

**PERCEPTIONS OF NURSES AT NDOLA TEACHING HOSPITAL TOWARDS
SEXUAL HEALTH NEEDS OF PEOPLE WITH MENTAL HEALTH PROBLEMS**

BY

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A dissertation submitted in partial fulfilment of the requirements for the Degree of Master of
Science in Midwifery and Women's Health

THE UNIVERSITY OF ZAMBIA

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March, 2022

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The University of Zambia approves this dissertation by Alice Chambatu on “Perceptions of Nurses at Ndola Teaching Hospital towards Sexual health needs of People with Mental Health Problems” in partial fulfilment for the requirements for the award of Master of Science in Midwifery and Women’s Health

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ACKNOWLEDGEMENTS

I wish to acknowledge the lecturers at the University of Zambia, School of Nursing Sciences for equipping me with knowledge in the field of my study as well as with knowledge on how to conduct research.

Particularly, I acknowledge my research supervisors; Dr C.N. Kwaleyela (Main supervisor) and Mrs K.C. Mutambo (Co-supervisor) for guiding me in the writing of this research.

Lastly I acknowledge my family and friends for the encouragement and help rendered to me during the process of the research proposal development.

DEDICATION

This work is dedicated to my husband Enerst Nyambe Kamunu and my daughters; Precious Kamunu and Gracious Kamunu for their support in my quest for higher education.

ABSTRACT

Sexual and reproductive health (SRH) is among the fundamental packages of health care, which all clients seeking health care should receive. Thus, it is essential to understand nurses' perceptions towards sexual health needs of people with mental problems because they are champions of sexual and reproductive health rights (SRHR) for all. The aim of this study was to explore perceptions of nurses at Ndola Teaching Hospital towards sexual health needs of people with mental health problems.

A general descriptive qualitative study design was utilised and data were collected using three focus group discussions (FGDs). Purposive sampling was used to select the 21 nurses who participated in the study. Nine were male, while 12 were female. Each FGD comprised of seven participants. The discussions were audio recorded and transcribed. Thematic analysis was used to analyse the data, and six major themes emerged. Trustworthiness of the study was achieved through maintenance of credibility, transferability, dependability and confirmability.

Six themes emanated from the participants: Physiological interplay among different body systems such as the nervous, endocrine and cardiovascular systems in the regulation of sex, disease process itself as well as effects of psychotropic, participant differences in their age, gender, educational level and cultural backgrounds, staff shortages in mental health units and deficient record keeping. Social stereotypes and labelling theories were mentioned as societal contributions to sexual misdemeanours by people with mental health problems.

Participants acknowledged existence of sexual activity among people with mental health problems and there were diverse negative perceptions. Mental health specialists equipped with knowledge in SRH should be at the centre of this care provision as well as facilitating advocacy. This would in turn reduce morbidity and mortality from sexually engineered illnesses and conditions among people with mental health problems.

Key words

Sexual health, Sexuality, Perception of nurses, Sexual and Reproductive Health, Mental health

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LIST OF ABBREVIATIONS

AIDS: Acquired Immunodeficiency Syndrome

ED: Erectile Dysfunction

ENT: Ear, Nose and Throat

FGD: Focus Group Discussions

HIV: Human Immunodeficiency Virus

MoH: Ministry of Health

NHRA: National Health Research Authority

NTH: Ndola Teaching Hospital

OCD: Obsessive Compulsive Disorder

OPD: Out Patient Department

PHO: Provincial Health Office

PID: Pelvic Inflammatory Disease

PND: Postnatal Depression

RSA: Republic of South Africa

SMS: Senior Medical Superintendent

SRHR: Sexual and Reproductive Health Rights

UK: United Kingdom

UNZABREC: The University of Zambia Biomedical Research Ethics Committee

UNZABREC: University of Zambia Biomedical Research Ethics Committee

USA: United States of America

WHO: World Health Organisation

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CHAPTER ONE: INTRODUCTION

1.0. INTRODUCTION

Sexual health needs are among the fundamental requirements of most living individuals, including people with mental health problems (Bonfils et al, 2015). These needs include presence of sexual feelings, desire to have sexual gratification, and responsiveness during sexual intercourse (Leckie, 2016; Barbosa et al 2015). Other sexual health needs are the ability to attract the opposite sex, maintaining intact intimate relationship through open communication, and sexual abstinence. Although various people have different perceptions of sexual health needs in individuals with mental problems, it is essential to understand perceptions of nurses because they are among frontline health workers that offer health care to patients who seek health services from mental institutions (McCann, 2019). One such institution where people with mental health problems seek health services is Ndola Teaching hospital located in Ndola district, Zambia.

1.1. BACKGROUND INFORMATION

The sexual dimension is part of a person's overall functionality. It encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction (Barbosa et al, 2015). In some instances, a person's sexual health needs can be temporarily or permanently affected by illness or treatment. In such instances communication is crucial for a functioning sexuality of a client (McCann, 2019). Since nurses are among the frontline health care providers, they are often called upon to talk to clients about their sexuality and sexual concerns. The perpetual contact and the close relationship that nurses have with clients provide an opportunity to discuss sexual issues and sexual health (Egholm, 2015). Globally, there is a tendency by most health care providers to omit sexual history taking (Bonfils et al, 2015). The usual behaviour of family members, nurses and social acquaintances of people with mental health problems is essentially the repression of any manifestation of sexual behaviour or complete denial of its existence (Barbosa et al, 2015).

Society members in many instances avoid discussing sexual aspects of people with mental health problems because the subject is perceived to be taboo. Moreover, some nurses may feel uncomfortable discussing matters related to clients' sexual life due to feelings of embarrassment for both the client and themselves (Dlamini and Shongwe, 2019). The omission of sexual assessment can lead to late or non-detection of sexually transmitted infections (STIs) among people with mental health problems (Bonfils et al, 2015). The presence of undetected and untreated STIs can lead to complications such as deterioration of the mental condition or sexual and reproductive complications (Chalklen, 2014). For example, most patients with mania in health institutions as well as in their homes have an increased risk for STIs owing to their hyperactive behaviour and vulnerability that predisposes them to unprotected sex, yet, most of the cases are undetected, unreported or not researched upon (Wainberg et al, 2018). In a study conducted in the United Kingdom (UK) by McClure (2015), mental health nurses acknowledged not being free to discuss the sexual dimension of clients. About 72% of nurses stated that they only discussed a patient's sexual dimension if the client initiated the discussion, while 10% never at any time discussed the subject with clients (McClure, 2015). The omission affects the nurse-patient therapeutic relationship and is considered wrong because most patients do not initiate discussions of sexual concerns unless first approached by a health professional (Klaessen, 2016).

In another related study conducted in Sweden, 80% of nurses did not take time to discuss sexual concerns of patients, while 60% did not feel confident in their ability to address clients' sexual concerns (Sandfort, 2018). The authors concluded that advanced nursing education was essential to improve nurses' ability to give patients the holistic care they deserved. Other reasons for not providing the therapeutic nurse-patient relationship in psychiatric nursing care that were identified included personal values, institutionalised fear, educational level, and the social stereotypes among nurses concerning the sexual dimension of people with mental health problems (Hendry et al, 2017). With increased concern among stakeholders, a study in Brazil revealed a 25.8% prevalence of STIs among people with mental health problems from a sample of 2,145 clients (Dura et al, 2014).

These findings indicate that most psychiatric patients, especially those with mania are sexually active with a high prevalence of STIs, and hence, emphasise the need for implementing sexual and reproductive health services, screening, treatment and counselling for behavioural modification (Dura et al, 2014).

Under related circumstances in South Africa, it was discovered that there are barriers to addressing issues relating to sexuality for clients with mental health problems. The social position of nurses, personal feelings regarding sexuality and gender norms influenced nurses' practice and care provision (Macleod and Nhamo-Murire, 2016). The study further acknowledged that nurses play a key role in the provision of services in relation to sexuality in both primary health care as well as sexual and reproductive health care. There were also significant incidences of STIs that were unaddressed with a range of injustices to clients seeking health care, especially in people with mental health problems (Macleod and Nhamo-Murire, 2016).

Likewise, some people living with mental health problems in Zambia petitioned Constitutional lawmakers on their vision of the Charter for people with mental health problems, so that it conforms to trending human rights that include sexual and reproductive human rights (SRHR) (Chalklen, 2014). In addition, the incumbent National Mental Health Bill of 2019 seems not to address the plight of people with mental health problems with regards to their sexual and reproductive health rights and responsibilities (Mwansa, 2019). There is no clause in the current Bill that addresses the sexual and reproductive health of mental health service users. This omission has the potential to subject people with mental health problems to STIs and deprive them of their self-esteem. On the other hand, providing information about clients with mental health problems' sexual health needs can benefit and enhance their quality of life. People with mental health problems have a fundamental right to adequate and appropriate reproductive health care (Wainberg et al, 2018).

In many instances, sexuality in people with mental health problems has been viewed as that of pathology and dysfunction, as clients are frequently labelled to be having a higher than normal sexual drive, hyposexual, or asexual (McClure, 2015).

Thus, it is generally felt that people with mental health problems have limited capacity to make appropriate decisions about their sexual life. For example, if nurses feel that distributing condoms in mental health institutions is inappropriate, they would not distribute the condoms. The Theory of the sexual scripts by sociologists John H. Gagnon and William Simon best explains this phenomenon. The originators of the theory addressed sexuality, desire and love as social constructs, and scripted or acted-out behaviour in individuals of different age groups. The scripts were explained to make people choose sexual behaviours in a certain context, and have relationships in a particular way, according to shared norms and conventions, based on three intertwined sets of scripts (Barbosa et al, 2015). The first set of social scripts called cultural settings is associated with collective meanings of sexuality. The second set of scripts referred to as interpersonal scripts is based on the level of social interaction. This second set of scripts forms a linkage between cultural settings and psychic life (Barbosa et al, 2015). The third level of scripts called Intrapyschic scripts clarifies the relationship between the development of individual characteristics of sexual desire and their life experiences (Barbosa et al, 2015). These scripts represent the interpretation of an individual's mental health and highlight that an individual's sexual behaviour is not guided by one single script, but rather by interplay between the scripts (Balswick and Balswick, 2018; Boyd, 2018).

The systematic incorporation of exploration of sexual issues for clients seeking health care requires a significant paradigm shift; not only in the nursing field but in the entire health sector. In the absence of such information that could assist in attaining the paradigm, this study, therefore, necessitates an exploration into nurses' perceptions of sexual health needs in people with mental health problems in Zambia. Researchers suggest that there is need to boost nurses' confidence and comfort levels in investigating and addressing sexual health needs among clients (Wainberg et al, 2018).

When clients' sexual concerns are not explored and addressed, they may end up developing low self-esteem, impaired interpersonal relationships as well as health complications (Wainberg et al, 2018). In addition, the constant interactions and the close relationship that nurses have with mental health patients and clients with mental health problems provide them with an opportunity to explore and discuss sexual health needs for clients.

This in turn could help identify health risks for clients and hence, come up with solutions to prevent the potential or available health risks, and complications. The remedy to these problems would be for nurses to create an atmosphere that educates clients that sexual health is a subject that can be discussed so as to detect deviations from normal (McClure, 2015). In order for this to happen, nurses need to accept that sexual health is an important aspect of healthcare and realise that patients need nurses to initiate conversations about sexual health (Egholm, 2015).

Ideally, there is need for more open conversations between clients with mental health problems seeking health care and nurses because the sexual aspect is as important as any other aspect of the human physiology (McClure, 2015). However, exploration of sexual history from clients with mental health problems is mostly overlooked during history taking, as evident from omissions of sexual history in the case notes obtained during history-taking and personal acknowledgement of this omission by over 70% of nurses (Salkeld, 2015; Chalklen, 2014). Consequently, this affects the nurse-patient therapeutic relationship during nursing care provision as nurses perceive sexual health needs of people with mental health problems as being non-existent or insignificant (McClure, 2015). Overlooking sexual aspects of clients with mental health problems, particularly those with mania, during history taking and needs assessment can lead to late diagnosis of STIs. The situation is 0.6% higher in individuals diagnosed with mental health problems than in those not diagnosed (Barbosa et al, 2015).

1.2. STATEMENT OF THE PROBLEM

Perceptions of nurses at Ndola Teaching Hospital (NTH) towards SRH needs of people with mental health problems are not known. Insufficiency of knowledge on perceptions of nurses towards SRH needs of clients leads to omissions in patient sexual history at NTH. This consequently has psychological, physiological and physical impact on the wellbeing of a client. In human physiology, the sexual aspect is as important as any other aspect (McClure, 2015); hence, there is need for more open conversations between clients, especially those with mental health problems and nurses because nurses are among frontline health workers that offer health care to people who seek health services (McCann, 2019).

Although various people have different perceptions of sexual health needs in individuals with mental problems, it is essential to understand perceptions of nurses because their overlooking of this important aspect in human physiology has the potential to lead to reduced self-esteem, unwanted pregnancy, sexual abuse, and undiagnosed STIs among people with mental health problems (Hendry et al, 2017; McClure, 2015).

1.3. FACTORS INFLUENCING PERCEPTIONS OF NURSES TOWARDS SEXUAL HEALTH NEEDS OF PEOPLE WITH MENTAL HEALTH PROBLEMS

Factors influencing nurses' perceptions of the sexual health needs of clients may be viewed as physiological, socio-cultural or educational as explained in the following information.

1.3.1. BIOLOGICAL FACTORS

The following information describes the perceptions that could be termed as physiological.

1.3.1.1. Basic human needs

Nurses, as well as other health care providers need to realise that people with mental health problems do not cease to be human beings. Just like most people without mental health problems, they want to feel loved and to have intimate relationships with other people (Wainberg et al, 2018). One way of expressing intimacy between two people is through sexual intercourse, something which is driven by stimulation of physiological chemistry in the human body governed by hormones and the nervous system.

In a detailed explanation of the application of Abraham Marslow's popular psychological theory of the hierarchy of needs to sex and sexual fulfilment, nurses can learn how to approach the subject of sexuality and how it operates in people's lives. Goggard (2016) explains that before meeting the higher needs in a person's hierarchy (safety and security needs, love and belonging, self-esteem and self-actualisation), a human being must first of all address the basic physiological needs, among which is sex.

Having sexual relations with the opposite sex could be useful in procreation and relieving stress, so that safety and security needs, as well as love and belonging are met (Goggard, 2016). In addition, many people fulfill self-esteem needs with sex. However, if self-esteem is at stake, it can lead someone to act inappropriately or feel like something is missing and hence make someone feel unable to accept and prioritise their own desires (Goggard, 2016). In intimate relationships, this can be toxic. Since nurses generally have basic orientation to the theory of Maslow's hierarchy of needs, the knowledge can influence their perceptions towards sexual health needs in people with mental health problems.

1.3.1.2. Gender of clients and nurses

People with mental health problems, who are mostly women, are frequently coerced into sexual activity (Wainberg et al, 2018). This puts them at greater risk for STIs and unplanned pregnancies. Additionally, it is reported that male nurses are freer to discuss sexuality issues with clients than their female counterparts (McClure, 2015). However, sexuality issues must be a concern for people of all genders (Wainberg et al, 2018).

1.3.1.3. Age of clients and nurses

It is purported that older health care providers, particularly those with ages above 40 years are much freer to discuss matters concerning sexual lives of clients (McClure, 2015). In another observation, clients that are of the younger generation tend to be more comfortable revealing matters to do with their sexual lives, as opposed to their older counterparts who tend to be more conservative especially if being attended to by a much younger health care provider (Wainberg et al, 2018).

1.3.2. SOCIO-CULTURAL FACTORS

Socio-cultural factors that can influence nurses' perceptions about sexual health needs in people with mental health problems include:

1.3.2.1. Culture

The culture of a nurse may have an influence on how they perceive the sexual dimension of clients (Wainberg et al, 2018). Generally, discussing the sexual dimension with clients among

nurses is considered a taboo; therefore, most clients do not feel comfortable discussing the subject (McClure, 2015). Moreover, nurses think that they would be promoting sexual promiscuity among patients if the subject of sexuality is legalised or routinely discussed (Chalklen, 2014). In addition, because the hospital is considered an inappropriate place for sexual expression, such expressions are considered psychopathological. Health care providers consider the hospital as a place for protection, giving emphasis to medical therapeutic environment (Wainberg et al, 2018). It is for this reason that most mental institutions strip away privacy and monitor sexual lives for in-patients (Chalklen, 2014).

Clients seeking health care are not allowed to have sexual relations with their intimate partners in designated rooms within the hospital and are prohibited from relieving sexual desire through masturbation because health care providers consider this as unacceptable (McCann, 2019).

1.3.2.2. Comfort zone

Some personal values among health care providers and feelings of discomfort to discuss sexual issues may directly affect willingness of nurses to include sexual and reproductive care in their package of care. Unless a patient asks questions pertaining to their sexual life, majority of nurses would not initiate or explore this important aspect for clients (McCann, 2019). Moreover, discussing sexual issues tends to be an embarrassing subject among nurses as well as most other health practitioners; leading to omissions in history obtained. On the other hand, it is the duty of nurses as well as other health care providers to provide counselling to families of these patients and to advocate for better discernment regarding the subject of sex (McClure, 2015).

1.3.2.3. Social stereotypes

Most health workers have prejudices regarding sexual lives for patients in conformity with culture. Nurses in particular believe that sex in clients under institutional care must be surveilled, controlled, and punished (Volkh, 2014). It is also supposed that individuals with mental health problems are not capable of expressing feelings or emotions from a sexual relationship as a normal activity because they are not able to regulate their emotions and

passions, which are interpreted as antisocial and abnormal, therefore preventing them from being integrated into society (McClure, 2015). Persons with mental health problems discovered to be engaging in sexual relations are perceived to have committed that which society does not accept in this population (Wainberg et al, 2018). Furthermore, society endorses that it is a crime to have sex with the mentally ill because they lack capacity to make informed consent. However, this notion consigns the people with mental health problems to a sexless and diminished life (Voloikh, 2014).

1.3.3. EDUCATIONAL FACTORS

The following may affect nurses' perceptions of sexual health needs in people with mental health problems:

1.3.3.1. Area of specialty

The knowledge level of nurses about STIs and knowledge of how to talk to clients about sexual matters is very important in addressing the sexual dimension of clients. Nurses may specialise into various fields such as in psychiatric nursing, midwifery and advanced clinical medicine just to mention a few specialties. For this reason, nurses feel they can best help clients with their sexual dimension when they undergo additional training in human sexuality. For example, nurses feel they can help clients to address sexual concerns following additional training in sexual and reproductive health (McCann, 2019; McClure, 2015).

1.3.3.2. Level of education in nursing

The expertise of nurses in collecting history related to sexual health including application of counselling techniques depends on the level of training in the nursing field; ranging from Certificate, undergraduate all the way to postgraduate levels. Novice nurses may have limited know-how on how to assess client sexual health needs, and may overlook the whole phenomenon if the patient being cared for is considered to have mental health problems (Kalra et al, 2015). However, acquisition of extra qualifications such as in psychosocial counselling has predisposed nurses to confidently discuss sexual issues with clients (McClure, 2015).

The higher the education level of the nurse offering health care, the more they are likely to discuss all aspects of patient functionality, which includes the sexual dimension (Hendry et al, 2017).

1.4. JUSTIFICATION OF THE STUDY

Conducting this study has provided perceptions of nurses at NTH towards SRH needs in people with mental health problems. Nurses' perceptions on sexual health needs in people with mental health problems have provided basis on which history taking, nursing care, and needs assessment of clients with mental health disorders can be improved and conducted. Interventions can be put in place based on the collected client case history in order to strengthen care, address barriers in care and justify curriculum reviews by the Nursing and Midwifery Council of Zambia (NMCZ). Based on the findings, provision of client-centred holistic care will also be advocated for to include early detection and management of STIs in people with mental health problems, especially clients with mania, and remedies to prejudices about clients' sexuality can be sought. Moreover, the findings of this study could be utilised to develop strategies for eliminating barriers to sexuality assessment by nurses caring for people with mental health problems as well as other patients in general.

Understanding nurses' perceptions of the sexual health needs for people with mental health problems could also help establish links with sexual health services being advocated for by concerned civil rights movements (Lomas, 2009), such as the "Sexual and Reproductive Health for all" concept. Through this information, the Ministry of Health (MoH) and other stakeholders could review standard treatment guidelines in order to identify health risks among clients and strengthen service delivery.

1.5. RESEARCH PURPOSE

The purpose of this study was to investigate perceptions of nurses at Ndola Teaching Hospital towards sexual health needs of people with mental health problems.

1.6. RESEARCH OBJECTIVES

1.6.1. General Objective

The general objective of this study was to explore perceptions of nurses at Ndola Teaching Hospital towards sexual health needs of people with mental health problems.

1.6.2. Specific Objectives

The specific objectives of the study were to:

1. Evaluate the perceptions of nurses at Ndola Teaching hospital towards sexual health needs of people with mental health problems.
2. To explore how knowledge influences perception of nurses at Ndola Teaching hospital towards sexual health needs of people with mental health problems.

1.7. RESEARCH QUESTION

What are the perceptions of nurses at Ndola Teaching Hospital towards sexual health needs of people with mental health problems?

1.8. CONCEPTUAL DEFINITION OF TERMS

Human sexuality: This refers to the way people experience and express themselves sexually involving biological, erotic, physical, emotional, social or spiritual feelings and behaviours (Balswick and Balswick, 2018).

Sexual health: A state of physical, emotional, mental and social wellbeing related to sexuality, not merely the absence of disease, dysfunction or infirmity (WHO, 2002)

Gender: This refers to the socially ascribed state of masculinity or femininity to an individual (Goggard, 2016).

Age: This is a period of human life, measured by years from the day of birth, usually marked by a certain degree of mental or physical development and involving legal responsibility (Stevenson, 2015).

Cultural belief: This defines the characteristics and awareness of a particular group of people encompassing language, religion, cuisine, social habits, music and arts (Zimmermann, 2017).

Knowledge: This is the theoretical or practical familiarity, awareness, or comprehension of something in relation to facts, information or descriptions of the subject matter (Stevenson, 2015).

1.9. OPERATIONAL DEFINITION OF TERMS

Human sexuality: The way people experience and express themselves sexually involving biological, erotic, physical, emotional, social or spiritual feelings and behaviours towards others

Perception: This refers to a respondent's interpretation of sexual health needs in people with mental health problems

Stereotype: This is an image or idea of a particular type of person or thing that has become fixed through being extensively held.

Comfort level: This is a psychological state in which a respondent feels familiar to a person and that person is at ease as well as in control of their environment, with low levels of anxiety and stress.

CHAPTER TWO: LITERATURE REVIEW

2.0. INTRODUCTION

The purpose of this literature review was to critically analyse and evaluate findings and recommendations of studies from different regions of the world related to the phenomenon of sexual need in people with mental health problems. The review of literature included studies providing global, regional as well as local perspectives of the phenomenon. The explored data bases included PubMed, Hinari, Science Direct and Google Scholar. Information was also sought from unpublished theses in different libraries in the country. Qualitative, quantitative and mixed methods researches were included in the review. The literature review is presented under the following headings: general overview of nurses' perceptions of sexual health needs in people with mental health problems, gender of clients and nurses in relation to discussion of sexual issues with clients, influence of the nurse's age on sexual health needs of a client, influence of cultural beliefs on nurses' perceptions of clients' sexual health needs, and nurses' knowledge of the sexual health needs of people with mental health problems.

2.1. GENERAL OVERVIEW OF NURSES PERCEPTIONS OF SEXUAL HEALTH NEEDS IN PEOPLE WITH MENTAL HEALTH PROBLEMS

The World Health Organisation (WHO) conducted a study to explore nursing attitudes to client sexual health needs. Findings showed that most of the nurses did not ask about sex issues, felt uncomfortable with the subject and generally ignored the sexual domain in assessments (WHO, 2015). Recommendations were that a thorough sexual history should consider the physical, emotional, intellectual, social and spiritual spheres. These omissions in client assessment that were observed by the WHO are similar to what is prevailing at Ndola Teaching hospital where client history taking is deficient, thereby affecting provision of holistic nursing care. After the 2015 findings, the WHO formulated universal guidelines on provision of sexuality counselling in health care settings with the ultimate goal of ensuring access to sexual and reproductive health services for all, and promoting sexual health rather than mere treatment of STIs (WHO, 2018).

In congruence with the WHO's views and finding, a Brazilian study by Barbosa et al, (2015) discovered that people with mental health problems; especially those with mania, were regarded as potential victims of HIV and AIDS. Unprotected sex was among the factors that were attributed to the high rates of HIV/AIDS among mania patients in comparison to the general population (Barbosa et al, 2015).

Barbosa et al, (2015) further state that it was difficult for nurses to talk about sex and to negotiate safe sex in people with mental health problems. Furthermore, Barbosa et al, (2015) discovered that most clients seeking health services preferred discussing sexual issues with nurses rather than other health practitioners, because they perceived the nurse-patient relationship as less intimidating. However, although patients preferred to discuss their sexual issues with nurses; the nurses seem to be uncomfortable to address such issues, much to the disappointment of the patients (Barbosa et al, 2015). In another Brazilian study; nurses perceived the sexual life of people with mental health problems according to their own values and prejudices, which indicated unpreparedness to address concerns about sexual expression in individuals receiving care for mental illnesses (Weinberg et al, 2018).

In a related study conducted in the United States of America (USA), the findings also revealed that nurses perceived the sexual manifestations of people with mental health problems according to their own values, taboos and prejudices (Quinn, 2015). This showed the nurses' unpreparedness in dealing with sexuality for individuals receiving care for mental health problems. The study found that generally nurses felt uncomfortable discussing sexual matters with clients, especially the mentally ill, thereby neglecting the concerns of the clients regarding their sexual health needs. Still in USA, results of another study concluded that lack of data in patients' documents showed little recognition of sexuality in hospitalised patients particularly those with mental disorders, highlighting the need to promote the training of health personnel (McCann, 2019). Another researcher in USA states that sometimes adult people with mental health problems can succumb to consensual sex with their intimate partners, and as such the partners to such clients should not be legally sanctioned or persecuted (Vолоkh, 2014).

According to the findings of these studies from the USA, conclusion could be drawn that nurses are in a unique position to discuss the sexual health care needs of all their clients regardless of the client's mental health state. This care is important to the goals of health promotion. It allows nurses to function as advocates and enables them to meet the growing demand for informed, responsible patient care. Nurses need to have attributes such as, giving patients information; listening to patients' views and concerns; ensuring their need for confidentiality and privacy; and involving patients in decisions about their sexual lives.

Another study in the USA found that women and young people living with mental health problems have many sexual health care needs. McClure (2015) reported that women were at greater risk of sexual abuse and exploitation due to unequal power balances in relationships or experiences of sexual abuse in childhood, resulting in increased rates of re-victimisation in adulthood. The author also reported that clients diagnosed with borderline personality disorders; mostly women, were frequently compelled into sexual activity by some adult males.

With reference to the aforementioned studies, there is evidence that the sexual dimension of health service consumers has been poorly addressed by nurses, causing lapses in sexual and reproductive health care provided to clients. Most health care practitioners acknowledge importance of sexual expression by clients but are reluctant to inquire about consumer concerns and ignore sexuality care for clients. No wonder Quinn et al, (2015) concluded that nurses perceived the expression of sexuality in people with mental health problems to be of less priority, and that the topic is not their responsibility to address.

Another study in the UK concluded that gender stereotypes especially on the part of health care providers caused significant damage to the sexual health of clients, especially people with mental health problems (Hughes, 2018). In this same study, 23% of people with mental health problems reported having contracted some STIs, and the rate of HIV/AIDS was higher than that of the general population. This qualitative study further revealed that 80% of respondents who were nurses agreed that sexual health was an important part of their role, but only 30% routinely discussed sexual health with clients having mental health problems (Hughes, 2018). 14% of nurse respondents felt uncomfortable discussing sexual issues with mental health clients, and 13% were uncomfortable discussing gay and lesbian issues (Hughes, 2018). The conclusion of the study was that such situations prevented clients from achieving full societal potential, hence predisposing them to high HIV prevalence. Further research discovered that adult clients at psychiatric out-patient department (OPD) reported stigma as well as denial of psychosexual guidance by health practitioners and society in general (Wainberg et al, 2018).

In Netherlands, Klaessen (2016) discovered that nurses perceived history taking, screening and lifestyle intervention as a part of their role in sex education for clients. But contrary to the findings by Klaessen; Egholm (2015) discovered that nurses did not provide sex education and related treatment packages to people with mental health problems. Moreover, nurses were neither comfortable nor confident in their ability to discuss sexual dimension with their clients due to personal cultural conflicts.

In the Republic of South Africa (RSA), MacLeod and Nhamo-Murire (2016) reported that there were barriers to integration of issues relating to sexuality of clients in nursing practice; and these included social position of nurses and personal feelings regarding sexuality and gender norms influence nurses' practice. Likewise, research by Leckie (2016) explains that presence of mental health problems has an impact on the sex life of an individual. For example, patients with depression have little or no interest and energy for sex. In addition, patients on psychotropic medications tend to develop altered sexual function and physiology (MacLeod and Nhamo-Murire, 2016). On the other hand, it is assumed that mental health problems such as mania are associated with deliberately seeking risky situations such as having unprotected sex with strangers (Kline, 2015). Such situations put clients at risk of contracting STIs that could further aggravate their mental conditions, and lead to severe complications. Unplanned pregnancies could also be a consequence for these omissions in care provision on the part of health care providers. Moreover, it was discovered in Eswatini that the unwillingness to discuss medication sexual side effects not only contradicts opportunities for freedom of treatment choice, but also conflicts with current practices relating to informed consent, partnership, therapeutic alliance, and client involvement in care decisions (Dlamini and Shongwe, 2019).

In a study jointly conducted in Kenya and Zambia; nurse midwives' discussions about patient sexuality were deficient (Chalklen, 2014). In this study nurse midwives were found to disprove discussions of the sexual dimension in clients especially adolescents seeking health services, as well as people with mental health problems. This phenomenon or attitude by society as a whole has caused vulnerable people such as the mentally ill and adolescents to have unwanted pregnancies and STIs. In criticising the conduct of nurse midwives in Kenya and Zambia towards some vulnerable populations, another author says the situation denies people with mental health problems that are married and are ready to have sexual relations or procreation with their sexual partners based on mutual understandings (Kimmel, 2018).

Nurses acknowledge stigma and apathy in sexual dimension of people with mental health problems, but there is reluctance in discussing sexual lives of clients among nurses (Chalklen, 2014). In as much as nurses acknowledged the presence of sexual expressions in people with mental health problems, the sexual lives of clients were considered insignificant in some way, because the guidelines and infrastructure in most mental health institutions of Zambia do not allow for complete privacy of the clients (Chalklen, 2014). It could be these inadequacies in the system that cause incomplete history taking for clients, as well as deficiencies in privileges that promote personal sex worth and gratification for clients; especially clients who are institutionalised in mental health institutions for considerable lengths of time. Some mentally ill patients are considered to be committing something unacceptable in the eyes of society if they expressed themselves sexually. Such patients may end up being nursed in highly secluded and restricted sections of mental health hospitals; such as Chainama East wing of Chainama Hills Hospital, which is the highest mental institution in Zambia. Anecdotal information state that matters of sexuality among people with mental problems are complicated in that some people who have had sexual relations with the mentally ill have been sued by relatives of the involved mentally ill persons.

2.2. GENDER OF CLIENTS AND NURSES IN RELATION TO DISCUSSION OF SEXUAL ISSUES WITH CLIENTS

In a quantitative study conducted by McClure (2015), sexual coercion was mostly attributed to women, irrespective of whether they had mental health problems or not. This vice put women at greater risk for contracting STIs and having unplanned pregnancies. In order to curb the vice, the authors stated that sexuality issues must be a concern for both males and females providing care to clients, regardless of the psychological state of the clients.

Converse to the views of McClure (2015), a qualitative study conducted by Sandfort (2018) discovered that it is mostly the male nurses who are free to discuss sexuality issues with clients compared to their female counterparts. The male folk are generally regarded to have apathy when it comes to accessing professional medical advice, which includes sexual and reproductive health (Quinn, 2015). This phenomenon creates barriers because most of the nursing workforce is comprised of the female folk (Sandfort, 2018).

2.3. INFLUENCE OF THE NURSE'S AGE ON SEXUAL HEALTH NEEDS OF A CLIENT

The frontline workforce in the Scandinavian health sector, especially nursing is mainly composed of the youthful and energetic people between the ages of 25 and 50 years (Sandfort, 2018). This phenomenon advantages clients that are seeking medical advice because the able workforce is capable of having patience and insight in addressing sexual issues due to various educational attainments. However, health care providers below 25 years of age may not have insight or adequate experiences to relate to when counselling clients about sexual issues. In agreement with this concept, McClure, (2015) states that nurses that are above the age of 40 years are capable of tactfully moderating discussions that contain issues of sexual nature with clients; for example, during history taking and routine nursing care.

In Central Africa, according to Chalklen (2014) it was observed that adolescents, regardless of the mental health status, have knowledge deficit and live with misconceptions and deprivation of services such as sexual and reproductive health; sometimes perpetrated by trained medical personnel. This phenomenon exposes the adolescents to unwanted pregnancies, early marriages, STIs as well as complications of criminal abortion. In agreement with Chalklen's (2014) observations, a study in USA by Quinn (2015) revealed that some younger nurses between the ages of 25 and 35 years in a quantitative study responded that they would only discuss a patient's sex life when the patient had questions; citing sensitivity of the subject matter as a deterrent.

To further explain the phenomenon of age affecting nurses' perceptions of sexual health needs of clients, a quantitative study conducted in Turkey involving 650 youthful respondents studying midwifery found that it is the clients that initiated the sexual topic in 74.9% of respondents (Oren et al, 2017). The study also found that less than half of the respondents (48.8%) had insight about responsibility of discussing sexual matters with clients. The author discovered that students of midwifery did not feel comfortable counselling women on sexual issues. The conclusion was that even though attitudes of midwifery students towards sexual counselling were good, students were often uncomfortable to provide counselling especially to particular groups of women, such as homosexual women or sex workers who may have potentially been carrying HIV (Oren et al, 2017). Similar to the western region scenario, most of the workforce in the Central African health sector is composed of youthful care providers, majority of who are nurses (Chalklen, 2014).

As much as the age of the health care providers seemed to have an influence on nurses' perceptions of clients' sexuality, the age of clients as well that of the general populous seemed to have an influence. According to a systematic review of both qualitative and quantitative literature published by Bauer et al (2015), sexuality remains important for many people aged 65 years and above, regardless of mental capability. However, embarrassment, treatment deficiencies, negative attitudes and perhaps indifference on the part of health care providers can inhibit discussions on sexuality, thereby compromising the much needed holistic care and lowered self-esteem in the older populations. This situation is common even in the Zambian traditional setting, where older people are generally regarded to have sexless lives and traditional sanctions and stereotypes are applied (Chalklen, 2014).

2.4. INFLUENCE OF CULTURAL BELIEFS ON NURSES' PERCEPTIONS OF CLIENTS' SEXUAL HEALTH NEEDS

The cultural beliefs of a nurse may influence how they perceive the sexual life of clients (Guscoyne, 2016). Most nurses in USA find it difficult to discuss the sexual lives of clients due to barriers on the topic that is considered forbidden in their respective cultures of origin (McClure, 2015). In addition, the nursing culture influences nurses to think that they would be promoting sexual promiscuity among patients if the subject of sexuality is legalised or routinely discussed, because the hospital is considered an inappropriate place for sexual expression. It is for this reason that most mental health institutions in Central Africa do not prioritise patient privacy during care of these patients (Chalklen, 2014). To add to this belief in the nursing culture about not prioritising the client's privacy, one qualitative study in USA found that the nurse's original ethnic background and norms influence the discussion of sensitive matters about the clients, such as sexual life (Sandfort, 2018). In the RSA, religion is another aspect of a service provider's culture that can influence how patient history is obtained, particularly omitting sexual history. Muslims in particular are cited to have difficulties asking clients about sex life; in this way providing deficient or inadequate health care provision (Arousell and Carlbom, 2016).

2.5. NURSES' KNOWLEDGE OF THE SEXUAL HEALTH NEEDS OF PEOPLE WITH MENTAL HEALTH PROBLEMS

Nurses in America feel they can best help clients with addressing their sexual life when they attain specialised training such as midwifery (Quinn, 2015; McClure, 2015). Ivanova et al (2016) also acknowledges in a qualitative study that a clinician's knowledge about sexual health topics influences collection of sexual history and impacts on the outcome of patient care. This is in agreement to the findings published by Oren et al (2017), in a cross-sectional quantitative study also conducted in the USA. On the other hand, a descriptive quantitative study conducted in Portugal with a sample of 155 physicians drawn from a cross section of physicians; 63.9% stated they did not address sexuality of clients in medical interviews due to limited time, fear of embarrassing the patient and technical inability to obtain the sexual history (Cherpak and Dos Santos 2016). The authors reported that geriatrics and endocrinology were the specialties that addressed the issue of sexuality more often (Cherpak and Dos Santos, 2016).

Similar to findings of the studies conducted in the USA earlier, Chalklen (2014) in Central Africa concurred and recommended for specialised training in sexual and reproductive health as well as adolescent sexuality management and psychosocial counselling courses among nurses as frontline health workers. Varshney et al, (2018) argue that if many nurses are empowered with midwifery skills where sexual and reproductive health matters are key in knowledge acquisition and service provision, then all populations will be catered for across all departments during routine service provision.

2.6. SUMMARY

A number of studies on sexual health needs of clients in health care provision have been conducted globally and nationally. From the variety of reviewed literature, the commonest methodology utilised was qualitative, and data collection method using focus group discussions (FGD) were ideal for data collection. Some of the identified factors that influence the provision and discussion of sexual issues by health care providers with clients include gender, age, cultural factors and knowledge of care providers.

CHAPTER THREE: METHODOLOGY

3.0. INTRODUCTION

This Chapter presents the methodology and methods that were used to conduct the study. The chapter presents the study design, the study setting, study population, sampling, data collection, validity and reliability, ethical considerations, plans for dissemination of findings, as well as limitations of the study.

3.1. STUDY DESIGN

A general descriptive qualitative study design (Rossiter and Hazelton, 2018; Hyejin et al, 2017; Creswell, 2015) was utilised in this study. General descriptive qualitative study design is a type of design widely used in healthcare and nursing-related phenomena, if the qualitative study does not fit into the typology of phenomenology, ethnography, or grounded theory (Rossiter and Hazelton, 2018; Hyejin et al, 2017; Creswell, 2015). It is based on the general premises of naturalistic inquiry and its focus is to offer a description of phenomenon under study for the sake of knowledge and not manipulation (Rossiter and Hazelton, 2018; Hyejin et al, 2017; Creswell, 2015). Therefore, this research design was found to be appropriate for this study because the focus was to offer a description of nurses' perceptions of sexual health needs in people with mental health problems for the sake of knowledge and not manipulation.

3.2. STUDY SETTING

The study was conducted at Ndola Teaching Hospital, which is a third level health facility offering mental health services at a tertiary level. Other health services being offered at the health institution are general medical, general surgical, maternity care, neonatal care, as well as speciality services such as, ophthalmology, ear, nose and throat (ENT). The institution is the second largest health institution in Zambia, located in the urban area of Ndola district in the Copperbelt province. It is a referral centre for mental health cases, as well as other medical-surgical and specialty cases from the Copperbelt and northern regions of Zambia. The hospital is also a practicum site for students from across the country pursuing medical related courses in various disciplines such as medicine, nursing, midwifery, biomedical science and various specialties.

3.3. STUDY POPULATION

The study population comprised of all nurses that provided health care to people with mental health problems at Ndola Teaching Hospital. The target population were nurses from the psychiatric unit at the institution, as well as nurses who handled clients with mental health problems in the postnatal, OPD and general medical wards.

3.4. SAMPLING

Purposive sampling was used to select Ndola Teaching Hospital on the basis that the hospital is the largest health facility offering mental health services in the northern region of Zambia. Purposive sampling was also used to select participants for the study based on the diversities that existed among the nurses in terms of age, sex, marital status, culture and educational levels. These diversities were necessary in order to elicit a variety of perceptions among the nurses on sexual health needs in people with mental health problems.

3.5. INCLUSION AND EXCLUSION CRITERIA

3.5.1. Inclusion criteria

To have been included in the study, nurses had to meet the following criteria:

- At least six months of working in a psychiatric unit or experience of attending to clients with mental health problems.
- This experience should have been current, not spanning back more than five years prior to data collection time, due to reforms in health care.

3.5.2. Exclusion criteria

Nurses were excluded from participating in the study if:

- Working in a managerial position.
- Not available in Ndola during the period of data collection.
- Not willing to participate in the study.

3.6. SAMPLE SIZE

Sample size depended on data saturation, which entails that no new information was emerging from participants (Creswell, 2015). Taking cognisance of the aforementioned diversities in the study population, data were collected from a sample size of 21 derived from hospital departments that deal with clients with mental health problems.

3.7. DATA COLLECTION

Data collection was done by the researcher between 5th and 20th January, 2021. This was after obtaining written permission from the relevant authorities.

3.7.1. Data collection tool

Data was collected using three focus group discussions (FGDs) comprising of seven participants each. The FDGs were guided by an interview guide (Appendix III). To avoid loss of data, the FDGs were audio recorded and notes about how each discussion took place were written immediately after.

3.7.2. Data collection technique

On each day of data collection, the researcher began by introducing herself. A brief description of the purpose and process of the study was provided to potential participants. Nurses who were willing to participate in the study were given a Participant Information sheet (Appendix I), containing detailed information about the study. Participants that consented to participate in the study were given a consent form (Appendix II) to sign before commencement of data collection.

Before commencement of each data collection, the researcher ensured all participants met the inclusion criteria, and they were assured that they were at liberty to express themselves in a language of self-preference, provided there was no communication breakdown with fellow participants. Each participant was recruited in only one FGD. Each discussion started with an open-ended question: ‘what are your views concerning sexual health needs of people with mental health problems?’ The opening question was followed by subsequent questions such as: ‘Describe a situation when you had to deal with sexual health needs in a person or people with mental health problems?’; ‘Have you ever thought of the existence of sexual health needs in people with mental health problems?’; ‘Give an explanation for your answer’; ‘How did that make you feel?’. The questions allowed participants to provide explanations and descriptions for their answers. In order to focus on the phenomenon under study, there was need to utilise prompts such as: ‘Does it happen?’; ‘What do you think?’; ‘What was your reaction?’; ‘How did you address the situation?’ Notes from the FGD proceedings were taken and time was monitored by an assigned time keeper. Attention was paid to the non-verbal cues among participants and recorded appropriately; for use during data analysis.

3.7.3. Data management and storage

The discussion notes that emanated from data transcriptions and audio recordings were securely locked in a cabinet and were only accessible by the researcher. Pseudonym identification codes were assigned to participants during the FGDs, and typed data were stored on a Password protected personal computer known only by the researcher.

3.8. ETHICAL CONSIDERATIONS

In addition to obtaining ethics clearance from the University of Zambia, Biomedical Research Ethics Committee (UNZABREC) (Appendix X), written permission was sought from the National Health Research Authority (NHRA) at the MoH headquarters (Appendix.. XI), from the Senior Medical Superintendent for Ndola Teaching Hospital (Appendix...IX), and from the ward in-charges.

The purpose of the study was explained to participants. They were notified about the possibility of inherent discomforts of the topic and were urged to be at liberty not to answer questions they found uncomfortable or disturbing. In addition, privacy throughout discussions was maintained by closing the door to the room where FGDs took place.

Each participant signed a consent form. Confidentiality, privacy and anonymity was ensured by keeping obtained information in the custody of the researcher, and not shared with anyone, apart from the supervisor for supervision purposes. In the event that some information needed to be heard by other parties, appropriate shared confidentiality and referrals was done with the full knowledge of the participants. No identifying information, such as names of the participants, were included in written or in any other form. Pseudo identifications such as initials instead of names were used on transcribed verbatim transcripts, and no pictures were taken. Participation in the study was voluntary, without any form of coercion, and participants had the right to leave at any time of the discussion without suffering any consequences.

3.9. TRUSTWORTHINESS

Trustworthiness was achieved through maintenance of credibility, transferability, dependability and confirmability. Credibility was ensured through use of direct participant quotes from the FGDs and participant debriefs, as well as by availing audio recordings and transcripts to research supervisors. Transferability was ensured by having a variety of demographic characteristics of study participants. For dependability, the researcher was accountable and allowed peer review of data and supporting documents. Confirmability was achieved by probing some responses further using follow-up questions.

CHAPTER FOUR: DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.0. INTRODUCTION

This chapter presents how the data were analysed and the findings elicited from the FGDs that were conducted with the nurses who participated in the study. The findings are presented in line with the objectives of the study under the themes that emerged from the FGDs.

4.1. DATA ANALYSIS

Thematic analysis expounded by Caulfield (2019) was used to analyse the data. To begin with, data from the audio tapes were transcribed verbatim. Guided by Creswell (2015), the transcripts were checked for any mistakes that could have been made during the transcriptions by listening repeatedly to the audio recordings. This also enabled the researcher to get immersed in the details of what was being said, in order to generate themes.

The next stage involved writing short notes in the form of short phrases in the margins of the text and themes were identified. This was followed by highlighting and sorting out quotes and making comparisons both within and between the phrases. The next stage involved lifting the quotes from their original context and rearranging them under the newly developed appropriate themes. Finally, interpretation was undertaken to theorise the significance of the highlighted patterns in relation to the respective research objective. Six major themes emerged with each having sub-themes. The major themes, subthemes and supporting verbatim statements are presented in Table 1.

Table1: Major themes, sub-themes verbatim statements

MAJOR THEME	SUB-THEME	KEY STATEMENT
1. Physiological interplay	Sex being a basic physiological human need	<ul style="list-style-type: none"> • <i>“Mental illness is just like any other illness, it is just that the brain is affected... but in terms of their sexual life, they are still active, so no wonder you find that most of the times, some of the patients will have sexual advances towards the opposite sex.”</i> • <i>“Yes I have seen them having sexual gratification. They masturbate.... playing with their private parts.”</i>
2. Medical factors affecting sexual behaviour	Mental disorder and drugs given affect sexual activities	<ul style="list-style-type: none"> • <i>“If the patient comes in with mania, definitely you expect that patient to be hypersexual. If the patient comes with depression, of course you expect that patient to have Anhedonia, they will have no interest in any sexual activities.”</i> • <i>“Some clients become sexually active or sexually inactive because of the drugs that they take, they have got side effects that affect libido. You find that some will make them high, others will make them low.”</i>
3. Differences in demographic characteristics of	Educational level and work specialty affecting nurses’	<ul style="list-style-type: none"> • <i>“I think one of the factors is education....if you are knowledgeable, you understand that these people are also human beings and what is just affected is</i>

<p>nurses as well as clients affect therapeutic relationships between clients and nurses</p>	<p>perceptions</p> <p>Age of the nurse affects nurses' perceptions</p> <p>Gender of nurses and clients affecting therapeutic relationship</p>	<p><i>their thinking capacity, but otherwise, the rest of their body is just working normally.</i>"</p> <ul style="list-style-type: none"> • <i>"Also age, when you have old age, when you are mature enough you will be able to know that it is normal, for someone to have sex."</i> • <i>"If a person of opposite sex enters a ward in psychiatric unit, especially when a male enters female ward, the female patients will start advancing sexually. They will even be saying things such as "I want my husband, it is you who has come, you are my husband, come here." So they are also human, and they have sexual desire."</i>
<p>4. Deficient health system and environment as a cause of sexual misdemeanour</p>	<p>Staff shortage causes sexual misdemeanour by patients</p> <p>Poor record keeping causes disruption in patient history analysis</p>	<ul style="list-style-type: none"> • <i>"Due to the low staffing levels that we have, it really creates a negative impact. You find that as they make advances some female staff are alone on duty and have small stature, they cannot even defend themselves. So as the male clients make advances this staff cannot defend themselves and they can be raped. Even the male staff working in the female wards, they can be enticed."</i> • <i>"There is a problem everywhere...it is very important that records are kept intact because we deal with the history of the patients... it is very important that the records are intact in case a patient is transferred. Maybe Smart care is more important than what we have now, it is very important that we have that".</i>

5. Existence of social stereotypes	Presence of labelling theory in the community against mental patients	<ul style="list-style-type: none"> • <i>“These people in the communities, when they just see a mental patient maybe in the neighbourhood....they always say... Take them so that they can be castrated, because it is them who rape people. They feel their school going children are not safe by having a male patient just living nearby their home or those who roam the street. Sometimes they will tell the relatives to the patient to be locking up the patient so that they are not having access to the sex.”</i>
6. Need for psychosexual support and advocacy by the nurses	<p>Need to provide non-judgemental care</p> <p>Recognising sex as an aid to recovery</p> <p>Human rights advocacy</p>	<ul style="list-style-type: none"> • <i>“When the time comes if they marry, they are free to have sex, and we shouldn’t judge, and the community should not perceive it wrongly to say she is not supposed to get married.... as long as they are educated, they are counselled, they can manage to take care of a home and take care of the spouse, the patient has got the right like anyone of us.”</i> • <i>“And also sex plays an important role in stabilising our patients because if you look at the functions of sex, it is not just for reproducing but it also helps to relieve some stress.”</i> • <i>“These are people like any other; we shouldn’t deprive them the conjugal rights.”</i>

4.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Twenty-one nurses participated in the study; nine were male, while 12 were female. All of them were mental health nurses with Certificate, Diploma or Bachelors qualifications. Their ages ranged between 22 and 54 years, and all were licensed with the Nursing and Midwifery Council of Zambia (NMCZ) with over six months working experience in the psychiatric unit and Ndola Teaching Hospital. The participants had varying professional credentials ranging from Certificate to Bachelor's Degree in Nursing. Eighteen of the participants were married and three were single. Most of the female participants were married. All the participants were Christians belonging to different denominations such as, Roman Catholic, Seventh Day Adventist, African Methodist Episcopo, and Evangelical. The participants were from different cultural and ethnic Zambian backgrounds. Among them were Tongas, Lozis, Bembas, and Kaondes. The diversities were significant because they enabled eliciting of views from an assorted pool of nurses.

4.3 PRESENTATION OF FINDINGS

4.3.1 THEME ONE: PHYSIOLOGICAL INTERPLAY

This theme entailed participants' perception that mentally ill persons too have sexual feelings and thus, intercourse was also normal to them as it is for those who are mentally stable. This was despite society's view that it was abnormal;

"In my opinion, these people are not functioning well mentally, so allowing them to have sex will make them feel that they can do whatever they want, it is not normal...." (Mrs T.T, FGD3).

Physiological interplay relates to the interaction among different systems in the body such as the nervous, endocrine and cardiovascular systems in the regulation of sex. These systems complement each other in regulation of sex. Participants acknowledged having witnessed mental health clients having sexual gratification by seeing them masturbate; indicating that people with mental health problems were indeed sexually active. Some of the statements from participants relating to sexual gratification were as follows:

"Yes I have seen them having sexual gratification. They masturbate. They will be masturbating, playing with their private parts. Others will just openly say... Come and sleep with me; I am also a human being. I also want...you have locked me up..." (Mr L.P, FGD1)

The theme was supported by the subtheme namely; “Sex being a basic physiological human need”.

4.3.1.1 Sex being a basic physiological human need

Participants related sex to basic physiological human need irrespective of one’s mental state. This line of thought was based on the scientific reasoning that human beings possessed hormones that give them the sex drive, and the central nervous system (CNS) that controls the sexual cycle (Edris and Sitota, 2019). One of the participants said:

“Mental illness is just like any other illness, it is just that the brain is affected... but in terms of their sexual life, they are still active, so no wonder you find that most of the times, some of the patients will have some sexual advances towards the opposite sex.” (Mr T.F, FGD1)

When asked what their reactions would be if they encountered a client with mental health problems who had sexual desires, the response from a one participant was:

“I think for me my opinion will be just to think that, he is also just a human being like I am, so he can express himself in that manner. If you understand what mental health is, then you will not have any bad opinion about that person...” (Mrs T.T, FGD3)

In addition, when tactile gestures such as touching a woman’s bums by a male person take place, this creates a psychological trigger on the mind of the people involved, thereby triggering the physiological interplay among the body systems:

“Male patients will beat your bums, or they will just express how they are feeling. You find that even if you are with colleagues they will start saying oh that sister.....I like her, I would like to have sexual relations with her, or they will just express themselves the way they are feeling there and then...” (Mrs P.B, FGD2)

“There was one incidence in female ward, there was a female patient, one of the men came to visit her, I don’t know whether it was a boyfriend, or they just know each other. So now, that patient started saying that Hey, my boyfriend, and they locked themselves in one of the rooms. So that patient expressed their feelings. Sex didn’t take place, they were discovered in time and the door was unlocked, but they were naked.....the matter was reported to the police and he was taken there for questioning...” (Mrs Y.C, FGD3)

4.3.2 THEME TWO: MEDICAL FACTORS AFFECTING SEXUAL BEHAVIOUR

Sexual behaviour in people with mental health problems can be affected by many factors, including the disease process itself as well as effects of drugs being used to manage specific mental conditions. These perceptions are substantiated in the following responses from participants:

4.3.2.1 Mental disorder and drugs given affect sexual activities

According to **Mr S.M of FGD3**, the nature of mental illness can have an effect of the sex drive of the patients. Some patients may even be taken advantage of by fellow patients or people without mental health problems. This is what Mr S.M had to say;

“Depending on the condition that the patient comes with; affective disorders which comprises of the mania and the depression; if the patient comes in with mania, definitely you expect that patient to be hypersexual. If the patient comes with depression, of course you expect that patient to have anhedonia, they will have no interest in any sexual activities. So like in our ward, the male ward, you find that patients they will openly express their sexual health needs by just telling you that I want to have sex with you, but due to the layout, they may not do it, they will just mention it”.

To support this response, another participant said;

“Some patients may engage in sexual activities not at will, but because they have got sexual disorder. So now our role will be to diagnose sexual disorders so that at least since they have sexual desires it shouldn't disturb the environment where they are. Those who have got sexual issues, they have to be treated for sexual disorders...” (**Miss N.M of FGD1**)

In order to substantiate the earlier arguments, some participants explained that people with mental health problems can be taken advantage of by people without mental health problems whether in the community or inside a mental institution. This was attributed to the fact that these clients did not have a sound mind to make an informed decision regarding sex. There were reported incidences of when the mentally ill were sexually violated, as in the following account by one of the participants;

“There was another incidence, there was a security guard, sometime late in the evening, he enticed a patient to go with him in the kitchen and the patient agreed, so it happened, they enjoyed themselves (at this point all participants broke into laughter). There were two patients taking vigil, one was guarding to see if people are coming. So that security guard was reprimanded by management, and I think he was punished.” (Mrs T.T, of FGD3)

Concerning the effects of drugs, it was perceived that the prescribed psychotropic drugs which these patients take affect their libido. These drugs can make a patient to be sexually hyperactive or have low libido as narrated by some participants;

“Some clients become sexually active or sexually inactive because of the drugs that they take, they have got side effects that affect libido. You find that some will make them high, others will make them low.” (Mr B.C, of FGD2)

Another participant said;

“So it is our work to tell them that this medicine you are taking, whether it is prescribed or not, it has side effects such as these. So you can come so that we substitute it with another one if it becomes worse. We explain and we give them IEC on the drug side effects.” (Mrs M.P, of FGD2)

4.3.3 THEME THREE: DIFFERENCES IN DEMOGRAPHIC CHARACTERISTICS OF NURSES AS WELL AS CLIENTS AFFECT THERAPEUTIC RELATIONSHIPS BETWEEN CLIENTS AND NURSES

Demographic characteristic include qualities such as age, gender, education level, occupation and race among others. Demographic characteristics in medical research are important because they provide a broad understanding of different features of a population that have a bearing on the care provided to clients (Wainberg et al, 2018). This theme gave rise to three subthemes: “Educational level affecting nurses’ perceptions”, “Age of nurses affecting nurses’ perceptions” as well as “Gender of nurses and clients affecting therapeutic relationship”. Therapeutic relationship refers to the relationship between a health care professional and a client or patient. It is the means by which a therapist and a client hope to engage with each other and effect beneficial change in the client (Gault, 2021).

The nurses caring for people with mental health problems at Ndola Teaching Hospital are of different ages and gender as well as education level. The theme related how the educational level, age and gender of the nurse influenced their perception of sexual need among people with mental health problems. The following are the discussion contents, from FGDs comprising nurses of different ages and educational levels.

4.3.3.1 Educational level and work specialty affecting nurses' perceptions

In response to a question on factors that affected participants' perceptions of sexual health needs in people with mental health problems; the responses given included work specialty and educational level. One of the responses during the discussion was;

"I think one of the factors is education. So people who don't understand the conditions, they wouldn't know. They would think that the mentally ill are mad, therefore everything is gone. You see uh? So if you are knowledgeable or specialised, you understand that they are also human beings and what is just affected is their thinking capacity, but otherwise, their rest of their body is just working normally." (Mrs B.C, 53 years old, of FGD3)

4.3.3.2 Age of the nurse affecting nurses' perceptions

In relation to age of the nurse affecting nurses' perceptions, a participant had this to say;

"Also age, when you have old age, when you are mature enough you will be able to know that it is normal, for someone to have sex". (Mrs B.B, 50 years old, of FGD1)

4.3.3.3 Gender of nurses and clients affecting therapeutic relationship

This subtheme brought about issues to do with gender of clients and nurses affecting nurses' perception of sexual health needs in people with mental health problems. It was explained that some patients with mental health problems make sexual advances to people of the opposite sex, whether these people are fellow patients, members of staff or indeed the community, indicating that they want to fulfill their sexual desires. This was also mentioned by one of the participants in the FGD, who was 25 years old;

"If a person of opposite sex enters a ward in psychiatric unit, especially when a male enters female ward, the female patients will start advancing sexually. They will even be saying things such as "I want my husband, it is you who has come, you are my husband, come here. So they are also human, and they have sexual desire..." (Miss M.M, FGD2)

4.3.4 THEME FOUR: DEFICIENT HEALTH SYSTEMS AND ENVIRONMENT AS A CAUSE OF SEXUAL MISDEMEANOUR

In any given ward there should be enough nurses to look after patients effectively if quality health care is desired. Ndola Teaching Hospital psychiatric unit in particular has a deficit of about 16 nurses as per establishment, thereby contributing to poor observation and control of clients (Ndola Hospital Management Team, 2018). In psychiatric wing, staff shortage can contribute to deficient observation of clients, coupled with the antique layout of buildings that compromise safety of both staff and clients. Participants related their perceptions about client sexual behaviour on staffing levels per working shift, as well as on the existing infrastructure and record keeping as health systems described in the following information:

4.3.4.1 Staff shortages causes sexual misdemeanour by patients

From the discussions, this subtheme emerged in that staff shortages also created a situation where a nurse worked alone in a shift, especially making the female nurses vulnerable to sexual assault and harassment by patients. A participant said this;

“Due to the low staffing levels that we have, it really creates a negative impact. You find that as they make advances the female staff is alone on duty, someone who cannot even defend themselves. So as the male clients make advances this staff cannot defend themselves and they can be raped. Even the male staff working in the female wards, they can be enticed...”

(Miss M.M, 25 years old, of FGD2)

Sometimes, health workers tend to ignore the associated medical-surgical conditions that a patient with mental health problems can have, rather health workers concentrate on over-sedating the client to the extent that the medical-surgical conditions are ignored or not attended to, leading to health complications. This is what **Mr M.D of FGD3** and 27 years old had to say;

“When you are working alone on shift and a patient wants to assault you or other patients sexually, or if he is behaving in a sexual way, I can just give a high dose of sedatives to prevent it...”

4.3.4.2 Poor record keeping causes disruption in patient history analysis

Owing to staff shortages, nurses reported being overwhelmed with work, a situation that caused them not to collect enough patient history that includes sexual history. There was also a problem with record keeping system for the patients, since client records are hard copy files. Some participants had this to say;

“I think with records, there is a problem everywhere, but I think that here, it is very important that records are kept intact because we deal with the history of the patients. We cannot collect comprehensive sexual history because of compromised infrastructure. History is very important, so it is very important that the records are kept intact in case a patient is transferred. Maybe Smart care is more important than what we have now, it is very important that we have that”. (Mr T.M, 40 years old, of FGD2)

4.3.5 THEME FIVE: EXISTENCE OF SOCIAL STEREOTYPES

‘Existence of social stereotypes’ defined the way society generally believed and regarded people with mental health problems regarding sexual intercourse. This theme was constituted by one subtheme namely “Presence of labelling theory”.

4.3.5.1 Presence of labelling theory in the community against mental patients

Participants discussed that people with mental health problems are mocked and mistreated by people in the community. People may not want to associate with the mentally ill, they think these patients belong to mental institutions and that is where they should be kept to avoid social nuisance. One of the participants, **Mrs N.M, 30 years old, of FGD1**, said to this;

“These people in the communities, when they just see a mental patient maybe in the neighbourhood, or these which just roam around the streets, they always say “Take them so that they can be castrated, because it is them who rape people. They feel their school going children are not safe by having a male patient just living nearby their home or those who roam the street. Sometimes they will tell the relatives to the patient to be locking up the patient so that they are not having access to the sex”.

Asked what their reaction would be upon encountering a person with mental health problems wanting to get married, some participants responded in the negative while some affirmed as shown in the following response;

“They are not allowed to marry, I can’t encourage them”. (Mrs M.M, 25 years old, of FGD2)

“Me I would ask the patient if they can manage to go for counselling, in the presence of the spouse, to be counselled together, so that together, in case the patient breaks down if future, the spouse has to know how to take care of the patient. But they have to openly disclose to their partner about the condition that I have a mental condition, sometimes I have episodes of madness”. (Mrs B.B, 50 years old, of FGD1)

Some participant, however, explained that stereotypes on people with mental health problems were not fair, because some of their decisions regarding their sexual lives made a positive impact in society. Mrs T.T, 52 years old, of FGD3 had this to say;

“There was a girl in Masaiti District who used to stay with the grandmother, she used to trouble the grandmother that she wants to get married, and consequently she became pregnant, she safely delivered and the child has grown, and the child is the one taking care of the old grandmother now”.

4.3.6 THEME SIX: NEED FOR PSYCHOSEXUAL SUPPORT AND ADVOCACY BY THE NURSES

Nurses play a big role in counselling clients about their sexual lives and sexual conditions. Participants acknowledged the need to help people with mental health problems by advocating for them on issues relating to sexuality and sexual behaviour, as well as offering professional counselling and psychosexual support as described in the following information.

4.3.6.1 Need to provide non-judgemental care

This subtheme “Need to provide non-judgements care” reflected the need to be neutral in addressing the sexual health needs of people with mental health problems. Some participants emphasised the need to apply non-judgemental approach when addressing client sexual health needs. This is how Mr T.F expressed himself;

“When the time comes if they marry, they are free to have sex, and we shouldn’t judge, and the community should not perceive it wrongly to say she is not supposed to get married they are mentally ill, as long as they are educated, they are counselled, they can manage to take care of a home and take care of the spouse, the patient has got the right like anyone of us”. (Mr T.F, 27 years old, of FGD1)

4.3.6.2 Recognising sex as an aid to recovery

Some arguments that arose indicated that nurses really cared about their clients without discrimination, including people with mental health problems. In view of this, one of the participants had this to say:

“And also sex plays an important role in stabilising our patients because if you look at the functions of sex, it is not just for reproducing but it also helps to relieve some stress. So our patients are supposed to be having it, especially the ones who are married, it is important that you should be allowing them to have sex. We had a situation in my ward where a patient’s wife had a baby. So the moment the wife decided to go to the mother after delivery, the husband broke down, he became sick. But the moment the wife returned, the husband became well again”. (Mrs B.T, of FGD2)

4.3.6.3 Human rights advocacy

From the discussions by participants, it was evident that nurses working in psychiatric units understood the sexual health needs in people with mental health problems, and advocated for human rights in these people. There are some arguments from participants which supported this phenomenon, thereby indicating that nurses did advocate for human rights of people with mental health problems as follows;

“These are people like any other, we shouldn’t deprive them the conjugal rights”. (Mr L.P of FGD1)

Another participant continued with the advocacy saying;

“And sometimes, grant them leave as you are taking care of them, so that they can have their conjugal rights. Assess that they have over stayed, they are married, you let them go for two weeks, then come back. You find that they will even stabilize at home, and finally they will be discharged. Not only that, some of us are here working and when we knock off we go home to enjoy our conjugal rights, so what about these patients, why can’t we accord them such an opportunity also, because this condition can happen to anyone, and will also need appropriate treatment if it happened to us”. (Miss L.T of FGD1)

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.0 INTRODUCTION

This chapter presents a discussion of the findings presented in chapter four with reference to related literature and support drawn from other research findings. The discussions are done under the major themes.

5.1 PHYSIOLOGICAL INTERPLAY

Interactions among different body systems such as the nervous, endocrine and cardiovascular systems play a major role in regulating sexual behaviour in all human beings. The neurotransmitter dopamine is produced in response to sexual stimulation, a situation which leads to enjoyment of sex (Edris and Sitota, 2019). At the same time, oxytocin, also known as “the love hormone” is produced and released into the bloodstream by the posterior pituitary gland. This oxytocin helps in the regulation of cortisol, the stress hormone, leading to a calming effect perceived during and after sex (Gault, 2021). The increased cerebral blood flow helps the brain to better process the response to anxiety that may be present before, during and after sex (Edris and Sitota, 2019).

Many participants in this study acknowledged that people with mental health disorders engaged in sex or some form of sexual activity, as argued, for instance, by a participant who said “*in terms of their sexual life, they are still active.... some of the patients will have some sexual advances towards the opposite sex*”. This participant in other words was acknowledging that sex is physiological and inevitable, since people with mental health problems are human too. These arguments are in congruence with present day scientists who acknowledge that sexuality is part of being human; so if someone is not having a healthy sex life or has been raised to believe that sex is taboo and avoids it, this can certainly have long-term consequences on a person’s mental health (Gault, 2021). It is for this reason that quality sexual and reproductive health care should be implemented in mental health care units, preferably by midwives because they have knowledge in SRHR. In this case, midwives would be able to provide quality pre-conception reproductive counselling as well as perinatal care, thereby preventing perinatal complications as well as STIs as elucidated by Osborne, (2019).

The arguments by the participants of the current study are also in congruence with what Wainberg et al (2018) said; that adult people with mental health problems also want to feel loved and to have intimate relationships with other people, and one way they can achieve this is through sexual intercourse; something which is driven by stimulation of physiological chemistry in the human body governed by hormones and the nervous system. Therefore, as opposed to discouraging people with mental health problems from expressing themselves sexually, they should be protected and guided on how to have safe sex, as a fulfilment of the global and local human rights, which Zambia is a signatory to. In this case, people with mental health problems will participate in procreation, something they are entitled to (Goggard, 2016).

On the other hand, allowing people with mental health problems to procreate simply because it is their right to do so can lead to undesired societal problems, such as Streetism for the children (Edris and Sitota, 2019). When there are street kids, even criminal activities such as pick-pocketing, murder and rape among other misdemeanours can increase, because street kids are known for such vices due to lack of parental and social guidance. Consequently, intersectoral collaboration will be necessary to try and mitigate the effects of Streetism, and this will put a strain on the national budget and economy at large. It is for this reason that experts should be involved in assessing and determining whether consensual sexual intercourse among people with mental health problems is safe, because there seems to be equilibrium between the risks and benefits.

Based on the arguments from participants, there was an acknowledgement that both the male and female mental patients engaged in some form of sexual activity either individually or with another person. This argument was derived from a participant who said *“I have seen them having sexual gratification. They masturbate.”* To consolidate this, another participant added that *“Male patients will beat your bums, or they will just express how they are feeling”*. Further one participant narrated a story that confirmed existence of sexual relations among people with mental health disorders, saying;

“There was one incidence in female ward, there was a female patient, one of the men came to visit her.....that patient started saying that hey, my boyfriend, and they locked themselves in one of the rooms.....but sex didn't take place, they were discovered in time and the door was unlocked, but they were naked (Mrs Y.C, FGD3).

This incidence should give a signal to hospital authorities to intensify surveillance and enforce security to protect vulnerable staff and patients. The deserving patients, whether in the hospital or in the communities should be closely monitored to ensure that those indulging in sex should have safe sex, as well as mental, physical and social capacity to withstand it.

Conversely, allowing people with mental health problems to engage in penetrative sexual intercourse with the opposite sex can predispose them to STIs because use of barrier protection such as condoms is not guaranteed, leading to serious reproductive health complications due to non-diagnosis, re-infections and poor compliance to medication. This assumption is supported by finding from a quantitative study that was done on both patients and medical staff in psychiatric units of three hospitals in England. The findings indicated that of the 100 patients who participated, 30 reported engaging in some form of sexual activity including 10 who had sexual intercourse. All sexual intercourse was consensual, but only two respondents used condoms (Warner and Amin, 2004). This underlined the conflict between an individual's right to sexual expression and the need to protect vulnerable patients. From the narratives from participants, it is evident that involvement in some form of sexual expression is inevitable in both male and female patients with mental disorders; however, careful regulation and protection need to be applied. Lack of regulation of sex in people with mental health problems can also be a societal nuisance, both in the hospitals and in the community.

5.2 DISEASE PROCESS AND TREATMENT

Sexual dysfunction is sometimes prevalent among mental health patients and may be attributed to both the psychopathology and the pharmacotherapy as described in the following information derived from participants of this study. Participants alluded that there is a connection between a person's mental condition and the way they behave sexually. They attested that mental conditions such as depression, anxiety disorder and mania can have an effect on someone's libido and social behaviour that is sexually inclined. These assertions are supported by Gault (2021) who stated that depression puts a damper on desire to have sex. The author went on to say that people with depression may feel less interested in creating intimate social interactions, thereby lessening their chances of creating opportunities for love and intimacy.

The impact of this is that it may perpetuate depressive condition, especially in females where depression is common. There is also a connection between obsessive compulsive disorder

(OCD) as well as mania with sexual misconduct. Patients with these conditions report a feeling bombarded by sexual obsessions, or unwanted sexual thoughts such as an attraction to children, family members or even animals (Anderson and Mitchell, 2017).

The phenomenon of uncontrolled sex puts mental health patients at risk of acquiring STIs, and if untreated, the condition may deteriorate and complicate into serious reproductive health issues such as infertility and pelvic inflammatory diseases (PIDs) in females (Coates and Foureur, 2019). This puts a burden on the country's efforts to provide quality effective reproductive health for all. In addition, when women with history of mental health problems indulge in procreation, they are at risk of developing perinatal mental health complications such as postnatal depression (PND) and also puerperal psychosis (Anderson and Mitchell, 2017). It can be a challenge to manage these complications especially in remote areas where there are no clinicians, midwives or other specialists who can recognise the condition in order to make appropriate referrals, thereby contributing to maternal deaths (Coates and Foureur, 2019).

Substance abuse has also been attributed to alteration in libido. Drugs and alcohol, especially if chronically consumed, can alter the brain so that the person cannot have sex without consumption of these substances, for example, methamphetamine because of the addictive effects (Rodgers, 2019). Some substances can also rob someone of their sexual arousal, and cause problems such as erectile dysfunction (ED) (Anderson and Mitchell, 2017).

It was, however, interesting to note that throughout the FGDs there was no instance when any participant linked the specialty of mental health to midwifery. In relation to midwifery, depression, anxiety and stress can also affect the hormones that control ovulation, thereby making it difficult for a woman with a mental health condition to become pregnant if she intends to procreate (Coates and Foureur, 2019). Positive mental health is critical in helping women transition into motherhood. It is for this reason that midwives need specialist mental health training in order to support women with mental health problems beyond screening and referring. In this regard, thorough history taking is necessary when midwives are booking perinatal clients, as well as when attending to client with mental health problems (Gault, 2021).

Psychotropic medications are administered to help manage or treat people with mental health disorders. However, these medications can have adverse effects. Some participants argued that treatments that are given to manage mental conditions have been inclined to influence sexual behaviour in people who are mentally ill. These assertions can be validated by findings explained by Gault (2021), where he said that psychotropic drugs increase serotonin in the brain that tempers depression, but reduces libido as well as ability to experience sexual pleasure. The author further quantified that 46% of women and 41% of men with mental disorders experience postcoital dysphoria, a feeling of tearfulness and negative emotions after sexual intercourse. Other authors attributed the first generation antipsychotics as well as antidepressants to causing deterioration in erectile and orgasmic function in animals (Anderson and Mitchell, 2017). Therefore, it is vital that nurses explain the effects of drugs that they administer to clients with mental health problems, so that clients are afore-warned about what to expect and how to cope. Nurses and clinicians should also shoulder the responsibility of explaining the disease process to clients as well as their significant others, by providing psychosexual support.

5.3 DIFFERENCES IN DEMOGRAPHIC CHARACTERISTICS OF NURSES AS WELL AS CLIENTS AFFECT THERAPEUTIC RELATIONSHIPS BETWEEN CLIENTS AND NURSES

Perception of nurses towards sexual needs of clients can be affected by factors such as age, gender and education level. One participant said; *“I think one of the factors is education....if you are knowledgeable, you understand that these people are also human beings and what is just affected is their thinking capacity.....”* **MRS TT, FGD3**. The big age range among participants elicited a wide range of views. Those who were aged above 30 years expressed their views more freely than the younger participants. This could be attributed to the fact that the older participants understood issues of sexuality better than the younger ones, based on their own social and work experiences, because they have been handling issues of sexual nature with clients for a longer period of time (Rodgers, 2019). This assumption was drawn from a qualitative study that was done to determine whether the age of nurses affected how the nurses viewed sex and sexuality (Wainberg et al, 2018). The findings from the study stated that the older the nurse, the more capability they had in helping clients deal with sex and sexuality (Rodgers, 2019).

To support the argument by Rodgers (2019), results from a qualitative study that was done to compare two cohorts of participants with age groups between 18-21 years and over 43 respectively was used. The study involved exploring midwives' experiences of psychosexual care provision to patients in Australia. The results were such that the younger midwives had little experience dealing with client sexual matters, as opposed to their older counterparts (Capper et al, 2020). Older midwives explored more during history taking, and during counselling (Capper et al, 2020). This could explain why mostly during the FGDs in the current study, older respondents who were also married participated more. The much younger participants aged below 25 years were less active in discussing client sexuality.

These reservations in discussing sex and sexuality matters by the younger nurses could be likened to what Dlamini and Shongwe (2019) concluded in their study to determine whether nurses discuss client sex matters. It was discovered that most nurses, especially the younger ones, were not free to discuss sexual matters of clients, due to feelings of embarrassment for both the client and themselves. In addition, patients that are of the younger generation tend to be more conservative when revealing matters to do with their sexual lives especially if being attended to by a much younger health care provider (Wainberg et al, 2018). This finding is accentuated by a study conducted in the UK by McClure (2015), where mental health nurses acknowledged not being free to discuss the sexual dimension of clients. Therefore, since frontline health care providers involved in caring for people with mental health problems seem not to be free to discuss issues of sexual nature with clients, it would be beneficial if more midwives, especially the older and experienced ones are deployed to work in mental health units because the focus of the midwifery profession is on both male and female reproductive system. This professional collaboration can in turn reduce the incidence of STIs and other complications in clients, and hence, better the sexual lives of the mentally ill.

From the demographic characteristics of the study participants, the ratio of female to male nurses was 3:2. This could make work easy when it comes to implementing SRH to patients because there is evidence that most male nurses are not free to discuss client sexuality (McClure, 2015). Maybe this could explain why there were reduced cases of SRH complications among patients at Ndola Teaching Hospital psychiatric unit, as , most of the nurses providing the care are female (Ndola Hospital Management Team, 2018). This is in line with assumptions by Quinn (2015) that female nurses are more capable of providing comprehensive SRH services provided they are oriented and motivated to do so, thereby reducing sexual related complications in patients.

Participants acknowledged that being educated or specialised played a role in the way health professionals perceived client sexuality. Findings from a study that was conducted by Beek et al (2019), stated that midwives have an essential role to play in the provision of effective SRH services even in the most unusual situations owing to their unique knowledge and skills. One of the unusual situations could be mental health illness. Therefore, it would be beneficial if the SRH component in the training of mental health nurses is strengthened in the curriculum because it is a critical issue that professionals are bound to encounter in their day to day routine care of clients. Those who are already working in the psychiatric units could be oriented to SRH through mentorship. This would fulfill what another scholar argued that nurses can best help clients with their sexual dimension when they undergo additional training in human sexuality (McCann, 2019). Achieving this in Zambia can be easy because the nurses working in the psychiatric units have already been trained in basic psychosocial counselling, which is one of the components of human sexuality, as acknowledged by the study participants.

5.4 ADVOCACY AS PART OF TREATMENT PACKAGE

One of the official roles of nurses and midwives is advocacy (Egholm, 2015). In the nursing profession, advocacy means preserving human dignity, promoting patient equality and providing freedom from suffering (Beek et al, 2019). Advocacy should be done in an objective manner, being careful not to show approval or disapproval of a patient's choices. Nurse advocates also respect the family's important role in patient care. This may be done by clarifying any communication problems and ensuring information collected is complete and correct, to be used as an aid to diagnosis and treatment (Anderson and Mitchell, 2017).

Nurses are expected to be the voice of the voiceless when it comes to accessing quality health care. One of the components of quality health care is provision of quality sexual and reproductive health for all. Participants in this study tried hard to showcase this role. They ascribed to the view that people with mental health problems should be given the option to gratify themselves sexually in order to promote quick recovery. One participant said "*sex plays an important role in stabilising our patients!*" Anderson and Mitchell (2017) published that having sex helps the immune system, lowers blood pressure and burns calories.

There is also evidence that having sex can lower stress levels by triggering release of dopamine, endorphins and oxytocin, all which increase motivation and trigger feelings of compassion (Beek et al, 2019). Following an orgasm, the body releases the hormone prolactin, which often leads to drowsiness and a feeling of relaxation, comfort and sleep. This effect is very essential in helping mental disorders to abate (Gault, 2021).

In congruence to the aforementioned views, there is evidence that lack of sex is associated with feelings of depression and low self-worth, therefore, sex boosts that self-esteem. Eminent psychologist Abraham Marslow suggested that there were five categories of fundamental human needs (Goggard, 2016). In addition to obvious needs such as water, food and sleep, sex is also mentioned. Further in the hierarchy, self-esteem is a critical need. If too many psychological needs go unmet for too long, the mental health can be negatively affected, to the extent of even death (Anderson and Mitchell, 2017).

Therefore, nurses and midwives are mandated to provide professional care to all patients, regardless of the condition, in all matters related to sex and sexuality so as to facilitate informed consent and protection from abuse and exploitation. Examples of specific interventions should include psychosexual counselling, provision of conducive in-patient environment, provision of condoms for dual protection, dispelling harmful myths and misconceptions regarding sex in the communities. There should also be treatment of STIs and provision of quality pre-conception and perinatal care that are currently not being provided at Ndola Teaching Hospital psychiatric unit. Mental health clients should also not be denied comprehensive abortion care services, provided the international and national legal frameworks are respected.

5.5. CONCLUSION

Participants acknowledged existence of sexual activity among people with mental health problems and there were diverse negative perceptions. SRH should be addressed systematically and holistically in people with mental health problems because the phenomenon constitutes part of their fundamental human rights. Physiological interplay among different body systems such as the nervous, endocrine and cardiovascular systems in the regulation of sex, for the sake of pleasure or procreation was cited. Others attributed the sexual activity to disease process itself as well as effects of psychotropic. Participant differences in their age, gender, educational level and cultural backgrounds contributed to differences in perception. Furthermore, staff shortages in mental health units and deficient record keeping were cited as deficiencies in the health care system that contributed to poor monitoring and management of clients. Social stereotypes and labelling theories were mentioned as societal contributions to sexual misdemeanours by people with mental health problems. Mental health specialists equipped with knowledge in SRH should be at the centre of this care provision as well as facilitating advocacy. This would in turn reduce morbidity and mortality from sexually engineered illnesses and conditions among people with mental health problems. Demographic characteristics of the nurse such as age, gender, educational level and culture have been attributed to affecting nurses' perceptions towards sexual health needs in people with mental health problems.

5.6. IMPLICATIONS OF FINDINGS TO NURSING AND MIDWIFERY PRACTICE

Sexual and Reproductive Health rights are fundamental and universal; therefore, all people regardless of mental status should be protected and given chance to enjoy these rights. The paramount concern in mental health is to have an individual that is able to realise their full ability, cope with the normal stress of life, work productively and fruitfully, and is able to make a contribution to his or her community. Therefore, the findings of this study have the following implications:

5.6.1. Nursing Administration

Nurse administrators should participate in formulating policies that promote sexual and reproductive health rights for people with mental health problems. They should also sensitise nurses in other departments on the need to obtain comprehensive sexual history from all clients, in order to facilitate thorough screening and referral. The nurse administrators should also conduct nursing audits on discharged mental health clients, to determine whether quality

health care is offered. There should also be improvement in planning to better infrastructure in the psychiatric unit to allow for privacy.

5.6.2. Nursing and midwifery Practice

Majority of staff working in mental health departments are primarily mental health nurses who have limited training and experience in physical health. Therefore, nurses in this department must be given in-service trainings in how to manage the physical aspect of patients. Standard history-obtaining stationery should also be formulated for use when collecting comprehensive sexual history from clients. Additionally, there is need to integrate mental health services with SRH services, since the two disciplines interlock.

5.6.3. Nursing Research

The review of literature showed that limited research has so far been conducted in the area of perceptions of nurses towards sexual health needs for people with mental health problems. Nurse researchers, therefore, need to scale up investigations in this area and come up with appropriate recommendations. The researchers should employ either qualitative or quantitative approaches or a mixture of both and analyse effectiveness of the designs employed. Not only will this improve on the body of knowledge, it will also lead to improvement in service provision.

5.6.4. Nursing Education

The findings of the study imply that there is need to train more mental health nurses in Zambia, and to strengthen the component of SRH in order to better the care given to both male and female clients. The scope of mental health cuts across all disciplines, therefore, this implies that midwives should undergo additional training in mental health for them to execute holistic health care to all clients and patients. Educators for nursing and midwifery should also undergo a comprehensive training in mental health in order for them to properly educate nurses and midwives in mental health.

The Nursing and Midwifery Council of Zambia (NMCZ) as a regulatory body for nursing and midwifery education should facilitate curriculum review to include more comprehensive scope in SRH for people with mental health problems. In the Department of Content Development for nurses, subject matter experts in mental health and indeed other disciplines should be engaged to offer technical support.

5.7. RECOMMENDATIONS

The following recommendations are made based on the study findings;

5.7.1. Ministry of Health

The Government must spearhead policy formulation and implementation on SRH needs for people with mental health problems in the quest for universal and equitable health care. Funding in form of grants must also be increased and disbursed timely for mental health institutions, to accommodate effective service delivery. There should be policies to conduct routine testing of mental patients for STIs and pregnancy on admission and at periodic times during hospitalisation. Furthermore, psychiatric units should have infrastructure conducive enough for privacy and if possible for promotion of conjugal rights for in-patients that have been admitted for too long.

5.7.2. Nursing and Midwifery Council of Zambia (NMCZ)

NMCZ should strengthen knowledge component in Nursing and Midwifery curricula on SRH in people with mental health problems. It is also important to recognise the impact that midwives can have when supporting positive mental health for women in pregnancy, childbirth and post-natal period. Furthermore, NMCZ should ensure that training institutions implement the set period (6 weeks) for psychiatric units so that students can gain competence.

5.7.3. Nursing and Midwifery Training Institutions

There should be robust implementation of the revised curricula in training nurses and midwives who will in turn provide quality care in SRH to all clients, including people with mental health problems. Schools should adhere to NMCZ period of allocation for practicals at psychiatric units, so that students can have ample practice.

5.7.4. Ndola Teaching Hospital

Patients admitted with mania should be closely monitored for sexual misconduct, and clients with depression should be protected from sexual abuse. There should also be rotational allocation of midwives to the psychiatric unit to deal with sexual and reproductive health needs of clients. Drug holidays are also for patients showing signs of improvement in their condition, to dampen the effects of the drugs. Record keeping and security in the psychiatric unit should also be improved.

5.7.5. To the Community

Community stakeholders such as traditional counselors, trained Traditional Birth Attendants, Safe Motherhood Action Groups and Community Health Workers should be enlightened to identify vulnerable people with mental health illness to protect them from sexual abuse and help them access reproductive health services.

5.8. LIMITATIONS OF THE STUDY

The study was conducted at Ndola Teaching Hospital, psychiatric unit, thus generalisation of findings should be done with caution because of contextual differences that include healthcare professionals who participated in the study.

5.9. PLAN FOR DISSEMINATION OF FINDINGS

Bound copies of the completed manuscript will be distributed to the UNZA School of Nursing Sciences, MoH, and to the Senior Medical Superintendent at Ndola Teaching Hospital. Online publications in psychiatric and peer review journals will be done. Presentation of findings will be done at local, national and international audiences, such as conferences, symposiums and meetings.

REFERENCES

- Anderson, R. and Mitchell, D. (2017) **Regular sex benefits your mental health, too.** Retrieved on 12.07.2021 from <https://theconversation.com>
- Aroussell, J. and Carlbom, A. (2016) **Culture and religious beliefs in relation to reproductive health.** Retrieved on 25.01.2019 from <https://www.sciencedirect.com>
- Balswick, J.K. and Balswick, J.O. (2018) **Authentic human sexuality: An integrated Christian approach.** Retrieved on 29.03.2018 from <https://www.revolvvy.com>
- Barbosa, J.A.G., Giami, A. and de Fátima Freitas, M.I. (2015) **Gender and sexuality of people with mental disorders in Brazil.** Retrieved on 13.12.17 from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1984-64872015000100067
- Bauer, M., Haesler, E. and Fetherstonhaugh, D. (2015) **Let's talk about sex: older people's views on the recognition of sexuality and sexual health in the health care setting.** Retrieved on 17.05.2019 from <https://onlinelibrary.wiley.com>
- Beek, K., McFadden, A. and Dawson, A. (2019) The role and scope of midwives in humanitarian settings: A systematic review and content analysis. Retrieved on 17.07.2021 from, <https://human-resources-health.biomedcentral.com>
- Bonfils, K.A., Firmin, R.L., Slayers, M.P. and Wright, E.R. (2015) **Sexuality and intimacy among people living with serious mental illness: Factors contributing to sexual activity.** *Psychiatric Rehabilitation Journal*, 38(3), 249-255.
- Capper, T., Muurlink, O. and Williamson, M. (2020) **Being bullied as a midwifery student: Does age matter?** Retrieved on 12.07.2021 from www.magonlinelibrary.com
- Caulfield, J. (2019) **How to do Thematic Analysis.** Retrieved on 08.07.2021 from <https://www.scribbr.com>
- Chalklen, S. (2014) **The home and the community: Family support and harm (Human rights and mental health)** 5(A) p24
- Cherpak, L.G. and Dos Santos, C.F. (2016) **Assessment of physicians' addressing sexuality in elderly patients with chronic pain.** Retrieved on 25.01.2019 from <https://www.ncbi.nlm.nih.gov>

- Coates, D. and Foureur, M. (2019) **The role and competence of midwives in supporting women with mental health concerns during the perinatal period: A scoping review.** Retrieved on 12.07.2021 from <http://onlinelibrary.wiley.com>
- Creswell, J.W. (2015) **A concise introduction to mixed methods research.** Sage, Washington DC.
- Dlamini, S.B and Shongwe, M.C. (2019) **Exploring Mental Health Nurses' perceptions on factors contributing to psychiatric readmissions in Eswatini: A qualitative study.** Retrieved on 08.05.2020 from <https://www.sciencedirect.com>
- Dura, M.R., Campos, L.N. and Guimaraes, M.D. (2014) **Sexually Transmitted Diseases among Psychiatric Patients in Brazil.** Retrieved on 12.11.2018 from <http://www.ncbi.nlm.nih.gov/m/pubmed/2393340>
- Edris, S. and Sitota, G. (2019) **Causes and consequences of Streetism among street children of Harar city, Ethiopia.** Retrieved on 14.07.2021 from <https://files.eric.ed.gov>
- Egholm, A. (2015) **Nurses' attitudes and beliefs towards discussing sexuality with patients.** Retrieved on 28.03.2018 from https://www.theseus.fi/>Egholm_Aurel
- Erlingsson, C. and Brysiewicz, P. (2017) **A Hands-on guide to doing Content Analysis.** African Journal of Emergency Medicine (7) 93-99
- Gault, A.M. (2021) **Tell me all I need to know about sex and mental Health.** Retrieved on 12.07.2021 from <http://www.psychom.net>
- Goggard, A.J. (2016) **A hierarchy of sexual health needs?** Retrieved on 25.04.2018 from <https://amyjogoddard.com/posts/a-hierarchy-of-sexual-needs/>
- Guscoyne, S. (2016) **The sexual health and relationship needs of people with severe mental illness.** Journal of Psychiatric and Mental Health Nursing 23(5), 338.343.
- Hendry, A., Snowden, A. and Brown, M. (2017) **When holistic care is not holistic enough: The role of sexual health in mental health settings.** Journal of Clinical Nursing/ Volume 27, issue 5-7. Retrieved on 19.08.2018 from <https://onlinelibrary.wiley.com>
- Hughes, E. (2018) **Identifying and addressing sexual health in serious mental illness.** Retrieved on 08.05.2020 from <https://pure.hud.ac.uk>

Ivanova, D.K., Jones, E. A. and Clayton, A.H. (2016) **Medical Student Attitudes, Knowledge and Comfort levels related to patients' sexual health**. Retrieved on 25.01.2019 from <https://www.jsm.jsexmed.org>

Kalra, G., Ventriglio, A. and Bhugra, D. (2015) **Sexuality and mental health: what next?** Retrieved on 07.05.2020 from <http://www.ncbi.nlm.nih.gov>

Klaessen, N. (2016) **The gap between mental health nurses' perception on their role in somatic screening and lifestyle coaching for patients with a severe mental health illness and their perceived actual practice: A qualitative study**. Utrecht University, Netherlands.

Kimmel, M. (2018) **Navigating Pregnancy with a Mental illness**. Retrieved on 16.04.2019 from <http://healthtalk.unchealthcare.org/navigating-pregnancy-with-a-mental-illness/>

Kline, D. (2015) **Sex, intimacy and mental well-being**. Retrieved on 12.05.2018 from www.heretohelp.bc.ca

Leckie, S. (2016) **Sex, Intimacy and Mental Illness**. Retrieved on 12.05 2018 from <http://www.sane.org>

Leung, L. (2015) **Validity, reliability, and generalisability in qualitative research**. Retrieved on 13.06.2018 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4535087/>

Macleod, C. and Nhamo-Murire, M. (2016) **The emancipatory potential of nursing practice in relation to sexuality: a systematic literature review of nursing research 2009-2014**. Retrieved on 30.08.2018 from <https://www.ncbi.nlm.nih.gov>

McCann, E. (2019) **Sexuality and intimacy among people with serious mental illness – a qualitative systematic review**. Lippincott Williams and Wilkins, Inc., London. Retrieved on 07.05.2020 from <https://journals.lww.com>

McClure, L. (2015) **Where is sex in mental health practice? A discussion of sexuality care needs of mental health clients**. Oxford, UK

Muijeen, K., Kongvattananon, P. and Somprasert, C. (2020) **The key success factors in focus group discussions with the elderly for novice researchers: A review**. Retrieved on 17.03.2021 from www.emerald.com

Mwansa, A. (2019) **Zambia Mental Health Bill**. Retrieved on 05.05.2019 from www.parliament.gov.zm

Ndola Hospital Management Team (2018) **Ndola Teaching Hospital Action plan** for 2017 to 2019 MTEF period, Ndola Printing press, Ndola.

Ndongmo, T.N., Ndongmo, C. and Michelo, C. (2017) **Sexual and reproductive health knowledge and behaviour among adolescents living with HIV in Zambia: A case study.** Retrieved on 26.03.2018 from <https://www.researchgate.net>

Nowell, L.S., Norris, J.M., White, D.E. and Moules, N.J. (2017) **International journal of Qualitative methods: Thematic Analysis.** Retrieved on 14.06.2018 from www.journals.sagepub.com

Oren, B., Zenging, N., Yazici, S, and Akinci, A.C. (2017) **Attitudes, beliefs and comfort levels of midwifery students regarding sexual counselling in Turkey.** Retrieved on 25.01.2019 from <https://www.midwiferyjournal.com>

Osborne, M. (2019) **HCA's' views on sexual health in people with severe mental illness.** *Nursing Times*; 115:1, 25-29

Quinn, C. (2015) **Consumer sexual relationships in a forensic mental health hospital: Perceptions of nurses and consumers.** Retrieved on 08.05.2020 from <http://www.europepmc.org>

Rodgers, P. (2019) **Sex and Aging.** Retrieved on 12. 07.2021 from <https://www.healthline.com>

Rossiter, R. and Hazelton, M. (2018) **Thematic analysis guided by Max van Manen: Hermeneutic (Interpretive) Phenomenological approach.** *Journal of Health Science Research* 12 (2), 39-48. Retrieved on 28.08.2019 from <http://www.tci-thaijo.org/index.php/JHR/article/view/164236>

Rotter, M. (2007) **Sexual offenders with mental illness: special considerations for a special population.** Retrieved on 20.04.2018 from www.psychiatristimes.com

Salkjeld, J. (2015) **Assessing sexual health in mental health service users.** *Nursing Standards*, California

Sandfort, G.M. (2018) **Same-sex sexual behaviour and Psychiatric disorders.** Retrieved on 08.05.2020 from <http://www.jamanetwork.com>

Siegle, D. (2018) **Educational research basics: Variables.** Retrieved on 27.03.2018 from <http://researchbasics.education.uconn.edu>

Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R. and Sinha Deb, K. (2018) **Violence and mental illness: what is the true story?** Retrieved on 11.06.2018 from <http://www.jech.bmj.com>

Volokh, E. (2014) **Sexual autonomy rights of the mentally ill.** Retrieved on 20.04.2018 from <http://www.washingtonpost.com>

Wainberg, M.L., Cournos, F. and McKinnon, K. (2018) **Mental illness sexual stigma: Implications for health and recover.** Retrieved on 08.05.2020 from <http://www.ncbi.nlm.nih.gov>

Warner, J. and Amin, R. (2004) **Sexual activity among patients in psychiatric hospital wards.** Retrieved on 12.07.2021 from <http://www.ncbi.nlm.nih.gov>

World Health Organisation, (2015) **Brief sexually-related communication: Recommended for a public health approach.** Retrieved on 28. 03.2018 from <http://www.ncbi.nlm.nih.gov>

World Health Organisation (2018) **Developing sexuality counselling guidelines for health care providers.** Retrieved on 11.06.2018 from www.who.int

World Health Organisation (2019) **Ndola Teaching Hospital Profile.** Retrieved on 26.11.2019 from <https://www.who.int>

Zimmermann, K.A. (2017) **What is Culture: Definition of culture.** Retrieved on 20.01.2019 from <http://livescience.com>

APPENDICES
APPENDIX I: PARTICIPANT INFORMATION SHEET

For correspondence with the Principal Researcher, the contact details are: Chambatu Alice, Ndola College of Nursing and Midwifery, Postal Agency, Ndola. Telephone number: +260974003054. Email nyadiwema@gmail.com

You may alternatively contact the University of Zambia Biomedical Research Ethics Committee: P.O. Box: 50110, Telephone number: 256067, Email: unzarec@unza.zm, Ridgeway Campus, Lusaka.

NAME OF INSTITUTION: THE UNIVERSITY OF ZAMBIA, SCHOOL OF NURSING SCIENCES

STUDY TITLE: PERCEPTIONS OF NURSES AT NDOLA TEACHING HOSPITAL TOWARDS SEXUAL HEALTH NEEDS OF PEOPLE WITH MENTAL HEALTH PROBLEMS

Introduction

My name is Chambatu Alice; a student pursuing Masters' Degree in Midwifery and Women's Health at the University of Zambia School of Nursing Sciences. In partial fulfilment of this postgraduate degree as well as in endeavouring to contribute to quality health care provision, I am required to undertake a research study.

Purpose of this investigation

The aims of the study are to assess perceptions of nurses at Ndola teaching hospital towards sexual health needs of people with mental health problems, as well as identify factors influencing nurses' perceptions towards sexual health needs of people with mental health problems. The information you give will help in coming up with guidelines on addressing sexual health needs in people with mental health problems, thereby improving the nurse-patient therapeutic relationship

Do you have to take part?

While you have been purposefully selected to participate in this study, I wish to inform you that participation is voluntary and you are free to withdraw from the study at any stage if you so wish without any consequences.

What will be your role in the project?

Your role will be to take part in the Focus Group Discussion (FGD) or interview to be moderated by the researcher. Participation in this study will not warrant any form of remuneration or reimbursement. The FGDs will take place at dates convenient to the participants, to last for about 1 hour (60 minutes) and will take place within the locality of your work place.

Why have you been invited to take part?

You have been invited to take part owing to the fact that you are a nurse, currently working at Ndola teaching hospital offering frontline healthcare to clients that include people with mental health problems.

What are the potential risks to you in taking part?

There will be no potential or substantive risks in you taking part in the study, because the study does not involve any invasive procedures on yourself and neither does the study cause deprivation of nutrition, sleep or other basic life necessities.

What happens to the information in the study?

Any information you give will be kept confidential and no name will be recorded on any of the transcripts generated. The information will be analysed and your responses will add to the body of knowledge in nursing, and may influence policy formulation and review.

Thank you for reading this information, please ask any questions or seek clarification if you are unsure about what has been provided here.

**APPENDIX II: INFORMED CONSENT
THE UNIVERSITY OF ZAMBIA**

DIRECTORATE OF RESEARCH AND GRADUATE STUDIES

UNIVERSITY OF ZAMBIA BIOMEDICAL RESEARCH ETHICS COMMITTEE

Telephone: 260-1-256067

Ridgeway Campus

Fax: +260-211-290258/293937

P.O. Box 50110

E-mail: unzarec@zamtel.zm

Lusaka, Zambia

For correspondence with the Principal Researcher, the contact details are: Chambatu Alice, Ndola College of Nursing and Midwifery, Postal Agency, Ndola. Telephone number: +260974003054.

Email nyadiwema@gmail.com

CONSENT FORM

(Translated into vernacular if necessary)

TITLE OF RESEARCH: PERCEPTIONS OF NURSES AT NDOLA TEACHING HOSPITAL TOWARDS SEXUAL HEALTH NEEDS OF PEOPLE WITH MENTAL HEALTH PROBLEMS

REFERENCE TO PARTICIPANT INFORMATION SHEET:

1. Make sure that you read the Information Sheet carefully, or that it has been explained to you to your satisfaction.
2. Your permission is required if tape or audio recording is being used.
3. Your participation in this research is entirely voluntary, i.e. you do not have to participate if you do not wish to.
4. Refusal to take part will involve no penalty or loss of services to which you are otherwise entitled.
5. If you decide to take part, you are still free to withdraw at any time without penalty or loss of services and without giving a reason for your withdrawal.
6. You may choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so.
7. The information collected in this interview will be kept strictly confidential.
8. If you choose to participate in this research study, your signed consent is required below before I proceed with the interview with you.

VOLUNTARY CONSENT

I have read (or have had explained to me) the information about this research as contained in the Participant Information Sheet. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction.

I now consent voluntarily to be a participant in this project and understand that I have the right to end the interview at any time, and to choose not to answer particular questions that are asked in the study.

My signature below says that I am willing to participate in this research:

Participant's Initials (Printed):
Participant's signature: Consent Date:
Researcher Conducting Informed Consent (Printed)
Signature of Researcher: Date:

APPENDIX III: FOCUS GROUP DISCUSSION GUIDE

THE UNIVERSITY OF ZAMBIA

SCHOOL OF NURSING SCIENCES

RESEARCH PROPOSAL

**PERCEPTIONS OF NURSES AT NDOLA TEACHING HOSPITAL TOWARDS
SEXUAL HEALTH NEEDS OF PEOPLE WITH MENTAL HEALTH PROBLEMS**

FGD GUIDE

DATE FOR FGD:

VENUE FOR FGD:

NUMBER OF PARTICIPANTS IN FGD:

INTERVIEWER (INITIALS):

INSTRUCTIONS TO INTERVIEWER/MODERATOR

1. Introduce yourself to the respondent.
2. Explain the purpose of the FGD.
3. Get written consent from the respondents and do not force them to be interviewed.
4. Assure the respondent of confidentiality and anonymity.
5. Instruct respondents feel free to express themselves during the FGD
6. Inscribe briefly details of the discussion, also observe for non-verbal cues and record appropriately.
7. Advise the respondent to ask for clarification if need arises.
8. Thank the respondent at the end of interview.

Interview Introduction

Greetings dear participants, thank you so much for agreeing to be part of the discussion group. I know you have busy schedules and really appreciate your willingness to participate in this project. As stated earlier, I am a Master student at the University of Zambia, School of Nursing Sciences conducting a study of nurses' perceptions of sexual health needs in people with mental health problems. Today I hope to glean insight into your perceptions on this subject according to your various experiences.

Any information you share will not be attributed to you or used to identify you or anyone else. You will remain anonymous in any ensuing presentations or publications that may stem from this study. As a result of your participation, there should be no risks for you personally or for your working institution. Your participation is strictly voluntary and may be discontinued at any time during the interview. You may also decline to answer any question during this interview.

For ease of note taking, getting all of your input, and not slowing down the interview, I would like to record our conversation. The recording made today will be kept confidential and in a safe place. The only people that will hear the audio recording will be me and my research supervisor. It will be kept in a secure location and destroyed when the study is complete. If at any time you would prefer that I turn the recorder off, please let me know, and I will do so immediately.

Focus group logistics and ground rules

a) Logistics

- Focus group will last about one hour (60 minutes)
- Feel free to move around
- Where is the bathroom? Exit?
- Help yourself to refreshments

b) Ground rules

- It is important for us to hear everyone's ideas and opinions and only one person talks at a time
- There are no right or wrong answers to questions – just ideas, experiences and opinions, which are all valuable
- The session will be audio recorded to help us gather more detailed information about your responses than the handwritten notes that will be taken by the research assistant, and it will allow us to double check our data for accuracy
- Stay with the group, please don't have side conversations, and speak clearly to increase recording quality
- Turn off or silence cell phones.
- Enjoy the discussions

Any questions before we begin? Did you sign the Informed Consent to participate in this study? Do I have your permission to begin recording our discussion?

Turn on Tape Recorder

DISCUSSION GUIDE

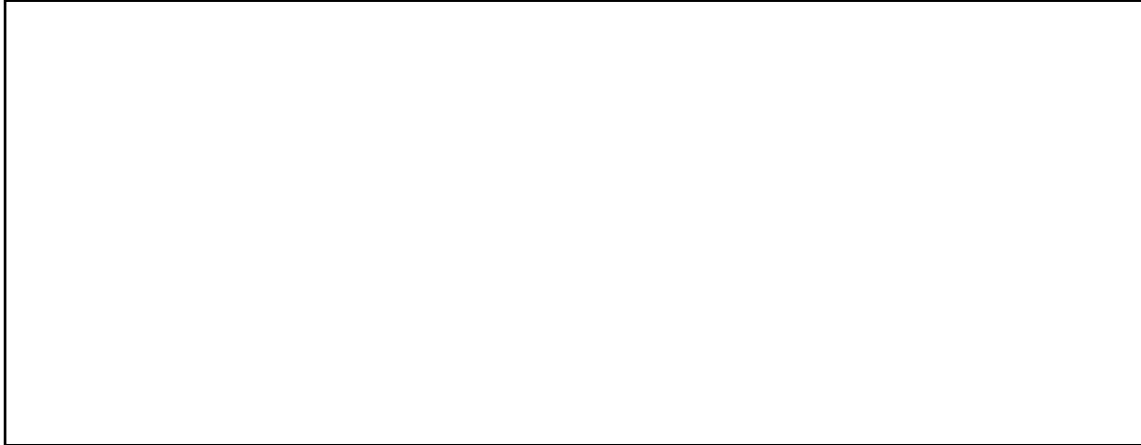
1. Ask them about their perceptions of sexual health needs in people with mental health problems: “What are your views concerning sexual health needs in people with mental health problems? Have you ever perceived sexual health needs in these people, how did that make you feel?”

a. General perception

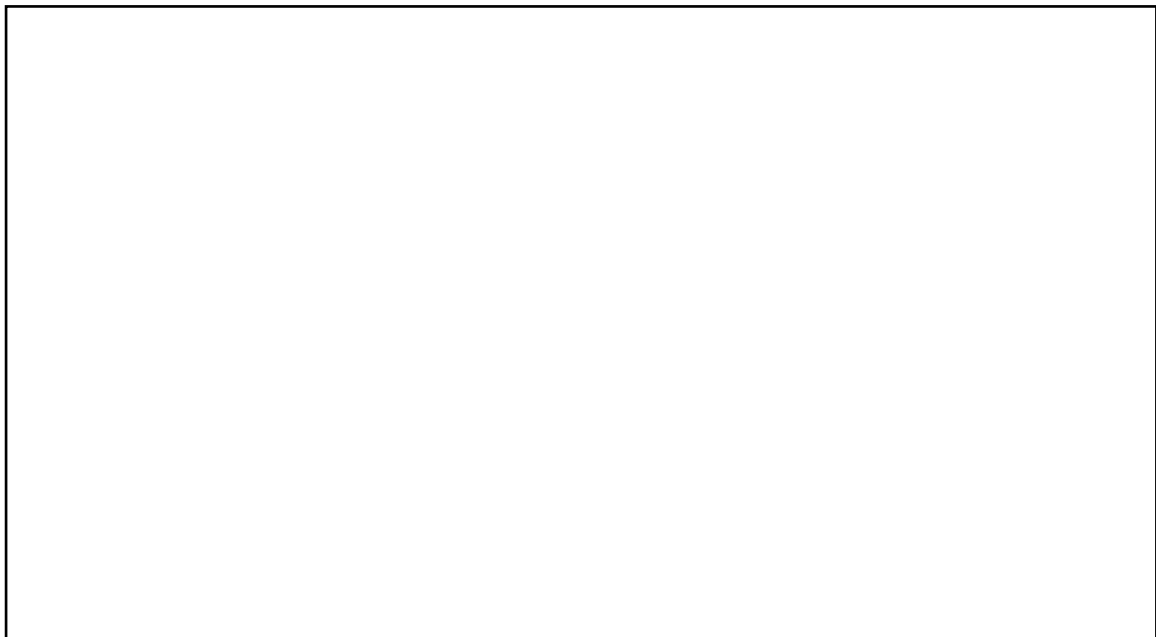
b. Ask them whether it is normal for people with mental health problems to have sex, let them explain their answer.

2. Find out their reaction, opinion or conclusion if they encountered people with mental health problems that have desire to have sex.

3. Find out whether participants have experienced people with mental health problems wanting to express sexuality. Find out how the patients behaved.



4. Ask about factors that have influenced participants' perception of sexuality and sexual health needs in people with mental health problems; for example, age, your gender, comfort zone, stereotypes, work specialty or indeed your education level.



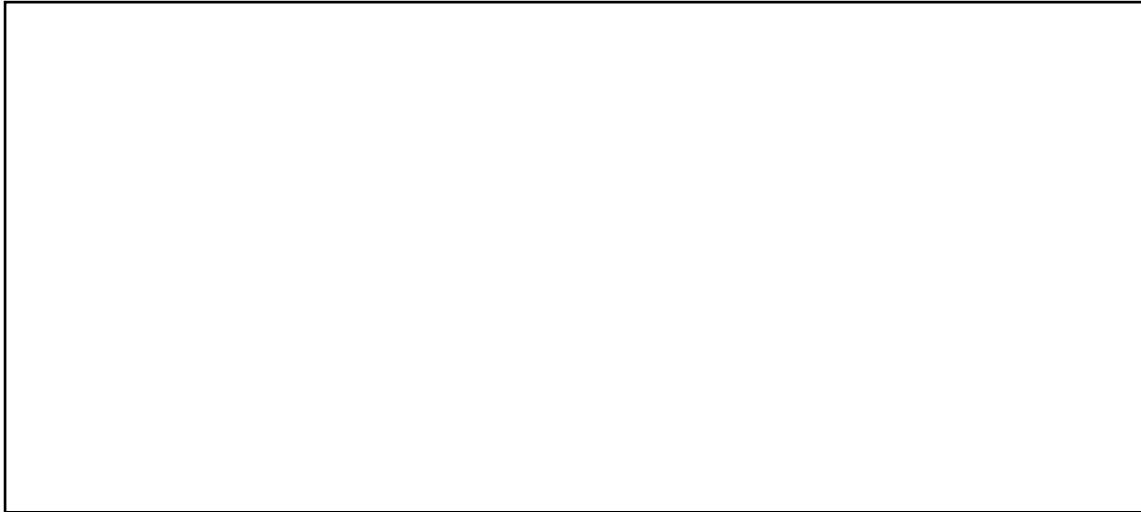
5. Ask participants whether their work environment provide for addressing of sexual health needs in people with mental health problems with regards to:

- a. Infrastructure
- b. Hospital records, for example history taking
- c. Work culture
- d. Access to medical, surgical and speciality services or care

Let them substantiate their answers.

6. Allow participants to comment on society's stance on sexuality and sexual health needs in people with mental health problems.

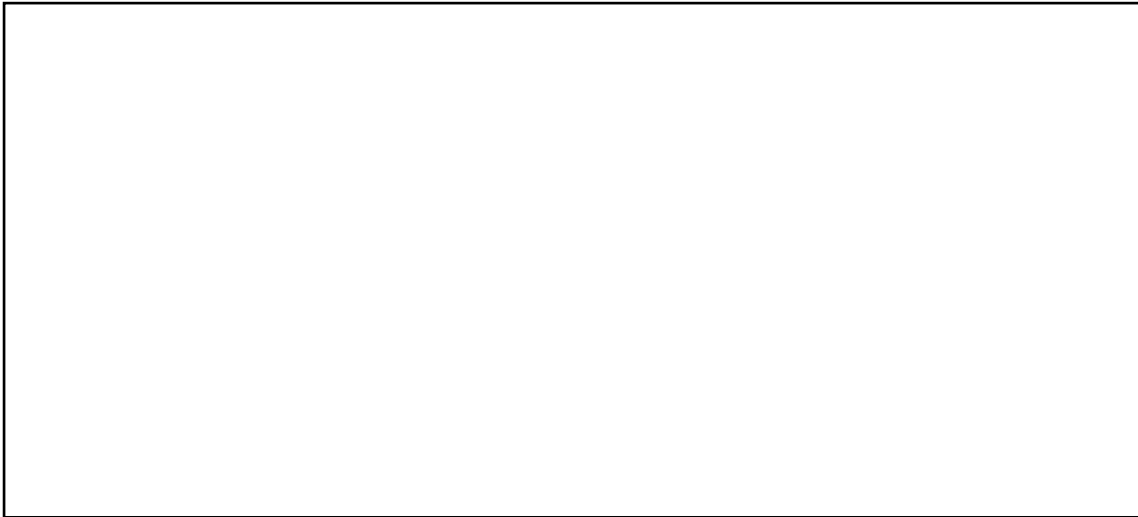
7. Ask participants what they would do if a person with mental health problems approached them to tell them that they would like to get married sooner or later and start a family.



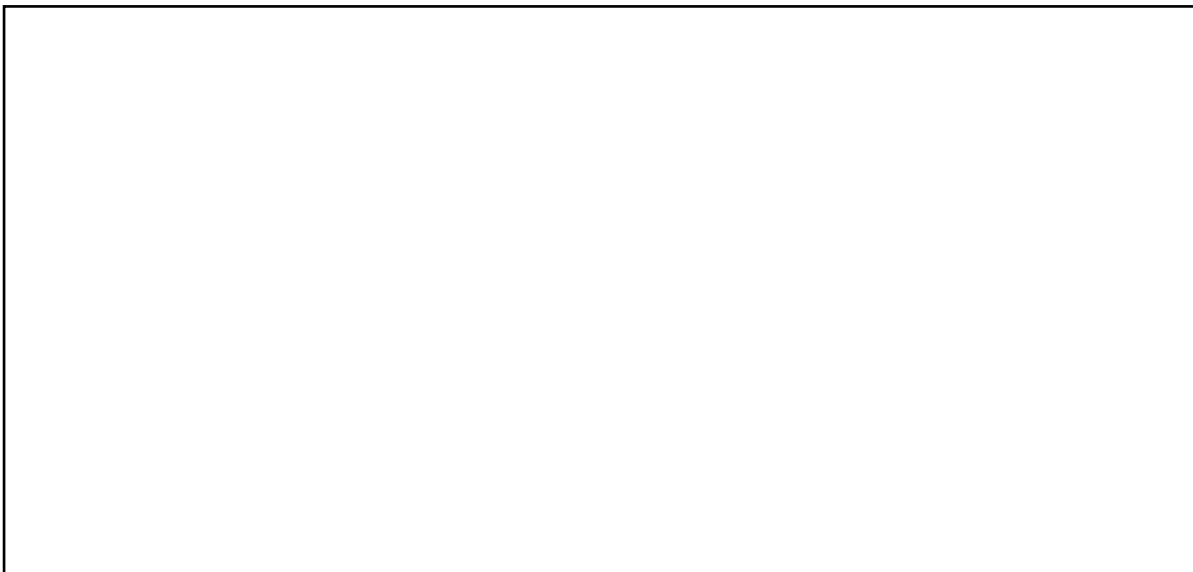
8. Probe participants' opinion on people with mental health problems that are sexually active either by will or otherwise.



9. Ask them what they would do to change how people with mental health problems' holistic care is currently given, approached or regarded.



10. Ask participants if there is anything concerning sexuality and sexual health needs in people with mental health problems that they would like to talk about.



CONCLUSION

This concludes our interview/FGD for today. Thank you so much for participating, please do not hesitate to contact me at any time. As a reminder, this information will remain confidential and will be destroyed at the end of the project. Do you have any final comments or questions? Thank you and have a great rest of the day.

APPENDIX V: BUDGET

Item Description	Unit Cost (In Kwacha)	Quantity	Total (In Kwacha)
STATIONERY			
Plain paper	70.00	5	420.00
Note books	20.00	4	80.00
Pencils	1.00	5	5.00
Sharpener	5.00	2	10.00
Ball pens	2.00	10	20.00
Stapler	40.00	1	40.00
Erasers	2.00	4	8.00
Staples (box)	25.00	1	25.00
Box files	40.00	2	80.00
Scientific calculator	200	1	200
Subtotal			818.00
SECRETARIAL SERVICES			
Printing research proposal	2.00	1 000	2 000.00
Photocopying services	1.00	100	100.00
Printing focus group discussion guide	2.00	25	50.00
Binding draft copies	35.00	3	105.00
Binding final report	300.00	6	1 800.00
Internet expenditure	1 500.000	1	1 500.00
Subtotal			5 555.00
PERSONAL EXPENDITURE			
Transport expenditure	2 000.000	1	2 000.00
Lunch expenditure	500.00	1	500.00
Airtime	200.00	2	400.00
Bag for carrying items securely	300.00	2	600.00
Audio recorder	500.00	1	500.00
Padlock	50.00	1	50.00
Payment to UNZABREC	1 000.00	1	1 000.00
Subtotal			5 050.00
Total Budget			11 423.00
Contingency fund (10% of total budget)			1 142.30
GRAND TOTAL BUDGET			12 565.30

APPENDIX VI: BUDGET JUSTIFICATION

This research proposal has taken into consideration the aspects of stationery, secretarial services, personal expenses and contingency expense.

Stationery

Stationery will be needed for the researcher to carry out the research successfully. These items will assist during literature review, data collection, analysis and report writing as well as for producing draft copies for submission at stipulated timings. The researcher will ensure confidentiality and safety of the information collected, therefore a bag will be needed for the safe keeping of the documents. Five copies of the completed research document will be produced to be distributed as follows:

- One copy for the researcher
- Two copies for the supervisors (a copy for each supervisor)
- One copy for the University of Zambia School of Nursing Sciences school
- One copy for Ndola Teaching Hospital
- One copy for Ministry of Health Headquarters

Personal Expenses

The researcher will need to move from one point to another during supervisory sessions, pilot study, final collection of data and during dissemination of completed report. The researcher will need transport fare and lunch, which has been tabulated in the budget. Besides, secure bags will be needed for carrying stationery as final report.

Contingency Fund

This is 10% of the total budget which has been added to cover for unforeseen extra costs and to cushion inflation that might occur in the course of the research period.

APPENDIX VII: LETTER SEEKING PERMISSION TO CONDUCT RESEARCH

THE UNIVERSITY OF ZAMBIA
SCHOOL OF NURSING SCIENCES
P.O. BOX 50110
LUSAKA.
24TH June, 2020.

THE SENIOR MEDICAL SUPERINTENDENT,
NDOLA TEACHING HOSPITAL,
POSTAL AGENCY,
NDOLA.

Dear Sir/Madam,

RE: PERMISSION TO CONDUCT RESEARCH

Reference is made to the above subject matter.

I am a postgraduate student at the University of Zambia pursuing a Masters in midwifery, child and women's health degree. I would like to conduct research to explore nurses' perception of sexual health needs in people with mental health problems at Ndola Teaching Hospital in departments where clients and patients with mental health problems are managed.

The research will be conducted in partial fulfilment of the award of Master of Science degree in midwifery, child and women's health. The research findings will be used to give recommendations on how to conduct history taking and nursing care at the institution.

I therefore request for permission to conduct the research. Thank you in advance.

Sincerely yours,



CHAMBATU ALICE.

5. **Kwaleyela, C.N.**, Greatrex-White, S. and Walsh, D. Clash between modern and traditional methods of attending childbirth (Accepted for publication - *Africa Journal of Nursing and Midwifery*).
6. Mayimbo, S., Haruzivishe, M. C., Kaonga, P., Zyambo, K. and **Kwaleyela, C. (2018)** Micronutrient Status as Predictors of Low Birth Weight and Pre-Term Delivery in Women Attending Antenatal Care in Chilenje, Lusaka, Zambia. *Journal of Nursing and Health Science*, 7(2), 22-27.
7. Maimbolwa Connie Margaret, Mukwato Katowa Patricia, Muleya Mutinta, **Kwaleyela Concepta**, et al., (2019) Women's experience with socio-economic factors associated with perinatal morbidity and mortality in Lusaka and Mumbwa districts of Zambia. *Health*, 11(1), 733-754.
8. Katowa-Mukwato Patricia, **Kwaleyela Namukolo Concepta**, Mwiing-Kalusopa Victoria, et al., (2019) Evaluation of quality of antenatal care services in selected healthcare centres of Mumbwa and Lusaka districts of Zambia: Pregnant women's perspectives. *International Journal of Nursing and Midwifery*, 11(5), 32-40.
9. Kabwe Chitundu, Lonia Mwape, **Concepta Kwaleyela (2018)** Perception of Community towards Child Sexual Abuse: A Case of Chawama, Lusaka, Zambia. *Open Journal of Psychiatry*, 8(1).
10. Priscar Sakala Mukonka, Patricia Katowa Mukwato, **Concepta Namukolo Kwaleyela**, et al., (2018) Household factors associated with use of postnatal care services. *African Journal of Midwifery and Women's Health*, 12(4), 189.
11. Priscar Sakala Mukonka, Patricia Katowa Mukwato, **Concepta Namukolo Kwaleyela**, et al., (2018) Care of postpartum women following complicated labour and delivery at the University Teaching Hospital, Lusaka, Zambia: Self-reported practices by midwives. *International Journal of Nursing and Midwifery*, 10(11), 134.
12. Priscar Sakala Mukonka, Patricia Katowa Mukwato, **Concepta Namukolo Kwaleyela**, et al., (2018) Understanding midwives' perspective on care of post caesarean section women at the University Teaching Hospital – Women and Newborn, Lusaka. *Open Journal of Nursing*, 8(12), 918.
13. Victoria Mwiinga Kalusopa, Sebean Mayimbo, Crecious Muleya, **Concepta Kwaleyela**, et al., (2017) Use of the partograph among midwives at UTH: A LAMRN project in Zambia. *African Journal of Midwifery and Women's Health*, 11(2).

POSTGRADUATE THESIS EXAMINATION (Past 3 years)

2019: University of Zambia: Nancy Namukolo Wamundila: Prevalence and factors contributing to Gender Based Violence towards Women in Lusaka Urban, Zambia.

2019: University of Zambia: Erick Musala Kunda: Caregivers' experiences of violence by mentally ill patients discharged from Chainama Hills Hospital, Lusaka Zambia.

2019: University of Zambia: Jaclyn Mulenga Kasongo Chileshe: School health services and tobacco use prevention among school going adolescents in Ndola district, Copperbelt province, Zambia.

2017: University of Zambia: Naomi Bweupe: Clinical supervision of midwifery students at UTH school of nursing and midwifery in Lusaka district.

2017: University of Zambia: Mental health problems experienced by HIV positive adolescents: A case of Choma district, Southern province.

2017: University of Zambia: Factors influencing utilisation of cervical cancer screening services by women at selected clinics of Lusaka urban district.

2017: University of Zambia: Daisy Mulenga Syakantu: Uptake of measles booster vaccine among under-five children at selected clinics in Lusaka, Zambia.

2017: University of Zambia: Sanford Nyirongo: Adherence to treatment by patients with Type 2 diabetes mellitus at Monze mission hospital, Monze, Zambia.

2017: University of Zambia: Kabwe Chitundu: Perceptions of the community towards child sexual abuse in Chawama, Lusaka, Zambia.

2017: University of Zambia: Beatrice Chisashi Mwansa: Factors associated with stress among mental health nurses in Lusaka and Ndola, Zambia

POSTGRADUATE RESEARCH SUPERVISION (Past 3 years)

2019: University of Zambia: Jane Kumalinga Nkhosi: Family adaptation patterns of caring for a child with autism spectrum syndrome disorder in selected households in Lusaka, Zambia.

2019: University of Zambia: Bridget Munkombwe Sikapande: Experiences of parents of non-school going children with epilepsy: A case of Lusaka.

2019: University of Zambia: Rabson Lungu: Care burdens experienced by family caregivers of people with mental disorders discharged from Chainama hills college hospital in Lusaka.

2017: University of the Western Cape: Ruth Fisayo Abiodun: Knowledge of NGO personnel on motivational interviewing: Substance use during pregnancy in Cape Town.

2017: University of the Western Cape: Boss Mwafulirwa: Women's experiences of amenorrhoea following depo-provera used at a district hospital in Malawi.

2017: University of the Western Cape: Unathi Mecia Paul: Challenges faced by midwives in implementing prevention of mother to child transmission of HIV programme during the postnatal period in Khayelitsha community health clinic, Western Cape province.

CURRENT POSITION

Lecturer and Head: Department of Research, Monitoring and Evaluation, School of Nursing Sciences, University of Zambia,

APPENDIX IX: PERMISSION LETTER FROM THE SMS

All correspondence should be addressed to the
Senior Medical Superintendent
Ndola Teaching Hospital
Postal Agency, **Ndola**
Telephone: 611585-9
Fax: 612204
E-mail: ndolateachinghospital@gmail.com



REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH
NDOLA TEACHING HOSPITAL

2nd July, 2020

The University of Zambia
School of Nursing Sciences
Department of Midwifery, Women and Child Health
Lusaka

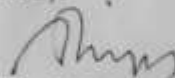
Dear Sir/Madam,

Re: Acceptance to Conduct Research Project at Ndola Teaching Hospital

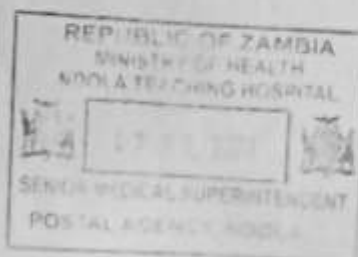
I wish to inform you that we have granted permission to **Chambatu Alice Computer No. 2016144820** to conduct a research project at Ndola Teaching Hospital in the Psychiatry department from July to August 2020.

Ndola Teaching Hospital embraces research activities from students and members of staff. Research enhances informed decision making at any organization. Hence, management demands that the findings of any research conducted at the hospital is shared. The student is mandated to submit the research proposal and the final report to Ndola Teaching Hospital Research Committee through the Planning department.

The student is hereby advised to uphold confidentiality in the chosen topic of study.


Dr. Joseph Musowoya

Senior Medical Superintendent



APPENDIX X: ETHICS CLEARANCE FROM UNZABREC



UNIVERSITY OF ZAMBIA BIOMEDICAL RESEARCH ETHICS COMMITTEE

Telephone: 260-1-256067
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753
Federal Assurance No. FWA00000338

Ridgeway Campus
P.O. Box 50110
Lusaka, Zambia
E-mail: unzarec@unza.zm
IRB00001131 of IORG0000774

14th September, 2020.

Your REF. No. 1131-2020.

Ms. Alice Chambatu,
Ndola Teaching Hospital,
College of Nursing and Midwifery,
Zambia.

Dear Ms. Chambatu,

**RE: "NURSES' PERCEPTIONS OF SEXUAL NEEDS IN PEOPLE WITH MENTAL HEALTH PROBLEMS: A CASE FOR NDOLA TEACHING HOSPITAL."
(REF. NO. 1131-2020)**

The above-mentioned research proposal was presented to the Biomedical Research Ethics Committee on 11th September, 2020. The proposal is **approved**. The approval is based on the following documents that were submitted for review:

- a) Study proposal
- b) Questionnaires
- c) Participant Consent Form

APPROVAL NUMBER : REF. 1131-2020

This number should be used on all correspondence, consent forms and documents as appropriate.

- **APPROVAL DATE** : 12th September 2020
- **TYPE OF APPROVAL** : Standard
- **EXPIRATION DATE OF APPROVAL** : 11th September 2021
After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the UNZABREC Offices should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING**: All SAEs and any other serious challenges/problems having to do with participant welfare, participant safety and study integrity must be reported to UNZABREC within 3 working days using standard forms obtainable from UNZABREC.
- **MODIFICATIONS**: Prior UNZABREC approval using standard forms obtainable from the UNZABREC Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report must be submitted to the UNZABREC using standard forms obtainable from the UNZABREC Offices.

- **NHRA:** You are advised to obtain final study clearance and approval to conduct research in Zambia from the National Health Research Authority (NHRA) before commencing the research project.
- **QUESTIONS:** Please contact the UNZABREC on Telephone No.256067 or by e-mail on unzabrec@unza.zm.
- **OTHER:** Please be reminded to send in copies of your research findings/results for our records. You're also required to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study. Use the online portal: unza.rhinno.net for further submissions.

Yours sincerely,



Sody Mweetwa Munsaka, BSc., MSc., PhD

CHAIRPERSON

Tel: +260977925304

E-mail: s.munsaka@unza.zm

APPENDIX XI: NHRA CERTIFICATE



NATIONAL HEALTH RESEARCH AUTHORITY
The Health Research Act
(Act No. 2 of 2013)



CERTIFICATE OF REGISTRATION

THIS IS TO CERTIFY THAT

Alice Chambatu

has been registered as a Health Researcher
Dated this 15th Day of December 2020
Registration Number NHRAR-R 2020-11-0059



For 

DIRECTOR
PROF. GODFREY BIEMBA