A STUDY OF FAMILY PLANNING PRACTICES AMONG QUALIFIED NURSES AT THE UNIVERSITY TEACHING HOSPITAL

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TABLE OF CONTENTS

CHAPTER PAGE

LIST OF TABLES

DECLARATION

I hereby declare that the work presented in this study for the degree of Bachelor of Science in Nursing has not been presented either wholly or in part for any other degree and is not being currently submitted for any other degree.

SIGNED:.....

APPROVED BY:.....

STATEMENT

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

SIGNED: ..Rivera..

DEDICATION

Dedicated to my brother and guardian Mr. Enerat R. Chirambo, my sister Grace, my daughter Molly and my niece Wongani.

ABSTRACT

The aim of the study was to determine family planning practices among qualified nurses.

Literature on family planning practices was obtained from literature presented in other countries especially developing countries. Problems of family planning practice are similar in most developing countries for example inadequate knowledge on the service, lack of personnel to teach the community about family planning, fear to use modern family planning methods because of the associated side effects and traditional and moral values attached to family planning practice.

The sample was randomly selected from Obstetrics, Medical and Surgical Departments. The sample consisted of fifty (50) registered and enrolled nurses. Data were collected with the use of a questionnaire. The main reason for the choice of the instrument was that the target population was literate. Secondly, the topic under study was personal and private where respondents could not have answered probing questions in a face to face situation.

Data were collected in February, 1985 and were analysed manually by the investigator. The findings of the study revealled that most nurses practice family planning and modern family planning methods were the most popular. Nurses' professional quealifications or their religious affiliations had minimal influence on the nurses' decisionsto practise or not practise family planning. However side effects associated with methods of family planning did influence the nurses' decisions to practise family planning.

Although most nurses in the sample practise family planning, the findings revealed that they do not appreciate the need for having a periodic family planning check-up which is necessary for assessing their health. Hence, these nurses may not teach their clients effectively on all aspects of family planning. It is therefore necessary for nurses to be re-educated on the importance of family planning so that they can be effective teachers of family planning to the community they serve as they are expected to be role models.

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CHAPTER I

INTRODUCTION AND OPERATIONAL DEFINITIONS

1. INTRODUCTION

Governments in the developing and developed countries are concerned with the rapid population growth which means they are compelled to support family planning services as a way of controlling the population growth (Gilles, 1984). Family planning aims include control of birth rate in line with family community's economic capabilities of child upbringing and offering education, job opportunities and not merely the amount of arable land (Mazala, 1984). Therefore, family planning means having children at the time that the family wants them. It is generally agreed by many Governments that all couples and individuals have basic human right to decide freely and responsibly on the number of children they are to have and the education and the means to do so.

Apparently, modern family planning services have not been readily accepted by most people and have been faced with apathy among intended users. This has led to underutilization of

the servicesamong women at risk of pregnancy; some of these are nurses. This could be attributed to the fact that nurses who are supposed to be role models to clients they serve and the community they live in have some degree of apathy towards family planning.

Lack of family planning has tremendous adverse effects on the family as a whole. Mothers' physical and psychological well-being will be impaired as a result of frequent pregnancies. The father who is the bread winner tends to get psychologically upset as he has to provide for more people financially in terms of food, clothing, shelter and education which often, he cannot afford. Furthermore, a mother does not spend enough time with her children since she is nursing either a pregnancy or a small baby which leads to poor mother-child bonding. Mother-child bonding is important for the psychological development of the child, failure of which may lead to lasting adverse effects in the child such as mistrust. The first year of life is important for building trust with significant others especially the mother (Munn et al, 1969).

Lack of family planning has already depleted the available resources in the community such as schools and recreational facilities and will continue to do so if the present yearly birth rate of 3.1 percent is not controlled. Other provisions such as health services have also become saturated and this leads to artificial shortages for instance of drugs. More money is needed to run the health institutions effectively but this is becoming more and more a problem due to the country's poor economy. In addition, lack of family planning has other long term effects like low job opportunities, mushrooming of shanty compounds and black marketeering in order for the families to overcome their existing economic difficulties. The above problems were also reported by Munkonze (1984) in her study on the relationship between the role of a housewife and the incidence of mental illness among women admitted to Chainama Hills Hospital. She stated that difficulty in accomplishing developmental tasks confronting the families led to mental ill health among women.

Interest in doing the study arose from observation of some qualified nurses who are frequently on maternity leave and their youngest children are too small and need constant care. Above all they contribute to the chronic shortage of qualified nurses in health institutions, sometimes these shortages are artificial mainly due to the above problem.

Personnel Division Circular number 8.17 (1982) which will be included in the next General Orders, stipulates that a female Civil Servant is entitled to 90 days maternity grant if she has served for 24 months continuously. The nurse who goes on confinement leave every year will forfeit the privilege. This means she will have to take unpaid leave for the time that she will be away. Not only does this lead to shortage of manpower in health institutions but also causes financial constraint on her family because of the high inflation rate in the country. Some of the nurses are single parents and are solely responsible for bringing up their children.

The nurse who is frequently on maternity leave may jeopardise her opportunity of self growth and development the profession may offer

because she is either pregnant or nursing a small baby most of her reproductive years.

For the above reasons, there is need to discover or identify family planning practices among qualified nurses and also factors that make some nurses go on frequent maternity leave and yet they seem to have the knowledge about family planning. It is believed that nurses should be role models if they have to make an impact on health education related to family planning.

2. DEFINITIONS OF TERMS

For the purpose of the study the following terms are operationally defined as:

1. Family Planning

   A term describing the practice of having children at the time the couple wants them.

2. Qualified Nurse

   A person who has undergone a two or three year nurse education and training programme and is licensed to practise as a nurse.

3. Registered Nurse

   A person who has undergone a three year nurse education and training programme and is licensed by the General Nursing Council to practise as one.

4. Enrolled Nurse

   A person who has undergone two year nurse education and training programme and is licensed by the General Nursing Council to practise as one.

5. Child Bearing Age

   A term describing women from the onset of menstruation or menarche to the time menstruation ceases (menopause).

6. Frequent Pregnancies

   Conceiving within a period of less than 18 months.

7. Maternity Leave

   The period a woman takes away from work to await the birth of the baby up to the time she returns to work.

CHAPTER TWO

LITERATURE REVIEW

Zambia is and has been experiencing a general shortage of qualified nurses in health institutions for many years. The shortage of nursing personnel is accentuated by inadequate numbers of qualified nurses. This can be attributed to the short history of nurse education and training in the country. Enrolled nurse training has been in existence only for four decades while that of registered nurse training has been in existence for only two decades. This means that the number of qualified nurses from these schools is not enough to meet the staff needs of the increasing number of health institutions in the country. Secondly, a good number of nurses have to be on various types of leave, for instance, vacation or maternity leave. Observation has shown that many nurses go on maternity leave frequently. Frequent pregnancies among nurses may indicate that nurses do not practise family planning, though they teach the community about the importance of the same. Ng'ombe (1984) and People (1984) report that there is population explosion in Zambia which now stands at 6.6 million compared to 4 million in 1974.

The concept of family planning is an old one. It has been used in traditional society through traditional methods. The methods used include coitus inturrupticus, rythm, polygamy, abstenance where a woman who has just given birth went away to live with her parents for as long as two years and breast feeding, (Kane, 1981). Some of these methods are not feasible for the working woman including the nurse. The nurse may not be away from her home for longer than two months following delivery, as she has to go back to work early. Families today tend to be more cohesive, keeping their own children so that the mother stays at home rather than going away to live with her parents during the puerperium. Polygamy is minimal in urban society probably due to society changes towards the western one wife style. The current world wide recession and inflation may also influence the husband to have a monogamous family. This exposes a woman to early pregnancies. Coitus inturrupticus, rythm method and breast feeding tend to be unreliable for the couples that use them often resulting in unwanted pregnancies, (Kane, 1981).

Traditional plants and roots are other methods used for fertility control but their effectiveness has not been proven scientifically.

This is because the traditional values attached to their use are top secret only known to few individuals who act as consultants. Soejarto (1982) in his article on plants to control fertility reports an Amazonian woman who for many years successfully controlled her fertility with the use of a plant root given to her by an elderly woman. When the woman wanted more children she consulted the same elderly woman who gave her another root, after which she had the children she desired. From observation the qualified nurse uses similar roots of plants in various forms as a method of fertility control. This may mean that the nurse has no confidence in modern family planning methods as such, she may not advise her clients on modern family planning. Kane (1981) has observed that traditional methods of fertility control are on the increase and he attributes this to bad publicity of modern methods of family planning, which has resulted in new interest in traditional techniques in the third world countries. This, therefore, means that it is modern family planning which is not being utilized properly by couples and adults in the childbearing age which has contributed to the population explosion. The problem is compounded by the fact that the therapeutic fertility value of traditional family planning methods has not been proven scientifically.

Nevertheless, having adequate knowledge on family spacing means that nurses should spearhead education of the community on control of population growth. This teaching would be more effective if nurses led by example by practising family planning, otherwise their clients will question the value of their teaching. This idea was supported by Kibaki (1984 p.25) in his speech "Calling for African Governments' Commitment to Family Planning". He says, "We must make use of those who have accepted family planning and are practising it to teach others." Kibaki (1984) suggested that other fields of extension work use the same approach. He gave an example from Agriculture where this approach was successfully used in Kenya when a new method of hybrid seeds was introduced. To promote its use, groups of farmers were persuaded to spend one morning with a farmer who had adopted the hybrid seeds as a new method of agriculture and could speak their language. The farmer gave answers to fears that other farmers had resulting in the other farmers adopting the new method which proved very successful in a short time. From this example, it would seem that if the nurse practised family planning she would persuade the client to use the service more effectively because of her personal experience

which would give her an opportunity to explain better the benefits and methods of family planning.

A few studies have been carried out on family planning practices among health workers including qualified nurses. Nurses are part of the population in the childbearing age who are not utilizing family planning services adequately (Pauncefort, 1982). This is supported by Smith (1972) in his assessment of the Family Planning Association in the United States of America. He reported that out of eight (8) million women in the fertile age, aged between 15 and 45 years, only four (4) million use contraceptives. Smith (1972) stressed that this leads to tragedies like unwanted pregnancies and a high suicidal risk. Similar health problems are observed among nurses where unplanned frequent pregnancies lead to poor health and lowered vitality (Akhter, 1983). A nurse with lowered vitality will not contribute adequately to the delivery of health care in the health care organisation of which she is a member.

In a study on knowledge and attitudes of Public Health Nurses on family planning conducted in Philadelphia in the United States of America by Howard et al (1972), it was found that the

subjects had knowledge of family planning and that they could give information to the community about family planning. It was also found that personal use of a method contributed to one's knowledge of birth control methods. The above was supported by Okediji (1968) in his study on attitude, knowledge and practice of family planning techniques conducted in Ibadan, Nigeria. He reported that women who used contraceptives had more knowledge on the methods of family planning. From the above discussion, it could be argued that the nurse who also has knowledge of family planning would readily give information to the community about family planning. She would value family planning more if she practised it herself. Teaching her clients will also have more meaning to her as she will be relating to her personal experience with family planning.

There are many factors which lead to underutilization of family planning services among women in general. Van Dougen (1975) in his study on the effects of contraception and family planning reported that nature's main concern is the continual survival of the species, which form the most fundamental forces in life of survival and reproduction.

He further states that control of reproduction is contrary to this natural instinct, hence the concept of family planning will meet with resistance among the intended users of the service including the qualified nurses. Kayembe (1983) reported that customs and beliefs influence decision-making on fertility of the couple. For example, in Zaire, in a matrilineal society, the wife's brothers have the greatest influence while in patrilineal society the husband's father and brothers are the most influencial. This could affect Zambia as it has both patrilineal and matrilineal lines and nurses are members of these families. However, the nurse still has an advantage over the woman in the community because of her professional education and training which should help her perceive health issues with a different perspective. For example, the nurse fully understands the various methods of contraception, their advantages and the associated discomforts, complications, and yet she cannot fully utilize family planning. Probably this is due to lack of encouragement from family planning workers.

Yusuf (1983, p. 191) subscribed to the above in his article, "No one is realistic about family planning". He says, "A doctor in a developing country is kept busy throughout his working hours

with disease conditions and has no time to see women needing family planning". It can be argued that the doctor will not have time to attend to the nurse needing family planning since she is working with him/her most of the time attending to the sick, This, therefore, calls for the reorganisation of health services to give nurses sometime to attend such services which is the right of everyone (Wulf and Willson, 1984). The World Bank Report (1984) supported the above when it highlighted the importance of intended users of family planning service to have easy access to these services, if the service has to make an impact on population control. The nurse has access to family planning services which is in her work place, she needs encouragement from family planning workers to utilize the service.

The methods of contraception open to the nurse are many and are offered free to the clients. The methods of family planning include oral contraceptives, barrier, rythm, sterilization and coitus inturrupticus. The most effective and commonly used method is the oral contraceptive pill as revealed by Westoff (1978) in his study on unmet needs for birth control in five Asian countries. Bahl and Chanda (1976) subscribe to the above

statement in their report on Family Spacing Clinic conducted at Lusaka Civic Centre, Zambia. They state that the majority of women (72.7 percent) used the oral contraceptive pill. Westoff (1978) further states that sterilization is favoured as the second best method of contraception followed by barrier and rythm methods. From observation the Zambian nurse who practises family planning uses the pill most followed by barrier methods. This observation is supported by Smith (1972), Bahl and Chanda (1976) when they state that the most effective and commonly used type of contraceptive is the oral contraceptive pill followed by intra-uterine contraceptive device.

Though the qualified nurse is equipped with the necessary knowledge and has easy access to family planning services, she may be unable to use the facility because of fear of the effect of family planning methods on future fertility. Infertility threatens womanhood and a sense of security (Gilles, 1984). Geraty (1975) conducted a study on social factors influencing the use of contraceptives in the black population of Rhodesia (now Zimbabwe). She identified infertility fears, general health fears and doubts as some of the problems connected with modern methods of birth control. Population Reports

(1984) in an article, "Dealing with Rumours" has also identified permanent infertility and damage to children born later as fears experienced by women using modern methods of family planning.

The need to control fertility through family planning is great to the individual family and the community. The World Bank Report (1984, p.98) states:

> Fertility control is not an end in itself but a means along with other development efforts to help individuals achieve better health and greater prosperity, and to help governments achieve more rapid economic progress and greater stability.

In an attempt to control fertility, health authorities are trying to determine reasons affecting the achievement of the aim of family planning which is to assist families to have children at the time that they want them. Many studies have been conducted to determine attitudes towards family planning. One such study was done in California on attitudes of married students on overpopulation and family planning by Dafley (1970). The findings revealed that subjects had a positive attitude toward family planning. Okediji (1968, p. 211) supports the above when he says "... the higher the educational level of the women the more favourable their attitudes towards the use of contraceptives for family planning." Since nurses have

knowledge of family planning,they should have a positive attitude towards the service although knowledge of the service does not mean using it, (Roux, 1984). Thus, there is need to motivate the intended user of the service if population growth is to be controlled, (Kibaki, 1982).

Religious denomination influences the practice of family planning particularly Catholic nurses as reported by Ng'andu (1982) in a study conducted at Chilonga Mission Hospital on the feelings of Roman Catholic medical and nursing personnel on artificial contraception as a method of family planning. The study revealed that a Catholic nursing personnel had a negative attitude toward artificial family planning which adversely affected client teaching. Ng'andu (1982) further states that this group favours natural family planning methods which demand a lot of self discipline. However, MacDonald (1982) does not subscribe to this idea. She found religious beliefs to have little effect on the use of family planning. MacDonald drew these conclusions from a study done in Salisbury (now Harare) on factors influencing black women to accept family planning. Similarly, Mrouch and Chamie (1978) in their study on Education not religious factor on Birth Control in Lebanon

supported the above. They found that religious fertility differentials were mixed between the Moslems and Christians, especially with voluntary sterilization as a method of birth control. From the above observations, it would appear that the nurse would be free to choose any method of her choice for family planning regardless of her religious affiliation.

In the same study, MacDonald (1982) also found that the death of a child was associated with lack of family spacing. Similarly, in a survey conducted in rural Mexico by Distituto Mexicano del Seguro Social IMSS (1981), it was found that high fertility was associated with high infant mortality rate. Gumbi and Hall (1968) made the same observation. They reported that high mortality rate in childhood will affect decision-making on the number of children the family desires to have. It has been observed that some nurses also loose children from various causes; a development which may force one to replace the dead child by conceiving sooner than she could otherwise have planned especially if she has lost her youngest child.

African traditions favour large families, particularly male children who carry on the ancestral name. Other

reasons for favouring large families are that children are viewed as a form of investment to support parents in old age, contribute to family income as they grow up and the parents derive satisfaction and pleasure from their children (World Bank Report, 1984). The former reason will force the nurse without a male child to carry unwanted pregnancies in her attempt to have a male child irrespective of the number of children she has. At the same time having more children is a proof of womanhood (Gillies, 1984). Ojiambo (1984, p.11) in an article, "Africa Assessed" states:

> As it is true elsewhere in the developing world, Africa's population problem is compounded by attitudes and traditions that favour large families. Children provide status and male children are eagerly desired to carry on ancestral line because despite women's dominance in agriculture, traditional education has inculcated male supremacy in African Society.

A similar picture is reported in other third world countries, for example, in Korea where the use of contraceptives by the population at risk of pregnancy is delayed by a large number of families until one or two sons are born (Westoff, 1978). From observation the desire for male children remains high in most Zambian families as the male child will carry on the family name. He is given more support than the female child throughout his growth and development. The chances of the male

child completing his education and securing a job are higher since his progress will not be interrupted by an unwanted pregnancy as may be the case with a female child. Unwanted pregnancies among school girls is one of the major social problems worrying parents and the population at large.

Another factor that may influence a qualified nurse to practise family planning is her socio-economic status. The nurse's salary is very low and may not meet all her financial needs and those of her family. This is compounded by the current inflation where the Kwacha buys very little. A nurse who falls pregnant frequently may have two or more small children requiring close attention at the same time plus feeding among other things. The high cost of living may lead to children not getting adequate food required for growth and development, leading to ill health. It has been observed that some senior medical personnel including nurses have lost children as a result of malnutrition.

Bertrand et al (1984) have identified family planning as a nutrition intervention. This was from a study on family planning and nutrition conducted in Zaire. The study showed nutritional improvement to be potential consequence of family planning. They concluded that an aggressive

family planning programme was an appropriate and potentially effective nutrition intervention which is feasible within Africa. This may mean that a nurse practising family planning will have a small family which she will be able to provide for adequately in terms of food, clothing, education and shelter. Africa Health Institutions Project (1977) describe socio-economic factors as influencing the use of family planning methods. Brown (1969) conducted a study in Kampala on attitudes towards family planning among peri-urban Africans. He found that families preferred small families as large families increase the family expenditure, affect the rate of growth of children and make it exceedingly difficult in providing for the family as a whole. This observation was supported by Van Dougen (1975 p. 422) who stated:

> Over population although created by individuals will inevitably have harmful effects on the community. Lack of food, shortage of living amenities together with air, water and land population, overpopulation must be regarded as a community disease in its own right much as any other chronic epidemic disease.

In view of the foregoing, women in the childbearing age need to be encouraged to control their fertility so that population growth can be controlled. One way of encouragement would be to introduce incentives and disincentives for the couples and adults in the childbearing age. Some governments have

introduced financial and other incentives and disincentives as ways to encourage parents to have fewer children (World Bank Report, 1984). Chen et al (1982) in a study "Chinese Government Opt for Only Child Glory Certificate" reported the cash incentives given to families who comply with the government policy of only one child per family followed by sterilization. The families would receive incentives for as long as 14 years while those that do not comply are penalised by paying heavy fines for longer than 16 years. This is an effort by the Chinese Government to reduce the natural rate increase from 12-13 per 1000 to 0 per 1000 by the year 2,000.

The Indian Government has taken similar drastic steps in controlling population growth. Couples that opt for sterilization as a method of family planning are given cash and grain incentives (Chowdhury, 1982). The results have been encouraging with more couples opting for sterilization as a method of family planning, for both males and females. Dusitsm and Satayapan (1984) in their study on Sterilization of Women by Nurse Midwives in Thailand, report that as a result of more women opting for sterilization, the few doctors cannot cope. The Thai Government allowed midwives to sterilize women needing the service after training.

The Zambian Government may use similar cash incentives to motivate women, including nurses to practise family planning. It has been noted that nurses' salaries are low, so such incentives could improve financial status for those who practise family planning. Some nurses are already equipped with special family planning skills. Infact they conduct family planning clinics in most health centres. If more women were motivated to practise family planning, the nurse would be able to cope with the work. In Zambia, doctors conduct sterilization. As a result the nurse is unlikely to learn sterilization methods for a long time to come since the number of clients needing the service can be managed by doctors.

In conclusion therefore, it is necessary to investigate family planning practices among qualified nurses because they are directly involved with the delivery of these services and should set an example to the community they serve. It is hoped that findings from the study will help identify family planning practices among nurses and also help to devise ways and means of motivating and encouraging nurses to use family planning services.

CHAPTER 3

STATEMENT OF THE PROBLEM

There is population explosion in Zambia today with the population growing at an accelerated rate of 3.1 percent per annum. It has infact doubled in the past thirty (30) years from 2.5 million in 1950 to 5.6 million in 1979 (Mazala, 1984). The population has since risen to 6.6 million (People, 1984) giving great concern to the Government. Unfortunately, observations show that nurses in the child-bearing age contribute to the population explosion. They fall pregnant frequently, which is an indication that they do not practise family planning, despite the fact that they have adequate knowledge and easy access to the service.

Modern family planning can only be fully accepted by the intended users if nurses become role models to the community they teach the importance of family planning. Studies on family planning education have shown that teaching of family planning is more effective if done by individuals who practise it (Kibaki, 1984).

Records at the University Teaching Hospital (U.T.H.) show that some nurses are on maternity leave every

twelve (12) or eighteen (18) months, which causes a shortage of qualified nurses in health institutions. Out of three hundred and eighty-two (382) registered nurses and four hundred and sixty-one (461) enrolled nurses, seventy (70) registered nurses and one hundred and seven (107) enrolled nurses were on maternity leave in 1982. The following year in 1983, fifty-four (54) registered nurses and one hundred (100) enrolled nurses took the same leave for a period of three to six months per nurse; the other nurses who remained in service had each to take fourteen days local leave and thirty days vacation leave annually. Nurses often get urgent affairs leave which further reduces the number of nurses on duty at any given time. The few remaining nurses will be over-worked and their performance will be below standard. Such shortages adversely affect the service, the number of nurses is not adequate for twenty-four (24) hours coverage to render quality patient care. Nurse administrators find problems in assigning nurses to various areas which affects attainment of the institutional goals.

Lack of family spacing leads to frequent child birth. Nurses are either pregnant or breast feeding most of their productive years. Their bodies do not have time to replenish stores of vital nutrients, leading to lowered vitality

(Akhter, 1983). A nurse with lowered vitality will be susceptable to ill-health, therefore productivity at work will be lowered. Since the nurse has mixed roles of mother, wife, advisor and many more in society, she is expected to continue with her family role after official work. If she is already overworked and tired, she will not perform this role adequately.

Like any other member of the Zambian Society, the nurse with the unplanned family will have socio-economic problems related to poverty. The family may not have adequate nutrition and clothing. Overcrowding in homes is made worse by the extended family system. These problems contribute to high morbidity and mortality rates among women in the reproductive years and also infant mortality which is 140 per 1,000 (Health Statistics, 1980).

In conclusion, family planning services should be highly utilised by nurses because of the nature of their profession and educational back ground which have equipped them with knowledge about family planning services. Nursing demands a lot from the nurse physically and psychologically; hence the nurse needs to maintain good health at all times in order to contribute effectively towards providing quality patient care. One way of doing this is by spacing her pregnancies.

In view of the above, the study aims at determining family planning practices among qualified nurses. The findings may help to encourage nurses utilise family planning services so that they live by example to their clients and the community at large. The community will be encouraged to practise family planning if the teachers,qualified nurse, who give advice and issue contraceptives use the service. Family planning will also make the nurse happier, healthier and more productive in her daily work. Ultimately, the nurse will contribute more to national development. Thus, family planning practices among qualified nurses will be determined by answering the research question· What are the family planning practices among qualified nurses?

The hypotheses for the study are:

1. Religious convictions and beliefs interfere with nurse's choice of family planning method.

2. Registered nurses practise family planning more than enrolled nurses.

3. A nurse's decision to practise or not practise family planning depends on her security in marriage.

4. Knowledge of side effects associated with methods of family planning influence the use of contraceptives among nurses.

CHAPTER 4

METHODOLOGY

1. RESEARCH DESIGN

The purpose of the study was to determine family planning practices among qualified nurses. Therefore, a descriptive survey design was thought to be more appropriate to the study. Treece and Treece (1982) describe descriptive surveys as studies which are designed to describe phenomena. Thus, the study aimed at describing family planning practices among qualified nurses including factors influencing nurses' decisions to practice or not practise family planning.

Gathering of data in descriptive surveys is done in a natural setting thereby providing an opportunity to examine variables (Seaman and Verhonick, 1982). Thus,the design allowed gathering data in the University Teaching Hospital's three departments where nurses work; the hospital provides family planning facilities as well which would help to provide current information on the use of family planning services among qualified nurses.

Other reasons for choosing the descriptive survey design are that it is less expensive as respondents remain in their natural setting which eliminates subjecting respondents to unpleasant conditions, hence co-operation is easily obtained. In addition, descriptive surveys help to complete the study in a shorter period of time compared to the experimental design.

Case studies could have been used to determine family planning practices among qualified nurses, but because of limited time in which to complete and submit the study to the Department of Post Basic Nursing, case studies were unsuitable because they are time consuming. Another reason is that there is an element of subjectivity as possibility of becoming personally involved in the study is high which could have biased the findings, (Treece and Treece, 1972).

2. RESEARCH SETTING

The study was conducted at the University Teaching Hospital (U.T.H.) which is located in Lusaka, the Capital of Zambia. The U.T.H. is the largest health institution in the country. It has a bed capacity of 1,500

distributed among six departments namely: Obstetrics and Gynaecology, Paediatrics, Medical, Surgical, Neonatal Surgical and administrative departments. The U.T.H. has most specialists and it serves as a referal hospital in the country.

The hospital offers training facilities for registered nurses and midwives, theatre nurses, doctors, Physiotherapists, radiographers as well as post-graduate courses in various fields of medicine including research.

The study was conducted in obstetrics, medical and surgical departments. The obstetric department carters for antenatal, intranatal and postnatal clients. It consists of two antenatal wards, a labour suite, four post-natal wards and an antenatal clinic. It has a total of one hundred and forty-one (141) nurses - sixty-two (62) are registered nurse/midwives and seventy-nine (79) are enrolled nurse/midwives. Medical and surgical departments have each an average of one hundred and two (102) nurses - twelve (12) registered nurse/midwives, twenty (20) registered nurses and sixty (60) enrolled nurses. Each department has six (6) wards catering for male and female medical and surgical conditions respectively. Average bed capacity per department is two hundred and seventy (270).

U.T.H. was chosen for the research setting because of its proximity to the institution of learning. Secondly, there is limited time in which the study had to be completed and submitted to the Department of Post-Basic Nursing.

3. PILOT STUDY

Abdellah and Levine (1979) define a pilot study as a study carried out before a research design is completely formulated to assist in:-

(a) the formation of the problem or

(b) the development of the hypothesis.

A pilot study is designed to acquaint the researcher with problems to be encountered in preparation for the larger research project. The researcher makes a trial run to "get the bugs out" of his instrument and study design. It also provides the researcher with an opportunity to carry out the procedure for collecting data (Treece and Treece, 1982).

A pilot study was not done due to limited time in which the study was to be completed and submitted to the Department of Post-Basic Nursing. Since a study of this kind has not been conducted in this country before, the study can be said to be a pilot study in itself, and it is a small-scale study. In order to ensure validity and reliability of the instrument used for data collection, the clarity

and sequence of questions were checked by colleagues and the supervising lecturer several times until a consensus was reached. Another reason why a pilot study was not done was other academic pressures.

SAMPLE: SELECTION AND APPROACH

The target population for the study was qualified nurses, both enrolled and registered working at the University Teaching Hospital (U.T.H.), obstetrics, medical and surgical departments. This population was chosen because the study was on qualified nurses. Secondly, the areas where the nurses worked could have influenced their decision to practise or not practise family planning. It was felt that the information gathered from the three groups of nurses would give a fair assessment of knowledge and practice of family planning among qualified nurses at U.T.H.

The sample of fifty (50) nurses was obtained from a population of three hundred and fifty (350) nurses working in the three departments named above. The sample size was for convenience due to the time limit in which the study had to be completed.. The sample was thought to be manageable within the time available and limited resources needed to prepare the questionnaire.

The sample comprised of twenty-five (25) registered nurses and twenty-five (25) enrolled nurses with or without midwifery training. The selected sample had to meet the following criteria:

1. Qualified nurses both enrolled and registered.
2. Nurses aged between eighteen (18) and forty-five (45 years).
3. Should have one child or more.
4. Should be of any marital status.

Permission to administer the questionnaires to nurses in the Obstetrics, Medical and Surgical Departments was sought for by letter to the Departmental Nursing Officers on 17th January, 1985, (example Appendix I). Written replies granting permission were received dated 28th January, 1985 from the Surgical Department, 31st January, 1985 from the Medical Department and 15th February, 1985 from Obstetrics Department, (example Appendix 2). The Nursing Officers took the responsibility of informing the Sisters-in-Charge about the request to administer the questionnaire to the nurses on the wards concerned. The ward sisters and charge nurses were met personally for self-introduction and to explain the purpose of the study.

Sample selection was done by systematic sampling because of the size of the population and that every subject was given equal opportunity for inclusion in the sample. Sweeney and Olivieri (1981) define systematic sampling as a process of selecting a sample according to a system of choosing subjects at fixed intervals. It involves selection of subjects using already existing lists with the first subject being chosen by chance or randomly, then proceeding to find the interval by dividing the total population by the number of subjects required. In this case the three hundred and fifty (350) nurse population was divided by fifty (50) - the required sample size to get the interval as shown below.

$$\frac{350}{50} = 7$$

Every seventh name on the list of nurses was chosen for the sample. The sample of fifty (50) was obtained. Each nurse included in the sample was approached individually. Self introduction was done and the purpose of the questionnaire was explained. The subjects were then asked individually if they were willing to participate in the study. Fifty (50) subjects agreed to participate in the study; that is twenty-five (25) from Obstetric Department and twenty-five (25) from Medical and Surgical Departments. The participants

were then given the questionnaires to complete in their own time and were requested to return the completed questionnaires within one week.

5. INSTRUMENT USED TO COLLECT DATA

For the purpose of the study a questionnaire (Appendix 3) was used to collect data. A questionnaire is a self administered interview (Polit and Hungler, 1978). It allowed to collect data from qualified nurses on their attitudes, beliefs, feelings, practices and perceptions on family planning. The questionnaire also allowed for uniformity of the questions asked, the responses given as well as the maintenance of question and answer sequence. Other reasons for choosing a questionnaire were that the subjects were all literate and able to complete the questionnaires. Respondents remained anonymous as their names were not on the questionnaire which could have identified them. This was to maintain confidentiality since the problem studied was personal and private and subjects could not give information freely. Clarifications were given where necessary and most questions were answered. All completed questionnaires were returned by 16th February, 1985. In addition, the questionnaire has the following advantages.

1. Questionnaires are generally much less costly to administer.

2. The researcher is able to gather data from a widely scattered sample.

3. Questionnaires can be flexible concerning the type and order of items and the topics covered by the researcher.

4. Data from closed-ended items are relatively easy to tabulate, especially if they are checked off responses.

5. It is one of the easiest tools to test for reliability and validity (Treece and Treece, 1982, p. 228)

6. Respondents can remain anonymous (Seaman and Verhonick, 1982, p. 225, Treece and Treece, 1982, p.228).

7. A questionnaire provides more uniform responses (Seaman and Verhonick, 1982 p. 225)

However a questionnaire has several disadvantages in its use, some of which are as follows:

1. The information obtained from questionnaires tends to be somewhat superficial especially if closed-ended questions are used.

2. Questionnaire respondents are at liberty to skip around from one section of the instrument to another; different ordering of questions from the originally intended could bias the responses (Polit and Hungler, 1978, pp. 352-353).

3. Questionnaires can collect only self reports of recalled past action, they are unable to express attitudes and beliefs (Seaman and Verhonick, 1982 p. 225).

4. The respondent may omit or disregard any item he chooses without giving explanation.

5. The researcher does not have the opportunity to interact with the subjects (Treece and Treece, 1982, pp 225-229).

Some of the disadvantages were minimized by ensuring respondents' anonymity, confidentiality and by not recording their names on the questionnaires. A lot of open ended questions were asked to elicit detailed information and the questionnaires were checked for completeness before collection.

The questionnaire was preferred over the structured interview because of the nature of the subject studied. It was personal and private that respondents could have not been free to answer probing questions in a face to face situation. In addition, the questionnaire was chosen in favour of the structured interview for the following reasons:-

1. It is time consuming as the study was to be completed and submitted to the Department of Post-Basic Nursing within a limited period of time.

2. The face to face interaction in a scheduled interview decreases the respondent's feeling of anonymity. The problem under study demands anonymity and confidentiality.

3. Interview bias is removed (Treece and Treece, 1982, p. 246).

4. The interviewee usually has little or no choice in the date or the place of the interview, while respondents in a questionnaire were given time to complete it at their convenience (Treece and Treece, 1982, p. 246).

6 QUESTION SEQUENCE

The questionnaire constituted 24 questions. The first 3 questions were constructed to elicit respondent's demographic data such as age, professional qualification and marital status. Questions 4, 5, 6 and 7 sought information on the number of children the respondents have, their ages, sexes and whether the births of their children were planned, including information on whether some of the children were dead. Question 8 sought information on the number of abortions the respondents have had; while questions 9 and 10 elicited information on residential areas and religious affiliations of the respondents.

Succeeding questions 11, 12, and 13 sought information on where the respondents worked, number of nurses in their wards and whether the number of staff was adequate for ward coverage. Questions 14, 15 and 16 sought information on family planning practices and the methods currently in use. The following questions 17, 18 and 19 elicited information on the respondents' knowledge of traditional

family planning methods and whether these methods were practised by respondents and whether they were effective.

Question 21 sought information on the respondents' routine family planning check-up pattern and its importance. The last three questions 22, 23, and 24 elicited information on respondents' beliefs and attitudes on family planning.

7. DATA COLLECTION

Data were collected during the first week of February, 1985 using a questionnaire. The questionnaires were administered during the first two days and respondents were given up to the end of the week to return the completed questionnaires, in order to minimize sample mortality.

The questionnaires were administered during morning tea-break becauses there were more nurses on duty than at any other time of the day. This time did not interfere with doctors' rounds, nursing and diagnostic procedures since the same were completed and patients were settled. The time was also found to be convenient to the investigator because there were no formal lectures to attend between 10.00 hours and 14.00 hours.

The questionnaires were administered personally to groups of three and four nurses at morning tea-break. The purpose of the questionnaires was explained and nurses were given chance to ask questions. Finally, the respondents were thanked for accepting to be included in the study.

CHAPTER 5

DATA ANALYSIS AND PRESENTATION OF FINDINGS

1. DATA ANALYSIS

Data collected are not useful unless arranged in a meaningful manner, so that it is possible to derive patterns of relationships (Polit and Hungler, 1978). Seaman and Verhonick (1982) define data analysis as the process by which the researcher summarises and describes data, and if possible makes inferences from the study sample to the population from which the sample was drawn. All data were handled manually with the aid of a pocket calculator. Responses were processed and categorised. The tallying method of four vertical bars and slash for the fifth observation was used for example: Number of responses 𝍸 𝍸 𝍸

The tallying of data on worksheets brings together in one place the data collected on all study subjects (Abdellah and Levine, 1983).

Data were arranged in frequency counts and percentages. Percentages are descriptive statistics used to describe and sythesize obtained emperical observations and measurements according to Polit and Hungler, (1983).

Findings are presented in tabular form. Seaman and Verhonick (1982) point out that tables conserve space by presenting data in such a way that the narrative may be reduced. They add that tabulated data are easier to remember.

2. PRESENTATION OF FINDINGS

The purpose of the study was to determine family planning practices among qualified nurses. The findings are presented in table form. It was found suitable to use tables because they summarise results in a meaningful way enabling the reader to understand the authors' intention in the study (Sweeney and Olivieri, 1981).

Tables have been arranged according to question sequence. The first five tables show demographic data on respondents, and succeeding tables show data related to respondents' places and staffing patterns in their areas. The rest of the tables show data related to family planning patterns of respondents and their attitudes towards family planning. In some cases the number of responses exceeded the number of subjects hence some tables show more responses than the number of respondents.

TABLE I: AGE RANGE OF RESPONDENTS

Number of respondents	Age-range	Percent
19	23-28	38
18	28-33	36
6	33-38	12
5	18-23	10
2	38-43	4
50	total	100

TABLE 2: QUALIFICATIONS OF RESPONDENTS

QUALIFICATION	NUMBER OF RESPONDENTS	PERCENT
REGISTERED NURSE/MIDWIFE	15	30
ENROLLED NURSE	15	30
REGISTERED NURSE	10	20
ENROLLED NURSE/ MIDWIFE	10	20
TOTAL	50	100

TABLE 3: MARITAL STATUS OF RESPONDENTS

STATUS	NUMBER OF RESPONDENTS	PERCENT
MARRIED	48	96
SINGLE	2	4
TOTAL	50	100

TABLE 4: RESPONDENTS WITH CHILDREN BELOW 5 YEARS OLD

AGE OF CHILDREN	NUMBER OF RESPONDENTS	PERCENT
UNDER 5	31	62
ABOVE 5	19	38
TOTAL	50	100

TABLE 5 SEX OF RESPONDENTS' CHILDREN

SEX	NUMBER OF RESPONDENTS	PERCENT
BOYS & GIRLS	21	42
Females only	18	36
MALES ONLY	11	22
TOTAL	50	100

TABLE 6: NUMBER OF RESPONDENTS WHO PLAN THE BIRTHS OF THEIR CHILDREN

BIRTHS	NUMBER OF RESPONDENTS	PERCENT
PLAN	36	72
DO NOT PLAN	14	28
TOTAL	50	100

TABLE 7: RESPONDENTS' REASONS FOR PLANNING THE BIRTHS OF THEIR CHILDREN

REASONS	NUMBER OF RESPONSES	PERCENT
Allow proper growth in children	12	25.5
Economical	10	21.1
Mother's good health	7	15.0
Other	7	15.0
Mother studying	5	10.6
No response	4	8.5
Nunny problems	2	4.2
TOTAL	47	100

TABLE 8: REASONS WHY RESPONDENTS DID NOT PLAN THE BIRTHS OF THEIR CHILDREN

REASONS	NUMBER OF RESPONDENTS	PERCENT
CONCEIVED BEFORE MENSES	4	29.0
NO RESPONSE	4	29.0
LONG PERIODS OF AMENORRHOEA	3	21.0
HUSBAND REFUSED	2	14.0
NOT MARRIED	1	7.0
TOTAL	14	100

TABLE 9: TOTAL NUMBER OF RESPONDENTS WHO HAVE HAD LIVE CHILDREN

CHILDREN	NUMBER OF RESPONDENTS	PERCENT
LIVE	45	90
DEAD	5	10
TOTAL	50	100

TABLE 10 NUMBER OF RESPONDENTS WHO HAVE HAD ABORTIONS

STATUS	NUMBER OF RESPONDENTS	PERCENT
NO ABORTION	33	66
ABORTION	14	28
NO RESPONSE	3	6
TOTAL	50	100

TABLE 11: RESPONDENTS' RELIGIONS

RELIGION	NUMBER OF RESPONDENTS	PERCENT
ROMAN CATHOLIC	12	24
UNITED CHURCH	12	24
EVANGELICAL	10	20
ANGLICAN	5	10
S.D.A.	5	4
NO RESPONSE	3	10
JEHOVAS WITNESSES	2	6

TABLE 12: RESPONDENTS' RESIDENTIAL AREAS

RESIDENTIAL AREA	NUMBER OF RESPONDENTS	PERCENT
LOW DENSITY	22	44
MEDIUM DENSITY	17	34
NO RESPONSE	9	18
HIGH DENSITY	2	4
TOTAL	50	100

TABLE 13: DEPARTMENTS WHERE RESPONDENTS WORK AND ADEQUACY OF STAFF

DEPARTMENT	NO. OF RESPONSES	%	STAFF	NO. OF RESPONSES	%
OBSTETRICS	25	50	INADEQUATE	45	90
SURGICAL	13	26	INADEQUATE	5	10
MEDICAL	12	24	TOTAL	50	100
TOTAL	50	100			

TABLE 14: REASONS WHY RESPONDENTS WANT MORE STAFF

REASONS	NUMBER OF RESPONSES	PERCENT
MORE FOR NIGHT DUTY	18	29
HEAVY WORK LOAD	18	29
TO GIVE BETTER PATIENT CARE	15	24
NO RESPONSE	10	15
ALLOW FOR LEAVE	2	3
TOTAL	63	100

TABLE 15: TYPE OF LEAVE RESPONDENTS TOOK IN THE LAST ONE YEAR

TYPE OF LEAVE	NO. OF RESPONSES	%
LOCAL	29	44
MATERNITY	15	22
URGENT AFFAIRS	12	18
VACATION	7	11
OTHER	3	5
TOTAL	66	100

TABLE 16: NUMBER OF RESPONDENTS WHO PRACTISE FAMILY PLANNING

PRACTISE	NO.OF RESPONDENTS	%
PRACTISE	40	80
DO NOT PRACTISE	10	20
TOTAL	50	100

TABLE 17: QUALIFICATIONS OF RESPONDENTS WHO DO NOT PRACTISE FAMILY PLANNING.

QUALIFICATIONS	NO.OF RESPNDENTS	%
REGISTERED MIDWIVES	3	30
ENROLLED MIDWIVES	3	30
REGISTERD NURSES	2	20
ENROLLED NURSES	2	20
TOTAL	10	100

TABLE 18: RESPONDENTS' METHODS OF FAMILY PLANNING

METHODS	NO.OF RESPONSES	%
ORAL CONTRA-CEPTIVE PILL	20	39
INTRAUTERINE DEVICE	17	33
NATURAL FAMILY PLANNING	9	17
NO RESPONSE	3	6
TRADITIONAL	2	3
CONDOM	1	2
TOTAL	52	100

TABLE 19: REASONS GIVEN BY RESPONDENTS FOR NOT PRACTISING FAMILY PLANNING

REASONS	NO.OF RESPONDENTS	%
OTHER	3	30
PREGNANT	2	20
BAD OBSTETRICS HISTORY	2	20
NOT INTERESTED	1	10
WANTING A CHILD	1	10
NO RESPONSE	1	10
TOTAL	10	100

TABLE 20: EFFECTIVENESS OF FAMILY PLANNING METHODS USED BY RESPONDENTS.

EFFECT	NO.OF RESPONDENTS	%
EFFECTIVE	37	92.5
NOT EFFECTIVE	3	7.5
TOTAL	40	100

TABLE 21: TRADITIONAL FAMILY PLANNING METHODS KNOWN TO RESPONDENTS

METHODS KNOWN	NO.OF RESPONSES	%
DON'T KNOW	30	44
WEARING STRING/BEADS AROUND THE WAIST	13	19
ABSTENANCE	9	13.5
BREAST FEEDING	6	9
ORAL ROOTS/ POWDER	4	6.5
COITUS INTERUPTICUS	3	4
RYTHM	3	4
TOTAL	68	100

TABLE 22: COMMONLY USED TRADITIONAL FAMILY PLANNING METHODS.

METHOD	NO.OF RESPONSES	%
STRING/BEADS WORN AROUND THE WAIST	5	50
COITUS INTERUP-TICUS	2	20
RYTHM	2	20
ORAL ROOTS	1	10
TOTAL	10	100

TABLE 23: NUMBER OF RESPONDENTS WHO HAVE USED TRADITIONAL FAMILY PLANNING METHODS

USE OF METHODS	NUMBER OF RESPONDENTS	%	METHODS USED	NUMBER OF RESPONDENTS	%
NO	48	96	ORAL ROOTS	2	67
YES	2	4	STRING AROUND WAIST	1	33
TOTAL	50	100	TOTAL	3	100

TABLE 24: RESPONDENTS' FREQUENCY OF GETTING FAMILY PLANNING CHECK-UPS

FREQUENCY	NUMBER OF RESPONDENTS	PERCENT
EVERY 6 MONTHS	18	36
NEVER	17	34
NO RESPONSE	10	20
YEARLY	4	8
2 YEARLY	1	2
TOTAL	50	100

TABLE 25: RESPONDENTS' REASONS FOR FAMILY PLANNING CHECK-UPS

REASONS	NO. OF RESPONSES	%
TO EXCLUDE COMPLICATIONS	8	30
NO RESPONSE	6	22
ROUTINE CHECK-UP	5	18
AS ARRANGED BY DOCTOR OR NURSE	4	15
TO COLLECT PILL	3	11
WHEN PLANNING FOR BABY	1	4
TOTAL	27	100

TABLE 26: REASONS WHY RESPONDENTS DO NOT GO FOR CHECK-UP AT FAMILY PLANNING CLINIC.

REASONS	NO. OF RESPONSES	%
NO PROBLEM WITH METHOD	6	35
NOT INTERESTED	6	35
NO RESPONSE	3	18
SELF-EXAMINATION	1	6
LONG PERIODS OF AMENORRHOEA	1	6
TOTAL	17	100

TABLE 27: RESPONDENTS' FEELINGS TOWARDS FAMILY PLANNING.

FEELINGS	NO.OF RESPONDENTS	%
HIGHLY FAVOURABLE	30	60
FAVOURABLE	16	32
NO RESPONSE	4	8
TOTAL	50	100

TABLE 28: RESPONDENTS' REASONS FOR FAVOURING FAMILY PLANNING.

REASONS	NO.OF RESPONSES	%
CONTROL POPULATION GROWTH	15	25
BETTER CHILD CARE	15	25
ECONOMICAL	14	23
GOOD HEALTH OF MOTHER	10	17
NO RESPONSE	4	7
CHILD SPACING	2	3
TOTAL	60	100

TABLE 29: NUMBER OF RESPONDENTS WHO KNEW WHY NURSES MAY NOT PRACTISE FAMILY PLANNING

RESPONSE	NO.OF RESPONDENTS	%
NO	24	48
YES	18	36
NO RESPONSE	8	16
TOTAL	50	100

TABLE 30: REASONS WHY NURSES MAY NOT PRACTISE FAMILY PLANNING.

REASONS	NO. OF RESPONSES	%
SIDE EFFECTS OF FAMILY PLANNING METHODS	17	64
TRADITIONAL BELIEFS	2	7
RELIGIOUS CONVICTIONS	2	7
HUSBAND OBJECTS	2	7
DESIRE FOR A LARGE FAMILY	1	4
OTHER	1	4
TOTAL	27	100

TABLE 31: NUMBER OF RESPONDENTS WHO WOULD ENCOURAGE OTHER WOMEN TO PLAN THEIR FAMILIES.

RESPONSE	NO. OF RESPONDENTS	PERCENT
YES	45	90
NO RESPONSE	4	8
TOTAL	50	100

TABLE 32: RESPONDENTS' REASONS FOR ENCOURAGING OTHERS TO TO PRACTISE FAMILY PLANNING.

REASONS	NUMBER OF RESPONSES	PERCENT
BETTER CHILD FEEDING AND CARE	23	30
GOOD HEALTH, PROFESSIONAL DEVELOPMENT	19	25
CHILD SPACING	17	22
ECONOMICAL	8	11
HAPPINESS IN THE FAMILY	3	4
OTHER	3	4
NO RESPONSE	3	4
TOTAL	76	100

CHAPTER 6

DISCUSSION, NURSING IMPLICATIONS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

1. DISCUSSION OF FINDINGS

The results of this study are based on the analysis of responses from fifty (50) qualified nurses who were included in the sample. The aim of the study was to determine family planning practices among qualified nurses.

All respondents were female; the majority (38 percent) were aged between 23 and 28 years, 36 percent were aged between 28 and 33 years, 12 percent between 33 and 38 years, 10 percent between 18 and 23 years while the minority (4 percent) were aged between 38 and 43 years (table 1 p. 43). The majority of nurses in the sample are young women and are thus in the reproductive years of their lives which Myles (1979) has identified to range from 15-49 years. Also, the nurses in the study are relatively junior in the profession.

The sample consisted of registered and enrolled nurses. Table 2 p. 43 shows that 30 percent were registered nurse/midwives, 30 percent were enrolled nurses, 20 percent were registered nurses and 20 percent were enrolled nurse/midwives. The sample required equal representation of the

two categories of nurses so that findings could be representative of the two groups of nurses.

The majority of the nurses (96 percent) as shown in table 3 p. 43 were married while only 4 percent were single. The U.T.H. has a large percentage of married nurses for many reasons. Firstly, Lusaka being the capital city has many industries and the largest single population in the country, hence, many nurses are married here. Secondly, married women work where their husbands are. As a result it is Government policy that these women cannot be transferred to other hospitals even if there were critical shortages in other hospitals.

Table 4 p 44 shows that most respondents (62 percent) had children below 5 years. This is a reflection of respondents' ages in table 1. Most of them are young and sexually active desiring to raise a family soon after marriage. Children under 5 years demand constant care and supervision from their parents particularly the mother. Therefore, it would seem that most nurses in U.T.H. are required to be with their young children most of the time. This may take them away from work creating shortages of staff. Thirty-eight (38) percent of respondents had children above 5 years, most of whom are above 33 years old.

Most respondents (table 5 p. 44) had male and female children (42 percent). Respondents who had female children only were 36 percent, while those with male children only were 22 percent. Nurses with single sex children could probably desire to have more children in an effort to get children of both sexes, which may lead to frequent pregnancies. Kayembe (1983) made a similar observation in Zaire where families with single sex children tried for the other sex and in so doing they ended up with large families.

Fortunately, most nurses (72 percent) in the sample (table 6 p. 44) planned the births of their children. This is important as they should be role models to their clients of the health education on family planning they give to the public has to be a reality. As such it would be assumed that most nurses readily give advice on importance and advantages of planning the births of children to their clients. Only 28 percent of nurses in the sample did not plan the births of their children.

However, the reasons for the majority of nurses deciding to plan the births of their children are rather personal (Table 7, p. 44). The reasons given range from concern about the child's growth to nanny problems. These were to allow proper growth of children (25.5 percent, economic reasons

(21.2 percent), other uncategorized reasons accounted for 15 percent. Ten point six (10.6) percent planned the births of their children because they were in some form of studies and 4.2 percent experienced problems with getting help with the care of the children. Kayembe (1983) attributes this to the fact that families in the urban areas assume full responsibility for their own children rather than relying on support from the extended family. The varied reasons given by respondents for planning the births of their children relate to economic factors. This indicates that the nurse is fully aware of the current inflation in the country and is concerned with the well-being of her family, as such, she plans to have children that she can adequately provide for in terms of education, clothing and food. The meagre nurse's salary cannot meet all her economic needs, more so, if she had many children. Eight point five (8.5) percent of respondents did not respond to the question.

Table 6 also shows that 28 percent of respondents did not plan the births of their children. The reasons given in table 8, p.45 are varied. Twenty-nine (29) percent conceived before resuming menstruation following the birth of the previous

baby. Twenty-one (21) percent of respondents did not plan the births of their children because they have irregular periods or long periods of amenorrhoea. This group of nurses would benefit from the use of some form of contraceptive method for example, the pill, as it is known to regulate menses. Surprisingly, nurses who are supposed to be knowledgeable seem not to know this aspect. Husbands who refused their wives to plan the births of their children accounted for 14 percent, seven (7) percent of respondents did not plan the births of their children because they were not married. This is not a good reason as single women are also at risk of falling pregnant and that is why family planning services are free to all. If single nurses do not plan the births of their children, they may be inclined to discourage single clients from practising family planning. Twenty-nine (29) percent of nurses did not respond to the question probably because of the personal and private nature of information sought.

Most nurses (Table 9, p. 45) had live children (90 percent). Only 10 percent of respondents lost a child at one time or other. Table 10, p. 45, shows that 66 percent of respondents had no previous abortions, 28 percent had up to three abortions often two occurring in one year. Probably this

is the reason why nurses do not have frequent pregnancies since losing a child or pregnancy is seldom so they are more careful about an early pregnancy since they have to care for a young child. Gerety (1975) says that frequent pregnancies are associated with high infant mortality.

Table 11, p. 46, shows that nurses in the sample are members of many churches. The Roman Catholic and United Church of Zambia were in the majority with a membership of 24 percent each. The Evangelical Church had 20 percent, the SDA and Anglican Church had 10 percent each. Six (6) percent belonged to the Jehova's Witnesses Church while 10 percent of respondents did not respond. The variety of churches where nurses are members maybe attributed to the freedom of choice of religion enjoyed by Zambians.

The majority (44 percent) of nurses in the study (Table 12, p. 46) live in low density residential areas followed by 34 percent who live in medium density areas and 4 percent in the high residential areas. Eighteen (18) percent of nurses did not respond to the question. It may seem that most nurses are in the middle to high income groups

(78 percent) because of their husbands who earn more than the nurse to warrant to live in medium or low density areas. Otherwise very few nurses in senior administrative posts would be accommodated in low density areas.

Fifty (50) percent of the sample (Table 13, p.46) worked in the Obstetric Department, 26 percent worked in the Surgical Department and 24 percent worked in the Medical Department. However, the majority (90 percent) complained that they were short staffed and needed extra personnel. Reasons given by respondents (Table 14, p.47) for wanting more staff included the need to have more staff on night duty, (29 percent), heavy work load in various departments (29 percent), nurses desire to give better patient care (24 percent) and to allow staff gto go on leave (3 percent). Shortage of nursing staff is evident in health institutions, therefore, nurse administrators have a task to adequately staff health institutions. Jellife and William (1974) have also identified shortage of qualified personnel in health institutions as one of the constraints affecting the delivery of health services in developing countries. On the other hand, some wards are satisfied with the number of staff in their wards (10 percent) and

did not want extra staff. Fifteen (15) percent of respondents did not respond to the question.

All respondents had taken some type of leave during the previous year (Table 15, p. 47). Forty-four (44) percent took two weeks local leave, 22 percent went on maternity leave ranging from one to six months, 18 percent had taken urgent affairs leave of up to one week at a time, 11 percent took vacation leave of up to two months. Five (50 percent took other types of leave for example, study leave.

Table 16, p. 47, shows the number of respondents who practised family planning (80 percent) - including high acceptance of the service. This also indicates that nurses will be effective teachers of family planning. Kibaki (1983) also made a similar observation on teaching the community. He said that individuals who practise the service turn out to be effective teachers of the same service. Only 20 percent of the respondents were not interested in family planning.

Table 17, p. 48, shows that nurses who did not practise family planning were both enrolled and registered nurses. Thirty (30) percent were

registered midwives, 30 percent were enrolled midwives, 20 percent were registered nurses and 20 percent were enrolled nurses. Infact 60 percent of the nurses who did not practise family planning were midwives. Therefore, hypothesis number 2 which says "Registered nurses practise family planning more than enrolled nurses" is rejected. Since the sample was too small to make generalization,it can be assumed that one's nursing qualification does not influence her decision to practise or not practise family planning.

Respondents used mainly modern family planning methods (Table 18, p. 48). The pill was most popular (39 percent) followed by the intra-uterine contraceptive device (IUCD) (35 percent). Earlier studies revealed the same picture for example, that done by Bahl (1976) on contraceptive use in Lusaka. The pill was favoured most followed by the I.U.C.D. In the study the nurses who used the condon were found to have failed with other family planning methods. The use of natural family planning is becoming increasingly popular. In the sample, 17 percent of nurses used it. This could be due to the fact that it has minimal side effects as compared to the other methods. It also fosters unity between couples since it demands co-operation of both husband and

wife in its use. Three percent of respondents used traditional methods and 2 percent used the condom.

Reasons given in Table 19, p. 48, by respondents for not practising family planning were varied. Thirty (30) percent said they were sterilized or the husbands were jealousy. This indicates that nurses are unwilling to go against their husbands' words as it would threaten their security in marriage. Therefore, hypothesis number 3 which says "A nurse's decision to practise or not practise family planning depends on her security in marriage" is neither accepted nor rejected. Twenty (20) percent of respondents did not practise family planning because they were pregnant while an equal number did so because they had bad obstetric history. Ten (10) percent of nurses were not interested in family planning. These nurses may not advise their clients effectively on the use of the same. Few nurses (10 percent) stopped family planning because they were ready for another child. This is a reflexion of reasons in Table 7 why nurses practise family planning, which are mainly economical. Bahl (1976) also stated that the decision to have a large family depends on the family income.

Current inflation has contributed to families' decisions to have smaller families. The reasons

given by nurses for not practising family planning could be the same reasons other women have for shunning family planning. This means that nurses have to work hard and motivate the community to use family planning through health education.

The majority of methods of family planning used by nurses were effective (92.5 percent) and only 7.5 percent were ineffective as shown in table 20, p. 49. This can be attributed to the fact that most respondents (39 percent) used the pill (Table 18) which has 98 percent effectiveness (Mtoro, 1981) if correctly used. Failure of the method was observed among I.U.C.D. users in the study. Forty-four (44) percent nurses revealed that they were not conversant with traditional family planning methods (Table 21, p. 49). This is reflected in Table 18 where only 2 nurses use traditional family planning methods. Ignorance of the method among nurses in the sample could be that they are young and have been brought up in urban areas where they may not have been socialized to traditional methods of family planning. Soejarto (1980) says medicinal roots used in controlling births of children is a secret known only to a few elderly men and women. Nineteen (19) percent of respondents mentioned wearing of a

medicated string or beads around the waist, 13.5 percent knew of abstenance, 9 percent knew of breast feeding, 4 percent mentioned coitus interrupticus and 4 percent named the rythm method.

Fifty (50) percent of respondents identified wearing a medicated string or beads around the waist as the commonest traditional family planning method used (Table 22, p. 49). Coitus interruptiCus accounted for 20 percent, rythm method 20 percent and oral roots, 10 percent.

The majority of respondents (96 percent) had never used traditional family planning methods. Only 4 percent had used the method before (Table 23, p. 50). The methods used were oral roots (67 percent) and medicated string around the waist (33 percent). The majority of nurses do not know about traditional family planning methods, which could also be the case with other women in the community, particularly in the urban areas where modern family planning is easily available. Nevertheless, it has been observed that even modern family planning is underutilised. So, if traditional family planning methods are not used, then there will be rapid population growth; maybe this is why Zambia has a high population growth of 3.1 percent per annum.

Table 24, p. 50 shows that 36 percent of nurses had family planning check-ups every 6 months. Thirty-four percent never attended family planning check-ups, 20 percent did not respond, 8 percent had yearly check-ups and the other 2 percent consulted a doctor every two years. The apathy shown by nurses in getting family planning check-ups could be due to lack of understanding of the importance of this aspect of family planning. Such nurses may not advise their clients on family planning check-ups.

Reasons given (Table 25, p. 50) for attending family planning check-ups were varied. Thirty (30) percent consulted a doctor to exclude complications associated with the method of family planning used, especially the pill and loop. Twenty-two (22) percent did not respond, 18 percent went for the service to have a periodic routine check-up, 15 percent saw the doctor because the doctor or nurse asked them to do so, 11 percent did so only to collect the pill and 4 percent sought doctors advice when they wanted another child. Nurses who never have check-ups seem not to understand the importance of such a service especially that they are sexually active. This is confirmed by responses such as "having a check-up because the doctor made such an arrangement". It would seem that clients served by such

nurses will not be informed about the importance of such check-ups.

Thirty-five (35) percent of respondents did not have family planning check-ups because they did not experience any problems with the method of family planning used (Table 26, p. 51). Thirty-five (35) percent were not interested in the service while 18 percent did not respond. Six '6) percent carried out self examination and 6 percent said they experienced long periods of amenorrhoea. These reasons further indicate that nurses do not understand the need for family planning check-ups. Infact it is not possible for one to conduct a complete self examination. Besides, the action raises a lot of ethical and probably moral questions. Nurses who experience long periods of amenorrhoea actually need the check-ups.

Feelings expressed by nurses towards family planning were positive (Table 27, pp.51). Sixty (6) percent had highly favourable feelings, 32 percent expressed favourable feeling and 8 percent did not respond. The positive attitude could be attributed to the educational level which (Okediji, 1968) identified as a reason for women to have favourable attitudes towards use

of contraceptives for family planning. It would be expected that the community served by such nurses would be highly motivated to use the service. Unfortunately, this is not the case, family planning is being under-utilised in most health centres in the country, resulting in rapid population growth and the associated socio-economic problems.

Table 28, p. 51, gives reasons why respondents favour family planning. They were control of population growth (25 percent),better child care (25 percent) and economic reasons (23 percent). Seven percent did not respond to the question. It would seem that nurses are concerned with the rapid population growth and have recognised the need to limit its growth. This is an important factor in the country's socio-economic development. Kessler and Standly (1978) have also stated that limiting population growth is an important factor in the country's socio-economic growth and development.

Forty-eight (48) percent of respondents did not know why other nurses may not practise family planning, 36 percent had ideas and 16 percent did not respond to the question (Table 29, p. 52).

Most respondents (64 percent) identified side effects of family planning methods as the major reason why nurses may not practise family planning, (Table 30, p. 52). Therefore, hypothesis number 4 which states, "Knowledge of side effects associated with methods of family planning influences the use of contraceptives among nurses", is accepted. Geraty (1975) also identified side effects of contraceptive methods as a major cause of declining use of family planning; particularly if future fertility is threatened. Traditional beliefs, religious convictions and objecting husbands each had 7 percent respondents. This shows that these reasons have some effects on the nurses' choice of family planning method. Kessler and Standly (1978) also identified the same factors. Therefore, hypothesis number 1, which states that "Religious convictions and beliefs interfere with nurses' choice of family planning methods is neither rejected nor accepted because the figures were insignificant. Four (4) percent of respondents may not practise family planning because they want large families while other reasons (uncategorized) were also 4 percent. The reasons

given by nurses for not practising family planning have been documented by other writers. For example, Bhiwandiwala and Minor (1983) identified adverse rumours about the method, religious opposition and lack of physical examination and and full explanation.

The majority of respondents (90 percent) said they would encourage other women to plan their families Table 31., p. 52). Eight (8) percent did not respond and only 2 percent would not encourage family planning because of the side effects of modern family planning methods some of which respondents had experienced. This is a biased reason as it is based on unpleasant experiences only. This may be transferred to the clients getting advice from such a nurse.

Reasons given for encouraging other women to practise family planning were mainly economic in nature (Table 32, p. 53). Similar reasons were given by nurses for planning the births of their children and for practising family planning. Thirty (30) percent advocated for better child feeding and care which is possible with a small family. Twenty-five (25) percent said mothers

need good health and professional development. This could mean that nurses strive towards reaching self actualization and contribute effectively to national development. Twenty-two (22) percent would encourage other women to practise family planning because it enables couples to space the births of their children. Bahl (1976) in Lusaka in a study on Knowledge, Attitudes and Practise of Family Spacing found the same reasons why women practise family planning. Other reasons given by respondents were economic reasons (11 percent), 4 percent thought that family planning enhances happiness in the family; 4 percent gave other reasons such as allowing mothers to study while 4 percent did not respond.

2. NURSING IMPLICATIONS

Though the Zambian Government has no health policy on family planning, it actively supports the service by allowing the Planned Parenthood Association of Zambia to use its health institutions for issuing contraceptives to users. There is need for nurses to be well versed with all aspects of family planning so that they can be effective teachers to the community. Every interaction with the community should be utilized as

a teaching/learning opportunity in order to encourage more people in the childbearing group to effectively make use of family planning facilities. This will go a long way to reduce the present high birth rate 3.1 percent annually, Generally, it is expected that nurses act as role models to the community, teach them and motivate them to practise family planning. Bahl and Chanda (1976) say that the community is not well motivated to use the service. This indicates that there is need to re-educate the nurses on the importance of family planning in order for them to make an impact on the community and change their attitude towards family planning. Such a move should include prospective nurses in basic nurse education and training schools and students undergoing post-basic programmes. In-service facilities should also be utilized to update nurses' approaches to teaching family planning.

Most nurses do not have family planning check-ups. Those that do, do not seem to know the importance of the service though they are expected to be knowledgeable. Nurses who do not appreciate family planning check-ups will most likely forget or even discourage their clients to use the service. Such a development will adversely affect effective health education of the community on family planning. There is needd therefore to

to re-educate nurses on the importance of this service through in-service programmes and seminars.

Generally the questions asked to collect data were not all answered especially those that were important in determining nurses' family planning practices. This apathy could have been due to lack of understanding and appreciation of research among nurses, which is a relatively new concept in Zambian Nursing. Such an attitude by nurses make it difficult for the few researchers to collect data that will help find solutions to the numerous nursing problems. Research will also help the nurse develop professionally. There is need therefore, for basic research to be introduced early at basic nursing programmes and in-service programmes.

3. CONCLUSIONS

The study sought to determine family planning practices among qualified nurses. The study revealed that most nurses practise family planning. Many nurses identified economic reasons for limiting the size of their families. It was also found that most nurses do not have family planning check-ups - an indication that they do not understand the need for the service. The few nurses who have periodic family planning check-ups do not seem to know why they do so, hence emphasis is not put on the importance of periodic medical examination to their clients: and yet nurses are supposed to play an important role in the community as health educators and counsellors.

4. RECOMMENDATIONS

1. The sample size was too small therefore the findings could not be generalized to the larger population of nurses. The study should be done on a larger scale.

2. There is need to re-educate the nurses on the importance of family planning and and periodic family planning check-ups. This can be done at basic training and through in-service programmes.

3. Routine yearly medical examination for nurses should be re-introduced, so that it serves as a reminder to nurses to have a family planning check-up.

4. There is need to introduce research in the basic nursing programme so that the nurse can be educated on the importance of research. Even when the nurse is not conducting research herself, she assists other researchers to collect data from time to time and she is sometimes the information provider.

5. LIMITATIONS OF THE STUDY

The main limitation of the study is the small sample size compared to the number of nurses at U.T.H. This means that the findings cannot be generalized to the large population.

The other reason is the limited time in which data was to be collected and the study completed for submission to the School of Medicine, Department of Post-Basic Nursing. This meant that the sample had to be made small in order to collect data which could have been analysed within the stipulated time.

The third limitation was financial constraint which to a large extent influenced the sample size in order to minimize printing, typing and binding costs.

The fourth limitation is that the study covered nurses only in one health institution which is the largest and perhaps atypical of other health institutions in the country.

Finally, the reliability of the instrument was not pre-tested and some questions therefore were not critically analysed before execution of the study.

APPENDIX I

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

17th January, 1985

The Nursing Officer,
University Teaching Hospital,
Obstetric Department,
P.O. Box 50001
LUSAKA

Dear Madam,

RE: STUDY PROJECT

I am a student at the University of Zambia in the Department of Post Basic Nursing currently pursuing a course for the Bachelor of Science in Nursing.

I am required to submit a research paper in any selected area as part of course requirement. My area of interest is family planning practices among qualified nurses. I would be grateful if you could permit me to administer a questionaire to nurses in the Surgical Department to enable me to gather information required for the study.

Thanking you in anticipation.

Yours faithfully,

Margaret Chirambo (Ms)

c.c. The Principal Nursing Officer
University Teaching Hospital
P.O. Box 50001
LUSAKA

APPENDIX 2

Ministry of Health
Office of the Chief Medical Superintend.
Department of Surgery & Bioc.
University Teaching Hospital
Private Bag RW 50001
LUSAKA

28th January, 1985

M/s. M. Chirambo,
University of Zambia,
Department of Post Basic Nursing School,
P.O. Box 50110
LUSAKA.

Dear Madam,

RE: STUDY PROJECT

This is in reply to your letter dated 16th January 1985 in regard to the above subject. You are welcome to conduct a research on family planning on the nurses in our department.

I hope you will receive a favourable response. I have meanwhile informed the nurses of your anticipated visit.

Yours faithfully,

E. Munkanta
for/CHIEF MEDICAL SUPERINTENDENT

c.c. The Principal Nursing Officer
University Teaching Hospital
P.O. Box 50001
LUSAKA

/fc

APPENDIX 3

QUESTIONNAIRE

INSTRUCTIONS

1. The study involves family planning practices among qualified nurses.
2. Information you will give is strictly confidential.
3. It is not necessary to write your name on the questionnaire.
4. Please tick (✓) the appropriate answer or write your comments in the space provided.

1. What is your age? Please tick (✓)
   a. Below 18 years
   b. 18-23 years
   c. 23-28
   d. 28-33 years
   e. 33-38 years
   f. 38-43 years
   g. 43 years and above

For official use only

2. What are your professional qualifications?

   a. _____
   b. _____
   c. _____
   d. _____

3. What is your marital status? Please tick (✓)

   a. Single
   b. Married
   c. Divorced
   d. Widowed
   e. Separated

4. How many children do you have

5. What are the ages of your children?

a. 1st child _____

b. 2nd child _____

c. 3rd child _____

d. 4th child _____

e. 5th child and above _____

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8. How many of your children are:-

a. males _____

b. females _____

6A. Did you plan to have the children when you wanted them?

a. Yes

b. No

6B. If your answer to 6A is yes, what are your reasons for planning the births of your children?

a. _____

b. _____

c. _____

d. _____

6C. If your answer to 6A is no, why did you not plan the births of your children?

a. _____

b. _____

c. _____

d. _____

7A. Are all your children alive? Please tick (✓).

a. Yes

b. No

7B. If answer to 7A is no, how many children have died?

_____

8A. Have you had any miscarriages (abortions)?

a. Yes

b. No

B. If yes how many miscarriages have you had?

_____

C. In which year did you have the miscarriage(s)?

_____

9. In which part of Lusaka do you live?

_____

10A. Do you have any religious affiliations?

a. Yes

b. No

B. What is your religion?

_____

11. In which department do you work?

_____

12. How many nurses are in your ward?

_____

13A. Is the number of nurses adequate for ward coverage?

a. Yes

b. No

B. If no, how many nurses would you like to have in your ward?

_____

C. List the reasons for your answers.

_____

_____

_____

_____

_____

For official use only

14. How many times have you been on leave in the last 18-24 months?

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_____ ☐

B. What type of leave did you take? Please tick (✓)

a. Local leave ☐
b. Vacation leave ☐
c. Maternity leave ☐
d. Urgent Affairs leave ☐
e. Any other specify. ☐

_____
_____
_____
_____

C. How long was your leave?

_____ ☐

15A. Do you practise family planning?

a. Yes ☐
b. No ☐

B. If yes, list the method(s) of family planning you use.

a. _____ ☐
b. _____ ☐
c. _____ ☐
d. _____ ☐

C. If no, what are your reasons for not practising family planning?

a. _____ ☐
b. _____ ☐
c. _____ ☐

16A. How long have you used the method(s) of family planning listed in 15B? Give your answer in years.

_____ ☐

B. Have the method(s) been effective?

a. Yes

b. No.

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C. If no, give reasons.

a. _____

b. _____

c. _____

d. _____

17. Which traditional family planning methods do you know? Please list.

a. _____

b. _____

c. _____

d. _____

18. From your observation and experience, are traditional family planning methods widely used?

a. Yes

b. No

B. If yes, list the methods of traditional family planning which are commonly used?

a. _____

b. _____

c. _____

d. _____

19. Have you used any of the traditional methods of family planning?

a. Yes

b. No

B. If yes, which methods have you used before?

a. _____

b. _____

c. _____

d. _____

C. Were the method(s) effective?

a. Yes
b. No

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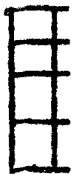
D. If no, give reasons.

a. _____
b. _____
c. _____
d. _____



20. Why did you choose traditional methods of family planning?

a. _____
b. _____
c. _____
d. _____

21. How often do you attend routine family planning check-ups?

a. I do not have check-ups
b. Every 6 months
c. Every year
d. Every 18 months
e. 2 yearly and above

B. Give reasons for your answer.

a. _____
b. _____
c. _____
d. _____

22. Taking into account your educational and professional background, what are your feelings towards family planning?

a. Highly favourable
b. Favourable
c. Unfavourable
d. Strongly unfavourable

B. Give reasons for your response.

a. _____
b. _____
c. _____
d. _____

For official use only

23. Do you know any reasons why nurses may not practise family planning despite that they are knowledgeable about the advantages of family planning?

a. Yes
b. No

B. If yes, list the reasons.

a. _____
b. _____
c. _____
d. _____

24 Would you encourage other women to practise family planning?

a. Yes
b. No

B. Give reasons for your response.

a. _____
b. _____
c. _____
d. _____

Thank you for completing the questionnaire.

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