SCHOOL OF MEDICINE AND HEALTH SCIENCES

FACTORS AFFECTING THE DELIVERY OF ESSENTIAL NEWBORN CARE AT KANYAMA LEVEL ONE HOSPITAL IN LUSAKA, ZAMBIA

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A research dissertation submitted to the University of Lusaka in partial fulfillment of the requirements of a Degree in Bachelor of Science in Public Health

DECLARATION

I, Matongo Hasalama, do hereby declare that this dissertation is my own work to the best of my knowledge and that it has never been produced or submitted for any degree, diploma or other qualification at the University of Lusaka or indeed any other university for academic purposes. I further declare that all other works of people used in this research have been duly acknowledged.

Signed : 

Date: 22/05/2022

DEDICATION

First and foremost, I would like to dedicate my work to my husband Fredrick Kunda Mubanga and my children, who have been patiently waiting for me to finish my education. This motivated me to continue my studies. I'd also like to dedicate this thesis to my father and mentor, Mr Hasalama Ernest, and my mother, Ms Emmy Mwiinga Hasalama, who never failed to express their faith in me. This work is also dedicated to my God, who has provided me with strength and wisdom.

To: The Dean, School of undergraduate Studies and University Management, UNILUS

This Dissertation, written by Matongo Hasalama, and entitled " Factors affecting the delivery of essential newborn care at Kanyama level one hospital in Lusaka.", having been approved in respect to style and intellectual content is referred to you for consideration as basis for awarding a bachelors in Public Health.

I have read this dissertation and recommend that it be approved.
Name: Dr Loveness A. Nkhata
Research Supervisor

Signature: _____ _____

Date: 20th May, 2022

The dissertation by Matongo Hasalama is approved.
Name: _____
Dean of School of Undergraduate Studies
University of Lusaka (UNILUS)
Signature: _____

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Abstract

Investing more resources in proven low-cost therapies aimed to address neonatal requirements could prevent millions of newborn deaths. Almost two-thirds of baby deaths are predicted to occur in the first month of life, with more than two-thirds dying in the first week and two-thirds dying in the first 24 hours.The goal of this study was to determine the characteristics that influence the delivery of critical infant care at Kanyama level one hospital in Lusaka. A cross sectional study was carried out on 370 women of procreative age at Kanyama level one hospital in Lusaka who had given birth during the previous year. A semi-structured questionnaire was used to collect data, which was then analyzed descriptively in SPSS version 16.0. The chi-square test was used to examine the relationship between the components, with a 5% cut-off point for statistical significance.The findings show that attendants cleansed hands 90.29 percent of the time, 83.78 percent had their perianal part cleaned, and 95.41 percent of babies were inoculated with OPV/BCG after birth. The findings showed that 86% of the participants gave breast milk as the first feed to newborns. majority of participants (68%) breastfed their children within 30 minutes and 1 hour following birth. 64% of those polled washed their breasts before breastfeeding. The study also showed that When either of them gets sick, the majority of participants (91.35 percent) indicated they'll go to the hospital, and 60% said they'll go to the drug shop to get medication. To keep their newborns from getting sick, about 85 percent of the participants said they bathed them with soap, sponge, and water, with or without disinfection (detol). while, 7% of mothers washed their kids in herbal preparations

Key findings: Except for the first feed after delivery, which was associated with age at p-value.16111, and feeding times, which was associated with marital status at p-value. 845287.

Limitations: This was based on self-reported data, and participants might not have remembered all of the events surrounding the childbirth episodes, resulting in ambiguous responses to the questions. It's also worth noting that the findings of this study are unique to

Kanyama level one hospital, despite the fact that identical scenarios could arise in other contexts.

Recommendations: To investigate other factors determining vital new born care, more research with large sample numbers and multivariate models is needed.

Keywords: Delivery, Essential, Newborn care.

CHAPTER ONE: INTRODUCTION

1.0 Background

Although it is a critical component in lowering child mortality, new-born health and endurance generally receives less than optimal attention (Lawn JE et al 2005). There have been arrangements made to reaffirm the international community's commitment to improve neonatal health. Current global evaluations show that investing in neonatal health has a significant socioeconomic impact (Yinger & Ransom, 2003). There are a variety of reasons why, despite the high mortality rates, newborn health has been ignored and why the majority of neonatal fatalities go unnoticed and unreported. Over the last 25 years, child survival initiatives have had the greatest impact on decreasing death from illnesses that disturb newborns and children over the age of one month. As a result, infant mortality rates are higher through the principal month of life (the neonatal period), when a child's risk of death is roughly 15 times higher than at any other time until turning one year old (Yinger & Ransom, 2003).

Though infant health is strongly linked to that of their mothers, Tinker and Ransom (2003) argue that newborns have a distinct need that must be treated within the framework of nurturing and adolescent health amenities. They went on to say that if more resources were put in proven low-cost therapies that addressed neonatal needs, loads of newly born losses can be prevented. Almost two-thirds of baby deaths are predicted to happen in the first month of life, with more than two-thirds dying in the first week and two-thirds dying in the first twenty four hours (Lawn et al., 2001).

Over the last four decades, global under-five and infant death rates have decreased, while high neonatal mortality rates have stayed essentially stable (United Nations, 2016). Neonatal fatalities account for almost two-thirds of all baby deaths and 38% of all deaths among children under the age of five, resulting in approximately 4 million neonatal deaths per year worldwide (World Health Organization, 2019). Premature birth problems (28%) are the leading causes of newborn death, followed by sepsis and pneumonia (26%), birth asphyxia and injuries (23%), tetanus (7%), congenital malformations (7%), and diarrhea (3%), with

low birth weight accounting for a significant share of infant deaths (World Health Statistics,2015).

Neonatal deaths account for over 98 percent of all deaths in underdeveloped nations, primarily in Asia and Africa, where several countries have neonatal mortality rates of more than 40 per 1000 live births and many nations have proportions of not less than 60 per 1000 live births (World Health Statistics, 2015).

1.1 Statement of the Problem

The Ministry of Health has implemented a number of measures to develop maternal health services, including the establishment of more nursing schools, the training of midwives, and the placement of skilled health personnel in health facilities, the procurement of equipment, the training of Community Health Assistants (CHAs), and the teaching of Safe Motherhood Action Groups (SMAGs) in societies by means of sensitizing communities on the importance of reproductive health, with a special focus on. The development of Pregnancy, Childbirth, and Postnatal Care Guidelines (PCPNC), as well as Domiciliary Official visit Procedures and Newly-born Procedures, was done to provide guidance to health workers on when post-natal care should be done, what to look out for, when it should be done, and where it should be done, whether at a health facility or at home. Health workers, policymakers, training institutions, and maternal and child health managers/officers will benefit from the guidelines in establishing and upholding maternity and new-born health services (WHO PNC guidelines, 2013). Despite the above efforts and the accessibility of open PNC services, communal demographic dynamics such as the mother's age have continued to have a detrimental impact on the delivery of vital newborn care, and Zambia's PNC coverage has remained below the national objective of 80%. Although the utmost current coverage at 48 hours has increased from 39% (ZDHS, 2014) to 63% (ZDHS, 2015), (ZDHS 2018).

1.2 Justification of Study

To reduce the risk of disease and promote optimal growth and development, all newborns require critical newborn care. The essential needs of a typical baby upon birth include warmness, standard inhalation, mum's milk, and infection prevention. These fundamental

requirements show that a baby's existence is entirely dependent on the mother and supplementary caretakers. As a result, all neonates must get immediate medical attention. However, factors such as the mother's status, level of education, profession, terrestrial determinants, religion, and ethnicity may have a negative impact on the newborn's health. The study's findings will affect policy by enhancing current PNC recommendations and assisting health workers, mothers, and caregivers in understanding the need of PNC within 48 hours. The study's findings will also serve as a foundation for future research.

1.3 General Objective

To assess the factors affecting the delivery of essential newborn care among mothers at Kanyama level one hospital in Lusaka, Zambia

1.4 Specific Objective

1. To assess the knowledge of mothers on essential newborn care in Kanyama, Lusaka.
2. To assess the practice of mothers on essential newborn care in Kanyama, Lusaka
3. To identify factors associated with essential newborn care by mothers in Kanyama, Lusaka.

1.5 Research Questions

1. What is the level of knowledge of mothers on essential newborn care in Kanyama?
2. What are the practices of mothers on essential newborn care in Kanyama?
3. What factors are associated with essential newborn care by mothers in Kanyama, Lusaka?

CHAPTER TWO

2.0 LITERATURE REVIEW

Newborn endurance is a major concern, particularly in underdeveloped countries. In parental and adolescent health programs, neonatal care is sometimes overlooked. Neonatal death continues to rise despite different government initiatives to prevent newborn mortality. Most neonates decease at their parent's houses while being be concerned for by mums, families, and customary delivery helpers, and 98 percent of the over four million global neonatal deaths occur in developing nation's world health organization (1996). Nearly two of three newborn demises happen within the principal month of living, with more than two-thirds dying within week one and two of three dying within 24 hours (World Vision International, 2013)

Improvements in newborn survival are dependent on antenatal, intranasal, and postnatal healthcare, i.e., interferences focused at mothers for the duration of prenatal period, delivery , and after delivery have a significant influence on baby endurance, particularly through the principal weeks of lifecycle, once the third quarters of neonatal humanity happens. More specifically, advances in newborn existence include the upkeep offered to females during prenatal period, as nourishment of young daughters, for example, might have an influence on their grown-up height, which can influence labor and delivery results. Another example is that the mother's folic acid level during pregnancy can influence the risk of some inherited malformations. Motherly upkeep is thus critical not just for lowering parental humanity nevertheless, and besides for lowering newborn mortality. In Sub-Saharan Africa, an estimated 12 million pregnant women do not receive tetanus vaccination; however, in industrialized nations, the existence of a mid-wives, nurses, or doctors at birthing is looked at casually (Vinod, 2005).

2.1 SOCIO-ECONOMIC FACTORS

Regional differences in prenatal and neonatal death and morbidity rates are linked to socioeconomic development, health-care quality, environmental factors, and cultural customs (WHO, 2002). The demise of a lady in the course of prenatal period or delivery period is a breach of her right to life, as well as a communal unfairness to the mother, her

household, and the public. Economic and social growth are directly related to a country's health. Hale and hearty living circumstances and admittance to adequate, eminence healthiness upkeep for wholly citizens of the country are also essential for social and economic development, and it is their right. Variations in monetary and communal situations so influence a society's or nation's health indices. Maternal and newborn mortality rates are the most influenced signs of health in a country. Women in India, for example, are mainly excluded from making decisions, have inadequate right of entry to and regulator over possessions, are limited in their movement, and are frequently threatened by male relatives (Deogaonkar, 2004). Individual, family, and community socioeconomic factors influence admission to health upkeep and contribute to maternal mortality. Depending on her degree of education, employment, personal income or wealth, and autonomy, each woman chooses her own health decisions. The woman's and her newborn baby's admittance to health upkeep may also be influenced by the family's combined income, occupation, and education. The collective wealth and resources of the community play an essential part in the socio-monetary elements of community members' health requirements (Bupe B et al, 2014).

Informational, communal, traditional, and monetary barriers to changing intrapartum care practices were identified by Parlato et al (2004). Clients' lack of information about present suggested vital newly-born care carry outs and their health results is an example of informational constraints; in other words, a main motive for not accepting a new drill might be absence of information and a thorough indulgent of its accessibility, usage, and remunerations. In many traditional areas, older relatives such as mothers-in-law always a have significant say over conclusions regarding pregnancy, delivery, and baby-sitting, but their effect might be fragile in up-to-date urban societies, the effect of the broadcasting could be resilient. For example, in more traditional communities, husbands may influence their wives' activities, whereas in metropolitan areas, where women have more independence and knowledge, this may be minor or absent. Inaccessibility of money to emolument for needed infant care services is an example of an economic constraint (Parlato et al., 2004).

2.2 LABOUR AND CARE CARRY OUTS

2.2.1 Immediate Newborn Care

Configurations of new-born care and involvements differ dramatically. In many circumstances, there is a lack of understanding of what is required for the best neonatal care. Warmth, hygiene, breast milk, safety, and vigilance are all basic needs of babies. Other preventive measures include thermal defense, lactating babies, and eye attention (to prevent impaired vision) (WHO, 2006).

Hygienic child-birth and thread upkeep to avoid contagion, updraft safety to avert and manage newly-born hyper-thermia, primary and proper lactating of babies to begin in one hour of childbirth, origination of inhalation and resurgence to facilitate initial lack of oxygen and proof of identity and administration, and eye attention to avert and cope ophthalmia are among the essential newborn care interventions recommended by the World Health Organization (WHO, 1996).

Identification and management of sick newborns, as well as upkeep for preterm and/or low delivery mass of newly-born, with (BCG) injection, Polio Vaccine, and injection of Hepatitis.

The study focused on practices like clean childbirth, initial and special breast-feeding, BCG and OPV immunization, and recognizing and managing unwell newborns.

2.2.2 Clean Childbirth

Newborns have a better chance of surviving if the birth is clean, which means that conscious steps must be done to assist prevent infection. To ensure a hygienic labour, all persons caring for the mum and the baby must clean their hands with a detergent and water beforehand, and during, and after labour, the perennial zone of the female birth canal must be cleaned prior to each inspection and beforehand of delivery, and no external things (except the examiner's hand) should be introduced into the vagina. Additionally, the delivery surface must be clean, or at the very least, birth should not take place on the plain ground (Parlato and colleagues, 2004).

In Pakistan, while participants were aware of the profits of hygienic birthing , they hardly used it. Furthermore, respondents had adequate information and carry outs for keeping the

baby warm, as well as delayed commencement of lactating, evasion of colostrum, and prelacteal nourishing. The standard was unsanitary cord care, which included an unhygienic cut and the submission of ghee on the cord stub. Although some risk indications in neonates were widely recognized, timely action was not offered (Yadav, 2007).

2.2.3 Drying and Warming

Conferring to (2004) of Parlato studies, neonates control their bodily heat lesser successfully than adults and drop temperature extra effortlessly, particularly on the scalp. According to the World health organization (1996), babies must be carefully dried up and kept warm instantly after birth. The baby must be carefully dried up with a hygienic bath towel as quickly as the skull and body are birthed to avert hypo-thermia. This also aids in restrictive body heat forfeiture, and the spur created might encourage inhalation and help an asphyxiated newly-born. Bathing should also be postponed for four to six hours subsequently of birth, according to experts (WHO 1996). In Pakistan, however, dais (traditional birth attendants) have been recorded leaving newborns unattended, occasionally on the base or floor, up to the placenta is conveyed, following which the offspring is bathed with Luke-warm water and cleanser one-two hours later. Platform doesn't just wipe newborns with a garbage towel (Khadduri, et al., 2007). According to an additional research conducted in Nepal, newborn newborns are measured dirty from the moment they emerge from their mother's womb, and nearly all newly-born children are washed during the principal hours of birth (Banda Chembe Chikoka, (2017) .

2.2.4 Cord Care

In order to prevent infection, clean cord care methods should be implemented. The umbilical cord should be cut and tied using hygienic (sterilized) constituents, and no materials should be applied to the cord stump (WHO, 1996). The string is sometimes cut with grass blades, bark fiber, reeds, or tiny roots. This is dangerous because these materials frequently include tetanus spores from the earth, increasing the risk of newborn tetanus. Threads, strips of cloth, and strings are utilized to bind the cord together (Woodruff et al., 1984). After birth, infection spreads mostly through the cord stump. The values of hygienic cord remnant upkeep are that the chord should be kept dry and clean, and that nothing should be put to it,

whether at home or in a health institution. Without any dressing, binding, or bandages, the remnant will dry-up and mummify. If it is kept clean and protected from urine and soiling, it will remain clean. Cleaning doesn't require any antiseptics. The cable can be washed and withered with hygienic thread or gauze if it becomes filthy. Local practices of applying various substances to the cord stump, either in health facilities or at home, should be thoroughly studied or, if discovered to be detrimental, should be discouraged and replaced with suitable alternatives (WHO, 2006). If the umbilical stump turns red, drains pus, and the redness spreads to the skin round it, the child stops sucking, becomes lethargic, doesn't wake up, or has trouble breathing, it could be an indication of a serious infection. A health facility should be contacted by the mother or caretaker. The baby must be taken to the hospital right away for treatment (WHO, 2006). Turmeric stood as the utmost and popular ingredient used on the cord stump following cord cutting in Bangladesh's Sylhet District. Bathing, mustard oil skin massage, and warmth rubbing on the umbilical stump were all part of the umbilical stump care regimen. During the neonatal period, mothers were the primary providers of skin and cord care. In the research location, unsanitary cord care methods are common. (Alam and colleagues, 2008).

2.2.5 Immunization

BCG should be given as soon after birth as possible in all groups at high risk of tuberculosis infection, according to the WHO (1996), and a lone amount of OPV must be administered at delivery or two weeks after birth in all populations at high risk of tuberculosis infection (this is recommended to increase early protection). By 1997, all nations had included the hepatitis B vaccine (HBV) in their national immunization programs. It is critical to administer the first dosage as quickly as probable after delivery in areas where perinatal illnesses are widespread.

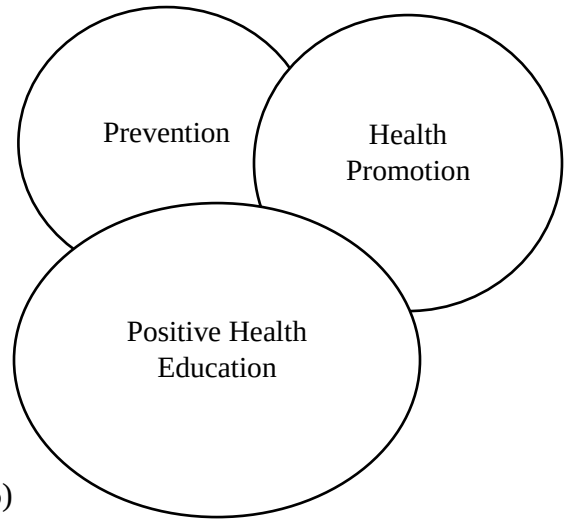
2.2.6 Breast-feeding exclusively from the start

Breast milk is related with enhanced development through the principal months of life, according to the WHO (2006). It delivers appropriate diet and stimulates the kid's development. Breast-feeding starts the vaccination procedure at delivery and guards a kid beside a number of virus-related and microbial diseases afore vaccination may provide lively protection. Breast milk possesses anti-infectious characteristics that are unique.

Breast-feeding, especially when other family planning options are not willingly obtainable or wanted, can be an effective form of fertility restriction for many women. However, according to a research piloted by Yadav (2007) on customary infant care carry outs in Nepal, colostrum is viewed as unclean milk in some groups, and offspring were suckled cow or goat milk shortly after labor in the widespread conviction that it would make the child smarter. According to the WHO (1999), early contact (soon after birth) among the mum and the child promotes breastfeeding. Early suckling supplies the newborn with colostrum, which protects the baby from infection, provides critical nutrients, and helps the mother's uterine contractions. Most women breastfed their kids, according to Khadduri et al. (2007), but starting in 1 hour of delivery and colostrum nourishing were not prevalent.

2.3 Theoretical Framework

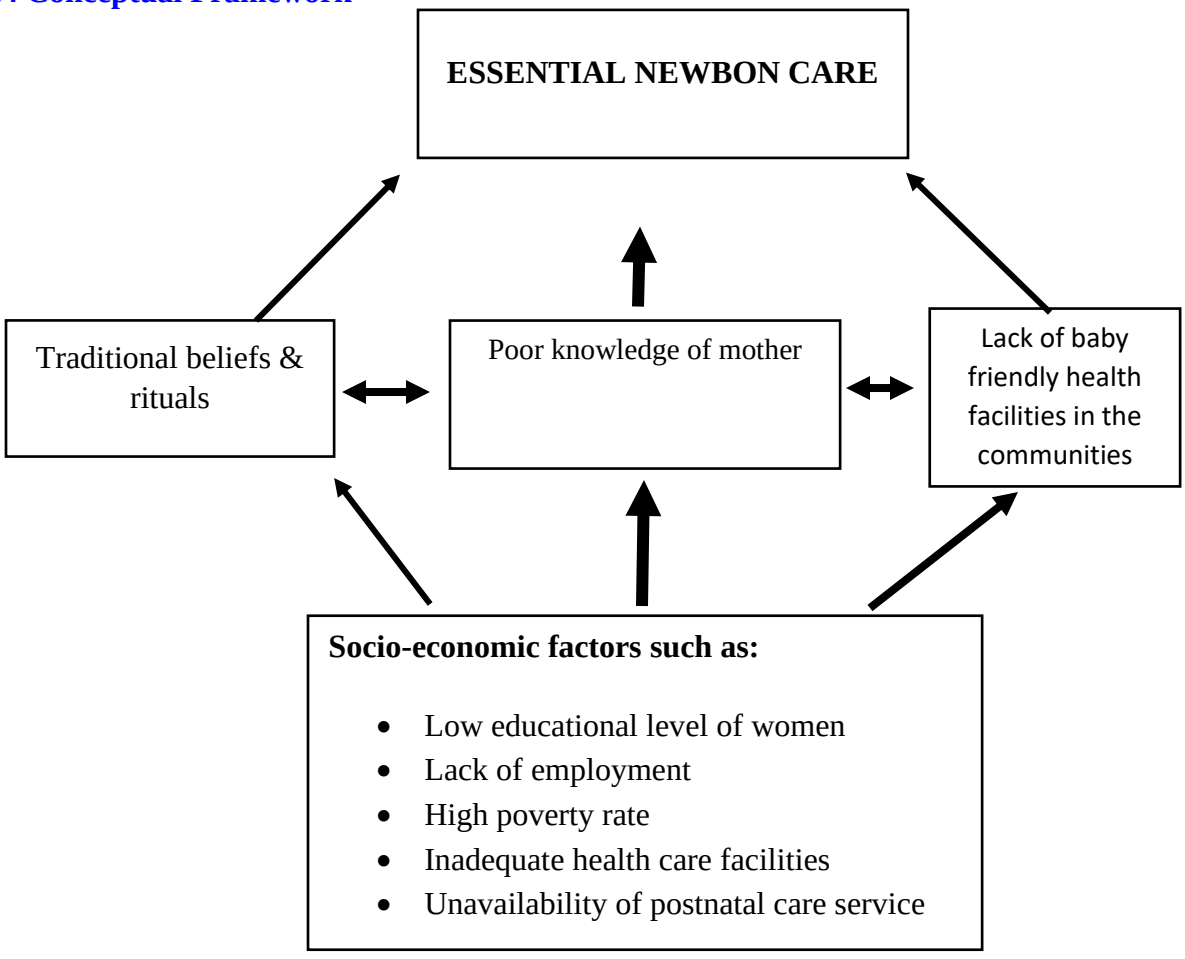
Tannahill model of health promotion



Downie et.al. (1996)

The Tannahill design is a health elevation design created by Tannahill and colleagues by means of the aim of defining, scheduling, and applying health elevation in mandate to show the relations among healthiness education, safeguarding, and prevention. Sharma (2016). As previously said, preventive focuses on taking down or eradicating the danger of sicknesses and infections. Constructive Health Tutoring focuses on increasing understanding and boldness in directive to increase comfort and avert illness. Protecting the healthiness of the people through legislative, economical, or social means. This model matches so well with the issues distressing the birthing of vital newly-born care, and we're looking for strategies to prevent it. To do so, we need to provide mothers with information on proper child monitoring.

2.4 Conceptual Framework



Source. Researcher's own work

CHAPTER THREE: METHODOLOGY

3.0.0. Introduction

The study scheme, study environment, study population, sample size, sample selection, addition and elimination benchmarks, data gathering implements, data collection procedure, rationality and trustworthiness, model study, and moral deliberation are all presented in this chapter.

3.1.1. Research design

The reading utilized a quantitative cross-sectional study strategy.

3.1.2. Study Site

The research took habitation in Kanyama level one clinic. The facility was chosen as the study location because it had the highest number of deliveries among the five first-level hospitals in the Lusaka District. According to the Lusaka District Health Office's 2016 Annual Labour Ward Report, Kanyama had 11,363 deliveries, Matero1st level Hospital had 8,040, and Chipata had 7,106. There were 5,053 deliveries in Chawama, and 3,712 deliveries in Chilenje. Hospitals like Kanyama First Level Hospital bring quality health care closer to the people, promoting healthy lifestyles and preventing sickness in the community.

3.2.0. Study population

The study population included post-natal mothers who were accessing services at Kanyama level one hospital. According to the 2021 hospital records approximately 650 mothers attend post-natal and under five clinics on a monthly basis.

3.3.0 Sample size

The sample size was calculated using Kirkwood and Sterne's statistical technique for cross-sectional studies (2003). Because there have been no previous studies in the region on newborn care practices, the maximum sample size was calculated using the prevalence assumption of 50% for any of the newly-born upkeep carry outs; the subsequent procedure was used.

$n= z^2 \times p (1-p) d^2$

n=required sample size

z= confidence level at 95% (standard value of 1.96)

p =proposed percentage of any of the newborn care practices (50%).

d = margin of error at 5% (standard value of 0.05).

$n= 1.96^2 x0.5 (1-0.5) = 384$

0.05^2

The number of expected live births in a year from a population was given by 4% of the population (KNBS 2012). Therefore, the number of expected live births in Lusaka will be; 190062*0.04 = 7602.48

Cs=n x N/N+n

Cs=the corrected sample size

N=the total number of target population (7602.48)

n=the calculated sample size before correction

=384 x7602.48/7602.48+384

=365.54. Minimum sample size therefore taken was 366 however, this was rounded off to 370.

3.4.0. Sampling Strategy

The study gathered 370 people from post-natal and under-five clinics using a non-probability purposive sampling method. When selecting people to participate in a survey, a researcher will use their own judgment (Palinkas, 2015). Furthermore, this type of sampling lets the scholar to convey the major effect of their findings on the populace (Palinkas, 2015).

3.5.0 Inclusion Criteria

All women of reproductive age who had given birth in the previous year at Kanyama level one hospital in Lusaka volunteered to partake in the study.

3.6.0 Exclusion Criteria

All women of reproductive age at Kanyama level one hospital in Lusaka who had given birth in the previous year and declined to participate in the study.

3.7.0. Data Collection Techniques, Management and Analysis

For data gathering, a semi-structured survey (questionnaire) was employed. The questionnaire data was organized into five levels: teaching, belief, marital status, occupation, and age. There were three sections to the questionnaire;

i. Section A focusing on socio-demographic data

ii. Section B, delivery care

iii. Section C, practices and perceived factors

Raw data was modified, and open-ended response categories and codes were categorized and coded before being loaded into SPSS description of 16.0 for descriptive analysis. The chi-square test was used to evaluate the association of components, and the cut-off value for statistical significance was established at 5%. To make the data easier to interpret, tables and figures were used.

3.8.0 Scientific Rigor and Pilot Study

The researcher employed credibility and trustworthiness to get reliable information since participants have to trust the researcher in order to obtain consistent and genuine data. The questionnaire was put to the test at Chilenje Clinic, where ten people were chosen to see if they knew the questions and spellings. Following the pilot study, it was discovered that question 5 had a spelling problem with the word attended, which was fixed.

3.9.0 Ethical Considerations

The university of Lusaka research committee provided ethical approval for this study, and the Kanyama hospital Medical Superintendent granted permission to conduct it. The goal and scope of the study, as well as how the results will be used, were presented to the respondents so that they could make an informed decision on their own time. Each volunteer gave their permission to speak with them, and if they were unavailable at the time, the Researcher asked a reschedule. The study was guided by the principles of autonomy,

individual rights, and the ability to choose one's own path in life. Participants were not compelled to offer their ideas or make whatever conclusion they made. Because it is their right, their decision was honored.

CHAPTER FOUR: RESULTS PRESENTATION

4.0 INTRODUCTION

This findings of the present study are presented in this chapter.

4.1 PARTICIPANTS SOCIO-DEMOGRAPHIC CHARACTERISTICS

This study included 370 people. Table 1 shows that the participants were mostly between the ages of 25 and 29, with 76 percent having completed primary school and 86 percent being Christians.

Table 1: participant's socio-demographic characteristics

Characteristic	N=370	%
Education		
None	52	14
Primary	282	76
Secondary	25	7
College	7	2
University	4	1
Religion		
Christians	319	86
Muslims	41	11
Traditional	1	2
Other	8	2
Marital Status		
Not Married	143	25
Married	227	75
Occupation		
Unemployed	83	22
Traders	135	37
Employed	152	41
Age		
20-24	120	32.4
25-29	139	37.6
30-34	60	16.2
35-49	51	13.9

4.2 PARTICIPANTS KNOWLEDGE ON ESSENTIAL NEWBORN CARE

Hand washing by helpers, washing of the perennial area, immunization, cord care, and management were all rated as part of the participant's new born knowledge. Table 2 reveals that attendants cleansed hands 90.29 percent of the time, 83.78 percent had their perianal part cleaned, and 95.41 percent of babies were inoculated with OPV/BCG after birth.

Table 2: Participants knowledge on essential newborn care

Knowledge on essential newborn care	Response Frequency	Percent (%)
Hand washing by attendants		
Yes	335	90.29
No	12	3.23
Can't tell	23	6.19
Cleaning of perianal area of the vagina		
Yes	310	83.78
No	44	11.89
Can’t tell	16	4.32
Cord care		
Instrument used to cut cord		
Sterilized scissors	127	34
New blade	74	20
Can’t tell	169	46
Instrument used to cut the cord sterilized		
Yes	346	93.51
No	10	2.70
Can’t tell	14	3.7
Material used to tie the cord		
Cord clamp	256	69.38
Thread	72	19.24
Can’t tell	19	5.15
others	23	6.23
Cord management		
Ointment	40	11
Herbs	44	12
Nothing	101	27
Warm water/gentian violet	138	37
others	48	13
Baby immunized after birth		
Yes	352	95.41
No	17	4.59

ESSENTIAL NEWBORN CARE PRACTICES

4.3.1 New born first feed after delivery

Participant practices in figure 1 reveal that 86% gave breast milk as the first feed to newborns.

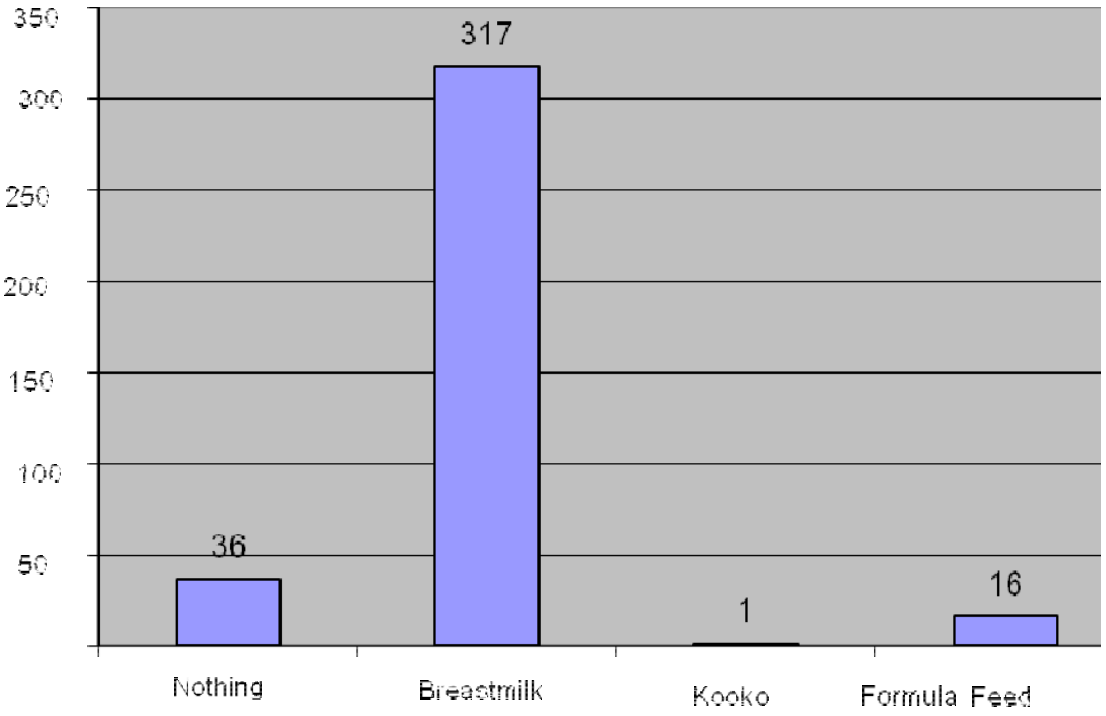


FIGURE 1: First Feed Given After Delivery

4.3.2 Time of initiating breast feeding

Figure 2 shows that the majority of participants (68%) breastfed their children within 30 minutes and 1 hour following birth.

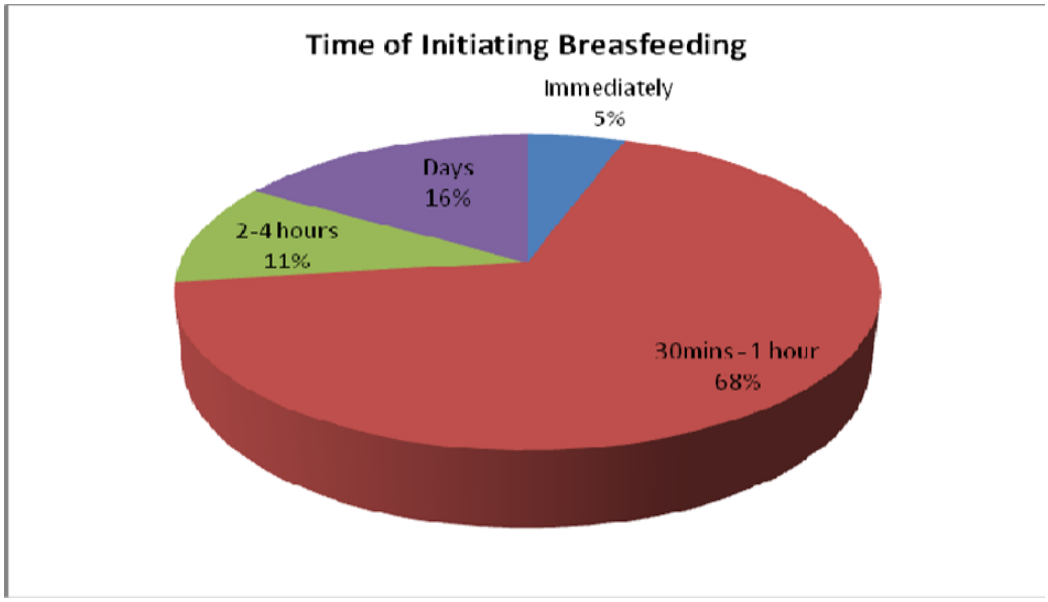


FIGURE 2: Time of initiating breastfeeding

4.3.3 Cleaning of breast before breast feeding

Figure 3 shows that 64% of those polled washed their breasts before breastfeeding. 22 percent of those surveyed (64%) said they washed their breasts with hand towel or a portion of cloth.

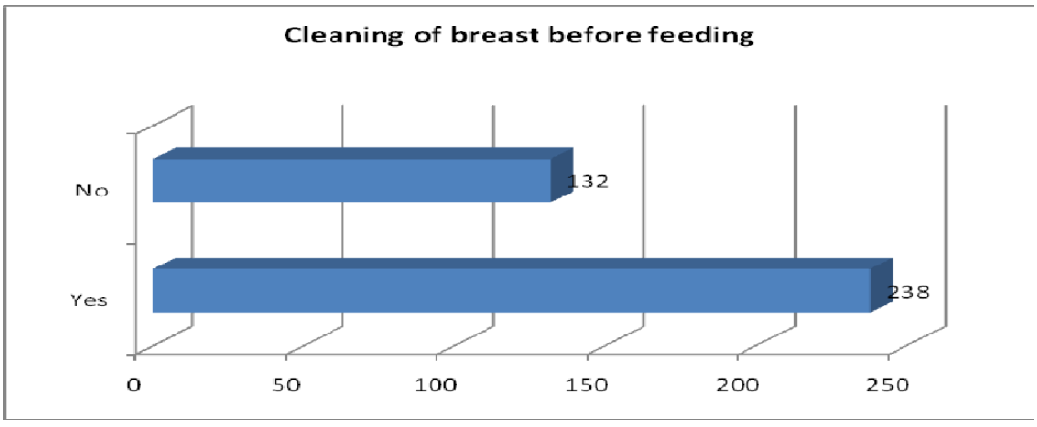


Figure 3: Cleaning of breast before feeding

4.3.4 Daily breast feeding practices

Figure 4 shows that 61% of participants nursed at set/regular times, while 38% breast-fed on demand. .

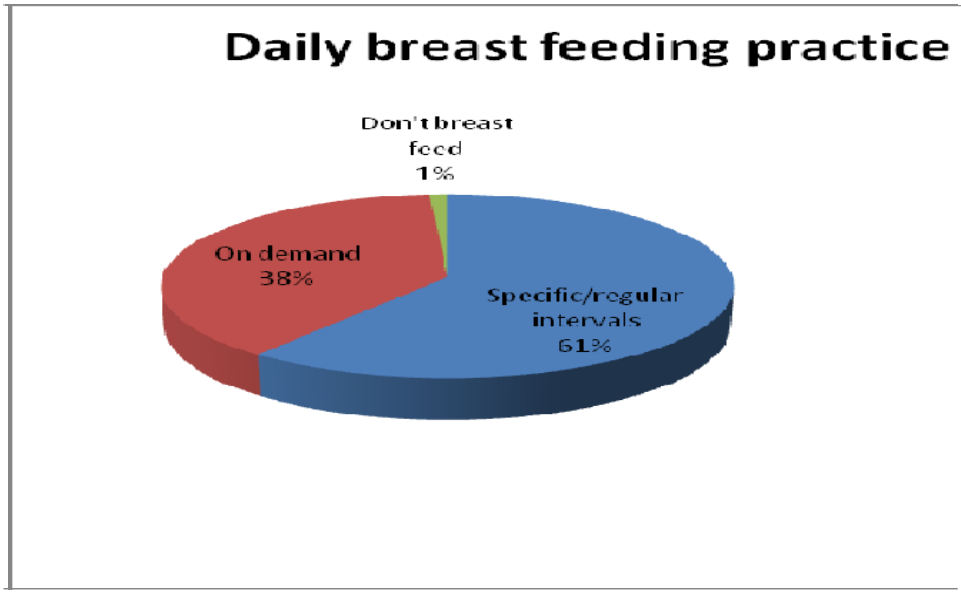


Figure 4: Daily breast feeding practice

4.3.5 Management of newborn illnesses

When either of them gets sick, the majority of participants (91.35 percent) indicated they'll go to the hospital, and 60% said they'll go to the drug shop to get medication.

Table 3: Management of newborn illnesses

Management of Newborn Illnesses		
Response	Frequency	Percent
Go to the Hospital	338	91.35
Give Enema	1	0.27
Give first aid	7	1.89

Buy drugs from the drug store	24	6.49
Total	**370**	**100**

4.3.6 Traditional practices

To keep their newborns from getting sick, about 85 percent of the participants said they bathed them with soap, sponge, and water, with or without disinfection (detol). In addition, 7% of mothers washed their kids in herbal preparations (without understanding what was in them) to protect them against "traditional sickness".

Table 4: Things done to protect baby from falling sick

Things done to protect baby from falling sick		
Response	Frequency	Percent
Bath baby with soap, sponge, water etc	313	84.51
Bath baby with Herbal Preparation	26	7.03
Bath baby with life buoy	15	4.05
Smear baby with baby powder	16	4.32
Total	370	100

4.4 CROSS TABULATIONS FOR FACTORS ASSOCIATED WITH ESSENTIAL NEWBORN CARE

The effects of age, education, occupation, and marital status on the first feed after delivery, breast washing before feeding, feeding times, and infant disease treatment were investigated. Table 5 shows that all of the dynamics took a positive relationship, with the exception of the first feed after birth, which had a p-value of.16111. Furthermore, the relationship between feeding times and marital status was negligible, with a p-value of.845287.

Table 5: Factors associated with essential newborn care

Category	Chi-square statistic	P-value	comment
First feed after delivery			
Age	**9.2289**	**.16111.**	**Insignificant**
Educational	133.7487.	< 0.00001.	Significant
Occupation	41.7384.	< 0.00001.	Significant
Marital status	8.4461.	.014654	Significant
Cleaning of breast before feeding			
Age	208.6533.	< 0.00001.	Significant
Education	185.6683.	< 0.00001.	Significant
Occupation	13.4168.	.001221.	Significant
Marital status	257.0666.	< .00001.	Significant
Feeding times			
Age	35.9974.	< 0.00001	Significant
Education	45.0975.	< 0.00001.	Significant
Occupation	20.8791	.000029.	Significant
Marital status	**0.0381.**	**.845287**	**Insignificant**
Management of new borne illness			
Age	15.1413.	.019186.	Significant
Education	74.5209.	< 0.00001.	Significant
Occupation	25.7208.	.000036	Significant
Marital status	8.4989.	.014272.	Significant

CHAPTER FIVE: RESULTS DISCUSSION

5.0.0 Introduction

The ramifications of the data acquired and reported in Chapter 4 are discussed in this chapter, as well as its relevance to the literature.

5.0.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The demographic data was crucial for interpreting the results. The mainstream of the females in our research were 25 years old, had completed primary school, and were wedded at the period of the interview. The results of this research are comparable to results of Mwaba's (2019) research on the factors influencing post-natal care utilization after 48 hours: Kanyama 1st Level Hospital in Lusaka, Zambia, is the subject of this case study. This is because most persons in that age group do not go to school and lack skills development, thus they are prone to drinking beer or selling alcohol in bars, while others work for Rwandan nationals who take advantage of them, and some engage in sexual behavior to make money.

5.0.2 SOCIO-ECONOMIC FACTORS

As proxy socio-economic variables, this study used the accessibility of healthiness services in the community, training, and profession. The bulk of the contributors in the study had only had basic schooling and were petty traders, indicating that they were of low socioeconomic standing. Because respondents had no consistent source of income, this could suggest a low income level. When it comes to Deogaonkar (2008) According to McCarty and Maine (1992), the combined household revenue, occupation, and education of family members can affect access to health care for the mother and her newborn baby.

Kanyama first level Hospital is the only significant healthcare facility in the area. This hospital acts as a key referral hub for the surrounding hospitals. Despite the fact that more than half of the respondents were aware of the reality of health facilities in their societies, the majority only preferred Kanyama Hospital because other health facilities lacked essential medicines and were run privately, incurring an additional cost for the participants.

5.2 IMMEDIATE NEWBORN CARE

Nearly all of the people polled remembered that the people who helped them deliver cleansed their hands and cleaned their vaginal perineal area. Although this indicates that the World Health Organization's (WHO 2016) recommendation is followed at the facility, a few respondents stated that their assistants did not wash-down their hands. This indicates that health-care workers still need to be educated on safe delivery procedures.

5.3 CORD CARE

Several respondents remembered their attendants cutting the cord with disinfected pairs of scissors and clamping it with a cord-clamp. The majority of people said they use warm water to get rid of the cord stump. This suggests that the facility's infection control is mostly in place. This is comparable to the findings of a study by USAID (2018) on updraft care and umbilical cord care carry outs and their links to newborn mortality. This is because the majority of individuals in our communities, as well as health professionals, are mindful that unsterilized utensils is a major risk factor for both mother and child cord infection. As a result, using sanitized equipment is a public health guideline.

5.4 IMMUNIZATION

The majority of participants had their newborns immunize with Oral poliovirus vaccines also bacille Calmette Guerin, with only % not immunizing their children. This indicates that the WHO's (2006) guideline of providing bacille Calmette Guerin and Oral poliovirus vaccines to newborns is widely followed, as well as the district's EPI coverage of 78.8% for annually (Asante, 2006).

5.5 EARLY BREASTFEEDING PRACTICES

Breast milk was given to their newborns as the first feed by a higher percentage of respondents, indicating that the WHO (1996) reference of initial and special breastfeeding, which should begin within one hour of childbirth, was followed. Though, around ten percent of participants said they didn't offer anything because breast milk wasn't developed right after delivery, and few people chose to give formula. This shows that most women are aware of the

benefits of providing colostrum to their infants, in contrast to Khadduri et al. (2017), who found that breastfeeding was not started within 1 hour of birth and that colostrum feeding was uncommon. Similarly, in Nepal, some moms feel that colostrum is unclean milk that should be rejected, so they feed their newborn babies cow or goat milk right after birth in the hopes of making them smarter (Yadav, 2007). This necessitates continual public awareness of the colostrum's benefits for newborns.

5.6 TRADITIONAL PRACTICES

Approximately 84 percent of mothers stated that they bathe their newborn babies with soap, sponge, and warm water with or without disinfectant (Dettol) to prevent them from becoming ill, while a few stated that they bathe their offspring using herbal arrangements to prevent them from becoming ill, particularly from contracting any diseases. Furthermore, virtually all of the respondents stated that they will not offer their newborns to strangers because they are afraid that the stranger will transmit diseases to the newborn baby, either spiritually or physically. This result is identical to Ashraful et al (2010) findings in Sylhet District, Bangladesh, regarding newly-born umbilical cord and skin care: Dettol and other traditional treatments are used to bathe newborn babies, which has implications for the elevation of umbilical cord cleanliness using topical chlorhexidine. The results are similar because of cultural beliefs that are passed down from generation to generation, teaching future generations that Dettol and extra herbal remedies bathed in by babies are good for them and make them stronger and more resistant to diseases.

CHAPTER SIX

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the findings, limitations, and recommendations based on the responses of the study participants at Kanyama level one hospital in Lusaka, Zambia.

6.1 Conclusions

It was shown that the majority of the participants had low socioeconomic indicators. Except for the first feed after delivery in relation to age and feeding times in relation to marital status, which were negligible, all connection elements affecting the delivery of basic infant care revealed a positive association.

6.2 Limitations

This was based on self-reported data, and participants might not have remembered all incidents surrounding childbirth episodes, resulting in ambiguous responses to the questions. The researcher also had a restricted amount of time and resources to complete the assignment.

It's also worth noting that the findings of this study are unique to Kanyama level one hospital, despite the fact that similar scenarios may arise in other contexts.

6.2 Recommendations

1. The ministry of health should conduct a larger study with a larger sample sizes and multivariate models are needed to look into other factors that affect crucial newborn care at multiple sites so as to understand the magnitude of the problem if any.
2. There is a need for ongoing sensitization and training among mothers by midwives on vital new-born care practices and the significance of the first 48 hours after delivery.
3. The Safe Motherhood Action Groups that comprise of a midwives, nurses and doctors should also carry out communal sensitization on post-natal care.

4. Midwives must continue to educate women about the need of visiting a postnatal clinic 48 hours after birth and the dangers of using unknown herbs on the newborn.

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BUDGET

SN	ITEM	DESCRIPTION	AMOUNT ZMW
1.	Airtime	All Network	K250
2.	Stationary	• 2 Pens	K20
		• 1 Note Book	K50
		• printing and binding 3copies of the proposal	K300
		• Printing and Binding Final Copy	K300
3.	Miscellaneous		K2000
		Research Assistants	2000
Total			K4,920

The table above shows a nitty gritty breakdown of the research spending plan. This study financial plan is a blend of the relative multitude of things that were expected to effectively lead this examination, The source of the funds was from own pocket.

4.0.0 GANTT CHART FOR THE WORK PLAN (2021-2022)

ACTIVITY	August	October	November	February	March	May
Proposal writing and editing						
Proposal presentation						
Data collection						
Analysis comparison and compilation						
Printing of project						
Final project submission						

This research was be conducted within a given time frame,from August 2021- May 2022. Data collection was conducted in February. Different components of the research were done systematically according to their designated times,and final dissertation submission was done in May.

APPENDIX

Appendix 1

CONSENT FORM

Dear participant,

My names are Matongo Hasalama; I am an undergraduate student at the School of Health Sciences at the University of Lusaka. I'm doing research to help me meet some of the requirements for a degree in public health. You have been chosen as a respondent, and I would greatly appreciate it if you could spend a few minutes answering the questions in this questionnaire. This is a study of the factors that influence the delivery of critical infant care at the Kanyama level one hospital in Lusaka, Zambia. All of the information you provide will be kept completely secret and used solely for educational reasons. If you could offer me honest answers to the questions, I would be extremely thankful.

You will not receive any direct benefits or monetary gain from the study, but the information you offer will aid in the assessment of factors affecting the delivery of important infant care at Kanyama level one hospital in Lusaka, Zambia, which will benefit the entire community.

Consent granted (please tick)

Yes ☐

No ☐

Signature of Respondent…….

Signature of Interviewer……

Appendix 2

INFORMATION SHEET

This study examined the factors that influence the delivery of critical infant care at Kanyama level one hospital in Lusaka, Zambia. The data acquired during this study will only be used for academic purposes.

At Kanyama level one hospital in Lusaka, Zambia, the participants were interviewed about issues affecting the delivery of basic newborn care. Other questions about the subject were also asked. The University of Lusaka's Ethics Board granted permission to perform this research.

INTERVIEW GUIDE FOR MOTHERS/ GUARDIANS

Appendix II: Questionnaire on newborn care practices

Section A

Socio demographic data

1. In which year were you born? ----------
2. How old were you in your last birthday?
3. Parity.....
4. Have ever attended school? Yes: NO:

5. What is your highest level of school you attended?

    1. Primary

    2. Secondary

    3. college/University

6. What is your current marital status?

    1. Single

    2. Married

    3. Divorced

    4. Widowed

7. What is your religion?

1. Traditional
2. Protestant
3. Catholic
4. Muslim
5. Other(specify)

8. At what age did you get your birth (yrs.)? ----------

9. Residence ……

10. Occupation

1. Unemployed
2. Casual laborer
3. Self-employed
4. Salaried job
5. Student

11. Husband/Partners occupation

1. Unemployed
2. Casual laborer

3. Self-employed

4. Salaried job

12. Baby‘s age (days)……

13. Baby‘s Sex

1. Male

2. Female

14. Is there a Health facility in this community

1. Yes

2. No

15. If Q17 is Yes, name the facility ----------

16. For this baby did you attend ANC?

1. Yes

2. No

17. How many months pregnant were you when you first received antenatal care for this baby? 1-3months 4-6months 7-9months

18. How many times did you receive antenatal care in the last pregnancy?

1 2 3 4 More than 4 don‘t know

Section B

Delivery Care

19. Where did you give birth from?

1. Private HF
2. Public HF
3. Home
4. On the way to HF
5. Others (specify) -------

If the answer is home go to Q 21

20. Why did you choose to deliver in the above if the answer is not home? --------

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21. If the answer to Q19 is Home, state why?

Section C

Known practices and perceived factors

22. What are the common practices affecting new born care?

23. What are the perceived factors contributing to essential new born care delivery?

24. How are newborns handled at home after delivery?

25. Are their any commons practices they can share?

26. What is the relevance of those practices?

INTERVIEW GUIDE FOR HEALTH WORKERS

1. Introductions.

2. Explain purpose of study.

3. Assure key informant of confidentiality.

4. Ask key informant for their informed consent to participate in the discussion.

QUESTIONS

1. In your own opinion why do most women in this region deliver at home?

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2. Are you aware of any traditional practices in this community that are detrimental to a newborn‘s health?

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3. In your opinion what challenges do women face as they provide newborn care in the community?

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4. What do you think can be done to improve newborn care among postnatal mothers in this community?

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5. What material do you use to cover the surface during delivery?

6. Do you wash your hands before attending to client(s)who come to deliver? Yes No

7. If yes, what do you use to wash your hands?

8. If no why?

9. Do you wash the perineum of your client(s) before delivery? Yes No

10. What instrument(s) do you use to cut the cord?

11. What do you apply on the cord?

12. Do you give babies to their mothers immediately after delivery? Yes No

13. How long do you wait before you give the baby it first bath?

Thank you for your cooperation.

REPUBLIC OF ZAMBIA
KANYAMA LEVEL ONE HOSPITAL
P.O BOX 10101
LUSAKA

20th April,2022

Matongo Hasalama
University of Lusaka
School of Medicine and Health Sciences

Dear Sir/Madam

RE: PERMISSION TO CONDUCT A RESEARCH AT KANYAMA LEVEL ONE HOSPITAL

Reference is made to the above subject matter.

Kanyama level one hospital is in receipt of your letter requesting for permission for permission to conduct a research entitled "**FACTORS AFFECTING THE DELIVERY OF ESSENTIAL NEWBORN CARE AT KANYAMA LEVEL ONE HOSPITAL IN LUSAKA, ZAMBIA**".

My office is happy to inform you that it has no objection to your request provided that you share the findings of the study before any publications are made.

Kindly ensure minimum interruption in health service delivery.

Yours sincerely

REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
KANYAMA LEVEL 1 HOSPITAL
OUTPATIENT DEPARTMENT
P.O. BOX 50927, LUSAKA - ZAMBIA

Medical superintendent

KANYAMA LEVEL ONE HOSPITAL

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E-mail:unilus@zamnet.zm,ictar@zamnet.zm

SCHOOL OF MEDICINE AND HEALTH SCIENCES RESEARCH ETHICS COMMITTEE

Ref no: IORG0010092-2022/019

Date: 17th January, 2022

MATONGO HASALAMA – BSPH18110804

Re: Research Title; FACTORS AFFECTING THE DELIVERY OF ESSENTIAL NEWBON CARE AT KANYAMA LEVEL ONE HOSPITAL IN LUSAKA, ZAMBIA

The above research was submitted to the research ethics committee for review. The study has no major ethical problems and is approved subject to the following:

1. The study cannot be changed without express permission of the UNILUS Research ethics committee
2. Approval from the Lusaka District health Management or equivalent health authorities should be sought.
3. The study tools should be added.
4. An informed consent form should be attached and filled by all study participants (If dealing with primary data)
5. The risks and benefits should be included in the consent form.

Congratulations and the committee wishes you success in your work.

Prof Kasonde Bowa
MSc(Glasgow),M.Med(UNZA),FRCS(Glasgow),FACS,FCS,DPH(LSTMH),MPH(UCL)
Chairman- UNILUS REC
Professor of Urology and Consultant Urologist
Executive Dean
University of Lusaka and University Teaching Hospital
School of Medicine and Health Sciences.

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E-mail: unilus@zamnet.zm, ictar@zamnet.zm

Date: 17th January, 2022

……

……

……

PERMISSION FOR **MATONGO HASALAMA No. BSPH18110804** TO CONDUCT A RESEARCH STUDY AT YOUR FACILITY/ INSTITUTION/ ORGANIZATION

Reference is made to the above subject matter

The University of Lusaka, School of Medicine and Health Sciences here by requests for permission for **Matongo Hasalama** a Public Health Student to conduct research at your facility/ institution/ organization, entitled; **FACTORS AFFECTING THE DELIVERY OF ESSENTIAL NEWBON CARE AT KANYAMA LEVEL ONE HOSPITAL IN LUSAKA, ZAMBIA.**

The research is in partial fulfillment of the requirements for the degree of Bachelor of Science Public Health. This is purely for academic purposes and information gained in such a way will not be used in the public domain without prior authorization from the institutions/ organizations involved.

The research topic has been cleared by the University of Lusaka, School of Medicine and Health Sciences Research Ethics Committee as per the attached copy. Data collection is expected to be done from **1st February, 2022 to 29th April, 2022**.

The University of Lusaka avails itself of this opportunity to review to your office the assurances of its highest considerations and looks forward to your timely and favorable response.

Prof Kasonde Bowa
MSc(Glasgow), M.Med(UNZA), FRCS(Glasgow), FACS, FCS, DPH(LSTMH), MPH(UCL)
Chairman- UNILUS REC
Professor of Urology and Consultant Urologist
Executive Dean University of Lusaka and University Teaching Hospital
School of Medicine and Health Sciences.

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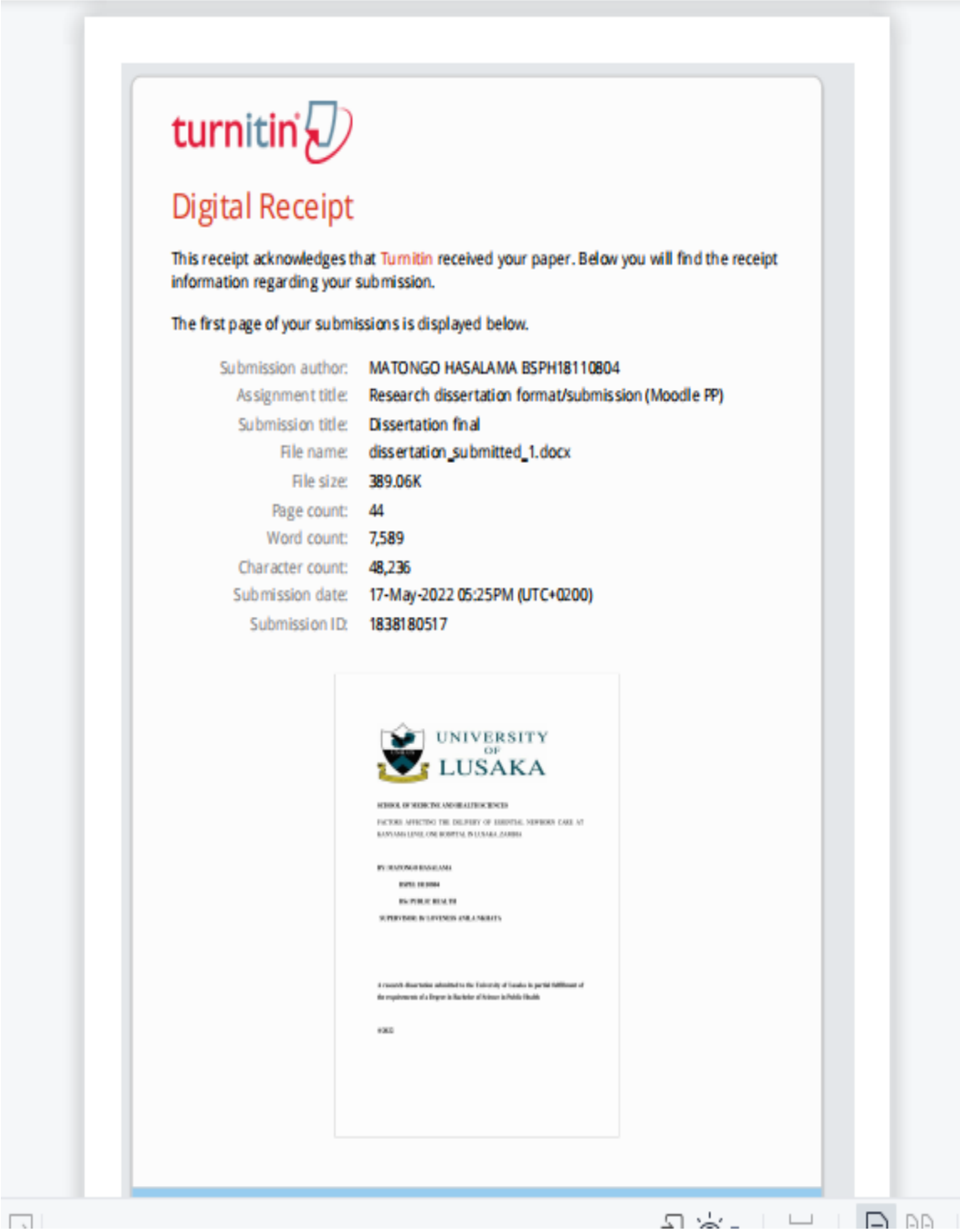

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