A Study to determine factors that affect the clients' choice of permanent method of contraception at UTH.

By

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THE UNIVERSITY OF ZAMBIA
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BY
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LIST OF ABBREVIATIONS

UTH University Teaching Hospital

WHO World Health Organisation

CSO Central statistical office

PPAZ Planned Parenthood Association of Zambia

IMSS Mexican Institute of Social Security

DECLARATION

I FELISTAS MWANSA MBEWE ..... Hereby declare that the work presented in this study for Bachelor of Science Degree in Nursing has not been presented either wholly or in part for another Degree and is not being currently submitted for any other Degree.

Signed by ..... CANDIDATE

Approved by ..... SUPERVISING LECTURER

STATEMENT

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

SIGNED .....

CANDIDATE

DEDICATION

This study is dedicated to my dear husband Pastor Conrad Mbewe, my sons Mwindula and Mwansa, my daughter, Mwape, and my foster daughter, Bwalya.

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to my previous sponsors Lusaka City Council and Bursaries Committee for the sponsorship to undertake the degree in Nursing.

I wish to thank my research supervisor Mrs Catherine Ngoma for her valuable supervision and suggestions when carrying out this research. Special thanks go to Mrs M Syacumpi for the support and encouragement she gave me.

I am most grateful to the UTH Management Board, and the Lusaka District Management Board for allowing me to use the hospital and their catchment areas respectively. I am deeply indebted to the subjects who participated in the study their co-operation is highly appreciated.

Special thanks go to my family, Mrs Judith Mumba and friends for their support and encouragement.

Last but not least my gratitude go to my group mates in class who helped me make this study a reality.

ABSTRACT

This study was done to determine the factors that affect the clients' choice of permanent method of contraception. Permanent method of contraception is one method of family planning though it has not been publicised compared to the other temporal methods. This method needs to be promoted among the people as it is good for those with medical conditions and those who can not use the hormonal methods and even those who feel that other method of family planning have disappointed them as they ended up conceiving. Permanent method of contraception ensures that families can only have the number of children they are able to meet their physical, educational, social, emotional and medical needs. This is important if the nation of Zambia should prosper and if life has to be enjoyed by families. The study therefore seeks to promote the use of permanent method of contraception.

A descriptive survey was used to obtain data by interviewing people so as to get an accurate description of factors that affect the client's choice of permanent method of contraception. This enabled the researcher to have good insight into the real situation.

The study was conducted in two urban residential areas that is Chilenje and Mtendere and lastly at UTH in July 1998.

Literature review about permanent method of contraception and its related factors was obtained locally and internationally.

Fifty (50) women who had undergone permanent method of contraception consented to the study. The subjects were selected using convenient sampling method.

All the respondents 50 (100%) were happy with the counselling they got. Most of the clients 46 (92%) said the nurses' attitudes were friendly. Majority of clients 28 (56%) chose permanent method of contraception because of too many children and most of the clients who came for the procedure were in the range of 35-40 and 40-45 years. Most

of the clients 49 (98%) travelled a distance of more than 5Km and they had to wait for one month and some waited more than a month for the procedure to be done. Some husbands 9 (18%) were not willing to sign the consent form while some women 11 (22%) had to find relatives to sign the consent because they were not married. Majority of clients 46 (96%) said women should sign the consent instead of their husbands. Most clients 26 (52%) heard about permanent method of contraception from their friends.

In conclusion permanent method of contraception can be promoted by intensifying counseling, information, education and communication. Advertising should also be intensified. The majority of clients who came for permanent method of contraception were those either entering menopause or near to menopause. But there are those who are in child bearing age who need to consider permanent method of contraception because they are capable of having many children if they do not consider to stop having children. Spousal consent had an effect in the utilisation of permanent method of contraception, so policy makers need to revisit its mandatory aspect. These aspects stated above need to be looked into if permanent method of contraception is to be promoted.

CHAPTER 1

1.1 BACKGROUND INFORMATION

Family planning gives the people the opportunity for a better life. World Health Organisation (1995) outlined the benefits of family planning as follows:

Children- are assured of better health, more food and other resources available, grater opportunity for emotional support from parents and a better opportunity for education.

Women- will enjoy better health, protection from diseases, freedom of decision, less physical and emotional strain and improved quality of life.

Men- will have less emotional and economic strain, greater care to each child and improved quality of life.

Couple and family- will have freedom to decide when to have children, less emotional and financial strain, increased education opportunities for children, increased economic opportunities, energy for household activities, more energy for personal development by individuals in the community activities.

Community- reduced strain on environmental resources (land, food, water), reduced strain on community resources (health care, education), and greater participation by individuals in the community affairs.

In Zambia, the economic growth rate has been slow and the living standards have fallen. Salaries of people are low hence poverty is on the increase. There is a

decline in health status of the population, especially the women and the children which indicates the need to create demand for reproductive health and family planning and this can be achieved through education and communication. Family planning will save lives, reduce fertility and help to relieve pressures that rapidly growing population's place on economic, social and natural resources.

The high Zambian population growth rate (3.7 percent per annum) makes it difficult to improve on education, health and environmental quality declines. The Zambian government encourages couples to have small families. For example the then Minister of Health Hon Kalumba, in Zambia reproductive Health News, (1996) said use of family planning methods reduces infant and maternal deaths and that many people are not sure about the benefits of family planning. He also said that quality care is needed to ensure that family planning services are acceptable and used. National Family planning Policy ensures that family planning needs of special groups such as couples, parents with four or more children are addressed as a matter of priority. Women with large families and their spouses will be adequately informed and counseled with the option of a permanent method of family planning according to their principles of informed choice and quality care. Women with four children are to be considered as high risk and priority group.

Over the past 30 years family planning programs have helped millions of people to have the smaller families that they want. As programs have learnt to meet people's needs, contraceptives use has spread rapidly. Strong endorsement from top government and from community leaders gives family planning high priority. A study done in 1988 by Planned Parenthood Association of Zambia (PPAZ), showed that the pill is by far the most popular method of family planning used by couples in Zambia. PPAZ has promoted all forms of family planning but no comprehensive evaluation campaign has been done yet, but the experts expect male support for family planning to grow, especially with extreme harsh economic climate acting as a catalyst.

In 1989, the government of Zambia adopted an explicit National Population Policy as an integral component of its National Development Plan. The overall goal of this policy was to improve the standard of living and the quality of life of all Zambians. Its objectives include among others, initiating and sustaining measures aimed at slowing the nations population growth rate, enhancing people's health and welfare, and preventing premature illness and death especially among the high risk groups of mothers and children. Another main objectives was to ensure that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and the means to do so. The targets of the 1990 policy, among others are;

(1) To reduce the rate of population growth from the current 3.7 per cent Per annum to 3.4 percent per annum by the year 2000 and 2.5 per cent per annum by the year 2015.

(2) To reduce the total fertility rate from 7.2 per cent at present to 6 by The year 2000 and 4 by the year 2015;

(3) to reduce the infant mortality rate from 97 per cent by 1000 live births to 65 percent per 1000 live births by the year 2000 and to 50 by the year 2015; and

(4) To make family planning services available, accessible, and affordable by at least 30 per cent of all adults in need of such services by the year 2000.

The family planning program in Zambia offers several methods of family planning including sterilisation or permanent contraception. Network, (1997) reported that permanent contraception is one of the options available to couples who have decided to end child bearing, Other long acting contraceptive methods include intra uterine devices, and norplant. These are the most effective and convenient methods available for preventing pregnancy. They require little or no effort on the part of

effort on the part of the user. However this means that good service delivery and giving adequate information and counseling to help clients make reproductive choices without undue influence.

Permanent method of contraception is safe to women and is the most effective method. Its effectiveness is 99 percent and failure rate is 1 percent. Unlike hormonal contraceptive methods that are contraindicated for women with certain health conditions, sterilization is safe for women with nearly any medical condition, as long as providers treat and stabilise the condition prior to surgery.

Hatcher et al, (1997) described voluntary sterilization as method which involves the blocking of tubes that carry eggs from the ovaries to the uterus and that it is a permanent method of family planning It has many advantages. For example once performed it protects against pregnancy for the reminder of the person`s life. When the procedure is performed correctly, its failure rate is lower than any contraceptive method. It increases sexual enjoyment because there is no need to worry about pregnancy. One does not need to get regular supplies from the health center, the client does not need to remember to take anything daily and no repeated clinic visits required. The method is unrivalled in both effectiveness and continuation. It has anaesthetic risks, for instance with local anesthesia alone or with sedation, there are rare risks of allergic reaction or over dose With general anesthesia, there is occasional delayed recovery and other anesthetic side effects for example that of over dose. Nevertheless general anesthetic complications are now minimized because the procedure is now performed under local anesthesia unless in selected cases.

The permanent method of contraception is one of the means by which a couple can control the number of children, it is therefore imperative that the method is promoted vigorously. Hence the need to investigate means and ways of improving existing services.

1.2 STATEMENT OF THE PROBLEM

The choice of contraceptive methods depend on many factors. These include counseling and privacy, attitudes of family planning providers, advertising, availability and accessibility of services, age of the client, desired number of children by the couple, spousal consent or the willingness of the client's partner to participate in family planning, the risks and benefits involved with each contraceptive method.

When clients are adequately counseled, they are likely to choose methods they will be comfortable to use and will continue to use the method. Sterilisation provides permanent protection that is safe and more than 99 percent effective (Hatcher et al, 1997). Counseling for Sterilisation must be done carefully and may require more time than counseling for other contraceptive methods. Clients need more time to decide whether to undergo Sterilisation or not particularly young women under 35 years old, in order to avoid regrets later in life and to reduce reversal requests Good counseling can ensure those appropriate candidates go for sterilisation and that they are also aware of the consequences of their choice. They will be free to make a decision about the procedure and give their informed consent rather than forcing them to do so. For instance women should not be asked to make major contraceptive decisions during labour, immediately after post partum, post abortion or at other times when their ability to make a choice is impaired.

The other factor that could affect clients' choice of permanent method of contraception is the family planning provider's training in counseling. An untrained family planning providers is likely to limit contraceptive choice, as she may not be able to provide adequate information to clients.

Culturally, in many African societies Zambia inclusive women lack autonomy to

Zambia reported that a woman said " For me the 3 children are enough but I have no power to determine how many children we should have if he does not want. I struggle to look after my children, nutritious food and clothing is hard to get." It is evident here that women lack autonomy to make decisions about fertility although they bear the greatest burden of reproductive health problems and they are at risk of complications of pregnancy and childbirth. It is therefore important that men who are the final approval of contraceptive use are involved in the family planning programs by providing them with adequate scientific information and educating them about family planning and reproductive health concerns, that both they and their wives and sex partners face. Then they would encourage their spouses to practice family planning.

Cates, (1994) said, most women perceive sterilisation as a risky procedure. They do not want to be sterilised because of fear of death but if couples were adequately counseled the perceptions, hear say, fears could be minimized and this could probably increase the utilization of the method. In order to assist couples make an informed choice, providers need the latest scientific information on the health risks and benefits of the contraceptive methods. They should also understand how most clients are likely to perceive the risks and benefits of each method. But the situation is likely to differ especially in Zambia where most of family planning providers are likely to be untrained in counseling.

Family planning providers' attitudes are more likely to limit the clients' contraceptive choice. For example a study done among 660 physicians in Sao Paulo, Brazil on their attitudes, recommendations and practice of male and female sterilisation, reviewed that physicians viewed permanent method of contraceptive as a valid method for themselves and they did not generally recommend the method to couples because they presumed that they would not be interested in the method. (Bailey et al, 1991).

When contraceptive information and services are available to women receiving

maternity care, many choose to use contraception in the post partum period in order to delay the next pregnancy. Some may choose to undergo sterilisation while still in the hospital. For instance the Mexican Institute of Social Security (IMSS) has designed a post partum contraception program that provide contraception methods to post partum women while they are hospitalized for labour and delivery. In one year, nearly 650,000 Mexican women delivered babies in hospitals administered by the Mexicans Institute of Social Security and more than half of these women 356,000 began using contraception including sterilisation (Network, 1990). UTH has 12,000 births per year but no program of post partum family planning counseling is organized. If a post partum contraception program was properly organized more women would adopt a contraception method including sterilisation.

Advertising of family planning method affects the choice of family planning method in that clients go for advertised methods. In our country the methods that are highly advertised on radio and television are the pill and condoms where as permanent method of contraception is not advertised at all. If all methods were equally advertised this would attract more clients. Therefore, there is need to advertise permanent method of contraception. Family planning approaches will need to be comprehensive and should include improved contraceptive supply services, education and counseling on permanent method of contraception.

In Lusaka, the University Teaching Hospital (UTH) is the only government institution where permanent method of contraception is done. The other institutions where this is done are Maina Soko Military Hospital, Monica Chumya Hospital and Hilltop Hospital. Access to the later institutions is not easy and this makes it impossible for clients to utilize their services as clients are expected to pay a fee.

1.3 JUSTIFICATION OF THE STUDY

(1) Most of the studies done in the past have been targeted at the would be users and the concentration has been on determining knowledge, attitudes and practices of family planning. No study has been done on the clients with permanent method of contraception. The study is in line with the principles of primary health care, which encourages community participation and involvement in the health care delivery system. This study will enable the family planning providers to know what the consumers think about their services hence improve on the services provided.

(2) In program Review and Strategy Development Report, (1996) it was reported that because of low contraception rate, which is 9 percent for modern methods, a reflection of major problems on both demand and supply equation exists. There is clearly room for more research about barriers that prevent clients from utilising family planning services.

(3) The findings of this study will be used by the National Policy makers to plan for and if necessary adjust future strategies, family planning providers such as Zambia Family Planning Services and UTH to make the permanent method of contraception service more appealing and so promote acceptance. Lastly this will help to control population growth and ultimately contribute to the well being of Zambians.

(4) The research project is also in partial fulfilment of the Degree of Bachelor of Science in Nursing.

1.4 HYPOTHESIS

(1) Adequate counselling and good family planning providers' professional knowledge and attitudes will increase use of permanent method of contraception.

(2) Government's policy of spousal consent for sterilisation has an effect on utilisation of permanent method of contraception.

1.5 OBJECTIVES OF THE STUDY

General Objective

To determine the factors that affects the client's choice of permanent method of contraception at UTH.

Specific Objectives

(1) To find out the types of clients who come for permanent method of contraception.

(2) To establish the effectiveness of the counselling being given to the clients.

(3) To establish the degree of privacy during counselling.

(4) To assess the family planning providers attitude towards their clients.

(5) To assess availability and accessibility of permanent method of contraception.

(6) To establish how advertising is done.

(7) To assess the effect of spousal consent on permanent method contraception.

(8) To assess the admission facilities.

1.6 ASSUMPTIONS OF THE STUDY

(1) Adequate counselling will promote utilisation of permanent method of contraception.

(2) Advertising of permanent method of contraception will go a long way to promote its usage.

(3) Increasing its availability and making the service accessible will promote its usage.

(4) Eliminating demand of spousal consent will increase utilisation of permanent method of contraception.

(5) Good quality care, family providers' attitudes and admission facilities will encourage clients to go for permanent method of contraception.

1.8 OPERATIONAL DEFINITIONS

For the purpose of the study the following operational definition were used

(1) Sterilisation - Blocking of tubes that carry eggs from the ovaries to the uterus.

(2) Counselling - Give guidance or advise or to recommend.

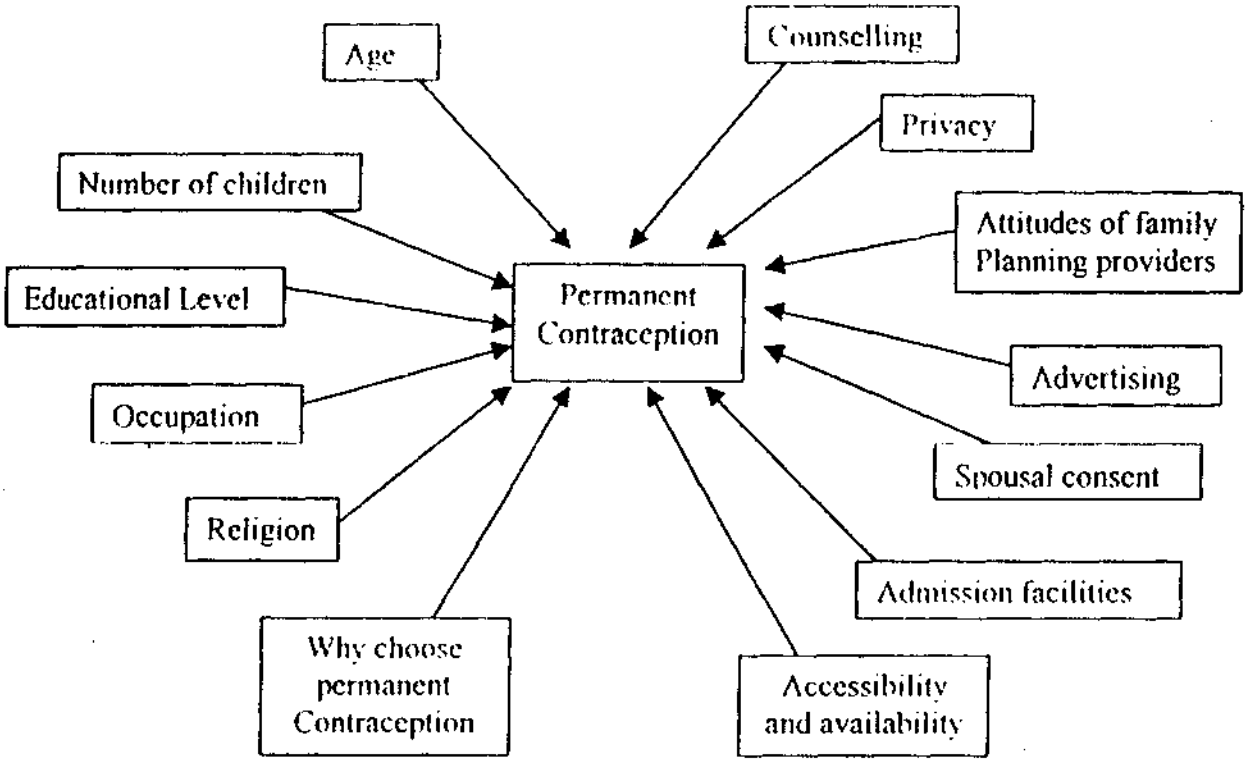
(3) Attitude – Mental view or disposition especially as it indicates opinion or allegiance.

(4) Availability - The action or practice of drawing public attention to goods, services and events.

(5) Accessibility - Easy to approach, enter or use.

(6) Consent - To give assent, permission, or agree.

1.9 DIAGRAM TO SHOW THE FACTORS THAT AFFECT CLIENTS CHOICE OF PERMANENT METHOD OF CONTRACEPTION AT UTH.



1.10 INDICATORS AND CUT OFF POINTS FOR VARIABLES

VARIABLES	CUT OFF POINTS
Dependent	
Permanent method of contraception	Favourable /unfavourable
Independent	
Counselling	Adequate/not adequate
Privacy	Yes/No
Attitudes of family planning providers	Friendly/unfriendly/not sure
Advertising	Friends/relative/mass media/health care providers
Availability and accessibility of services	Yes/No
Spousal consent	Yes/No
Admission facility	Happy /not happy

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CHAPTER 2

LITERATURE REVIEW

Uncontrolled growth of the population has been recognised as an important and world-wide problem with serious social, health and economic implications. In the third world, population control may be required for survival. The growing number of the people to be fed and provided for with basic necessities may out run a countries production capabilities, or exceed the amount that could be met with substantial international aid. Poverty, short life span, lack of employment, sub standard health and low levels of energy are the usual accompaniments of serious over populations. Literature Review revealed literature related to the research problem identified namely; counselling, privacy, attitudes of family planning providers, advertising, availability and accessibility of services, spousal consent and admission facilities which affect the clients choice of permanent method of sterilisation.

For the purpose of a systematic and orderly discussion, this will be discussed under the following headings:

- Counselling and privacy
- Attitudes of family planning providers
- Advertising
- Availability and accessibility of permanent method of sterilisation
- Spousal consent
- Admission facilities.

Counselling and privacy;

The International Planed Parenthood Federation believes that it is a fundamental right for people to receive family planning advice in order for them to have the number of children they want, bearing in mind their responsibility to the community in which they

live and society as a whole. According to Spieeler, (1992) there should be educational strategies designed to reach men. Information should be targeted to men so that they are informed about permanent contraception. Ezzeldin, (1993) of Egypt also said that better counselling and training of health providers are the main ways to expand use of family planning services. Egypt's population doubled during the past 30 years to 55 million, and examples of overcrowding were not hard to find. The government promoted family planning vigorously and there has been encouraging achievements ever since. Counselling needs devotion for the client to be adequately counselled. If clients are not adequately counselled it will result in discontinuation rates. In Jamaica, Ministry of Health and the National Family Planning Board trained non-nursing staff to do counselling on sterilisation and these counselled prospective tubal ligation clients. This increased the number of sterilisation clients. Counselling should be planned and the counsellors should be properly trained. A study done by Hapugalle and Jonawits et al, (1985) confirms the need for proper counselling. Women who had undergone sterilisation between 1980 and 1985 indicated that 14 percent subsequently regretted their sterilisation. The subjects said that they wanted to have another child or they wished they had been sterilised later or not at all. The most determinant of regret was not having a child of each sex at a time of the operation, being married for 5 years, being 25 years, having two children or fewer or having a child die. The researchers discovered that factors associated with regret had to do with failure of program staff to identify risk factors of regret in order to target for additional education or counselling prior to sterilisation. They concluded that adequate counselling could reduce regret. Counselling should be intensified and more time should be allocated to those with the potential to regret. Hatcher and Rinehart et al, (1994) confirmed that counselling is an important aspect in that the goal of counselling is to provide the client with the information and guidance that will result in their voluntary selection of a contraceptive method which they will use, which will be effective, and which will not have adverse effect. Counselling equips clients and makes them choose contraceptive method, which suits them and their need, and they are able to do that if they have the information and assistance from family planning provider. Counsellors need to strike a balance between providing too much technical information that may intimidate a client and providing too

little information for a client to make a truly informed choice. Face to face meeting between a client and provider may be the only chance the client has to ask questions, express concerns, or learn about different methods from someone who is knowledgeable and concerned. Counselling should be conducted in a quiet place without interference. Bruce, (1993) said clients need to be treated with dignity, offer services in ways which are culturally appropriate and acceptable to clients. In Zambia issues to do with reproductive health are considered confidential hence the need to talk about them in privacy. This kind of environment will make clients more at ease and comfortable.

Attitudes of family planning providers;

One way which family planning providers can employ in order to improve client satisfaction and perhaps increase user continuation is to improve the quality of provider client/interactions. Providers have focused their attention on technical aspects of care, and medical procedures and distribution of the most effective methods while clients have focused on personal aspects of care, how contraceptives will affect their health and to what extent those delivering the service express concern for a woman. This difference in perspective needs to be addressed repeatedly. This was confirmed by Marcos, (1993) who said that health providers attitude and treatment of clients often determine whether the woman will seek for services at all. This is because women who are treated badly discuss their experience with would be clients hence family planning services develop a bad reputation. The principle influence on sterilisation is the testimony of a friend or a relative who has undergone the surgery, is satisfied with it , and refers the good service of our clinic. There is need for family planning providers to be client oriented so that the clients feel that the staff is interested in them and that they are being treated as equals. The study done in a clinic in Santigo, Chile high lighted this notion that from the client's point of view, its not only the technical quality of service that is important but also other aspects, including privacy, confidentiality, competent counselling, friendly personnel, and opportunity to make an informed choice about a contraceptive. Counselling is therefore the most crucial step in a person's decision making process about family planning. Whittaker, (1988) in his article "Reviving the human face of family planning

" said Planned Parenthood Association of Zambia has adopted quality care as one of its motivation for developing and managing a family planning and reproductive health clinic in Zambia. Issues addressed were adequate training in motivation, counselling and knowledge of family planning and reproductive health for staff flexible hours of operation, provision of sexually transmitted diseases, screening, counselling, availability of all methods, adequate and constant supplies and confidentiality of services. The need to adequately train family planning providers provision of quality care is also stressed here.

Advertising;

Rutenberg and Landry, (1990) did a study in El Salvador, on how women came to know about sterilisation. They identified the fact that there was need for information, education, materials and counselling services in addressing issues related to accessibility of services. Women had learnt about sterilisation and became informed of its nature from mass media and through communication, with woman to woman who had had an operation, as well as with the health personal. This underscored the need for vigilance on the part of program administrators regarding methods of educating women about the operation and the systems of obtained consent. There was also another study done by the United Nations Population Fund in Zimbabwe, on the subject of "useful information and services rather than lack of interest, has kept men from taking a more active role in family planning". They launched an ambitious nation wide male motivation project. It was designated to increase knowledge of family planning method and to promote joint decision making. This was done through radio, serial drama, motivational talks and family planning leaflets. When they evaluated the program they found that radio drama was more effective reaching about two of every five men surveyed, and this covered rural and urban areas. This led to the promotion of permanent method of contraception. This was also supported by Nyambe, (1994) who did a study in Lusaka to determine factors contributing to under utilisation of vasectomy- her results also confirmed the need for publicising and providing information on permanent method of contraception. There should be strategies in place for making the permanent contraception known to the

people. A large mass media campaign was done in Nigeria and this increased contraception use significantly. The increase came among those most exposed to the campaigns radio, television, and print materials. This high lights the fact that intense campaign can change behaviour.

Availability and accessibility of services;

Jain, (1993) said contraceptive prevalence is higher in countries where methods are available than in those countries where there are one or two methods available. Availability and accessibility of family planning can be ensured by removal of policy barriers that limit certain methods making them illegal for example permanent contraception. Restricting advertising for contraceptive distribution only to physicians, requiring that contraceptives only be supplied to women who have husbands, consent and requiring unnecessary import duties and customs regulations for contraceptives. Clients are more likely to use contraceptives if they are presented with a choice of methods and services that are easily accessible. Knowledge of a source of sterilisation service is important for informed decision making as well as for acting on the decision to seek sterilisation. Hon Kalumba, (1996) said, " one of the primary barriers to using family planning is lack of knowledge about where to obtain family planning services. The Ministry of health made a statement that quality family planning services must be provided to clients. United Nations Convention also alludes to the fact that appropriate health facilities should be planned, designed, constructed and equipped to be readily accessible and acceptable.

Spousal consent;

United Nations Convention states that women should have access to adequate health care facility including information and services of family planning. "Paragraph 69 calls for the revision of civil codes particularly pertaining to family law to eliminate discriminatory practices where these exists and wherever women are considered legal minors". In addition, it calls for a review of legal capacity of married women in order

to grant them equal rights and duties Elimination of rules requiring spousal authorisation for family planning, since such regulations usually demand that only women obtain the approval of their husbands Removal of these laws has been shown to increase the use of family planning For example, in 1982 The Family Guidance Association of Ethiopia discontinued its requirement that a woman receive her husband's authorisation to obtain family planning services and within a few months, clinic use increased by 26 percent. WHO, (1995) said availability and accessibility to family planning can be ensured by removal of policy barriers that limit access and choice. Policies that unnecessarily restrict access to contraceptives include making certain methods illegal such as voluntary sterilisation. Akhter, (1986) said that when a man wants vasectomy he does not need a wife's consent; yet for a wife to get sterilised she needs her husband's approval. Akhter also says if a woman tells her that they discussed with the husband and her husband agreed consent should be obtained from her not the husband. The fact that women are told to go back home and get the husband's signature could be a factor that make women not use permanent method of sterilisation.

Admission facilities;

WHO, (1995) did an informal survey in Los Angels, and they found out that patients changed providers for a variety of reasons having to do with the providers style, including poor communication skills, disorganised atmosphere, an inability to inspire confidence in the patient, and personal habits or characteristics such as cleanliness. This view is supported by the research carried out in Egypt, in 1988 where they found that public clinics were poorly regarded compared to private clinics. So improvement program were designated to operate clinics with higher standards. Coupled with mass media efforts in advertising and high quality service care this lead to increased clinic attendance and other clinics aspired to higher quality. This shows that health care facilities have a role to play in the clients' utilisation of the service.

CHAPTER 3

METHODOLOGY

3.1 RESEARCH DESIGN

The researcher used a descriptive survey that is studies that obtain data by interviewing people so as to get an accurate description of factors that affect the clients' choice of permanent method of contraception. Treece and Treece (1986) defined survey research as a study in which a body of data is collected recorded and analysed. They add on to say that descriptive studies are non-experimental and they answer the questions, satisfy curiosity, solve a problem or establish the cause relationship. Descriptive study also has a high degree of representativeness in relation to the sample size. The researcher was able to get information with ease in the real world and not in an official setting. Therefore the researcher was able to have a good insight into the real situation.

3.2 RESEARCH SETTING

The study was conducted in two urban residential areas, ie. Chilenje and Mtendere, and lastly UTH in Lusaka. This was a good representation of the population because it represents the low and high-income groups. As for UTH, this is where the clients who came for review were interviewed.

3.3 STUDY POPULATION

This comprised of women who had undergone permanent method of contraception from 1997 to 1998. This seemed to be the ideal range of period because of the high turn over in residential areas.

3.4 SAMPLE SELECTION

Clients were conveniently selected from UTH and clinic registers. The UTH clients were interviewed as they came for review while the clients from Mtendere and Chilenje were interviewed in their homes. Convenience sample is the use

of the most readily available persons This was appropriate because it is not easy to find people's homes and at UTH only five clients are reviewed per week. The respondents were those who were available when the researcher was conducting the research. Laura (1995) states that a convenience sample is used when participants are easily accessible to the researcher and meet the criteria of the study. The advantages in using convenient sample are the ease in carrying out the research and the saving of time and money. The disadvantages are the potential for sample bias, the use of a sample that may not represent the population and the limited generalisation of the results. However the disadvantages will be controlled by restricting the respondents to only those who have had permanent method of contraception at UTH In this way the sample met the criteria of the study population

3.5 SAMPLE SIZE

The sample size was 50 (fifty) because of the limited time in which the study was to be done. 10 clients were from UTH, 20 from Chilenje and 20 from Mtendere making a total of fifty.

3.6 DATA COLLECTION TECHNIQUE AND TOOL

(1) Structured interview schedule was used. The instrument comprised of a series of questions that were both open and closed ended.

This was thought to be the most efficient way of gathering data more accurately since it allows for more probing and clear understanding of the questions. It is appropriate since the nature of the sample included both literate and illiterate respondents. It saves on time, as there is no need to go back to respondents to collect the questionnaires.

But it has disadvantages like the presence of the interviewer may lead to the interviewee not giving precise and accurate answers especially in

closed questions. It is also time consuming especially in terms of dealing with large populations because the interviewer does not need to be in a hurry if adequate information is to be collected. These problems were addressed by ensuring that the interviewer created good rapport with the respondents, and explained the purpose of the study and how the subjects were selected.

The interviewer introduced herself to each and every respondents and assured all the subjects that all information collected was going to be treated with high degree of confidentiality. Questions were simply and clearly stated to minimise the problems of misunderstandings. Where the respondent was not clear, the questions were clarified

At the end of each interview session, the researcher checked through the answers to clarify any information written in a hurry.

3.7 CULTURAL/ETHICAL CONSIDERATIONS

In order to conduct the study, permission was sought from UTH and Lusaka District Health Management Boards. Appendix (I). Verbal permission to interview clients was obtained and an explanation was given. The clients were told that, their names were not to be recorded on the interview schedule. This was done in order to ensure confidentiality.

3.8 PILOT STUDY/PRETESTING

This was done in July 1998 that is two weeks before the main study. It was done in order to assess whether the structured interview schedule was appropriate and clearly phrased and also to test the reaction of the respondents. After the analysis of the pilot study two necessary adjustments and rearrangements to the questions

was done. The pilot study was done in Kabwata Clinic catchment area because of the need to avoid bias if the same study setting was used. But the characteristics of the sample were the same. The sample size was 5 respondents because it is calculated by using 10 percent of the respondents of the study population in the main study. Clients were conveniently selected from UTH register. Convenience sample is the use of the most readily available persons. The respondents were those who were available when the researcher was conducting the research.

CHAPTER 4

DATA ANALYSIS AND PRESENTATION OF FINDING

INTRODUCTION

The analysed data is presented in form of tables and numerical description is given for each table. Presentation of data in this form reduces narration process and tabulated data is easier to remember. Data was analysed manually because the sample was small.

A total of fifty clients who had under gone permanent method of contraception were conveniently selected and interviewed in Chilenje, and Mtendere residential areas and University Teaching Hospital.

Data collected from the respondents was analysed in August 1998. Data was first edited for completeness and master sheet was prepared to avoid losses and mixing up of data. Responses for open-ended questions were categorised, coded and then tabled. Adding all the responses arrived at frequencies.

BACKGROUND INFORMATION

Table 1: Respondents age distribution

Age group	Frequency	Percentage
30 – 35 years	2	4%
35 –40 years	17	34%
40 –45 years	17	34%
45 –50 years	14	28%
Total	50	100%

Table 1 revealed that the respondents 17 (34%) were aged between 35-40years and 40 -45 years respectively, followed by 14 (28%) who were between 45 -50 years old, and 2 (4%) were between 30-35 years old.

Table 2: Respondents number of children

Number of children	Frequency	Percentage
1 – 3	2	4%
4 – 6	20	40%
More than 6	28	56%
Total	50	100%

Table 2 shows that 28 (56%) of the clients had more than 6 children followed by 20 (40%) who had 4-6 children and 2 (4%) had 1-3 children.

Table 3: Respondents education level

Educational level	Frequency	Percentage
Not attended school	5	10%
Primary school	21	42%
Secondary school	17	34%
College	7	14%
Total	50	100%

Table 3 illustrate that most of the clients were those of primary school level of education 21 (42%) followed by secondary school level 17 (34%) not attended school were 7 (14%) and 5 (10%) were those who had been to college.

Figure 1 : Frequency of Occupation of Respondents

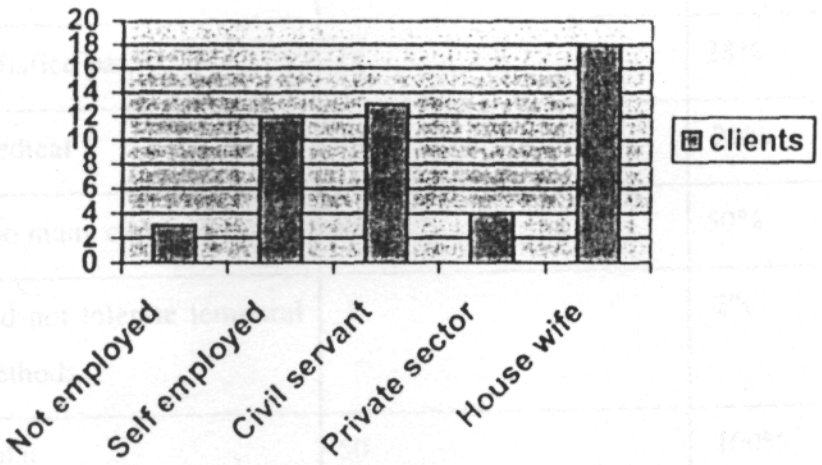

Figure 1 reveal that most of the clients were house wives 18 (36%) followed by civil servants 13 (26%), the self employed 12 (24%), 4 (8%) was private sector and 3(6%) were not employed.

Table 4 : Respondents religion

Religion	Frequency	Percentage
Roman Catholics	19	38%
Baptist	6	12%
United Church of Zambia	13	26%
Pentecostal	4	8%
Others	8	16%
Total	50	100%

Table 4 shows that the majority of respondents were Roman Catholics 19 (38%) followed by United Church of Zambia 13 (26%), 8 (16%) were others, 6 (12%) were

Baptists and the lowest was Pentecostal 4 (8%)

Table 5: Respondents reason for choosing permanent method of contraception

Reason	Frequency	Percentage
Satisfied parity	14	28%
Medical	10	20%
Too many children	25	50%
Did not tolerate temporal methods	1	2%
Total	50	100%

Table 5 indicate that most of the clients chose permanent method of contraception because of too many children 25 (50%) followed by satisfied parity 14 (28%), medical reasons 10 (20%) and 1 (2%) were because they did not tolerate temporal methods.

Counselling and Privacy

Table 6: Responses to whether the client were interrupted

Responses	Frequency	Percentage
Not interrupted	44	88%
Interrupted	6	12%
Total	50	100%

Table 6 show that the majority of the clients were not interrupted 44 (88%) and 6 (12%) were interrupted.

Table 7: Responses to how long the counselling session took

How long did counselling take	FREQUENCY	Percentage
10 minutes	6	12%
15 minutes	14	28%
20 minutes	7	14%
30 minutes	12	24%
45 minutes	11	22%
Total	50	100%

Table 7 shows that most of the clients 14 (28%) spent 15 minutes for counseling followed by 12 (24%) who spent 30 minutes, 11 (22%) spent 45 minutes with the counsellor and 6 (12%) clients spent 10 minutes with the counselor.

Advertising

Table 8: Responses to where they got information about permanent method of contraception

Responses	Frequencies	Percentage
Friend	26	52%
Family planning providers	17	34%
Health care providers	6	12%
Others	1	2%
Total	50	100%

Table 8 indicate that most of the clients 26 (52%) heard about permanent contraception from friends followed by 17 (34%) who heard from family planning providers and 6 (12%) heard from health care providers.

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Table 9: Responses to whether the clients have shared their permanent method of contraception experience with others

Responses	Frequencies	Percentage
Yes	38	76%
No	12	24%
Total	50	100%

Table 9 illustrate that 38 (76%) had shared their permanent method of contraception experience with others and 12 (24%) had not shared.

Table 9 A: Responses to reasons for yes

Reasons	Frequencies	Percentage
Wanted my friends to know	15	39%
It is good for those with medical conditions	6	16%
It is the best for those who want to stop having children	4	11%
It is the best for those with many children	13	34%
Total	38	100%

Table 9 A shows that 15 (39%) wanted friends to know about permanent contraception so that they can do the same, 13 (34%) said because it is the best way to stop having children so people needed to know, 6 (16%) said because it saves life and lastly 4 (11%) said because it is good especially for those with many children.

Table 9 B: Responses to reasons for no

Reason	Frequency	Percentage
Religious beliefs	2	17%
I am too old to discuss such things	2	17%
I feel shy	4	33%
It's a taboo to discuss sex	1	8%
It's a secret so people should not know	3	25%
Total	12%	100%

Table 9 B shows that 4 (33%) feel shy to tell others about it, 3 (25%) said it is a secret, 2 (17%) feel they can not tell others because of their religious beliefs and 1 (8%) feel it is a taboo to talk about sex.

Spousal consent

Table 10: Respondents to clients opinion on whether women should sign the consent as long as the wife and husband are in agreement.

Responses	Frequencies	Percentages
Yes	46	96%
No	4	8%
Total	50	100%

Table 10 shows that 46 (92%) of the clients were for the idea that women should sign the consent as long as the wife and the husband are in agreement, and 4 (8%) were against the idea.

Table 10 A: Respondents reasons for women signing the consent for permanent method of contraception.

Reason	Frequencies	Percentage
Husband's fear wife's relatives	1	2.2%
Some men do not understand	9	19.6%
Men fear that their wives will be unfaithful	1	2.2%
It is woman's right	15	32.6%
It is the woman who is at risk	8	17.4%
Unmarried have to find someone to sign	3	6.5 %
Women can have the method when they want	9	19.6%
Total	46	100%

Table 10 A shows 15 (32.6%) women feel that it is a woman's right, 9 (19.6%) feel because men do not understand, 8 (17.4%) feel that because it is the woman who are at risk therefore she should sign, 9 (19.6%) feel that women can have the method when they want and 3 (6.5%) said that because the unmarried have to find someone to sign for them.

Table 10 B: Respondents reasons against woman signing the consent

Reason	Frequencies	Percentage
Women will be unfaithful	1	25%
It will cause marital problems	3	75%
Total	4	100%

Table 10 B shows that 3 (75%) said it will cause marital problems and 1(25%) said it will make women unfaithful.

Admission facilities

Table 11: Responses to whether they were happy with the admission facility.

Responses	Frequency	Percentage
Yes	42	84%
No	8	16%
Total	50	100

Table 11 shows that 42 (84%) were happy with the admission facilities and 8 (16%) were not happy with the facilities.

Table 11 A: Respondents reasons for being happy.

Reason	Frequency	Percentage
Environment was clean	10	23.8%
I had no problems	32	76.1%
Total	42	100%

Table 11 A shows that 32 (76.1%) experienced no problems with the place of admission, followed by 10 (23.8%) who said that the environment was clean.

Table 11 B: Respondents reasons for not being happy.

Reasons	Frequency	Percentage
Other people had different diseases	2	25%
The bed sheets were dirty	1	12.5%
No privacy and congested	4	50%
Nurses not co-operative	1	12.5%
Total	8	100%

Table 11 B shows that 4 (50%) felt that there was no privacy and it was congested, 2 (25%) felt the place had patients with different diseases and 1 (12.5%) felt that the bed sheets were dirty and nurses were not co-operative.

Table 12: Responses to whether the clients were happy with the place of admission after the operation.

Responses	Frequency	Percentage
Yes	36	72%
No	14	28%
Total	50	100%

Table 12 shows that 36 (72%) of the clients were happy with the place they were admitted in after the operation and 14 (28%) were not happy with the place.

Table 12 A: Respondents reasons for being happy with the place of admission after the operation of permanent method of contraception.

Reason	Frequency	Percentage
Environment was good	1	2.7%
They had no problems	35	97.2%
Total	36	100%

Table 12 A shows that 35 (97.2%) were happy with the place of admission after the operation because they did not experience any problems and 1 (2.7%) said that because the place was clean.

Table 12 B: Respondents reasons for not being happy with the place of admission after the operation.

Reason	Frequency	Percentage
No privacy	2	14.2%
Bed sheets were not clean	1	7.1%
Nurses were not helpful and took long to check on us	7	50%
Was put in ward with people with other diseases	4	28.5%
Total	14	100%

Table 12 B shows that 7 (50%) of the nurses were not helpful and took long to check on the patients, 4 (28.5%) said because they were put in the ward with different diseases, 2 (14.2%) said there was no privacy and 1 (7.1%) said the bed sheets were dirty.

Table 13: Marital status in relation to spousal consent for permanent method of contraception.

Marital status	Spouse consent on permanent method of contraception			
	Yes	No	Not applicable	Total
Married	30 (60%)	9 (18%)	0	39 (78%)
Widowed	0	0	8 (16%)	8 (16%)
Divorced	0	0	1 (2%)	1 (2%)
Separated	0	0	2 (4%)	2 (4%)
Total	30 (60%)	9 (18%)	11 (22%)	50 (100%)

Table 13 indicate that 30 (60%) out of 39 (78%) spouses were willing to sign the consent for permanent contraception while 9 (18%) were not willing to sign the consent and 11 (22%) out of 50 (100%) had no husband to sign the consent for the following reasons 8 (16%) were widows, 2 (4%) were separated and 1 (2%) were divorced.

Table 14: Attitudes of family planning providers in relation to being happy with counselling.

Attitude	Happy with Counselling		
	Yes	No	Total
Friendly	46 (92%)	0	46 (92)
Unfriendly	1 (2%)	0	1 (2%)
Not sure	3 (6%)	0	3 (6%)
Total	50 (100%)	0	50 (100%)

Table 14 shows that 46 (92%) out of 50 (100%) clients counselled found family planning providers friendly, 3 (6%) were not sure of the family planning providers attitudes and 1 (2%) said they were unfriendly.

Table 15: *Availability of permanent contraception in relation to accessibility of* Permanent method of contraception.

Accessibility	Availability				
	One week	Two weeks	One month	More than a month	Total
Within 5Km	0	0	1 (2%)	0	1 (2%)
More than 5Km	1 (2%)	12 (24%)	21 (42%)	15 (30%)	49 (98%)
Total	1 (2%)	12 (24%)	22 (44%)	15 (30%)	50 (100%)

Table 15 illustrate that most clients 21 (42%) out of 49 (98%) waited for one month, and these covered a distance of more than 5km and only 1 (2%) clients covered less than 5km and had the procedure done after one month while 15 (30%) clients covered more than 5km and these waited for more than a month for the procedure to be done.

4.1 DISCUSSION OF FINDINGS

This study was aimed at determining the factors that affect the client's choice of permanent method of contraception at UTH. The sample consisted of (50) clients who were conveniently sampled at Mtendere, Chilenje and UTH. The findings were discussed in September 1998 and relevant implication to the health service has been made.

SOCIO-DEMOGRAPHIC DATA

Most of the clients were aged between 35-40 years and 45-50 years respectively 17 (34%) and 2 (4%) were aged between 30-35 years old as table 1 indicates. The picture here shows that the elderly women are the ones making use of permanent method of contraception. These women came for this method because of too many children as table 2 shows 28(56%) were the majority and had more than 6 children. A high percentage 21 (42%) had primary school level of education (Table 3) and 18 (36%) were housewives (Table 4). This is quite positive because the less educated and the housewives are the most in the utilisation of permanent method of contraception. These tend to start having children early in life and hence they are capable of having many children. The Roman Catholics 19 (38%) were the majority and the lowest were Pentecostals 4 (8%) according to table 5. This suggests that the Roman Catholics could be sharing the advantages of this method among themselves and this should be encouraged and recommended. The majority of clients 25 (50%) chose permanent method of contraception because they had too many children, 14 (28%) had satisfied parity and 10 (20%) was because of medical reasons as table 7 illustrates.

COUNSELLING AND FAMILY PLANNING PROVIDERS' ATTITUDES

The study showed that 14 (28%) spent 15 minutes in counselling and 12 (24%) spent 30 minutes as in (Table 5). These findings are inconsistent in the sense that the times for counselling seem to vary greatly. Counselling is crucial because it is the provider's responsibility to ensure that the client fully understands and freely makes consent to the procedure. Despite the disparity in the time spent in counselling all the clients were

satisfied with the counselling they received. This is in line with what Population Reports, (1990) reported that good counselling requires both empathy and information. Providers should have accurate information and know how to communicate it clearly to clients in the language that they understand. The clients said that counsellors explained everything they needed to know about permanent method of contraception and some said that the information they got helped them to make a decision.

The majority 46 (92%) of the respondents said that, the family planning providers' were friendly and that the clients were satisfied with their counselling. This confirms the researcher's hypothesis that adequate counselling, good family planning providers' professional knowledge and attitudes will increase use of permanent method of contraception. A study done in Santigo, Chile is similar to this study, they discovered that from the clients point of view, it is not only the technical quality of service that is important but also other aspects, including privacy, confidentiality, competent counselling, friendly personnel, and opportunity to make an informed choice about a contraceptive. Counselling is therefore the most crucial step in a person's decision making process about family planning. 3 (6%) clients were not sure of the family planning providers' attitudes (Table 16). Those who were not sure of the family planning providers' attitude said that, because the nurse asked them what they wanted and that the nurse looked serious.

ADVERTISING

Most of the clients 26 (56%) heard about permanent method of contraception from friends and 1 (2%) heard from others (Table 9). The findings confirmed the study done in El Salvador by Rutenberg and Landry, (1990) they discovered that women learnt about sterilisation and became informed of its nature through mass media and through communication, with woman to woman who had had the operation, as well as through the health personnel. This study underscored the need for vigilance on the part of program administrators regarding methods of educating women about sterilization. Advertising of permanent contraception is not done in mass media and other health care providers are doing very little advertising as the table 9 shows.

SPOUSAL CONSENT

Spousal consent has an effect on the utilisation of permanent method of contraception because some spouses were not willing to sign the consent as they feared wive's relatives or were afraid of its complications. This is illustrated in table 15, 30 (60%) out of 39 (78%) spouses were willing to sign the consent and 9 (18%) spouses were not willing to sign the consent. The widowed 8 (16%), divorced 1 (2%), 2 (4%) had no husbands to sign the consent they had to find relatives to sign. Most women (46 (96%) would like to sign consent for permanent method of contraception (Table 11). This confirms what WHO, (1995) said, accessibility and availability to family planning can only be ensured by removal of policy barriers that limit access of choice. Therefore it can be concluded that spousal consent has an effect on the use of permanent method of contraception. The hypothesis of the researcher has been proved that governments' policy on spousal consent for sterilisation has an effect on permanent method of contraception. 4 (8%) felt that women should not sign the consent because it will cause marital problems and that the women will become unfaithful.

AVAILABILITY AND ACCESSIBILITY OF PERMANENT METHOD OF CONTRACEPTION

21 (42%) out of 49 (98%) were asked to come for the operation after one month and they covered a distance of more than 5Km. While 15 (30%) came after more than a month and covered a distance of 5Km (Table 17). Though permanent method was done, the method was not easily available and accessible. Jain, (1993) confirms this notion that clients are more likely to use contraceptives if they are presented with a choice of methods and services that are easily accessible.

ADMISSION FACILITIES

The study revealed that 42 (84%) were happy with the admission place while 8 (16%) were not happy with the place (Table 12). The reasons for being happy were because the clients had no problems and that the environment was clean. Those who were not happy said that the place had other patients who had different diseases, there was no privacy, dirty bed sheets and that the nurses were not co-operative. This is also what WHO, (1995) discovered in Los Angels that patients changed providers for a variety of reasons having to do with the providers style, including poor communication skills, disorganised atmosphere, an inability to inspire confidence in the patient and personal habits or characteristics such as cleanliness. 36 (72%) were happy with the place they were put in after the operation while 14 (28%) were not happy with the place (Table 13) Those who were not happy said because the nurses took long to check on them and they were not helpful. Quality service care leads to increased clinic attendance.

4.2 IMPLICATION TO THE HEALTH SYSTEM

This study revealed that counselling is adequately done and that the clients were happy with the information they were given. However, there is need for targeted information, education and communication to the communities and to the various health service areas so that the people are aware of the permanent method of contraception. This implies that nurses need to intensify the efforts in educating the people about permanent method of contraception and this means that UTH should train the health care providers so that they all promote permanent method of contraception in stead of leaving this to the family planning providers alone.

Advertising is one aspect we need to exploit so that people are aware of this family planning method so that they can make wise choices especially those in the child bearing age who are capable of having big families leading to overcrowding in the home and unhygienic conditions. Big families will lead to poor health and the health sector won't be able to handle the situation, as the health sector budget will be too big in terms of

medicine and other overheads. The other method is to use other women to educate their fellow women about permanent contraception. There is need to promote good attitudes among the health providers so that they can provide quality service.

4.3 CONCLUSION

The purpose of this study was to establish the factors that affect the client's choice of permanent method of contraception at UTH. The objectives of the study were met. Fifty respondents were conveniently selected who had undergone permanent method of contraception. The study revealed that most of the clients choose this method because of too many children and the housewives are the majority using this method. Counselling is adequately done and the clients were happy with the information they were given. Most of the family planning providers were friendly because they were welcoming and helpful.

The majority of the clients travelled a distance of more than 5Km and they were given appointment of a month and more than a month in order for the operation to be done. The clients had to spend money to get to the hospital for the procedure.

Spousal consent revealed that some husbands are not willing to sign the consent and that those not married like the widowed, separated, divorced had to find some one to sign the consent on their behalf. Most women felt that women should sign the consent because it is their right, women are the at risk and that some husbands do not understand.

Advertising of permanent method of contraception is not done on mass media. The clients learnt about permanent method of contraception mostly from friends. Most of the clients were happy with the admission facility.

4.4 RECOMMENDATIONS

1. There is need to intensify information, education and communication of permanent

method of contraception in all health service departments and family planning managers need to consider this.

2. Family planning provider's attitudes must be promoted and encouraged by reinforcing the positive behaviours. The supervisors of family planning providers should reinforce the positive behaviours.
3. Advertising of permanent method of contraception must be done instead of leaving it to chance. The government, the Zambia Family Planning Services and Planned Parenthood Association of Zambia, need to do this.
4. Governments' policy on spousal consent for sterilisation should be optional and not a mandate.
5. Admission facilities in UTH should be of high quality with good nursing care and this Will motivate clients of permanent method of contraception.
6. A study should be done on the knowledge and attitudes of men towards permanent method of contraception.

4.5 LIMITATIONS OF THE STUDY

1. There was limited time in which to conduct the study and submit the result to the school for grading. The other reason is that the study was being done along side with other courses that were also demanding for the researcher's time.

2. The funds for the research were also limited hence the sample size of fifty (50) was chosen.

BIBLIOGRAPHY

1. Assessment of The Need for Contraceptive. (1995) *Expanding Family Planning Options.* WHO Geneva.
2. Bailey, P. E et al (1991) *Physicians Attitudes.* Recommendations and practice of male and female sterilisation. In Sao Paulo, Contraception, 44 (2): 191-207
3. Cates, W. (1994) *Family Planning Saves Lives.* Third Edition. P19.
4. Edmud's and Strachan et al. (1987) *Clients Responsive Family Planning.* Handbook for Providers, The Path Finder Fund. PP 11-12.
5. Family Planning in Reproductive Health. (1997) *Policy Framework Strategies Guidelines.* Republic of Zambia. PP 1, 13,28,32,36. March.
6. Hatcher, R. A. and Rinehart, W. et al. (1994) *Contraceptive Technology.* 16th Edition. Irving Publishers, Inc. New York. P159.
7. Hatcher, R.A. et al, (1997) *The Essentials of Contraceptive Technology.* Population Information Program, Centre for Communication Programs, The John Hokins School of Public Health
8. Health Benefits of Family Planning. (1995) *Family Planning and Population.* Division of Family Health WHO. Geneva PP 17,12.
9. Integration. (1996) *International Review of Population and Reproductive Health One World.* One Hope. P37.
10. International Family Planning perspectives. (1993) *Sterilization Use and Demand.* Vol. 19 Number1 P 6. March.
11. International Family Planning Perspectives. (1989) *Fertility Changed Women's Education* Vol. 15, Number 1 PP 22,28. March.
12. International Family Planning perspectives. (1986) *Sterilization Worldwide: A Review* Vol. 12 Number2 P34. June.
13. International Family Planning Perspectives. (1986) *Sterilization Worldwide.* Vol. 12 Number 2 PP 40, 43. June.
14. International Family Planning Perspectives. (1988) *Attitudes Towards Childbearing in Tunisia. Method Switching Among Sri Lankans. Impact of Sterilization on Fertility in Brazil.* Vol. 14 Number 2. June.

15. International Planned Parenthood Federation (1983) (IPPF) Special Tabulations of data from 1982 and 1983 annual reports and 1983 Half Yearly Report of Family Planning Association of Ethiopia.

16. Kondwani, C. (1990) *Anglo Phone East and Southern African Journalists Workshop.* Sponsored by Family Health International. Kenya.

17. Letten Maiere G. (1987) *Counseling Makes a Difference.* Population Reports 15(3) Series J (35) P 11.

18. Network. (1997) *Male and Female Sterilisation.* Family Health International. Vol. 18 No.1

19. Network. (1992) *"The Forgotten 50 Percent".* Family Planning International, Vol.13, Number 1 P17. August.

20. Network. (1993) *Improving Access to Contraception.* Family Planning International, Vol. 13, Number 3 P 5. March.

21. Nyambe, M. (1994) *A Study to Determine the Contributing Factors to Under Utilisation of Male Surgical Method of Family Planning Among Men in Lusaka.* Unpublished Paper.

22. Parenthood. (1988) *The Official Journal of the Planned Parenthood Association of Zambia.* Vol. 1 Number 6 Family Planning a Responsibility PP9,13.

23. Population Reports. (1994) 1 Series J, Number 40 P1. August.

24. Program Review and Strategy Development Report. (1996) *Zambia United Nations Population Fund.* PP 1,2,12-13,17-19,46.

25. Seaman, H. C. and Vehonick. (1982). Research Methods for Undergraduate Students. New York.

26. Simposya, F. (1998) *Feature.* Times of Zambia. April.

27. Tabott, A. L. (1995) Principles and Practices of Nursing Research. The C. V. Mosby Company P. 252.

28. Treece, J.W. and Treece,E.W. (1986). Elements of Nursing Researching. The Mosby Company.

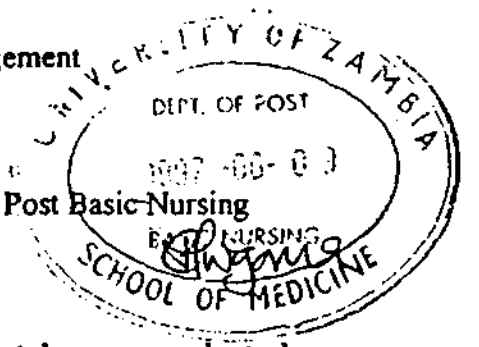
29. Zambia Demographic and Health Survey. (1997) *Central Statistics Office(CSO) (Zambia) Ministry of Health and Macro International Inc.*

Appendix 1

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P O Box 50110
Lusaka

8th June, 1998

The Executive Director
Univrsity Teaching Hospital Board of Management
P O Box
Lusaka



u.f.s Acting Head – Post Basic Nursing

Dear madam

RE: Permission to undertake a research study

I am a fourth year student pursuing a degree in nursing at the University of Zambia.

As part of the course requirement, I have to carry out a research study. I am, therefore, asking for permission to do a study in your institution. My research topic is: `A study to determine the factors that affect the client's choice of permanent method of contraception at UTH.' The target population will be those who have had permanent method of contraception. It is hoped that the results of this study will benefit the Univeristy Teaching Hospital Board of Management.

Thanking you in anticipation

Yours faithfully

Felistas M Mbewe (Mrs)

Appendix 2

University Teaching Hospita
(Board of Management)

P/Bag RW
Lusaka, Zaml
Tel: 227709-
Fax: 2503
Telex: ZA 402

ur Ref:

ur Ref:

1st July, 1998.

Felistas M. Mbewe
UNZA
School of Medicine
Department of Post Basic Nursing
P.O. Box 50110
LUSAKA.

Dear Madam,

RE: PERMISSION TO UNDERTAKE A RESEARCH STUDY

The UTH Board of Management has granted you permission to pe̶ue your research, to determine the factors that affect the client's choice of permanent method of contraception at UTH.

Yours faithfully,

A.M. Malewa (MS)
A/DIRECTOR OF NURSING

AMM/mmk.

Appendix 2

P. O. Box 50817
Lusaka
Tel: 235551
Fax: 236129

In reply please quote
No. . . . . .

MINISTRY OF HEALTH
LUSAKA DISTRICT HEALTH MANAGEMENT BOARD

15th June, 1998

Felistas M. Mbewe
UNZA
School of Medicine
Dept of Post Basic Nursing
P.O. Box 50110
LUSAKA.

Dear madam,

Re: PERMISSION TO UNDERTAKE A RESEARCH STUDY

The Lusaka District Health Management Board has granted you permission to use Lusaka catchment area for your study. "To determine the factors that affect the Client's choice of permanent method of contraception at UTH".

Kindly let us know which particular Clinics you are interested in.

Yours faithfully,

Mlanja

Dr S. Bvulani-Malumo
Manager Planning and development
for/DISTRICT DIRECTOR OF HEALTH

cc:- Chilenje Clinic
- Mtendere Clinic

Incharges Kindly be informed and assist the bearer.

Mlanja MPD

Appendix 3

STRUCTURED INTERVIEW FOR CLIENTS OF PERMANENT METHOD OF CONTRACEPTION.

This study is aimed at determining the factors that affect the clients' choice of permanent method of contraception at UTH.

Date:.....

Centre:.....

Serial Number: .....

Instructions for interviewer

Introduce yourself to the respondent.

Explain the purpose for the study.

Tell the respondent that they should be free to say no, if they do not like to be interviewed.

Tell the respondent that responses will be treated confidentially.

Do not write the name of the respondent.

Please ensure that all questions are answered.

Please tick the appropriate answer using [ ] boxes and write comments in the spaces provided.

Section A Background Data **For official use**

1. What is your age?

(a) 25 - 30 years [ ]

(b) 30 - 35 years [ ]

(c) 35 - 40 years [ ] [ ]

(d) 40 – 45 years [ ]

(e) 45 – 50 years [ ]

2. What is your marital status?

(a) Single [ ]

(b) Married [ ]

(c) Divorced [ ] [ ]

(d) Widowed [ ]

(e) Separated [ ]

3. How many children do you have?

(a) 1-3 [ ]

(b) 4-6 [ ] [ ]

(c) More than 6 [ ]

4. How far did you go in school?

(a) Not attended school [ ]

(b) Primary school [ ]

(c) Secondary school [ ] [ ]

(d) College [ ]

(e) University [ ]

5. What is your occupation?

(a) Not employed [ ]

(b) Self employed [ ]

(c) Civil servant [ ] [ ]

(d) Private sector [ ]

(e) House wife [ ]

6. What is your religion?

(a) Roman Catholic [ ]

(b) Baptist [ ]

(c) United Church of Zambia [ ] [ ]

(d) Pentecostal [ ]

(e) Others [ ]

7. Why did you choose permanent method of contraception?

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.....

Section B on Counselling and Privacy **For official use**

8. Were you satisfied with the information you were given on permanent method of contraception?

(a) Yes [ ] [ ]

(b) No [ ]

9. Give a reason for your answer?

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10. Did you feel free to ask questions about permanent method of contraception during the counselling session?

(a) Yes [ ] [ ]

(b) No [ ]

11. Give a reason for your answer?

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12. Do you think privacy was maintained during your counselling session?

(a) Yes [ ] [ ]

(b) No [ ]

13. Give a reason for your answer?

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14. How long did your counselling session take?

(a) 10 minutes [ ]

(b) 15 minutes [ ]

(c) 20 minutes [ ] [ ]

(d) 25 minutes [ ]

(e) 30 minutes [ ]

(f) 35 minutes [ ] [ ]

(g) 40 minutes [ ]

(h) 45 minutes [ ]

15. Were you interrupted during your counselling session?

(a) Yes [ ] [ ]

(b) No [ ]

16. If yes by who?

.....

.....

Section C Data on attitudes of family planning providers **For official use**

17. What experiences have you had with the family planning providers when you went for counselling?

(a) Friendly [ ]

(b) Unfriendly [ ] [ ]

(c) Not sure [ ]

18. Give a reason for your answer?

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Section D on advertising of permanent method of contraception

19. How did you know about the permanent method of contraception? Was it through

(a) Friend [ ]

(b) Mass media [ ]

(c) Family planning providers [ ] [ ]

(d) Health care providers [ ]

(e) Others [ ]

20. Have you ever shared your permanent contraception experience with friends, relatives and neighbours?

(a) Yes [ ] [ ]

(b) No [ ]

(c) Not sure [ ]

21. Give a reason for your answer?

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Section E Data on availability and accessibility of permanent method of contraception

22. How long did it take for you to have permanent method of contraception after being counselled?

(a) One week [ ]

(b) Two weeks [ ] [ ]

(c) One month [ ]

(d) More than a month [ ]

23. Why did it take that period of time?

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.....

.....

24. How far is your home from UTH?

(a) Within 5 kilometers from UTH [ ] [ ]

(b) More than 5 kilometers from UTH [ ]

For official use

Section G on Admission facility for permanent method of contraception

30. Were you happy with the place you were admitted in before the operation?

(a) Yes [ ] [ ]

(b) No [ ]

31. Give a reason for your answer?

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32. Were you happy with the place you were put in after the operation?

(a) Yes [ ] [ ]

(b) No [ ]

33. Give a reason for your answer?

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Thank you for participating.