WHY DO WOMEN FAIL TO UTILISE AVAILABLE FAMILY PLANNING SERVICES?

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1990

BY

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A RESEARCH STUDY SUBMITTED TO THE SCHOOL OF MEDICINE, DEPT. OF POST BASIC NURSING IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE BACHELOR OF SCIENCE DEGREE IN NURSING.

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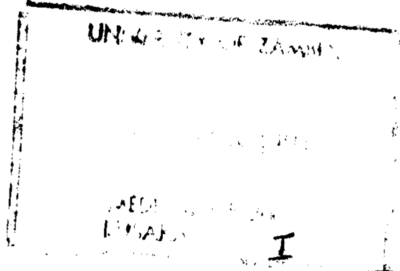

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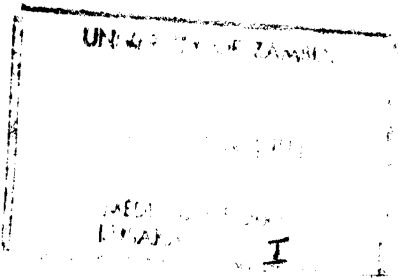

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DECLARATION

I declare to the best of my knowledge that the work presented in this study has not been presented for any other degree and is not being currently submitted for any other degree.

Signed by: ______________________
Candidate

Approved by: ______________________
Supervising Lecturer

STATEMENT

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

Signed: ______________________

Candidate

DEDICATION:

To my family, my husband Richard and our five daughters Wiza, Tamara, Chobela, Namangolwa and Pokela for their love, patience and support during this period.

ABSTRACT

This study was conducted to find out why women under utilize the available family planning services in Lusaka urban.

A sample of fifty (50) women of age 15 - 49 years were randomly selected from three health centres namely Chilenje, Kamwala and Kalinglinga. The data was collected during the months of April and May 1990.

The results of the study show that our serves favour married women 80 percent of respondents were married. Clinic based factors also came out strongly as being unfavourable. These are overcrowding, long queues and the health providers' negative attitude to the clients.

Social economic factors identified also influence the mothers utilization of services.

There is great need to make our health delivery centres more accessible, acceptable and more accommodating to mothers, if we are to increase and sustain the numbers of family planning acceptors.

ACKNOWLEDGEMENTS:

I would sincerely like to thank my sponsors the Directorate of Manpower Development and Training through recommendations by the Ministry of Health for the scholarship to undertake my studies.

I wish to thank my supervising lecturers Mrs Kamanga and Dr. Katele Kalumba for their objective guidance during the course of the study.

I would like to thank my colleagues and classmates for their encouragement and support especially Ms Hilda Ngulube, Ms Catherine Chilufya and Ms C. Chibala.

Lastly but not least my profound thanks go to Miss Edna Wakung'uma and Mrs.J.Tonga for typing this report.

CHAPTER I

INTRODUCTION and Statement of the Research Problem:

Family Planning Services are still underutilized despite the acceptance of the concept of Family Planning in Zambia and its integration in the maternal and child health services. Lusaka Parenthood Association of Zambia PPAZ (1986) points out that there are 182,000 females of 15 - 44 years in Lusaka Province and only 10,700 are acceptors of family planning. This only represents 5.9% of the total women population in the province. The report continues to say that out of teh 10,700 acceptors only 25% were active and 75% dropped out within one year of enrolment.

The Zambian population has continued to grow at the rate of 3.2% per annum. The National Commission for Development Planning in Zambia (1985) reports that the Zambian population has increased from 2.5 million in 1950 to 6.7 million in 1984. This means that the population has about trebled in 30 years. This population growth has had an adverse effect on the quality of Zambian life. Stalker (1984) states that the population problem represents a mismatch between population growth and income-producing ability, a mismatch that leaves many of the world's people in a vicious circle of poverty and high fertility because poverty and rapid population growth reinforce each other.

The rapid population growth has lowered the scope and quality of health care in Zambia which is reflected in:

High maternal mortality rate of 14 - 20 per 10,000 live births.

High infant mortality rate of 96 per 1000 live births as reported in Population Factors and Development Zambia (1985).

Population increase has affected available health resources. National Commission for Development Planning (1985) reports that in 1981 there were 21,300 beds in health institution. This means that there was one bed to every 280 persons and one physician for every 7.100 people. This has resulted in poor health services being reflected in overcrowding, lack of drugs and equipment in our institutions.

Rapid population growth has resulted in a high dependance ratio. Population Factors and Development Zambia (1985) reports that in 1985 the population of under 15 years of age was 3.3 million or 49% of the entire Zambian population. This has become a burden on household and country resources. Mazala (1984) reports that current food production has laged behind population growth causing persistancy of chronic under nutrition and malnutrition.

Another obvious result of rapid population growth is reduced Education facilities as there are more children wishing to get into the educational system than the educational system can cope with. Population Factors and Development Zambia (1985) reports that only 20% of primary school pupils go to secondary school due to limited physical, material and human resources available for them to join secondary school system.

Employment opportunities are also reduced as more people fail to be employed. Population Factors and Development Zambia (1985) reports that in 1985 14,900 school leavers failed to get employment. This has resulted into the eruption of crime in the country.

Another effect of population increase is that the country through its relevant sectors have failed to accommodate its citizen adequately. This has resulted in the formation of the many squatter settlements around our towns. Times of Zambia (1.12.89) reports that the population of squatters in Zambia stands at about 2.6 million. This means that about one third of the Zambian population live in squatter settlements.

The purpose of this study is to identify factors that contribute to the underutilization of family planning services in Lusaka urban. It is hoped that the findings will assist in devising ways and means of increasing the number of attendancies at family planning clinics. Therefore the study seeks to answer the research question: ***why do women fail to utilize the available family planning services in Lusaka urban?***

Operational Definition of the Terms:

1. *Family Planning:* Control of fertility by limiting the size of a family through spacing the births of the children.

2. *Service:* Work or duty done for someone.

3. *Woman:* Female in the reproductive age of 14 to 45 years old.

4. *Contraceptive:* a drug, object, material or practice used to prevent conception.

5. *Inadequate knowledge:* lack of adequate information and know how to enable one to take reasonable decisions and practice efficiently.

6. *Lack of privacy:* more than one health worker to a client or one attendant to a group of clients.
   - Exposure to the public.

7. *Counselling:* face to face helping of a client. Give advice.

8. *Low quality:* poor degree of goodness.

Major Variables that the Questionaire is going to operationalize:

Low Quality of Service offered

Lack of information/knowledge on Family Planning methods

Limited Time for F.P. provision say 2 hrs per week

Clients negative attitude to the service

Under Utilization of F.P. Services

Client percephori 8 Providers' attitude

Long distances to the services

Social & Cultural beliefs of the client

1. *Social and cultural beliefs of the client.*
2. *Long distances to the health centre.*
3. *Inadequate time for family planning provision in the health centres.*
4. *Lack of adequate information/knowledge on family planning services.*
5. *Low quality of services offered.*
6. *Long waiting for the services to be provided.*

CHAPTER II

LITERATURE REVIEW:

"Family planning is an essential component of any broad-based development strategy that seeks to improve the quality of life for both individuals and communities" (Conference on family planning Sakarta 1981).
Family planning prevents many unnecessary death among women and children by helping women avoid high-risk pregnancies, space the birth of their children and consequently enable them to have smaller managable families. Maine D. (1982).

There are a number of factors or reasons that affect family planning service utilization. These factors could be the client's socio-economic and cultural practices. Long distances to the health centres, long waiting for services at the health centre would affect utilization of services. Client's lack of knowledge/information on family planning and the negative attitudes of the provider to the client can frustrate one client. Ainsworth M. (1984).

The success of the family planning programmes therefore depends on the program's ability to meet individual needs of the clients. The performance of the family planning programs relies on the cooperation and satisfaction of the clients. There is need for the programmes to be flexible and acceptable to the client.

On accessibility (People Volume 7 No.4 1980) reports that: "many people prefer to get their contraceptives like, their vegetables from the cheapest and easiest source." A study done in Srilanka reports that community based distributors get contraceptives to the people especially those who cannot reach the health institutions. These community efforts help by supplimenting the available services and by satisfying most clients.

Lack of adequate information do hinder women from utilizing family planning services. Mauldin (1979) stated that "lack of familiarity with the characteristics of a product, how it will be used, what the associated side effects are, are barriers to the adoption of all new products including the contraceptives."

Whelan (1974) agrees with Mauldin by saying that clear instructions to clients is an important determinant of compliance. He further explains that the greater the side effects associated to a treatment the lower the compliance. Because family planning is preventive and cause side effects in otherwise health women, compliance for contraceptives may even be a much bigger problem. Therefore use - effectiveness and continuation may be significantly be influenced by good instructions to the client.
Brackett (1982) agrees that information/knowledge on contraceptive outlet has a significant and positive effect on contraceptive use. Knowledge of where to get services is another important issue that can influence contraceptive use. This shows that there is need for more information dissemination on the benefits of family planning, mode of action, side effects of contraceptives and where to find the services.

Low quality of service contributes to under utilization of family planning services. Dryfoos (1989) in a study done in New York shows that clients are more dissatisfied with clinics where they are subjected to long gueues and waiting, overcrowding, shortage of staff and inconvenient clinic hours. Radeck and Bernstein (1989) compares quality of service between public/government clinics and private clinics. They explain that public clinics gave little time and information to their clients during physical examination which was characterised by discomfort and embarassment. This was different in private clinics where practitioners discussed and communicated more with their clients.

Improvement in the provision of family planning services would attract more women and hence improve service utilization and satisfaction. Family planning service is the only source of preventive medical care for most women. Dryfoos (1989) in a study done in New York shows that 44% of all (STD) sexually transmitted diseases screening was done in family planning clinics.

The time allocated to offering of family planning services is an important contributing factor to under utilization of services. From observation in our clinics' services are offered only in the afternoon for two hours once or twice a week. This automatically puts the service out of reach of potential users, and prevents continuity by old acceptors.

People Volume 7 No.4 (1980) reports that in the Phillipines volunteers peddle information about family planning for 12 hours each day. The report continues that about 500 continuing acceptors rely on street stalls for fresh supplies of pills, condoms and foam.

Research Hypothesis:

1. *Inadequate knowledge about family planning keep women away from using the services.*

2. *Health workers negative attitudes keep mothers away from using family planning services.*

3. *Clinic factors like, overcrowding, long queues, inadequate time for offering services discourage mothers from using facilities.*

4. *Distances from health centres make women fail to use family planning services.*

Rationale for the Research:

Previous studies have looked at factors that influence choice of a contraceptive method for the woman. Apart from a method of contraception being safe and effective it must also be available to the user. Accessibility and acceptability of a service is important in the success of a family planning programme. Therefore there is need to identify reasons why women fail to utilize the available family planning services.

Objectives of the Research:

General Object:

To find out reasons why women underutilize the available family planning services.

Specific Objects:

1. *To establish the social, economic and cultural reasons why women do not use family planning services.*

2. *To examine the activities in the health centre that could hinder women from using family planning services.*

3. *To find out why family planning clients default or drop out.*

4. *To suggest alternative ways of offering family planning services that would be more conducive to the clients.*

CHAPTER III

METHODOLOGY

RESEARCH DESIGN

The purpose of this study was to determine factors that contribute to under-utilization of family planning services in urban health centres. A survey design was chosen to describe the subjects, attitudes, opinions and interests concerning family planning services.

RESEARCH SETTING

Chilenje and Kalingalinga health centres were used. Chilenje clinic is situated in Chilenje's compound near the main market. The health centre series a mixed population of high, medium and low income groups. The health centres catchment areas are Chilenje South, new and old Chilenje, Libala Stages II and III, Woodlands, Nyumba Yanga, part of Kabulonga, Susman Farm, Shangumbu village, Mahopo village and Magazine compound.

Chilenje health centre has three main sections. The out-patients section which deals with screening and treatment of minor ailments. The Mother and Child Health (MCH) section which carters for mother and children. The labour ward which operates 24 hours a day.

The out-patients and MCH sections operate from 0730 hours to 1600 hours everyday, and the out-patients is open up to 1230 hours on Saturdays and Sundays. There is a doctor who is stationed in the out-patient section.

The clinic has a telephone line and an ambulance for easy communication with other health centres. The ambulance mainly carters for maternity cases to and from University Teaching Hospital.

The staff at the centre are divided according to the three sections.

The out-patients section is manned by registered nurses, clinical officers both general and psychiatry, enrolled nurses and clerical officers.

The MCH section is headed by a public health nurse assisted by family health nurses, registered midwives, enrolled midwives and nutrition demonstrators.

The labour ward is manned by both registered and enrolled midwives.

The health centre is used for clinical experience by students from the school of medicine (UNZA) and University Teaching Hospital - Schools of Nursing and Midwifery.

Chilenje clinic was chosen for the study because it series a cross section of population from both urban and peri-urban areas.

The second centre used in the study was Kalingalinga site and service/shanty compound. The clinic carters for mothers and children. It offers maternity services which run for 24 hours everyday. It also offers antenatal, postnatal, family planning and children clinics.

The clinic has no out-patients' department for the screening and treatment of minor ailments. This means that residents of Kalingalinga have got to travel to other clinics for curative services.

The health centre was chosen for the study because of its concentration of mothers who come for MCH services.

Secondly, because the clinic carters for densely population shanty compound. It is important to know what the mothers' opinion and attitudes on family planning services are.

PILOT STUDY:

A pilot study was conducted on six mothers at Kalingalinga health centre. It was done to prevent the questionnaire on completeness, sequence and clarity. The pilot study also is aimed at detecting problems that must be solved before the major study is done. A pilot study also helps in the formulation of the research problem, development of hypotheses and the establishment of priorities for further research.

SAMPLE SELECTION AND APPROACH:

A sample of 50 women within the child bearing age of 14-45 years were chosen for this study. This group was chosen because it was easier to locate them while they are waiting for their children to be screened and immunized. It is convenient and easy to get information from these mothers because they are not anxious as their children are not sick.

Permission to interview the mothers was sought by letter from the Nursing Officer at Lusaka Urban District Council.

The technique used for sampling was interval or systematic sampling. Systematic sampling is a process based on the selection of elements at equal intervals, starting with a randomly selected elements on the population list. (Bless and Achola (1988).

In this sample, every fifth mother who queued up at the health centre was selected.

DATA COLLECTING INSTRUMENT:

A structured interview schedule was used to collect data.

This instrument was thought to be the best for data collection in this study because the sample was randomly selected from a population of mixed socioeconomic class. Some mothers could be illiterate. The interviewer was in a position to clarify and rephrase questions that are not clear and probe for more answers.

In order to create a good rapport between the mothers and the interviewer, she greeted the mothers, introduced herself and briefly told the purpose of the study.

CHAPTER IV

DATA ANALYSIS

A sample of fifty respondents were randomly selected from women of child bearing age group 15-45 years. The data was analysed manually, condensed and organized in tabular form.

TABLE I: Age Distribution of Respondents:

Age group	Number of Respondents	Percentage
15-20	12	24
21-26	24	48
27-33	13	26
34 - 39	1	2
40-45	NIL	0
TOTAL	50	100

Table I represents the age distribution of respondents which ranged from 15 years to 39 years. The majority of respondents were aged between 21 to 26 years. 48 percent. 26 percent were aged between 27 to 33 years. 24 percent were aged 15-20 years. Only 29 percent was aged 34-39 years.

TABLE II:

Respondent's Marital status:

Marital status	Number of Respondents	Percentage
Single	8	16
Married	40	80
Divorced	2	4
TOTAL:	50	100

Table II shows that 80 percent of the respondents are married. 16 percent single and 4 percent divorced.

TABLE III: Respondents Educational Status.

Educational level	No. of Respondent	Percentage
None	3	6
Primary	23	46
Secondary	22	44
College	1	2
University	1	2
TOTAL:	50	100

Table III shows that the majority of respondents 46 percent have primary education while 44 percent have secondary education.

TABLE IV:

Respondents Residential Area.

Residential area	No. of Respondents	Percentage
Low Density	7	14
Medium Density	15	30
High Denity	28	56
TOTAL:	50	100

Table IV shows that majority of respondents came from high density areas 56 percent 30 percent from medium density and only 14 percent from low density.

TABLE V: Respondents Employment status.

Occupation of Respondent	No. of Respondents	Percentage
House wife	38	76
Self Employed	6	12
Skilled worker	5	10
Professional	1	2
	50	100

Table V shows that 76 percent of respondents are house wives. 12 percent self employed 10 percent skilled worker and only 2 percent professionals.

TABLE VI

Respondents source of Family Planning information and usage in percentages

Source of F.P. Information	Percentage	Usage of F.P. YES	NO
Friends	40	10	30
Family	4	NIL	4
Health Workers	38	18	30
Other	8	8	NIL
Not heard	10	NIL	10
Totals:	100	36	64

This table shows:

Source of information in relation to usage of family planning. Friends seem to be the most popular source with 40 percent but with little usage of 10 percent. The health staff are the second source 38 percent with the highest usage of 18 percent.

TABLE VII

Respondents Educational level in realtion to contraceptive usage.

Educational Attainment	Percentage of Respondents	usage of contraceptives Percentage of Respondents	
None	6	4	2
Primary	46	38	8
Secondary	44	36	8
College	2	2	NIL
University	2	2	NIL
Total:	100%	82%	18%

This table shows that education has a positive effect on the usage of contraceptives. Out of the 82 percent users 78 percent have had some form of education.

TABLE VIII

Marital status and contraceptive use in percentage

Marital status	Percentage of Respondents	Percentage Respondents using contraceptives	
		Not using	Using
Single	16	4	12
Married	80	28	52
Divorced	4	NIL	4
Total:	100%	32%	68%

Most of our respondents are married 80 percent, 16 percent are single and 4 percent divorced. Married women are the majority of the users 52 percent and single women 12 percent.

TABLE IX

Respondents desired number of children in relation to their residential areas

No. of Desired Children	Percentage of respondents	Residential areas.		
		Low	Medium	High
1-4	46	10	10	26
5-8	50	6	16	28
Over 9	4	NIL	NIL	4
	100	16	26	58

Table IX shows that majority of respondents in high density areas prefere large families. 28 percent prefere numbers of children 5-8. 26 percent prefere numbers of children 1-4 relatively smaller families. While 4 percent prefere big families with over 9 children.

There is a big contract between the high and low density areas in regard to the number of children. 10 percent prefere small families 1-4 children, while only 6 percent want 5-8 children.

TABLE 10

Respondents opinion of family planning.

Opinion of family planning	No. of respondents	Percentage
Child Spacing	30	60
Preventing Pregnancy	10	20
Do not know	10	100
TOTAL:	50	100

Table XI shows that 60 percent of reponsents think that family planning is child spacing. 20 percent think it is prevention of pregnance while 20 percent do not know.

TABLE 11

Respondents answers on use of family planning.

Respondents Response	No. of Respondents	Percentage
Yes	16	32
No	34	68
TOTAL:	50	100

Table XII shows that majority of respondents 68 percent do not use family planning while 32 percent do.

TABLE 12: Respondents response on method of family planning used.

Family Planning Method used	No. of Respondents	Percentage
Pill	12	24
Condom	1	2
Natural	1	2
Traditional	1	2
Not using any	35	70
TOTAL:	50	100

Table XIII shows that the pill is commonly used method. The condom, natural and traditional 2 percent each. Those not using family planning being the majority 70 percent.

TABLE 13

Respondents resons for not using Family Planning.

Reason for not using family planning	No. of Respondents	Percentage
Wants more children	25	50
Side effects	5	10
Do not know about it	20	40
TOTAL	50	100

Table XIV shows that majority of respondents 50 percent want more children. 40 percent do not know about it (family planning) and 10 percent fear side effects.

TABLE 14

Respondents husband/partner's opinion of Family Planning

Partner's Opinion	NO. of Respondent	Percentage
In favour	26	52
Not in favour	14	28
Not discussed it	10	20
TOTAL:	50	100

Table XVI shows that 52 percent are in favour while 28 percent are not in favour and 20 percent have not discussed it.

TABLE 15

Respondents responses on nurses, attitude when they come to the clinic late.

Nurses reaction to late mothers	No. of Respondents	Percentage
Greeted and served	14	28
Asked why late and served	13	26
Scolded and served	10	20
Scolded and sent away	13	26
TOTAL:	50	100

Table XVII shows the nurses attitude to late mothers. 28 percent are greated and served. 26 percent are asked why and served while 26 percent are scolded and sent away.

TABLE 16 Respondents estimation of time spent out the health centre.

Time spent	Number of respondents	Percentage
30 mins - 1 hour	12	24
2 - 3 hours	26	52
4 - 5 hours	11	22
Over 6 hours	1	2
TOTAL:	50	100

Table XVIII shows that the majority of respondents 52 percent spend 2-3 hours to get medical attention. 24 percent spend 30 minutes to 1 hour while 22 percent spend 4-5 hours.

TABLE 17

Respondents responses on waiting conditions at health centres.

Respondents waiting position	No. of Respondents	Percentage
Sitting on chair/bench	28	56
Sitting on floor	14	28
Standing	8	16
TOTAL:	50	100

Table XIX shows that 56 per wait for services while sitted on benches 28 percent sitted on the floor and 16 percent standing.

TABLE 18

Respondents response as to whether an explanation is given for delay in services.

Respondents Responce	No. of Respondents	Percentage
Yes	12	24
No	38	76
TOTAL:	50	100

Table XX shows that 76 percent of mothers do not get an explanation as to the cause of delay and only 24 percent get an explanation.

TABLE 19

Respondents opinion on cause of delay.

Cause of delay	No. of Respondent	Percentage
Nurses do not care	4	8
Nurses come late	9	18
Nurses are few	20	40
Do not know	17	34
TOTAL:	50	100

Table XXI majority of people think that there are few nurses to attend to them 40 percent 34 percent do not know, 18 percent nurses come to work late while 8 percent think nurses do not care.

TABLE 20 Respondents suggestions to minimize delay.

Respondents suggestion	No. of Respondent	Percentage
Serve mothers as they come	19	38
Increase clinic time	14	28
Bring more nurses	14	28
Do not know	3	6
TOTAL:	50	100

Table XXII shows that 38 percent prefere serving mothers as they come, 28 percent want time for services increased, 28 percent want nurses increased while 6 percent do not know.

TABLE 21

Respondents source of satifaction.

Source of satisfaction	No. of Respondent	Percentage
Friendly nurses	22	44
Clear instructions	17	34
Nothing	10	20
Quick service	1	2
TOTAL:	50	100

Table XXIII shows that 44 percent are satisfied because nurses are friendly, 34 percent because instructions are clearly given, 20 percent have nothing to say 2 percent for quick service.

TABLE 22 Respondents source of dissatisfaction with health care.

Source of dissatisfaction	No. of Respondent	Percentage
Long queues	27	54
Nothing	13	26
No medicines	4	8
Buying charcoal	2	4
Toilets not working	2	4
Hurried instructions	1	2
Unfriendly staff	1	2
TOTAL:	50	100

Table XXIV shows that long queues are the biggest source of dissatisfaction, 54 percent 26 percent said nothing, 8 percent lack of medicines 4 percent buying charcoal 4 percent blocked toilets.

TABLE 23

Respondents mode of transport and money spent to come to the clinic.

Amount of money spent	Percentage of respondents	Mode of transport used to clinic	Respondent Percentage
No. money spent	76	Walking	76
Under K10	4	Public Transport	
K11 - 20	8		14
K30 - 40	2		
Over K40	10	Private transport	10
	100%		100

Table 23 shows that majority of respondents walk to the health centre 76 percent. This means that most people do not spend any money to get to the clinic. 14 percent of respondents use public transport and spend K10-K40 on transport depending on the distances covered. 10 percent of respondents use private transport and spend over K40 per trip to get to the clinic.

CHAPTER V

DISCUSSION OF FINDINGS NURSING IMPLICATIONS CONCLUSIONS OF RECOMMENDATIONS

This study was undertaken to find out reasons why our health institutions do not attract women to use the facilities. The (50) respondents were randomly picked from three health centres Chilenje, Kamwala and Kalingalinga. This was done to sample Lusaka urban residents.

Table 1 shows the age distribution of the respondents from 15 - 45 years. The majority of the respondents 48 percent were aged between 21-26 years. This can be explained that this is the prime age group of women for bearing children. Followed by 26 percent in the age group 27-33 years, 24 percent those between15-20 years. And only 2 percent between 34-39 years of age. This also demonstrates that due to girls staying longer in school the marrying age is going up. Also that the majority of the respondents are within the child bearing age 15-45 year. This group is vuluable to diseases associated with pregnancy, child bearing and rearing diseases. There is therefore need to instensify coverage and provisiion of services like antenatal, postnatal and family planning.

Table II deals with the respondents marital status, 80 percent were married 16 percent single and 4 percent divorced. This reflects the governments guidelines on who should use family planning services. The system favours married women as can be seen by their percentage. There are 'unwritten' rules that a woman needs to bring a letter from the spouse in order for her to be given family planning services. This agrees with the study done by Kalunga (1985). In this study 90 percent of respondents were married while only 10 percent were single. The study was on the choice of contraceptives. This shows that the institutions and the whole system has discriminated single women. We have exposed them to the evils of unwanted pregnancies like abortions and child dumping and desertion. The United Nations charter says that family planning is a human right that should be extended to every individual. There is need to extend the services to everyone, teenagers included. This is a controversial subject which needs to be addressed by the whole nation. Perhaps the population policy would show and tell exaCTLY WERE THE Zambian nation stands.

Table III represents respondents educational status. The majority have gone through primary education 46 percent and secondary education 44 percent. Only 2 percent have been through college and university.

Table IV deals with respondents residential areas, 56 percent come from high density 30 percent from medium and 14 percent from low density areas. This could be due to the fact that most health centres are built in either high or medium density areas like Kalingalinga compound and Chilenje. Therefore it is just logical that most of the people come from these areas. The clinics are most most accessible to people who are nearest and make the majority of the users.

Table V looks at the respondents employment status. 76 percent are housewives, 12 percent self employed, 10 percent skilled workers and only 2 percent professionals. This clearly shows that we are cartering more for the women who are not employed. What happens to the working class? How accessible and convinient are our health institutions to them. There is need to reach working women through the establishment of work based family planning services.

Table VI shows respondents source of family planning knowledge and usage. 40 percent of respondents heard about family planning from friends, 38 percent from health workers, 8 percent from other sources, 4 percent from their families while 10 percent have not heard about it at all. The majority of F.P. users 18 percent were informed by health workers and only 10 percent of users were informed by friends, while 30 percent of non users were informed by friends. This reveals that health workers are the best health educators of family planning, since the had the highest user percentage (18). Friends spread the information quickly but most of it could be distorted and has no factual base. 30 percent of non users were informed by friends. When people get roumours they are

scared to use the facilities. This agrees with first hypothesis that inadequate knowledge on family planning keep then away from using the facilities. There is therefore need for the health providers to intensify health education on benefits of family planning and the mode of action, side-effects etc. about the methods available of family planning.

Mauldin (1979) stated that "Lack of familiarity with the characteristics of a product, how it will be used, what the associated side effects are, are barriers to the adoption of all new products including the contraceptives. Whelan (1974) agrees that clear instruction to the clients is an important de erminant of compliance.

Table VII shows that there is a relationship between educational level and use of contraceptive. Out of the 82% of users 78 percent have had some form of education and only 18% are non users. This confirms the fact that it is easier for women who have been to school to change their beliefs on child bearing and rearing. This may be so because they can get messages communicated in English as most of our health educational leaflets and pamplets are not translated in local languages.

Table VIII demonstrates that most of our family planning clients are married women. 80 percent married and 52 percent using f.p. This could be due to the fact that our health institutions attract more married women than single ones. This is done by asking for sponses' written permission from the woman before she is offered family planning services. There is need to lift all restrictions on the provision of family planning services. The services should be made available to all women in the child producing age 15-49 years teenagers need special care as they are equally affected.

Table IX shows that the majority of respondents live in high density areas and prefere large families. 28 percent want 5-8 children. 26 percent want 1-4 children while 4 percent want over 9 children. There is a difference with respondents from low density areas who prefere small families. 10 percent prefere 1-4 children while only 6 percent want 5-8 children. This could be due to the fact that we have more people with low social economic status living in the high density areas. They also tend to have more children because of their traditional beliefs about the benefits of a big family, as offering of security in old age. Secondly, because of their low social economic status they are not sure of their childrens' survival. Malnutrition is responsible

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for 46% of infant mortality rare in University Teaching Hospital. Coupled with the high cost of nutritions foods it is difficult to reverse the situation. Thirdly, the enviromental situation in the high density areas do expose infants to communicable diseases like diarrhoea, measles etc. Sishekanu (1985) explans that poverty, large families and high child mortality rare is vicious ciecle which can only be broken by improving the living standards of the people.

Table XI shows the nurses' attitude towards late mothers. 26 percent of the mothers are scolded and sent away without being ofered services if they came late. 20 percent are scolded and served. Only 28 percent are greated warmly and served.

Table XVII shows how long respondents have to wait for the services. 52 percent spend 2-3 hours. 24 percent up to 1 hour and 22 percent 4-5 hours.

Table XIV shows that mothers are not given an explanation as to the cause of the delay. 76 percent say they do not get an explanation while only 24 percent say they do.

These findings do aggree with the hypothesis no. 2 that nurses have a negative attitude to mathers.

Table XXIII confirms this by showing that 54 percent of respondents are dissatisfied with the care given due to long queues. People vol. 7 no. 4 (1980) reports that "many people prefere to get their contracepts, like their vegetables from the cheapest and easiest source."

7/...

The findings accept hypothesis' 3 that clinic factors do discourage women from using the services. Therefore, there is need to make our institutions more acceptable, more accesible to the users. The menopoly of health workers providing family planning services should be stopped. There is need to take the services to the people by using community based workers. This would help by making the information and services/provision of contraceptives) more available to the peple. Follow up of family planning clients would be improved as each community based distributor knows his/her people better, than the nurse from another community.

There is also need to use all the people that are available to give F.P. information, like the chair man/woman of a market, church groups, bar tenders etc. People do not need to walk to the health centres to get family planning services and information.

Table XXIV show that most respondents 76 percent walk to the health centre and therefore do not need money for transport. 14 percent use public transport and spend about K10-K40 depending on the distances involved. 10 percent use public transport and spend over K40 per return trip. This finding rejects hypothesis no. 4 that long distances from health centres keep mothers away. This could be due to the fact that most high and medium residential areas have a health centre in their midst.

NURSING IMPLICATIONS:

Family Planning is an important component of mother and child health care services. As prevention is better and cheaper than cure, it is important to intensify and improve the provision of family planning services to all potential users. Increased use of family planning would improve the health status of both mother and child and the family as a whole.

Changing peoples beliefs, habits and behaviour takes time. This is more so with child bearing and rearing as sexual behaviour is a taboo. It is therefore not openly talked about. It is important that the health workers are respectiful and give the mothers individualized health education and counselling depending on their needs.

Clients do also have a right to be served on time. It is important clients are served on first come first served basis, than to keep them waiting unnecessarily.

RECOMMENDATIONS:

1. and other health workers to take an interest in conducting studies in their places of work, especially in the mother and child care area.
2. Family planning services to be included in the U.C.I. out reach team activities.
3. Introduction of the community based family planning distributors in order to take the services to the people, this would also improve followup of dropouts.

4. Training of traditional birth attendants (TBA) and Community Health Workers in family planning, so that they can reach people in the remote rural areas.
5. A nation wide campain to reach men at their places of work, clubs bars and churches, men influence decision making in the home.
6. Teaching of responsible parenthood in schools so that children grow up well informed.
7. Provision of work based family planning services for working women.
8. Increasing the time for providing family planning services instead of restricting it to two hours in the afternoon.

Offering family planning services on Saturdays in order to give more time to working women.

LIMITATION OF THE STUDY

1. The study sample was small 50 women from three institutions in the urban while the rural area was left out. This could make it difficulty to generalize the findings to all Lusaka residents.
2. Pressure of work made it not possible to engage in a large study.

Despite the above handicaps, I found the study a worthy while undertaking.

APPENDIX I

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

20th April, 1990

The Principal Nursing Officer
Lusaka District Council
LUSAKA

u.f.s. The Head
Department of Post Basic Nursing
School of Medicine
Lusaka

Dear Madam,

Re: RESEARCH PROJECT

I am a student at the above mentioned school in 4th year doing a Bachelor of Science Degree in Nursing. In partial fulfilment of the requirements for my study, I am required to conduct a research study within the area of Community Health Nursing. My topic of study is: Why do women underutilize available family planning services in Lusaka urban?

I would be most grateful if you could kindly allow me to collect data from the following health centres: Chilenje, Kamwala and Kalingalinga. I intend to interview 50 women.

Yours sincerely,

Monde Luhanga (Mrs)

APPENDIX II

LUSAKA URBAN MATERNITY CLINIC PROJECT

(IRISH AID)

ffice of Co-ordinator
oom 26, H.P.U.
vic Centre
l. ~~213999~~ 229302 Ext 26.

Co-ordinator's address
Res. P.O. Box 50815
'Phone 250563

23rd April, 1990

Mrs. Monde Luhanga
The University of Zambia
School of Medicine
Department of Post Basic Nursing
P.O. Box 50110
LUSAKA.

Dear Madam,

Re: RESEARCH PROJECT

Thanks a lot for your letter dated 20th April, 1990 in which you are required to conduct a research study in one of our health centres.

I am pleased to inform you that you can go ahead with your work.

Wishing you all the best in your studies.

Yours sincerely,

Anne Mbilishi Zimba (Mrs)
ACTING NURSING OFFICER (P.H.N.)

AMZ/fcm

APPENDIX III

DATA COLLECTING INSTRUMENT

INTERVIEW SCHEDULE

INSTRUCTIONS TO THE INTERVIEWER

1. Introduce yourself to the patient and explain the purpose of your visit.

2. Assure the patient of confidentiality and anonimity by explaining that all information will be confidential and that her identity will be anonimous.

3. Ask questions as phrased, only clarify where necessary without changing meaning of the question.

4. Tick and fill in responses appropriately to all the questions immediately.

5. Thank the respondent at the end of the interview.

SECTION I

DEMOGRAPHIC DATA:

For official use only

1. How old are you?

   (i) Under 15 years ☐
   (ii) 15 - 20 years ☐
   (iii) 21 - 26 years ☐
   (iv) 27 - 33 years ☐
   (v) 34 - 39 years ☐
   (vi) 40 - 45 years ☐
   (vii) Above 45 years ☐

   1 ☐

2. What is your marital status?

   Single ☐
   Married ☐
   Divorced ☐
   Widowed ☐
   Separated ☐
   Other ☐

   2 ☐

3. How far did you go in school?

   None ☐
   Primary ☐
   Secondary ☐
   Other ☐

   College ☐
   University ☐
   Other ☐

   3 ☐

4. What is your occupation?

Housewife	
Self employed	
Skilled work	
Professional	
Other	

4 [ ]

5. Where do you live?

Low density	
Medium density	
High density	

5 [ ]

SECTION II

CLINICAL ACCESSIBILITY DATA:

. How do you travel to this centre?

Walking	
Public transport	
Personal transport	

6 [ ]

. How much money do you spend per trip?

Less than K10	
K10 - K20	
K21 - K30	
K31 - K40	
Over K40	

7 [ ]

8. Do you fail to come to the clinic because you have no money for transport?

Yes ☐

No ☐

8 ☐

SECTION III

FAMILY PLANNING DATA

9. How many children do you have?

____

____

9 ☐

10. How many would you like to have?

____

10 ☐

11. Have you ever heard of family planning

Yes ☐ No ☐

11 ☐

12. If you have heard of Family Planning from whom?

Friends ☐

Family ☐

Health worker ☐

Other ☐

12 ☐

13. In your opinion what is Family Planning?

____

____

____

____

13 [ ]

14. Have you used Family Planning?

Yes	[ ]
No	[ ]

14 [ ]

15. If you have used Family Planning what method did you use?

Pill	[ ]
Condom	[ ]
Loop	[ ]
Natural	[ ]
Diaphram	[ ]
Other	[ ]

15 [ ]

16. If you have not used Family Planning what are your reasons for not using it?

Does not know about it	[ ]
Wants more children	[ ]
Religious beliefs	[ ]
Makes her sick	[ ]
Side effects	[ ]
Other	[ ]

16 [ ]

17. What is your husband/patner's opinion on Family Planning?

17 [ ]

- Strongly in favour [ ]
- In favour [ ]
- Not in favour [ ]
- Strongly not in favour [ ]

18. What do you think are the benefits of family planning?

18 [ ]

____

____

____

____

SECTION IV

DATA ON RECEPTION AT THE CLINIC /NURSES' ATTITUDE

19. What happens when you come late for the services?

19 [ ]

- Greeted and served [ ]
- Asked why you are late and served [ ]
- Scolded at and served [ ]
- Scolded at and turned away [ ]

20. How long do you normally take to be served when you come here?

20 [ ]

- 30 Mins - 1 hour [ ]
- 2 Hours - 3 hours [ ]
- 4 hours - 5 hours [ ]
- over 6 hours [ ]

21. How do you wait for your turn to be served?

sitted on a chair/bench ☐

sitted on the floor ☐

standing ☐

21 ☐

22. Does anyone explain to you why there is this delay?

Yes ☐

No ☐

22 ☐

23. What do you think causes this long waiting for services?

Nurses do not care ☐

Nurses come to work late ☐

Nurses take long tea breaks ☐

There are fewer nurses ☐

Do not know ☐

23 ☐

24. What do you think should be done to improve the situation?

Serve mothers as they come ☐

Increase time for Family Planning services ☐

Bring more nurses ☐

24 ☐

25. What things make you satisfied with the services you get?

25

Friendly nurses	
Short waiting time for services	
Clear instructions	
Other	

26. What things make you unsatisfied with the services?

26

Unfriendly nurses	
Long queues	
Hurried unclear instructions	
lack of privacy	

Thank you for helping in answering these questions.

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