14 |
| Finalising report | Researcher | 25th march to 28th April 2012 | 33 |
| Final binding | Researcher | 29th April, 2012 | 2 |
| Dissemination of results | Researcher & supervisor | April, 2012 | 7 |
| Monitoring and evaluation | Researcher | Continuous | Continuous |

## APPENDIX V: BUDGET

| BUDGET CATEGORY | QUANTITY | UNIT COST ZK | TOTAL |
|---|---|---|---|
| **Stationary:** | | | |
| Bond paper | 3 | 30,000 | 90,000 |
| Pens | 5 | 500 | 2,500 |
| Pencils | 4 | 200 | 800 |
| Rubber | 2 | 1,500 | 3,000 |
| Note book | 2 | 5,000 | 10,000 |
| Markers | 3 | 2,000 | 6,000 |
| Staples | 1 | 12,000 | 12,000 |
| Stapler | 1 | 15,000 | 15,000 |
| Manila files | 4 | 1,500 | 6,000 |
| Tipex | 1 | 15,000 | 15,000 |
| Research Bag | 1 | 55,000 | 55,000 |
| Scientific calculator | 1 | 60,000 | 60,000 |
| **Subtotal** | | | **275,300** |
| **Typing Services** | | | |
| Research proposal | 60 pages | 3,000 per page | 180,000 |
| Questionnaire | 7 pages | 3,000 per page | 21,000 |
| **Photocopying**(Questionnaire) | 500 pages | 250 per page | 125,000 |
| Typing draft report | 60 pages | 3,000 per page | 180,000 |
| Typing final report | 60 pages | 3,000 per page | 180,000 |
| Photocopying report | 60 pages | 250 per page | 45,000 |
| Binding the report | 5 copies | 50,000 per copy | 250,000 |
| **Subtotal** | | | **996,000** |
| **Personnel** | | | |
| **Lunch allowance** | | | |
| Researcher | 10 days | 50,000 per day | 500,000 |
| Research Assistant | 10 days | 50,000 per day | 500,000 |

| BUDGET CATEGORY | QUANTITY | UNIT COST | TOTAL |
|---|---|---|---|
| **Transport cost**<br>Researcher | 10 days | 50,000 per day | 500,000 |
| Research Assistant | 10 days | 50,000 per day | 500,000 |
| **Subtotal** | | | **2,000,000** |
| **Total** | | | **2,996,000** |
| **10% contingency** | | | **299,600** |
| **GRAND TOTAL** | | | **3,295,600** |

**BUDGET JUSTIFICATION OF THE BUDGET**

In order for the research to be carried out successfully, stationery, secretarial services and personnel will be needed.

**STATIONARY:** The reams of paper will be used for drafting the research proposal, interview schedule and research report. The scientific calculator will be used during the data analysis for calculations. The other accessories such as pens, pencils and rubber will be required for the routine collection and entering of data.

**SECRETARIAL SERVICES:** Secretarial services will be required when typing, printing and photocopying the research proposal and the research report with the appendices. Binding of the research proposal and research report will also be done.

**PERSONNEL:** Lunch allowance will be needed because data collection may take the whole morning to try and find the respondents. Transport will also be needed to enable the researcher move from home to the Hospital.

**DISSEMINATION OF RESULTS:** The researcher will have to disseminate the findings, hence the need for the funds for logistics.

**APPENDIX VI: GANTT CHART**

| TASK PERFORMED | RESPONSIBLE PERSON | JUN | JUL | AUG | SEPT | OCT | NOV | DEC | JAN | FEB | MAR | APRIL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finalize research proposal | Researcher | | | | | ↔ | | | | | | |
| | | | | | | | | | | | | |
| Literature review | Researcher & supervisor | ← | | | | | | | | | | → |
| Pilot study | Researcher | | | | | ↔ | | | | | | |
| Data collection | Researcher | | | | | | ↔ | | | | | |
| Data analysis | Researcher & supervisor | | | | | | ← | → | | | | |
| Report writing | Researcher | | | | | | | | ↔ | | | |
| Submit draft report | Researcher | | | | | | | | ↔ | | | |
| Finalise research report | Researcher | | | | | | | | | | ↔ | |
| Submit corrected copy | Researcher | | | | | | | | | | → | |
| Final binding | Researcher | | | | | | | | | | | → |
| Dissemination of results | Researcher & Supervisor | | | | | | | | ← | → | | |
| Monitoring and evaluation | Researcher | ← | | | | | | | | | | → |

## APPENDIX VI: MARKING KEY FOR STUDY VARIABLES

### A. KNOWLEDGE: Total 6 marks

| QUESTION | ANSWER AND SCORE |
|---|---|
| 7 | A: 1 |
| 9 | A: 1 |
| 10 | Any two correct answers: 2 |
| 11 | A: 1 |
| 12 | Any correct answer: 1 |

**KEY: High knowledge: 5-6 scores Moderate knowledge: 3-4 Low knowledge: < 2**

### B. ATTITUDE: Total 20 marks

| QUESTION | ANSWER AND SCORE |
|---|---|
| 13 | A: 1 B: 1 C:2 |
| 14 | A: 4 B: 3 C:2 D;1 |
| 15 | A: 4 B: 3 C:2 D;1 |
| 16 | A: 1 B: 0 |
| 17 | A: 4 B: 3 C: 2 D: 1 |
| 19 | Beneficial: 1 Not beneficial : 0 |

**KEY: Positive attitude: 10 -20 scores Negative attitude: less than 10 scores**

### C. PRACTICE: Total 10 marks:

| QUESTION | ANSWER AND SCORE |
|---|---|
| 22 | A: 0 B: 1 C: 2 D: 2 |
| 23 | A: 1 B: 0 |
| 25 | A: 1 B: 0 |
| 28 | A: 1 B: 1 C: 2 D: 0 |
| 30 | A: 1 B: 1 C: 2 |
| 31 | A: 1 B: 0 |

**KEY: Positive attitude: 6-10 scores Negative attitude: less than 6 scores.**