A SURVEY TO DETERMINE FACTORS THAT INFLUENCE THE UTILIZATION OF MATERNAL AND CHILD HEALTH SERVICES BY NORMAL WOMEN OF CHILD BEARING AGE WITH SPECIFIC REFERENCE TO FAMILY PLANNING

by

SOFIA BLACK

submitted in fulfilment of the requirements for the degree of

MASTER OF NURSING SCIENCE

at the

UNIVERSITY OF SOWETO

Supervisor: Prof A.S.J. van Dyk
November 1995

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Student number: **8637261**

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..... 1995-11-30

SIGNATURE DATE

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SUMMARY

A SURVEY TO DETERMINE FACTORS THAT INFLUENCE THE UTILIZATION OF MATERNAL AND CHILD HEALTH SERVICES BY WORKING WOMEN OF CHILD BEARING AGE WITH SPECIFIC REFERENCE TO FAMILY PLANNING

STUDENT: Sofia Black
DEGREE: Master of Nursing Science
FACULTY: Medical and Health Sciences
University of Namibia
DEPARTMENT: Nursing Science
SUPERVISOR: Prof A.S.B. van Dyk

Family planning is aimed at determining the size of families and effective spacing of wanted children. Thus birth control and child spacing not only becomes a matter of personal concern but takes into consideration the rights of others. By becoming informed about problems experienced with the utilization of family planning services, the health care provider is in a better position to find solutions to these problems.

A descriptive study was done to gather information which is directed at factors that influence the utilization of family planning services by working women in child bearing age. In this study a questionnaire was used to determine factors that influence utilization and non-utilization of family planning services.

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- occupational health services are almost non-existent in Namibia and need to be addressed by health care policy makers;
- family planning services and the distribution of information on these services are not sufficient for working women in Windhoek;
- strategies should be designed to improve the attitude of health providers towards clients so as to improve utilization of health services especially family planning services .

KEY TERMS

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CHAPTER 4 - ANALYSIS AND DISCUSSION OF DATA

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CHAPTER 1

INTRODUCTION TO THE STUDY

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1.1 INTRODUCTION

"Health begins at home" was the theme chosen for World Health Day 1973, on the 25th anniversary of the World Health Organization in recognition of the important role of the family in promoting and protecting the health of its members. In all, from nomads to suburbanites, the family has existed as a fundamental social institution. From the moment a child is born the course of his physical and mental development is determined by his parents and he can never free himself entirely from these early experiences.

The mother and child are not only at the very centre of the family unit, but they are also subjected to special health risks. The care of mothers and children, which includes nutrition and family planning, are important components of family benefits. The health impact of family planning occurs primarily through the following effects on human reproduction:

- the prevention of unwanted pregnancies and births, and the occurance of planned pregnancies
- a change in the total number of children born to a mother
- variation in the intervals between pregnancies (W.H.O., 1970: 1-8).

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Due to the health impact of family planning, interest, both in family planning and services for family planning, have developed rapidly in many countries throughout the world, especially during the past decade. The reasons for providing services for family planning include the improvement of health and the human right of individuals to determine their reproductive performances.

Because overpopulation and hunger have created such a magnitude of problems that affect all living beings, ecological insight forces us to look at life and the environment differently. This is because beyond the questions of survival is the question of quality of life. Family planning is aimed at determining the size of families and effective spacing of wanted children. Thus birth control and child spacing not only becomes a matter of personal concern but also takes into consideration the rights of others.

In a census carried out in 1991 in Namibia it was indicated that the country has a population of 1,4 million people with a growth rate of 3% (UNICEF, 1990: no page indicated). Although the country's population remains a small percentage of the world's population, the current high levels of fertility and mortality give rise to great concern about the region's ability to maintain living standards already attained since independence.

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The provisional census data also showed that about 33% of the population lives in urban areas and that the population density is 1,7 persons per square kilometre. About 60% of the population lives in the northern part of the country. Namibia is, thus, a country with a small population which is sparcely distributed but with a high population growth rate (Census data, 1991).

The census survey revealed a young population structure in Namibia with about 47% of the population being 14 years of age and under, 51% of the population being 15-64 years. This fact has far reaching social, economic and demographic implications for the future development of the continent.

Women of child bearing age and children under five years of age constitute about 40-50% of the entire population of 1,4 million people. This statement makes maternal and child health a very important issue in the delivery of health care in Namibia. According to the World Health Organization, maternal and child health care is a health care approach aimed at protecting and promoting the health of women in child bearing age (15-45 years) and children, particularly those under the age of five years (N.I.S.E.R., 1992: 60).

The services include the following:

- care during pregnancy, childbirth, childhood and adolescence

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- family planning with the aim of ensuring that at least two-thirds of all births are attended to by trained health workers and or traditional birth attendants
- access to essential preventive, promotive and curative care for children which includes immunization, treatment of chronic diarrhoeal diseases, acute respiratory infections and nutrition
- satisfaction of specific needs of women in all health programmes - social support, breastfeeding, nutritional aspects, occupational health aspects of working women (N.I.S.E.R., 1992: 60).

Because of the importance of maternal and child health services and family planning it is one of the major objectives of the World Health Organization and has to be implemented in a health care system both at governmental level as well as in the private sector, based on the primary health care approach (N.I.S.E.R., 1992: 60). Although mother and child health care is such an important aspect of health care delivery, it was reported during the safe motherhood conference held in Windhoek during 1991 that the health and socio-economic status of women and their children were not satisfactory.

The reasons for this are:

- the total fertility rate in Namibia which is estimated at 5,9 while some women have between 5-10 children and even more (UNICEF, 1990: no page indicated).

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- high maternal mortality and morbidity rates due to complications of pregnancy and childbirth;
- inadequate access to health services during pregnancy and delivery;
- poor quality of health services;
- lack of family planning services;
- poor nutritional status of women and
- high teenage pregnancies, abortions and sexually transmitted diseases.

Also in a report made by representatives of the W.H.O. and members of the directorate of primary health care of the Ministry of Health and Social Services during 1989-1990 the health situation of working women in child bearing age and their children in Namibia was pointed out as a major issue. This study has furthermore shown that one third of households in Katutura and Khomasdal are headed by working women who, in most cases, have five or more children, low immunization coverage for children, malnutrition due to the limited income as well as the large family size and unfavourable physical growth of children (UNICEF, 1990: no page indicated).

The above mentioned problems could be due to:

* inaccessibility of available health services to the working mother;
* lack of occupational health services in the industry to cooperate with primary health care services;

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* lack of knowledge of health services rendered so as to utilize it effectively, and
* lack of knowledge on family planning methods.

The concern to this matter has resulted in a proposal from SADCC countries that future strategies should include efforts to improve access to proper quality health services and family planning services and to raise the socio-economic status of women through systematic changes in the nature of policies and allocations of resources (Report on the First National Safe Motherhood Conference, 1991: 1-20).

1.2 STATEMENT OF THE PROBLEM

Uncertainty exists about the effective utilization of family planning services by working women of child bearing age (15-45 years). There are several questions underlying the problem of the study.

The first question is:

ARE THE FAMILY PLANNING SERVICES SUFFICIENT FOR WORKING WOMEN IN CHILD BEARING AGE?

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The report of (UNICEF, 1990: no page included) states that there was a complete lack of "planned rational and coherent public information and education programmes to support family planning services".

Unless a system that ensures efficient utilization of maternal and child health and family planning services exists, little progress is likely to be achieved.

The second question is:

HOW EFFECTIVELY ARE EMPLOYEES AND EMPLOYERS INFORMED ABOUT THE HEALTH NEEDS AND AVAILABILITY OF HEALTH FACILITIES?

Cooperation and dissemination of information is of utmost importance to ensure that findings of national and individual's health surveys reach all individuals concerned.

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Through general conversations with working women, the lack of a family planning service on the side of working mothers as well as on the side of the employer, has been identified by the researcher. Another complaint which was raised was that of rigidity of the employers who were more interested in productivity and time losses when employees were allowed to visit health facilities while they are supposed to be on duty. The above-mentioned could also be due to lack of effective health education programmes.

The third question is:

HOW MUCH KNOWLEDGE DO THE LAY PUBLIC (WORKING MOTHERS OF CHILD BEARING AGE: 15-45 YEARS) HAVE ON THE METHODS OF FAMILY PLANNING?

Personal interviews with clients in the community has indicated that women have very limited knowledge and information on the different family planning methods. Most of the interviewed women have only used Depo Provera and a few of them contraceptive pills.

Another factor that could lead to limited knowledge on family planning methods is the ignorance of health personnel to reach-out to the community especially those in the child bearing age.

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The last question underlying the problem is:

WHAT IS THE ATTITUDE OF THE HEALTH PERSONNEL IN THE DELIVERY OF FAMILY PLANNING SERVICES?

The use of family planning services seems to be hampered by the fact that the messages put across to women are not always clear on the effects, indications and contraindications of the different methods of contraception. Neither are the health workers, including even those who are trained to provide family planning services convinced to appreciate the health and social benefit of family planning which could form a justifiable basis for their professional practice (UNICEF, 1990: no page indicated).

Some contraceptive methods like injectable Depo Provera were abused in the past and thus gave a distorted impression to clients. Mentioned impressions were carried over to younger generations and the impact there-of can still be observed when interviewing some clients. The limited range of contraceptives especially in third world countries can also contribute to underutilization of family planning services.

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1.3 AIM OF THE STUDY

The aim of this study is to determine and describe the facilities and arrangements available at different industries in Windhoek for working women of child bearing age as well as the factors influencing the utilization of these facilities.

1.4 OBJECTIVES

* to identify available family planning services for working women;
* to determine the attitude of the employer towards the health of employees;
* to determine the knowledge of working women concerning the use of family planning methods;
* to determine the number of working women utilizing family planning services and
* to determine the reasons for non-utilization.

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1.5 SIGNIFICANCE OF THE STUDY

Any health profession has the responsibility to monitor itself in an attempt to improve health care delivery. Since the need for a more effective health educational programme has been identified in different studies, efforts should be made to improve the knowledge of working women as well as that of their employers with regard to health care facilities and how it can be utilized to the best possible effect. Findings of the study could possibly identify the need for the development of an occupational health service in this regard.

1.6 TITLE

A survey to determine factors that influence the utilization of maternal and child health services by working women of child bearing age with specific reference to family planning.

1.7 DESCRIPTION OF KEY CONCEPTS

1.7.1 Factors

Factors means; that, which helps to bring about a result or change (Hornby, et al ,1986: 305).

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That which has an effect on something or has a power to affect it (Hornby, et al, 1986: 437).

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1.7.3 Utilization

To make use of an available service (in this regard a health service) (Hornby, et al, 1986: 948).

1.7.4 Access

Potentiality to be able to use a given health service or set of services even if it is not actually used (Hornby, et al, 1986: 5).

1.7.5 Child bearing age

Age within which women are more likely to conceive and bear children 15 to 44 years also referred to as fertility age (Alcala, 1994: 10).

1.7.6 Family planning

The regulation of the numbers of children and the frequency of births (on a voluntary basis) (McKNorrie, 1985: 102-107).

1.7.7 Maternal and child health services

The field of maternal and child health represents one of the areas of basic preventive health services. It includes promotion of optimal health, of protecting the foetus, infant, child and youth during the period of physical and emotional growth and development, educating parents and children about personal health, disease prevention and child care, of improving nutritional knowledge and nutritional status of mothers and children, of improving the environment in which families live, of making it possible for parents to have the number of children they want and can care for, of preventing handicapping conditions and of promoting and providing care for handicapped children and other children requiring special care, services and protection (Wallace, et al, 1981: 1).

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1.8 DEMARCATION OF THE FIELD OF STUDY

The field of study is maternal and child health services with specific reference to family planning services in Windhoek. The study is limited to women of child bearing age employed in selected registered industries as defined in 3.4.

1.9 REFERENCE FRAMEWORK

Chapter 1 Introduction to the study

Chapter 2 Literature study

Chapter 3 Methodology

Chapter 4 Analysis and discussion of data

Chapter 5 Summary of findings, conclusions, limitations and recommendations

1.10 CONCLUSION

The foregoing chapter gives an explanation of the problem underlying this study. The status of family planning services in Namibia was discussed briefly and the purpose and objectives of the study, as well as the significance, was stated.

Finally, the field of study and reference framework were mentioned. In the light of the above-mentioned, the following chapter will be devoted to the historical background of family planning services as well as some different views and uses with regard to family planning.

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CHAPTER 2

LITERATURE STUDY

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CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION

This chapter presents a review of selected literature relating to mother and child care with specific reference to family planning services available to working women of child bearing age.

The literature study was undertaken with the view to:

* identify previous research done in relation to the subject;
* obtain some diversal and universal views of researchers and leading authors on the topic and
* obtain methodological suggestions for the actual conduct of the investigation.

A search for relevant literature has been undertaken with the assistance of the librarian of the University of Namibia. In order to retrieve the literature concerned, the following key aspects were used:

* mother and child health care;
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The list of sources related to the topic was obtained from the library of the University of Namibia. In addition, the references listed at the end of articles and bibliographies of different textbooks were used to seek literature which focused on the areas related to this study.

Information on maternal and child health services and research into this field in Namibia is limited. However, attempts have been made in recent years especially between 1989 and 1995 to establish a sound health information system on this issue.

In the literature study the following aspects were covered:

* Historical overview
  - Development of family planning services;
  - Development of occupational health services;
* Fertility and contraception;
* National family planning policy and legality of family planning;
* The extent of family planning services;

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2.2 HISTORICAL OVERVIEW

2.2.1 The development of family planning services

The idea of contraception and contraceptive knowledge dates back to some ancient practitioners like Aristotle, Pliny the elder, Aetius, Dioscorides, Soranus and Callius Aurchanu. Although contraceptive methods were primarily from Islamic sources it was refined and developed in Europe during the nineteenth and twentieth centuries.

Between the seventh and nineteenth century, medical theory, education and practices were controlled by the Roman Catholic Church and contraceptive practices were, thus, not heard of since the church did not approve of such practices. Another reason why contraceptive development and practices were neglected until the nineteenth century was insufficient physiological knowledge and research on reproduction and also the vigorous opposition from the British medical association. Some medical practitioners even referred to it as "....beastly" contrivances for limiting the number of offsprings (Peel, J. et al; 1971: 1-5).

The work of the Malthusian League of 1877 was the forerunner of modern birth control. Through this association H.A. Alibut published a booklet entitled the WIFES HANDBOOK in 1887.

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This publication contained information on the prevention of conception through the use of the Mensinga Diaphragm, impregnated sponge, the condom, douching, the Rendell's Quinine, Pessaries and Coitus interruptus. The latter being the most famous yet all these methods were still condemned on an ethical and moral basis and also because of the harmful physical and mental effects.

During the twentieth century attitudes to the birth control question had become a public issue and could not be ignored or denied any longer by the medical profession. Approval of the use of contraceptives in Europe was given in 1916 after the report of the National Birth Rate Commission. Usage of contraceptives then had to be approved by two medical practitioners. During 1930 contraceptives attained a legitimate and permanent place in preventive medicine although the provision of different methods were limited to certain classes of women (Peel, J. et al 1971: 9; Wallace, H.M. et al; 1988: 105-121).

Family limitation in western society started amongst upper-middle class and middle classes but, as the economic advantages of small families became apparent, broader sections of the population started to adopt family planning practices. Since 1896 a wider range of alternative techniques to choose from were offered and research in chemical methods mostly used during mentioned periods were condoms, douches, coitus interruptus, diaphragms, safe period and

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Family planning services were introduced in Namibia in 1971 by the Department of Health of the Administration of South West Africa. Being a politiced issue, it was only permitted to be used in the central and southern parts of the country but only on doctor's prescription. Doctors were issuing standing orders for Depo Provera 450mg, Minipill and Ovulen at provincial hospitals and municipal clinics (Personal interview with Mrs V Tjapepua and Mrs J Kloppers; Booker, M.E., 1980: 13-31).

The demand for these services increased markedly after 1978 and the Administration of South West Africa was forced to send professional nurses to Pretoria, South Africa to be trained in standardized family planning courses. The nurses who were sent away completed their training successfully and came back to implement modern views on family planning. These courses would enable them to prescribe some family planning methods independently from medical practitioners.

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2.2.2 The development of occupational health services

Occupational health care formerly called, industrial nursing began in the late 19th century and paralleled the industrial revolution. The health hazards related to workplace exposures and work conditions resulted in illness and injuries which could mostly be prevented.

The role of the nurse in today's workplace has expanded in scope since it does not only focus on emergency care and treatment of work-related injuries but also on management of the occupational health unit as well as on health promotion, health protection and disease prevention. Today's occupational health nursing services focus on seeking critical answers to difficult questions, resulting in the application of scientifically tested nursing interventions based on nursing research. Although Namibia is not an industrialized country it is not excluded from developing a sound occupational health care system.

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2.3 FERTILITY AND CONTRACEPTION

There are a number of important factors associated with fertility and contraception which have a bearing on maternal and child care. Fertility patterns are influenced to a large extent by socio-cultural norms and preferences for large families predominate, for example where a woman's social status is linked to her role as child-bearer and mother and where a pattern of extended family relationships can only be maintained by continuity in the reproduction of new members (N.I.S.E.R. AND UNICEF, 1991: 70-71).

A few studies on the attitude and use of modern contraceptives in Namibia (Mostert, W., 1989: 1-30, N.I.S.E.R. AND UNICEF 1991: 42; Ahrenson-Pandikow, H., 1992: 19-49, Tapscott, C., 1992: 1-21) revealed that modern birth control methods are not enough in Namibia and that the fertility rate of the population is still at a high level.

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The spread of peoples negative experience, combined with cultural, religious and political opposition to contraceptive methods seems to have reinforced the tradition of large families in Namibia (Ahrenson-Pandikow, 1992: 42).

2.4 HEALTH RISKS AND CONTRACEPTIVE EFFECTIVENESS OF SOME COMMONLY USED FAMILY PLANNING METHODS

2.4.1 Oral contraceptives

According to the (Vessey, M.P., 1981: 65) oestrogens have an effect on established breast cancer while progestogens "oppose" a possible carcinogenic effect of oestrogens. On the other hand, some diseases may be prevented by the use of oral contraception. The pill's protective effects are well demonstrated in studies conducted in America on benign breast tumours, ovarian cysts, iron deficiency anaemia, pelvic inflammatory disease and ectopic pregnancies.

Negative reports though, have been based on populations of women who tended to be older and who had a pregnancy when they began taking the pill. It is possible that young women who have never been pregnant are at a different risk (Vessey, M.P. 1981: 65; WHO 1990: 10-15).

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2.4.2 Injectable contraceptives

There is a growing interest in and demand for injectable contraceptives because of the need of an effective, safe and reversible method that does not interfere with lactation.

The two that have come to be the most widely used as injectable contraceptives are Depo Provera and Nur-Isterate. Injectable contraceptives are particularly useful for couples who have completed their families but are not ready to accept sterilization. It is also useful as a method of spacing for couples planning a birth interval of more than 2 years since fertility return may be delayed by an average of 6 months when the method is discontinued.

The advantages of injectable contraceptives will vary in importance depending on the user, but are highly effective, reversible and relatively long-lasting. Depo Provera may also be of help to decrease the likelihood of iron-deficiency anaemia among women of reproductive age. The major disadvantages are, the probability of irregular bleeding, episodes of heavy bleeding which may require professional attention, as well as the fact, that once administered, the contraceptive effect lasts until the drug has been fully metabolized by the user (Rall, H.J.S., 1988: 1-20; WHO, 1990: 3,4,10,11).

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2.4.3 Condoms, diaphragms and spermicides

Condoms and spermicides, if used correctly, could be highly effective in preventing the transmission of many sexually transmitted diseases like AIDS, Gonorrhoea, Syphillus, Trichomoniasis as well as Pelvic inflammatory disease which can cause infertility (Vessey, M.P., 1981: 83-91).

The potential hazard in using the methods lies in allergy to rubber and some local chemicals which might cause itching erythema on the penis or contact dermatitis in the male and female respectively (Vessey, M.P., 1981: 7, 67-70).

2.4.4 Traditional methods

Traditional methods are slowly disappearing but there is still evidence that some forms of fertility control/regulation are being used.

These are among others:

2.4.4.1 Breastfeeding and Abstinence

Breastfeeding has a clinically contraceptive effect primarily before menstruation returns but its effect and importance is greater when practised together with post-partum abstinence. This method has been used by some cultures in the past but the extent to which it is still used nowadays is unknown (Maine, 1983: 19-20).

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2.4.4.2 Traditional abortificients

Locally available plants have traditionally been used to control fertility. Some of these were used as teas to stimulate the flow of breastmilk. Others had a spermicidal effect while some contained labour-inducing agents and anti-implantation effects (Maine, D., 1983: 21-29).

2.4.4.3 Coitus interruptus

This method is used during lactation and is still in widespread use in many of the African countries (Maine, D., 1983: 21-29).

2.5 THE NATIONAL FAMILY PLANNING POLICY AND LEGALITY OF FAMILY PLANNING

From the seventies until after independence there was no national family planning policy and family planning was exercised on an ad hoc basis at clinics and hospitals. There were limited techniques to choose from and the health personnel at mentioned facilities were also not always sensitive enough to this very important issue.

Due to the vulnerability and problems experienced by mothers and children under five years, maternal and child health services and family planning were considered to be one of the main areas of concern by the Ministry of Health and Social Services.

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This concern evolved from certain factors which include the following:

- long distances to health facilities;
- lack of family planning policy and service guidance;
- limited training on family planning practices;
- shortage of staff;
- lack of counselling services;
- limited range of contraceptive methods;
- fears and rumours associated with contraceptives;
- restrictions on prescription of family planning methods;
- attitudes of health personal and
- traditional beliefs, cultures and attitudes

(National Family Planning Policy Guidelines, 1992).

The above-mentioned factors have led to the compilation of a policy on family planning. The national policy on family planning of Namibia is based on the rights of couples and individuals to decide freely and responsibly on the number of children and spacing, information and counselling on family planning and the means to implement their decisions. Individuality also has to be respected as far as their choices, age and marital status is concerned.

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The above-mentioned factors have led to the compilation of a policy on family planning. The national policy on family planning of Namibia is based on the rights of couples and individuals to decide freely and responsibly on the number of children and spacing, information and counselling on family planning and the means to implement their decisions. Individuality also has to be respected as far as their choices, age and marital status is concerned.

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Although there is no law that enforces family planning on an individual it is advisable that any family planning procedure which involves medical interference should be agreed upon by the sexual partners. It is also the moral and social right of those parties who have interest, as relatives, to be considered in this regard eg. parents/guardians of the mentally handicapped (McKNorrie, K., 1985: 101-103).

Legally and socially medical techniques like contraception, sterilization or abortion designed to prevent or terminate pregnancy or birth are now accepted in varying degrees by the community but contraceptive methods have to be seen as valid in law only when they are contraceptive. Any other procedure/method that acts after a woman becomes pregnant is no longer contraceptive and should be seen as an abortifacient.

Abortificients are only legal when applied according to the Abortion and Sterilization Act No 2 of 1975 which states that "in all cases of proposed termination of pregnancy, certification by two other medical practitioners - i.e. other than the doctor performing the abortion - is required. At least one of them must have practised for 4 years. In the case of the psychiatric indications, one of the certifying doctors must be a psychiatrist employed by the state (Strauss, S.A., 1981: 79).

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Furthermore the use of contraception is an individual choice and no one has a legally protected right to ensure that his or her partner does or does not use contraception. Sterilization, on the otherhand, is seen medically as a more severe form of contraception and might be claimed as denial of the other partners right when individuals are married. By implication this means that education and counselling about all aspects of family planning is important.

2.6 THE EXTENT OF FAMILY PLANNING

To educate the people and to change attitudes it has been found necessary to find the optimum combination of activities, personnel and settings to deliver family planning with other health activities. Some of the most common of these possibilities will be discussed broadly (Omran, A.R., et al, 1981: 1-28).

2.6.1 Family planning and maternal and gynaecological care

The method of combining birth control and post partum care has been used in most hospital-based maternity homes. Family planning methods have been introduced after delivery, foetal deaths and abortion to space pregnancies which are more probable during this period. Health workers providing community maternal and child health services, especially in developing countries, were provided with appropriate training and certain types of contraceptives to distribute among community members.

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This approach seemed advantageous because home deliveries outnumbered institutional based deliveries in most developing countries. Presently this method is widely used in Zimbabwe with success (W.H.O, 1970: 25-26, Mwaluko, G.M.P., 1992: 1-10).

2.6.2 Family planning and child health services

Activities connected with child health services/programmes whether it be growth monitoring, immunization or nutritional activities, may be suitable to be combined with family planning services. This approach can be advantageous because parents might be reluctant to practice family planning as long as they have no assurance that the children they already have will survive in good health (WHO, 1970: 24-25).

2.6.3 Family planning and specific disease control programmes

Some diseases like Tuberculosis, Psychosis, AIDS and some types of Cancers have clinical contraindications to pregnancy since it can be jeopardized by them or they can infect the unborn child. Family planning activities could be combined with these services provided that proper attention is given to either aspects (W.H.O., 1970: 25).

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2.6.4 Family planning and general medical care

Through this approach family planning is advantageously made available to those individuals who prefer not to have it known that they are seeking advice on birth control. It could also be used with success to combat teenage pregnancies (W.H.O. 1970: 25; Lesetedi et al, 1992: 30).

2.6.5 Family planning and community development

Educational programmes for future parents can also help to reduce the incidence of teenage - and out of wedlock pregnancies. Professional health workers can collaborate in good effect with community leaders to initiate educational activities relating to family planning (W.H.O. 1970: 20-30; Vessey, M.P., 1981: 83-91; Mwaluko, G.M.P., 1992: 1-10).

2.6.6 Family planning and occupational health services

There has been a tremendous increase in the number of women in the workforce as there are much more working opportunities which were non-existent a few years ago. Men today are encouraged to work and no longer is the woman's place only at home. This has resulted in a situation where women play a very important role in the labour market.

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Thus, the physiological, emotional and other needs of working women have to be taken into consideration and taken care of by their employers. Very often the employer is the first person to whom the female employee will go to discuss her problems.

It is also true that many women in child bearing age are young and inexperienced, especially when they start working for the first time. Occupational health services could play a useful role with regard to counselling, distribution of information on existing health services, family planning services and how they can be utilized, and how referral to such services is made. The need for occupational health services at all major industries are thus of vital importance (Baker, M., & Coetzee, A.C., 1983: 138-141; Kotze, A.J., 1992: 144-145).

2.7 SOME HEALTH BENEFITS OF FAMILY PLANNING

The important factors associated with family planning influence the outcome of pregnancies, the survival, health and development of children, the survival, health and reproductive potential of the mother within child bearing age and the general well-being of the family (Maine, D., 1983: 1-30).

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2.7.1 Maternal benefits

Mothers with well planned families are usually more healthy than those with large families and too closely-spaced children. Child spacing can protect women in significant ways because illnesses can be detected and treated during visits to the family planning service especially those family planning services which are combined with or linked to other maternal and child health services.

By spacing children, high risk pregnancies and illegal abortion practices can be avoided. Another maternal benefit is that the mother can express herself outside home and take part in social activities while enjoying a normal family life (W.H.O., 1970: 1-17; Maine, D., 1983: 1-30).

2.7.2 General family benefits

Couples have a more relaxed sexual relationship when confident that intercourse will not lead to an unwanted pregnancy. They have the freedom of completing their education which will make a significant difference in the economic future of the family. This again increases a sense of self respect and ensures the ability to provide education, shelter, food, clothing and recreation for the children. Parents who plan their families are also able to set a positive example to their children with regard to their own future reproductive lives (W.H.O., 1970: 1-17; Maine, D., 1983: 1-30).

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2.7.3 Benefits to the children

The likelihood of having birth defects and death before the first birthday is far greater for infants born less than one year before the mother's last pregnancy than for those infants born after a longer period of time. Childhood deaths posed by short birth intervals are also still very common in developing countries.

This could be attributed to the fact that children are displaced from the breast too soon. It can also be due to the decline in the nutritional deficiencies and higher susceptibility to infections caused by low body resistance. Children from larger families or those born too close together often do not do as well in school as others. This is probably because they do not get as much individual attention and simulation as children from smaller well-spaced families (W.H.O., 1970: 1-17; Maine, D., 1983: 1-30).

2.7.4 Benefits to the community

Family planning can benefit the community as a whole in the following ways:

- avoidance of overcrowding and overpopulation since the how, where and when of population growth will be understood better;
- more productive labour force thus;
- economic development and technical progress;

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- reduction of the welfare burden on the community which is caused by high hospital supplies and staff needed to care for uncompleted, septic abortions, high risk pregnancies, ill, malnourished children and mothers
- development plans can be made in relation to the number of people to be served (Maine, D., 1983: 1-30; W.H.O., 1970: 1-17; Booker, M.E., 1980: 1-33).

2.8 THE HEALTH STATUS OF WOMEN OF CHILD BEARING AGE

Ebrahim poses the following question "..... can a woman, subsisting on marginal nutrition, exhausted by repeated childbearing, find the energy to devote to the needs of a young child ...? added to this is the physical exhaustion of daily labour which leaves very little time and energy."

To achieve full-time parenting for their children, working mothers can only give hurried or preoccupied attention and can rarely become closely involved in the child's physical and emotional activities necessary for adequate development (United Nations, 1979: 1-10; Ebrahim, G.T. 1991: 88-89; Grant, J.P., 1992: 88).

In most cases labour hours do not allow mothers to care for sick children or to ensure proper immunization. The responsibility of caring is taken up by other women within the community who sometimes provide poor mother substitutes.

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Due to the colonial ideology of the past and also due to most traditional cultures in Namibia, women are legally and socially inferior to men. This inferiority is, among others, concerned with labour, income, ownership and decision-making powers. Discriminatory practices on the ground of sex are prohibited in the Namibian constitution but in practice little change is taking place (Gonglia, P.A., 1982: 5-20; Garfinkel, I., 1986: 5-43; Ginneken, J.K., 1987: 31-43; Grant, J.P., 1992: 60-80).

2.9 CONCLUSION

In this chapter some aspects of family planning were looked into. Although the existence of different views on the use of family planning cannot be denied, one has to look into the factors which hamper the utilization of these facilities.

By studying available literature on family planning the conclusion is arrived at that it is a very essential component of every health service and has to be strengthened in order to reduce population growth, maternal and child morbidity and mortality. The next chapter will explain the methods used in data collection.

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CHAPTER 3

METHODOLOGY

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3.1 INTRODUCTION

The aim of this chapter is to give an outline of the methods used to gather information for this research.

3.2 TYPE OF RESEARCH

This study is aimed at gathering information which is directed at factors that influence the utilization of available maternal and child health facilities by working women in child bearing age with specific reference to family planning services. The nature of the study lends itself favourably to the survey method. According to Treece and Treece, 1977: 149 the concept "survey" is ..... often applied to research that is broadly descriptive or explanatory.

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The study has been done in the industrial area of Windhoek, Namibia.

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3.4 POPULATION AND SURVEY SAMPLE

The total population is all the working women of child bearing age (15-45 years). Because of the large number of women employed by industries, the financial implications there of and also logistic problems, a sample was selected. It was done firstly by getting a list of registered industries in Windhoek.

Registered industries as used for this study refer to those settings where manufacturing or production of goods takes place. Other industries like commercial banks, hospitals and others were not included in this study since most of them have compulsory group medical aid schemes.

These industries were then contacted by telephone to determine the number of women employed from which all those in child bearing age would be selected. After this information was gathered all industries who employed ten (10) and more women were selected for the study. Thus, sampling by purpose was done. On this basis out of twenty-five (25) industries nine (9) were selected. The research population was identified as follows: There were two hundred (200) women employed in the nine (9) industries. Of these seventy eight (78) were above the age of forty five (45) leaving a target population of one hundred and twenty two (122). It was decided not to take a sample from this group but to include all the one hundred and twenty two (122) as possible respondents.

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TABLE [illegible] MODEL

[illegible]	[illegible]
[illegible]	[illegible]

[illegible] AUTOCORRELATION

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TABLE 1 SURVEY SAMPLE

Industries	Working women of child bearing age at selected industries
1	30
2	20
3	10
4	15
5	15
6	10
7	7
8	10
9	5
Total	122

3.5 DEVELOPMENT OF THE INSTRUMENT

It was decided to make use of a structured questionnaire (see Appendix B, p. 106). The aim of using this method was to give the researcher a fixed scheme according to which similar information could be gathered from all respondents (Bailey, K.D., 1982: 111). This method is also useful to make quantitative comparisons of information gathered.

A short discussion of the questionnaire will be given.

3.5.1 Section 1 Personal data

This is important to determine whether all respondents have the same personal characteristics. Personal data is also important to determine indicators of health status of mothers of child bearing age.

TABLE [illegible] OVERALL

[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
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Closed-ended questions were used in this section for the following reasons:

- it saves time and money;
- the respondents are clear about the meaning of questions;
- complete answers are given and
- closed-ended questions are easier to answer (Bailey, K.D., 1982: 123-124).

3.5.2 Section 2 Data on knowledge and utilization of family planning services

Closed-ended questions were used to gain knowledge on the reproductive history of the mother. One (1) open-ended question was used in this section to determine reasons for not using any family planning method.

3.5.3 Section 3 Data on available services

Closed-ended questions were used to determine the employee's knowledge on available services and also to determine the attitudes of health providers as experienced by the working mothers.

3.5.4 Section 4 The employer's attitude

Information in this section is important to determine the attitude of the employer towards the health of the employee as experienced by the employee.

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3.6 PRETEST

The researcher selected two experienced lecturers from the Community Health Science unit of the Faculty of Medical and Health Sciences as well as the Acting Director from the Primary Health Care directorate of the Ministry of Health and Social Services and a Senior Nurse Manager from Khomasdal Clinic to answer and comment on the questionnaire. This selection was done to ensure that comments could be given from different viewpoints, that is; from the clinical aspect, educational aspect and from a managerial aspect.

During pretesting it was pointed out that since personal data was involved some respondents might refuse to participate, some workers who do not use family planning services may not be very clear on the attitude of the employer while others might not wish to answer questions on the employer since they might fear that such information could threaten their position at work. The researcher also realized that it could be difficult to convince all respondents to take part in the survey because of their unfamiliarity with these types of studies. After the content of the questionnaire was controlled for validity by the above-mentioned individuals some adjustments were made.

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3.7 RELIABILITY, VALIDITY AND ETHICAL ACCEPTABILITY

All evaluation instruments have to fulfil a certain set of criteria from which reliability, validity and ethical acceptability would be determined. These three criteria will, thus, be discussed shortly.

3.7.1 Reliability

One of the major criteria for measuring quality and adequacy of an instrument is reliability. Reliability, according to Polit and Hungler, 1985: 242 "..... can be equated with the stability, consistency or dependability of a measuring tool."

The reliability of the questionnaire used was ensured during the pilot study when the individuals used scored the phenomena in a congruent manner; thus demonstrating a strong relationship between the ratings of each individual used (Polit and Hungler, 1985: 241-246).

3.7.2 Validity

Validity is defined by Polit and Hungler, 1985: 246; Uys et al, 1988: 77 as referring to "the degree to which an instrument measures what it is supposed to be measuring."

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3.7 RELIABILITY, VALIDITY AND ETHICAL ACCEPTABILITY

All evaluation instruments have to fulfil a certain set of criteria from which reliability, validity and ethical acceptability would be determined. These three criteria will, thus, be discussed shortly.

3.7.1 Reliability

One of the major criteria for measuring quality and adequacy of an instrument is reliability. Reliability, according to Polit and Hungler, 1985: 242 "..... can be equated with the stability, consistency or dependability of a measuring tool."

The reliability of the questionnaire used was ensured during the pilot study when the individuals used scored the phenomena in a congruent manner; thus demonstrating a strong relationship between the ratings of each individual used (Polit and Hungler, 1985: 241-246).

3.7.2 Validity

Validity is defined by Polit and Hungler, 1985: 246; Uys et al, 1988: 77 as referring to "the degree to which an instrument measures what it is supposed to be measuring."

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[illegible]

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[illegible] COLLECTION OF DATA

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[illegible] COLLECTION [illegible]

[illegible]

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3.7.3 Ethical Acceptability

The following ethical aspects were taken into consideration:

- permission from the personnel manager of each business to be able to conduct the study;
- the respondents could participate on a voluntary basis. Anonymity and secrecy were maintained at all times as no names were supposed to be submitted;
- the aim of the study was explained to the employer and respondents, and
- the results obtained from the study will be made available to the family planning division of the Ministry of Health and Social Services and on request to participating industries.

3.8 DISTRIBUTION AND COLLECTION OF DATA

3.8.1 First round

Two hundred questionnaires were distributed to the Personnel Managers of the different industries with the request to hand them to working women in the defined category. Only 122 were in this category (15-45), 78 were above the age of 45 years. It was not, at that stage, identified whether the proposed participants could read or write. The return date was set for the end of the second week of May 1994 when only 20 (16,3%) returns were received. This was unacceptable and the second round was introduced.

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[illegible]	[illegible]	[illegible]
[illegible]	12	50

[illegible]

[illegible]

TABLE 2

FIRST ROUND OF RESPONSES TO QUESTIONNAIRE

Industries	Questionnaires out N	Questionnaires back N
9	122	20

3.8.2 Second round

By making an appointment to see all 122 at the different industries, it was established that all possible participants could read and write. The researcher went through the process of how to answer the questionnaire with the participants, explained the purpose of the study and assured the confidentiality of the questionnaires. The first 20 returns were disregarded because of possible misunderstandings. A new 122 questionnaires were distributed and a return date for this round set for the end of the last week of August 1994. It was agreed that all questionnaires would be handed in to the Personnel Managers by that particular date and would be collected personally by the researcher. Only 81 (66,4%) questionnaires were returned.

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[illegible]

[illegible]	[illegible]	[illegible]
[illegible]	12	50

[illegible]

[illegible]

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[illegible]	[illegible]	%
[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
Total	[illegible]	[illegible]	[illegible]

[illegible] DATA ANALYSIS

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[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

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[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	10	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
Total	[illegible]	[illegible]	[illegible]

[illegible] DATA ANALYSIS

[illegible]

TABLE 3

TOTAL RESPONSE BACK ON QUESTIONNAIRES SENT OUT

Response	Woman of child bearing age	%
Questionnaires out	122	100%
Questionnaires back	81	66%

TABLE 4 RESPONSE TO QUESTIONNAIRE

Industries	Women of child bearing age population	Survey sample questionnaires out	Questionnaires back
1	30	30	20
2	20	20	16
3	10	10	8
4	15	15	10
5	15	15	10
6	10	10	7
7	7	7	2
8	10	10	5
9	5	5	3
Total	122	122	81 100%

3.9 DATA ANALYSIS

The data on the questionnaires were edited, coded and made ready to be programmed. The SPSS data analysis programme was used to analyse all data.

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6	10	10	7
7	7	7	2
8	10	10	5
9	5	5	3
Total	122	122	81 100%

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[illegible] CONCLUSIONS

[illegible]

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[illegible]

3.10 CONCLUSION

In this chapter an outline of the following methodological factors were discussed: the study area, population, survey sample, development of instrument, a short discussion of the questionnaire, the pretest, reliability, validity, ethical aspects and data collection. In chapter 4 the analysis of data gathered will be given.

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CHAPTER 4

ANALYSIS AND DISCUSSIONS OF DATA

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[illegible]

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[illegible]

[illegible]

[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

CHAPTER 4

ANALYSIS AND DISCUSSIONS OF DATA

4.1 INTRODUCTION

This chapter presents the analysis, presentation, interpretation and discussion of findings which are based on the information gathered from 81 (N=100%) respondents. Responses to each question are analysed and presented below.

4.2 ANALYSIS AND DISCUSSION OF RESPONSES

4.2.1 SECTION 1 - PERSONAL (BIOGRAPHICAL) DATA

Item 1 - Indicate your age

Table 5 - Age of respondents (N=81)

Age	Frequency	Percentage
15-19	26	32%
20-24	20	24.7%
25-29	19	23.5%
30-34	7	8.6%
35-39	5	6.2%
40-45	4	5%
TOTAL	81	100%

CHAPTER 4

ANALYSIS AND DISCUSSIONS OF DATA

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[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

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[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
TOTAL	[illegible]	[illegible]

Table 5 indicates the age distribution of the respondents. Twenty six (32%) of the respondents fell in the age group 15-19 while 20 (24.7%) fell in the group 20-24. Most of the respondents fell in the age category 15-29 (80.2%) while the age category 30-45 (19.8%) was the lowest. The age at which child bearing begins has numerous demographic consequences as well as important effects on maternal and child health services. High fertility is directly responsible for the high population growth in Namibia. Polit and Hungler (1983: 156) states that the reasons for collecting biographic data is that personal characteristics have been shown to be related to an individuals behaviour and attitude in a given situation and also that it plays a valuable explanatory role in this regard.

Item 2 - Indicate your present occupation

Table 6 - Occupation of respondents (N = 81)

Occupation	Frequency	Percentage
Professional	2	2.5%
Clerical	1	1.2%
Supervisor	10	12.3%
Cleaner	10	12.3%
Saleslady	53	65.4%
No response	5	6.3%
TOTAL	81	100%

[illegible]

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[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
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Table 6 reveals that all the 81 (100%) of respondents have an occupation. By implication it means that they are occupied for at least eight (8) hours per day. Family planning attendance will, in this situation, depend on the employers policy to allow for visits to facilities during working hours or on the availability of family planning services after hours, where these people could be served.

Item 3 - How long have you held your present occupation?

On the above-mentioned questions, the largest percentage of respondents that is, 64 (79%) had held their positions for less than 5 years while 11 (13.6%) indicated that they had held their positions for 5-10 years. Two (2.5%) indicated that they had held their positions for longer than 10 years and 4 (4.9%) did not respond to this question. This implies that 64 (79%) of the respondents are inexperienced workers who need to go a long way before they could be promoted to decision-making positions which would also improve their salaries. Better income could provide a better life. The possibility of falling pregnant could further affect promotion.

Item 4 - Your highest school (Academic) qualification

Responses on this question indicate that 27 (33.3%) have only standard 6 (Grade 8) and 43 (53.1%) standard 8 (Grade 10). Only 8 (9.9%) of the respondents have standard 10 (Grade 12) while 2 (2.5%) indicated something else and 1

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(1.2%) did not respond. The above-mentioned responses imply that most of the respondents fall in the low income group of the population who cannot afford to support a large family. This correlates with the finding in item 3 where 79% of the workers are inexperienced. There is also a relative risk associated with low levels of education and infant mortality (Belsey, M.A., 1993: 20).

Utilization of health facilities is lower for illiterate mothers (N.C.D. 1991: 91). The research findings of item 4 confirm the findings from many developing countries. As a general rule the number of children a couple bears declines as their level of education rises (UNFPA 1991: 13-15). Schooling has a powerful effect on reproductive behaviour, much of it independent of economic characteristics.

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All the 81 (100%) respondents indicated that they can read and write. This means, by implication, that they will be able to read health education slogans, posters and follow health talks.

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[illegible]	[illegible]	[illegible]

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Item 6 - Indicate your marital status

Table 7 - Marital status of respondents (N=81)

Marital Status	Frequency	Percentage
Married	16	19.8%
Single	62	76.5%
No response	3	3.7%
TOTAL	81	100%

According to table 7, only 16 (19.8%) respondents are married, 62 (76,5%) are single and 3 (3,7%) did not respond. This implies that most of the respondents are heading single parent households or are still living with parents. It has been proved in other studies that single parent households (especially those headed by women) are usually poorer than those with both parents present (UNICEF, 1990: no page indicated). These factors contribute to a low quality of life with consequent low nutritional status for both mother and child. The mother with a low nutritional status and low bodily resistance to disease cannot have a normal pregnancy and a normal healthy baby. According to Sellers, P.M., 1995: 1785, this often results in having a low birth weight baby.

The young mother might also be incapable of providing for her children's psychological, social and physical needs, probably because of her immaturity and also due to facing these problems without support from the father.

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[illegible]	[illegible]	[illegible]

Item 7 - What is your income per month?

Table 8 - Respondents income per month (N=81)

Income	Frequency	Percentage
N$ 200-399	24	29.6%
N$ 400-599	10	12.3%
N$600-799	20	24.7%
N$800-999	18	22.2%
N$1000-1199	4	4.9%
N$1200-1399	5	6.2%
No response	0	0%
TOTAL	81	100%

The findings reflected in table 8 reveal that 34 (42%) of the respondents have a salary less than N$500 per month and 38 (46.9%) below N$1000, which means that 88.9% of all the respondents fall in the low socio-economic groups. With reference to the results of item 4 and 5 education is a major factor which determines the level of participation of women in the various sectors of the modern economy.

Item 8 - Indicate your place of residence

Table 9 - Place of residence (N=81)

Residence	Frequency	Percentage
Katutura	32	39.5%
Khomasdal	45	55.6%
Other	4	4.9%
TOTAL	81	100%

[illegible]

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[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
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[illegible]

Table 5 - [illegible]

[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
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[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

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Table 5 - [illegible]

[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]

[illegible]

Table 9 indicates that 32 (39.5%) of the respondents live in Katutura where three community health clinics from the Ministry of Health and Social Services are available while 45 (55.6%) live in Khomasdal where one community clinic is available and 4 (4.9%) live in other areas where only one community health clinic is situated in the city centre. All these clinics function from 08:00 to 16:00 which is, unfortunately, also the time when most industries are functioning. This implies that it is difficult for some workers to attend services if not allowed by their employees to do so during working hours.

Item 9 - Indicate the type of family within your home

Table 10 - Type of family (N=81)

Type of family	Frequency	Percentage
Nuclear	32	39.5%
Extended	18	22.2%
Single Parent	15	18.5%
Other	16	19.8%
TOTAL	81	100%

It was found that 32 (39.5%) of the respondents belong to nuclear families while 15 (18.5%) are single parents who can also be classified under nuclear families. 18 (22.2%) of the respondents come from extended families and 16 (19.8%) from other types of families.

Table 9 indicates that 32 (39.5%) of the respondents live in Katutura where three community health clinics from the Ministry of Health and Social Services are available while 45 (55.6%) live in Khomasdal where one community clinic is available and 4 (4.9%) live in other areas where only one community health clinic is situated in the city centre. All these clinics function from 08:00 to 16:00 which is, unfortunately, also the time when most industries are functioning. This implies that it is difficult for some workers to attend services if not allowed by their employees to do so during working hours.

Item 9 - Indicate the type of family within your home

Table 10 - Type of family (N=81)

Type of family	Frequency	Percentage
Nuclear	32	39.5%
Extended	18	22.2%
Single Parent	15	18.5%
Other	16	19.8%
TOTAL	81	100%

It was found that 32 (39.5%) of the respondents belong to nuclear families while 15 (18.5%) are single parents who can also be classified under nuclear families. 18 (22.2%) of the respondents come from extended families and 16 (19.8%) from other types of families.

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The large percentage of mothers coming from extended families could be attributed to the fact that young mothers are left with few opportunities for education and better employment and end up at home with their parents or relatives, thereby losing part of their independence and responsibility to care for the children.

Item 10 - Indicate how many hours you are away from home each day

In Item 10 of Section 1 of the questionnaire 55 (67.9%) respondents indicated that they are eight hours away from their houses each day, while 21 (26%) indicated that they are away for more than eight hours. Four (4.9%) indicated less than eight hours, while 1 (1.2%) was missing. It is not clear why 21 (26%) of the respondents are longer than eight hours away from their homes.

Item 11 - Indicate whether you have any daycare arrangements for your children while you are at work

On the question "indicate whether you have any child care arrangements for your children while you are working" 31 (38.3%) of the respondents indicated that they have daycare arrangements for their children while 42 (51.9%) said they do not have any daycare arrangements for their children and 8 (9.9%) did not respond to the question.

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[illegible] DATA ANALYSIS AND INTERPRETATION

[illegible] PERSONAL PARAMETERS

[illegible] Table [illegible] Distribution of respondents according to age, gender, [illegible]

Table [illegible] [illegible]

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This implies that children are mostly left to care for themselves without any adult supervision (since only 18 respondents belong to extended families). In addition this affects negatively the psychological and physical support that children so urgently need during childhood. With larger family sizes, older children are given the responsibility to care for the younger ones and, thus, do not get enough time for personal development, recreation and leisure.

4.2.2 SECTION 2 - DATA ON KNOWLEDGE AND UTILIZATION OF FAMILY PLANNING SERVICES

Item 1 - Before you became pregnant for the first time, did your parents or anybody else discuss pregnancy and family planning with you?

Table 11 Discussion of pregnancy or family planning (N=81)

Discussion of pregnancy or Family Planning	Frequency	Percentage
Yes	21	25.9%
No	31	38.3%
No response	29	35.8%
TOTAL	81	100%

The findings illustrated in table 11 reveal that only 21 (25.9%) of the respondents had some kind of information on pregnancy and family planning from parents or other sources.

This implies that children are mostly left to care for themselves without any adult supervision (since only 18 respondents belong to extended families). In addition this affects negatively the psychological and physical support that children so urgently need during childhood. With larger family sizes, older children are given the responsibility to care for the younger ones and, thus, do not get enough time for personal development, recreation and leisure.

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Thirty one (38.3%) did not receive any information at all while from 29 (35.8%) no response was received. This is attributed to the fact that they do not have children yet. This implies a lack in the health information system and also in the social marketing system to disseminate information on family planning.

Item 2 - If "yes" who discussed family planning with you for the first time

Table 12 Respondent's reaction to who discussed family planning with them (N=81)

Who discussed Family Planning	Frequency	Percentage
Parents	16	19.8%
Nurse	7	8.6%
Other	7	8.6%
Missing	51	63%
TOTAL	81	100%

Table 12 indicates that 16 (19.8%) of the respondents got information from their parents while only 7 (8.6%) received information from nurses and 7 (8.6%) from other sources. Fifty one (63%) did not respond to this question. If one could consider the fact that these 51 would have responded if they had any information on family planning, this implies that all 51 (63%) do not have any knowledge on family planning. The fact that less than one third of the respondents received information from the parents implies that most parents are still not convinced to give sex- and family planning education to their children.

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Health workers and especially nurses also apparently neglect their educative role in conveying the message across to the broad population.

Item 3 - Indicate how many children you have

Table 13 - Number of children (N=81)

Children	Frequency	Percentage
1	15	18.5%
2	8	9.9%
3	24	29.6%
4	4	4.9%
5	2	2.5%
6 and more	6	7.4%
No response	22	27.2%
TOTAL	81	100%

It was found that 15 (18.5.%) of the respondents had only one (1) child, 8 (9.9%) had two (2) children, 24 (29,6%) had three children, 4 (4.9%) had four children while only 2 (2.5%) had 5 and 6 (7.4%) or more children. If one considers the fact that the majority (88.8%) of the respondents were in the age category of 15-34 years and only 11.2% in the age category 35-45 years, this implies that they have all given birth to children during their early child bearing age which is 15-45years. Of significance are those who have four to six children. The number of children one has given birth to is directly linked to spacing of pregnancies.

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According to (N.I.S.E.R., 1991: 80), at least three years are needed between pregnancies to regain full health status again after birth. Short spacing attributes to low bodily resistance and a higher maternal and child mortality. An exhausted mother has no energy to care for her baby and young children.

The findings correlate with a fertility survey (Mostert, W., 1989: 1-30) that revealed that women in Namibia start the reproductive process at an early age; the mean age at first birth being 19.5 (N.I.S.E.R., 1991: 81). Lack of child spacing services (Family Planning services) could limit the ability of women to control their fertility and could further determine the extent to which they are at risk during the reproductive years.

Item 4 - Have you ever given birth to a child who was born alive but died later?

On the above question 6 (7.4%) of the respondents have had live children who died later while 46 (56.8%) indicated that they did not have live children who died later. 29 (35.8%) did not respond.

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Item 5 - If "yes" how many?

According to the responses received for item 5, 4 (4.9%) respondents had one live child who died later, 1 (1.2%) had two live children who died later, while 1 (1.2%) had four children who died later. Seventy five (92.7%) did not respond.

Item 6 - Are you pregnant presently?

Only 4 (4.9%) indicated that they are pregnant, 23 (65.4%) indicated that they are not pregnant, while 24 (29.7%) did not respond. The crude mortality rates, especially in developing countries, are greatly influenced by preventable causes like malnutrition during pregnancy, exhaustion due to too short intervals between pregnancies and also low bodily resistance as mentioned above.

Not much is said about family planning in the Namibian Labour Code, but there are clear sections on pregnancy and motherhood. These include working hours which should not exceed 45 hours per week, not more than 12 hours per day for 5 days and not more than 10 hours per day for 6 days for pregnant workers.

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Section 34 of the code states that no one below the age of eighteen years should do night duty and that the pregnant mother is not allowed to work during the 9 (nine) weeks before the expected date of confinement/delivery and 8 (eight) weeks thereafter unless certified by a medical practitioner to do so (The Labour Code No. 6 of 1992: Labour Act 1992).

Item 7 - Have you ever used any method to avoid/delay pregnancy?

Table 14 The use of contraceptives to avoid/delay pregnancies (N=81)

Use contraceptives	Frequency	Percentage
Yes	32	39.5%
No	28	34.6%
No response	21	25.5%
TOTAL	81	100%

Table 14 reveals that 32 (39.5%) of the respondents used some type of family planning method to avoid pregnancy, 28 (34.6%) of the respondents never used any type of family planning method while 21 (25.9%) did not respond probably because they do not have children yet or because they consider it to be private. The findings could be an indication of the factors that influence women not to use contraceptives.

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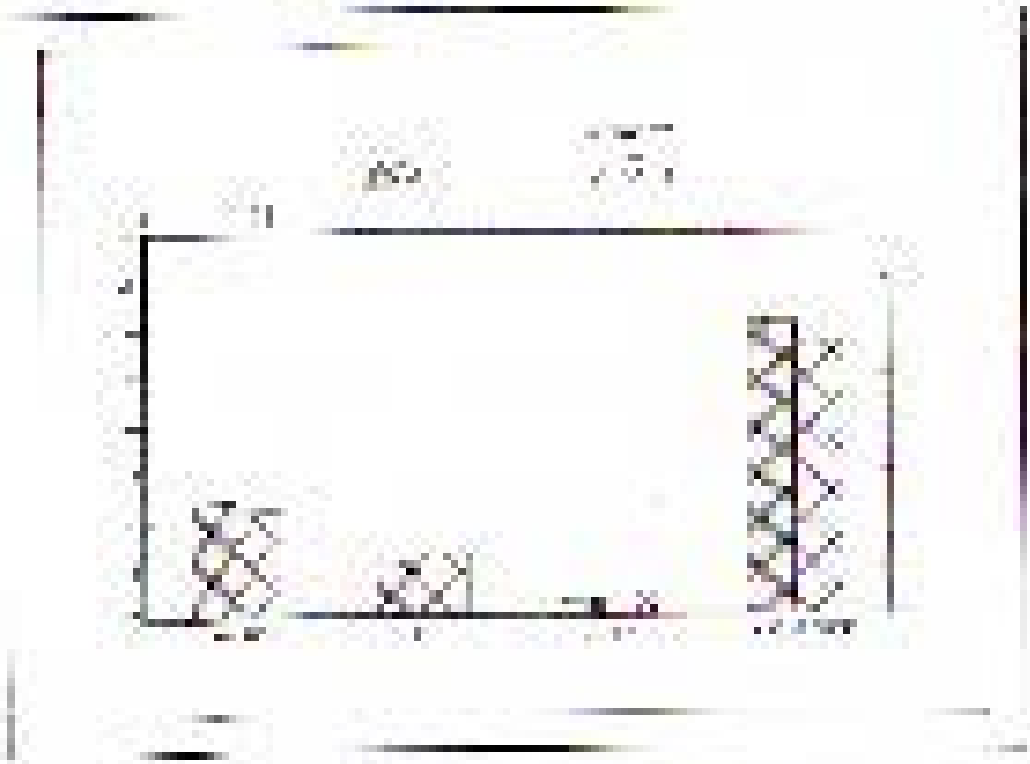

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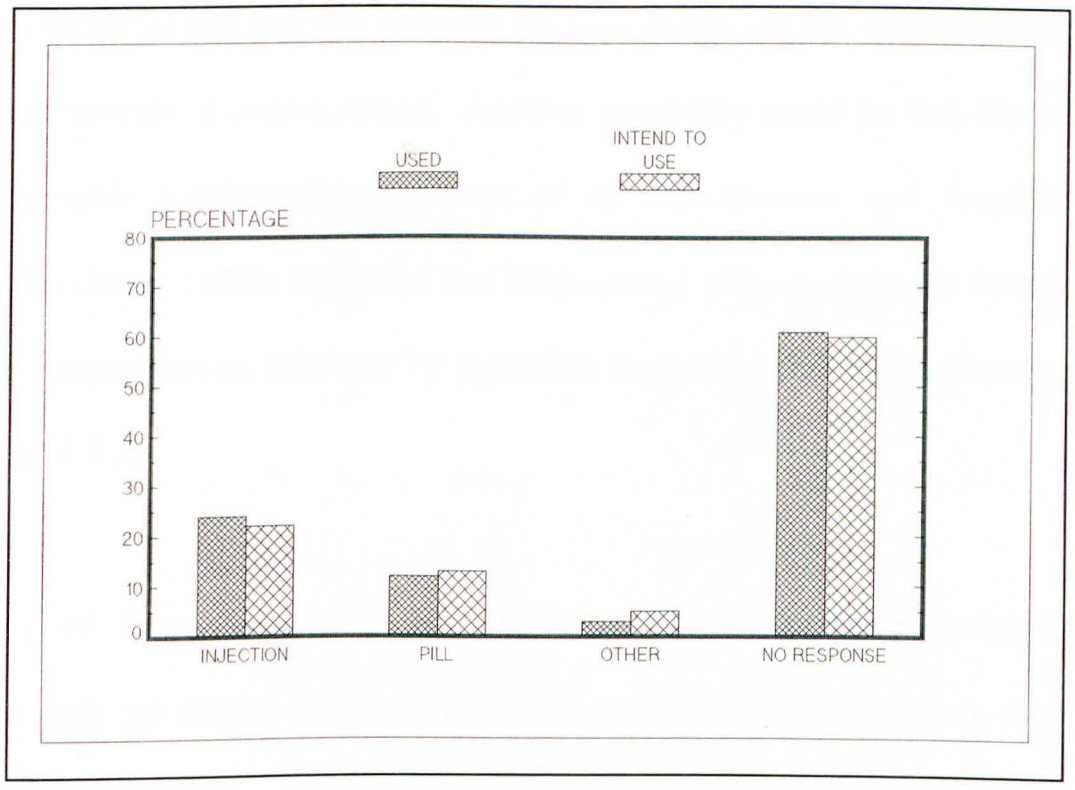
Item 8 - What have you used?

Item 11 - Which method are you using currently?

In figure 1 the different contraceptive methods that have been used by respondents are indicated (Item 8 and 11) as well as the methods they intend to use later.

Figure 1 Different contraceptive methods that are used by respondents (N=81)



According to the responses on these two items it is obvious in Figure 1 that most of the respondents who used contraception 20 (24.7%) or who intend to use it, 18 (22.2%) prefer injectable contraceptives. The Pill is indicated as second choice of contraception (used 10 = 12.3%, intend to use 11 = 13.5%) while other methods are only preferred by (used 2 = 2.5%, intend to use 4 = 4.9%) of respondents.

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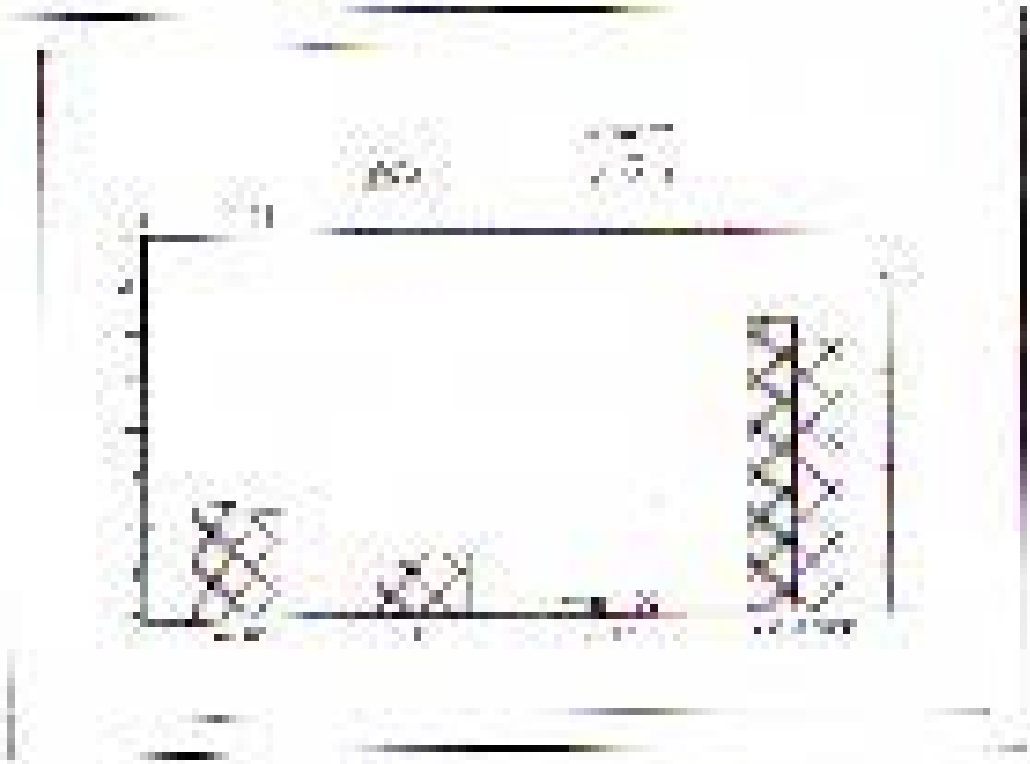

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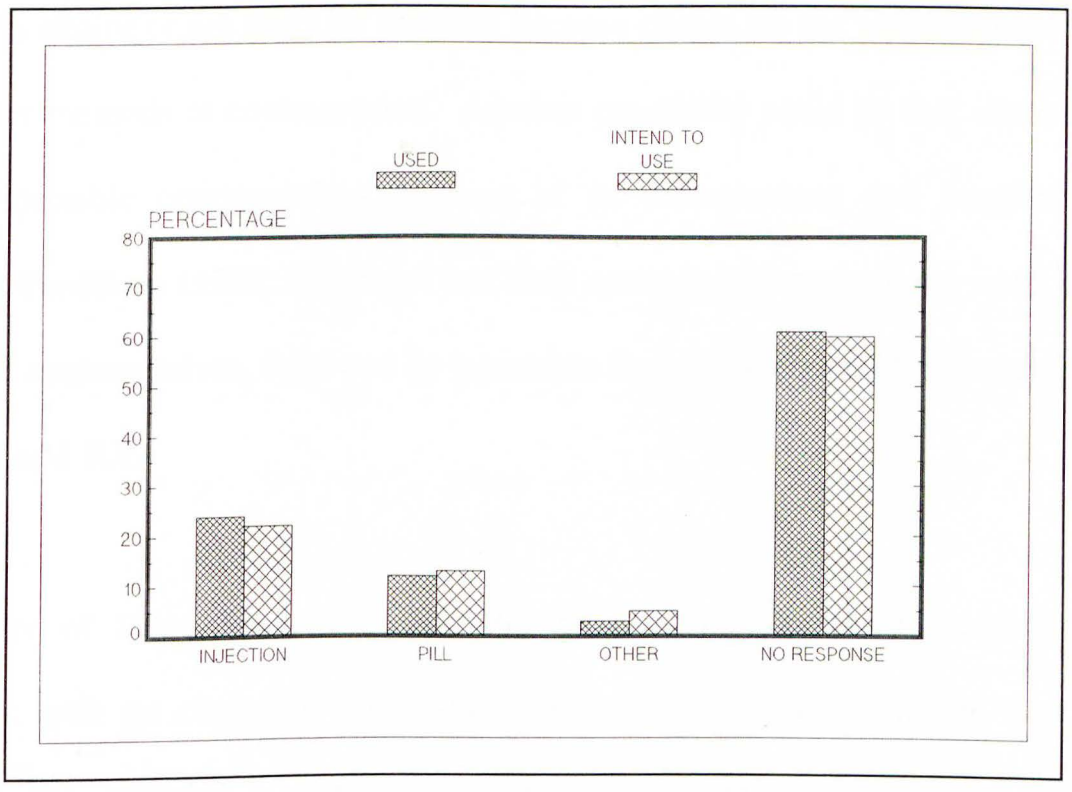

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The reason why so many 49 (60.5%) respondents did not respond could be a matter of ignorance because these age groups are normally sexually active. This needs attention from health care providers.

The preferability of contraceptives as indicated on the figure could probably be caused by the fact that injectable Depo Provera was mostly used in the past whether by choice or not and also possibly because clients are not well informed about other methods of contraception. Another possibility could be that clients choose injectable contraceptives because of its effectiveness and comfort. Ahrenson-Pandikow (1992: 52) found that birth control pills are the most widely prescribed contraceptives, followed by injectable Depo Provera and Nuristerate, Condoms and IUD.

Availability of Depo Provera or the Pill only as contraceptive methods, sometimes with no choice at all, makes access and availability rather than eligibility the criterion. Alternatively irregular supplies to sources of contraceptives and high costs hinder family planning efforts to improve client rates.

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Table [illegible]

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Item 9 - How many living children did you have when you started to use family planning methods?

Table 15 Living children before use of contraceptive (N=81)

Living children	Frequency	Percentage
1-4	24	29.6%
5-9	8	9.9%
No response	49	60.5%
TOTAL	81	100%

Table 15 shows that 24 (29.6%) of the respondents indicated that they had one to four children before they started using any family planning method while 8 (9.9%) indicated that they had five to nine children before using contraceptives. Forty nine (60.5%) did not respond. These findings correlate with those of Tapscott, C., 1992: 1-21 that contraceptives are, in some circumstances, used after health and financial needs are felt.

As most of the respondents have already indicated that they are single parents with limited financial resources, the implications of these responses for urban single mothers could be that most of the income is spent on means to survive. This is in many cases to buy cheap, not always nourishing food, which again adds to malnutrition, low resistance and a high mortality and morbidity rate.

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Table [illegible]

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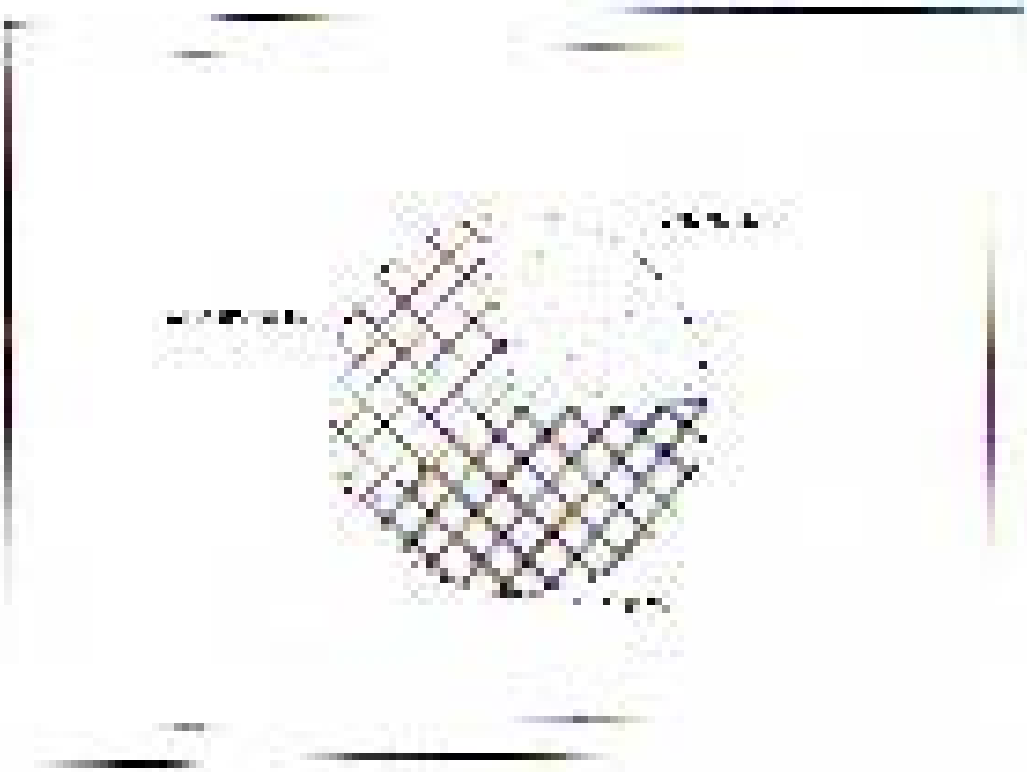

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Item 10 - Are you currently using any method to avoid pregnancy?

Figure 2 Current use of contraceptives (N=81)

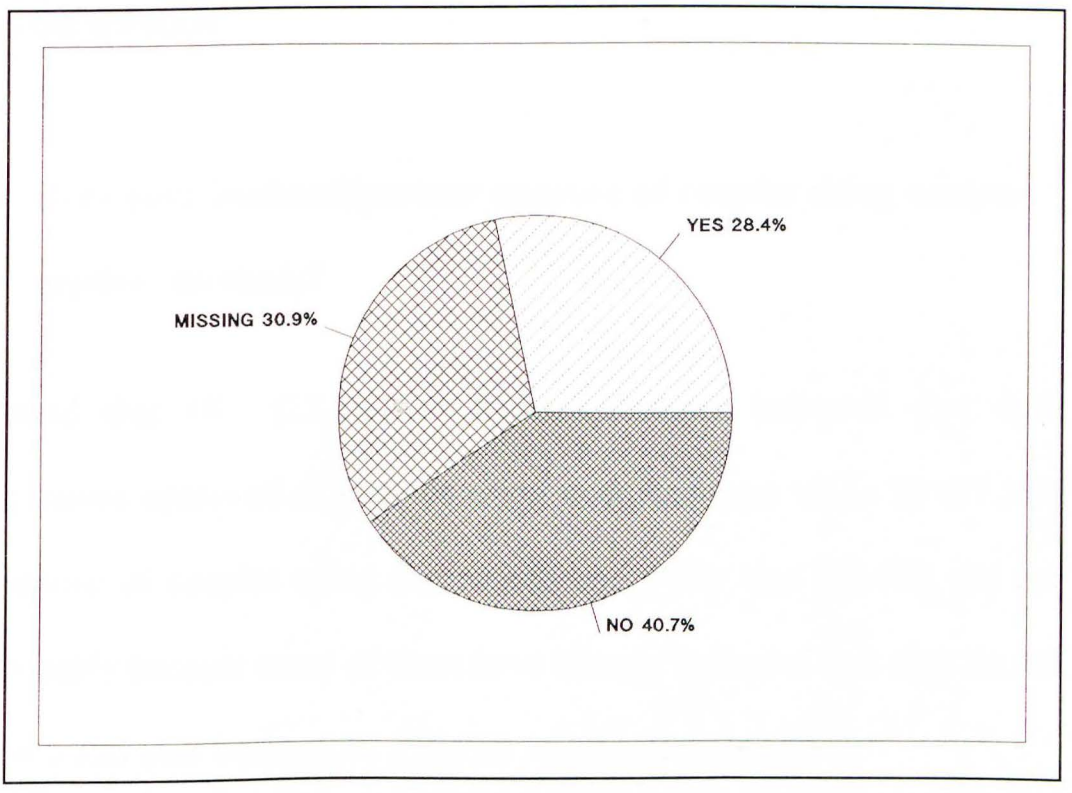

Figure 2 indicates that 23 (28.4%) of the respondents are using contraception while 33 (40.7%) of the respondents do not use any contraceptives 25 (30.9%) did not respond. The latter could again be attributed to the fact that they do not have children yet or because contraceptive methods are unknown to them. It was also found in a study done by Ahreson-Pandikow 1992 that the public, in general, was reluctant to answer questions about their personal experience with contraception or about service facilities in their environment (Ahreson-Pandikow, H., 1992: 41).

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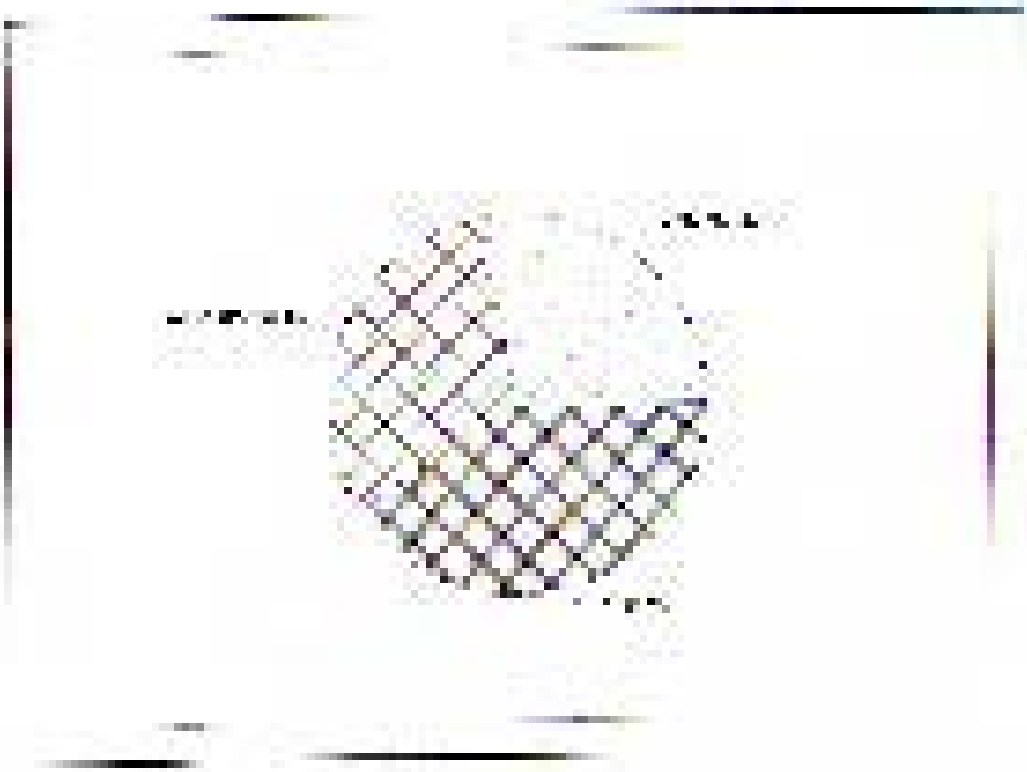

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Item 10 - Are you currently using any method to avoid pregnancy?

Figure 2 Current use of contraceptives (N=81)

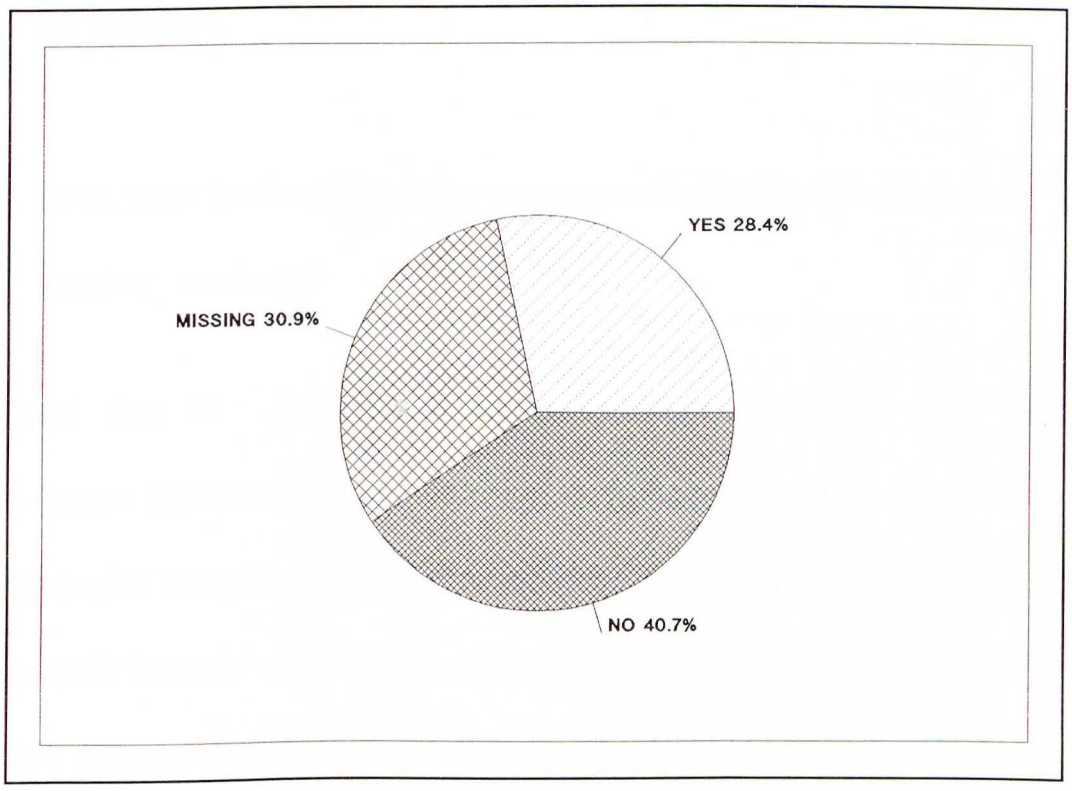

Figure 2 indicates that 23 (28.4%) of the respondents are using contraception while 33 (40.7%) of the respondents do not use any contraceptives 25 (30.9%) did not respond. The latter could again be attributed to the fact that they do not have children yet or because contraceptive methods are unknown to them. It was also found in a study done by Ahreson-Pandikow 1992 that the public, in general, was reluctant to answer questions about their personal experience with contraception or about service facilities in their environment (Ahreson-Pandikow, H., 1992: 41).

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Item 12 - Would you like to have more children?

On the above question 25 (30.9%) of the respondents want more children while 43 (40.7%) do not want children anymore. Twenty three (28.4%) did not respond to the question.

Item 13 - Does your husband/partner approve of couples using contraceptive methods?

It was found that 18 (22.2%) of the respondents indicated that their husbands/partners approved of couples using contraceptives while 22 (27.2%) did not approve of couples using contraceptives. Forty one (50.6%) did not respond probably because some of them have already indicated that they do not have children and also because 62 (76.5%) are single (table 7).

Item 14 - Indicate in not more than (3) three sentences why you are not using family planning methods

On the question that respondents should indicate why they do not use contraceptives (Ahrenson-Pandikow, H., 1992: 55; Tapscott, C., 1992: 22) provided similar information that lack of sex education programmes and information on methods as well as men's negative attitudes are important obstacles to increase the use of contraceptive methods.

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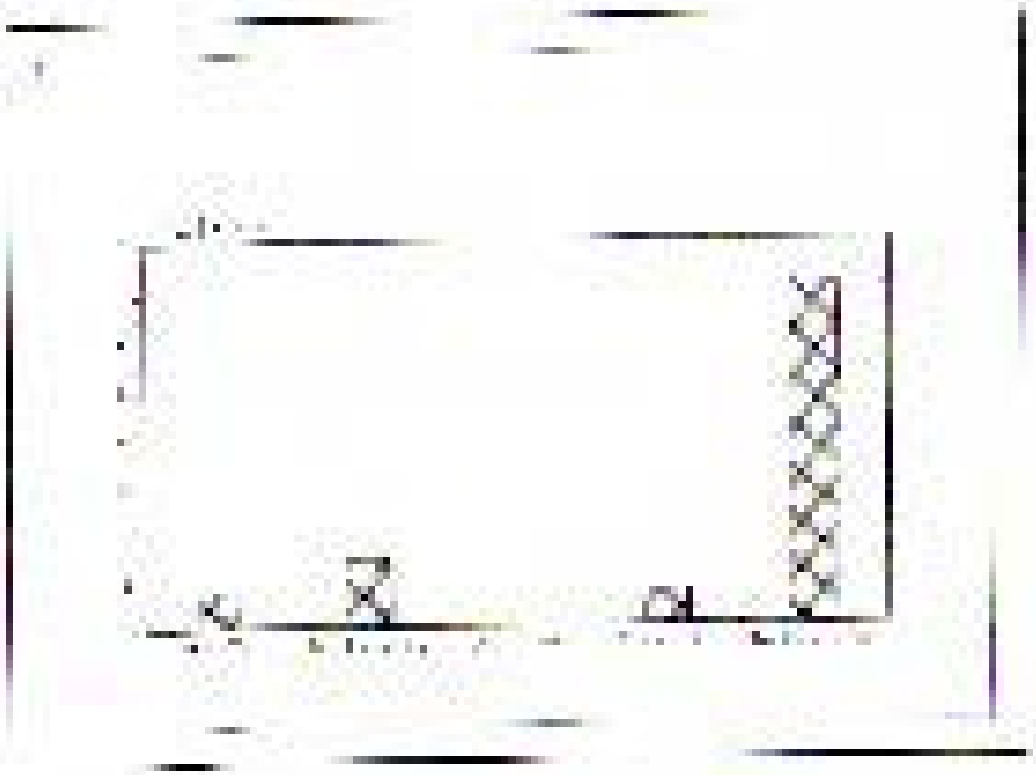

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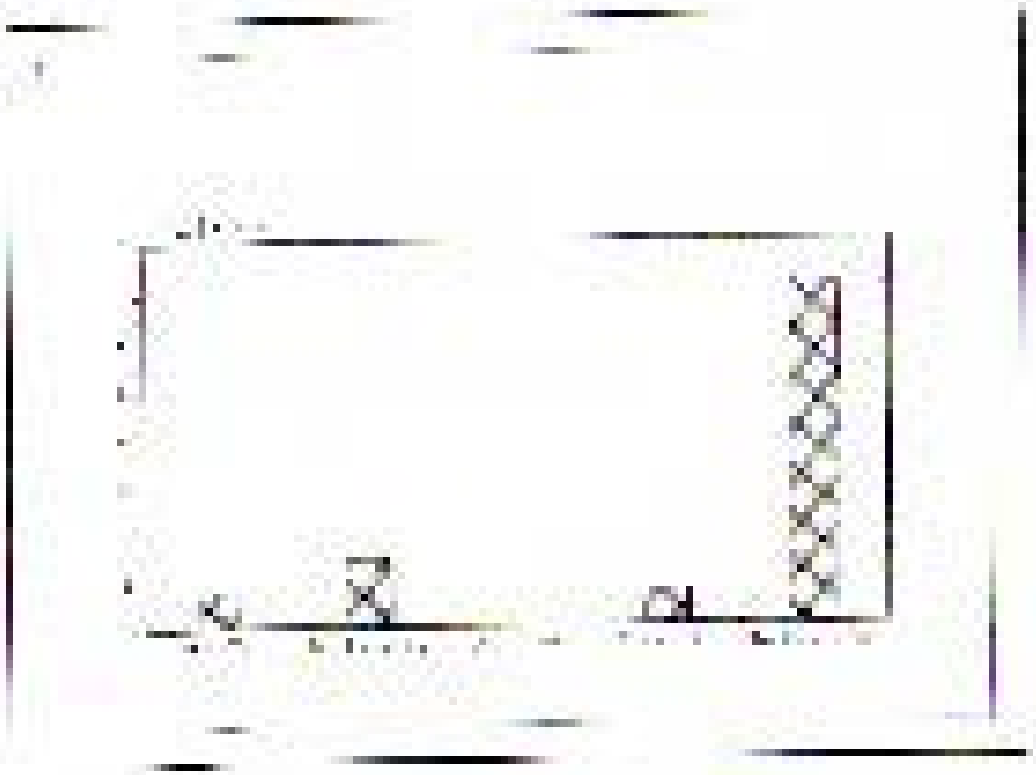

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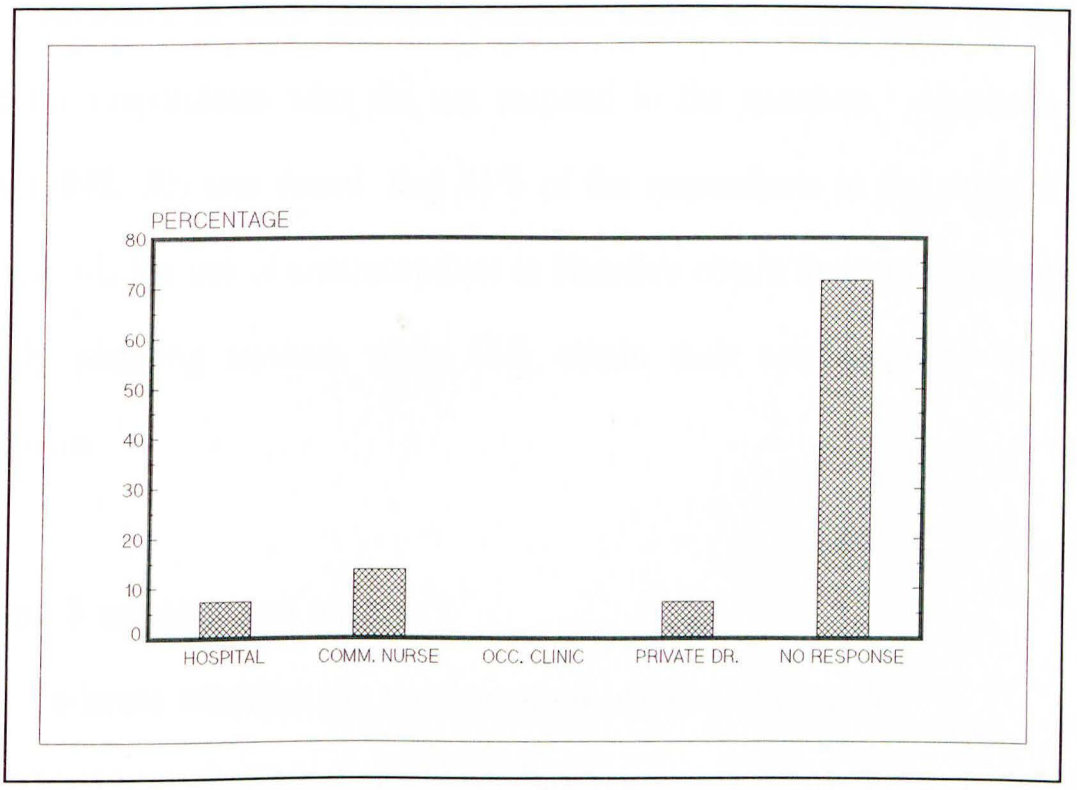
4.2.3 SECTION 3 - AVAILABILITY OF FAMILY PLANNING SERVICES

Item 1 - Indicate from where you receive your family planning supplies

Figure 3 Place where contraceptives are obtained (N=81)



Six (7.4%) of the respondents indicated that they receive their supplies from the hospital, 11 (13.6%) receive theirs from the community nurse while 6 (7.4%) of the respondents receive their suppliers from private practitioners. None of the respondents indicated services from occupational health clinics. Fifty eight (71.6%) did not respond to the question.

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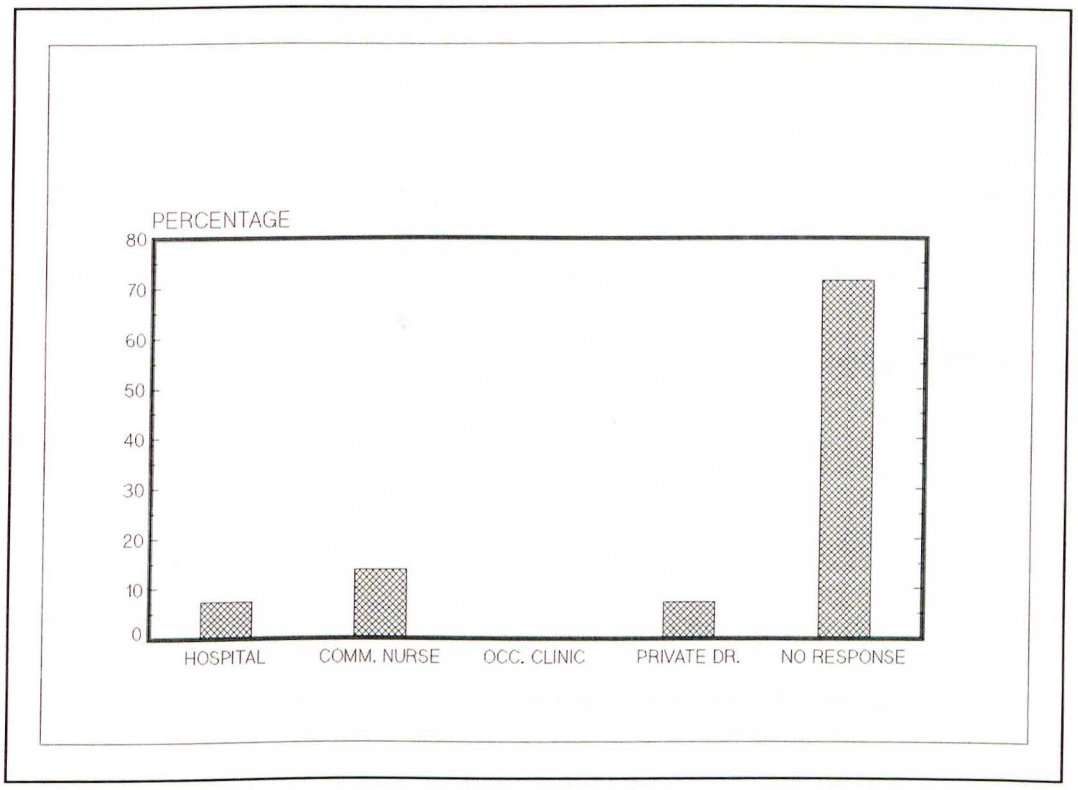

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From these answers one could come to the conclusion that those respondents who are using contraception do have access to the family planning services. It is may be selfexplanatory why 71.6% of the respondents did not respond to this item since 28.4% have only 1-2 children and 27.2% did not respond to this question. Attitudes to such intimate questions could be responsible for the 71.6% of the respondents who did not respond to the question. Ahrenson-Pandikow (1992: 30) also found that 41% of the respondents in the study on attitudes towards the use of contraceptives in Namibia obtain their prescriptions from family planning services while 58% obtain their contraceptives from private sources.

(Items 2 and 3 are discussed together)

Item 2 - Indicate whether the services used are easy to reach

Item 3 - Indicate whether there is regular transport available to health services

It was found that 31 (38.3%) of the respondents indicated that they do have regular transport available to health services. Nine (11.1%) of the respondents indicated that they do not have regular transport to health services while forty one (50.6%) did not respond to the question.

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[illegible]

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Item 4 - At what times does the service function?

On the above question 31 (38.3%) of the respondents indicated that the services function during working hours, 9 (11.1%) indicated that the services are functioning after working hours, probably because they are working on shift as clinic hours are from 08:00-16:00. Forty one (50.6%) of the respondents did not respond. If one could consider the responses given for item one of this section it seems that some workers the possibility to visit health facilities during working hours. This implies that some workers do experience problems in utilizing health facilities/family planning services.

Item 5 - Are there any occupational health services available at your working place?

Table 16 Availability of occupational health services (N=81)

Occupational Health Services	Frequency	Percentage
Yes	5	6.2%
No	69	85.2%
No response	7	8.6%
TOTAL	81	100%

Table 16 reveals that only 5 (6.2%) respondents have the availability of occupational health services at their working place.

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[illegible]	[illegible]	[illegible]

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Sixty (85.2%) of the respondents do not have occupational health facilities at their workplace while 7 (8.6%) did not respond. These responses imply that there is a very urgent need for health care facilities at the working place or for cooperative approach between the small industries to conduct a joint service, even if this is on a part-time basis.

Item 6 - Indicate whether there is anything you particularly disliked about the services

Table 17 Dislikes about services (N=81)

Client dislikes	Frequency	Percentage
Waiting too long	19	23.5%
Personnel unfriendly	5	6.2%
Method not available	1	1.2%
Privacy not observed	3	3.7%
Other	30	37%
No response	23	28.4%
TOTAL	81	100%

Table 17 indicates that clients do experience some problems at the health facilities they visit since 19 (23.5%) of the respondents indicated they wait too long before being attended to. Five (6.2%) complained of unfriendly personnel, 1 (1.2%) indicated that the contraceptive that she preferred to use was not available, 3 (3.7%) complained of privacy not being observed, 30 (37%) had dislikes which were not specified since the list of complaints could be too long.

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Item 5 . [illegible] available for fuzzy

parking [illegible]

Item 6 . [illegible]

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Twenty three (28.4%) did not respond.

Item 7 - Indicate whether there is information available on family planning methods at the service

Figure 4 Information on family planning (N=81)

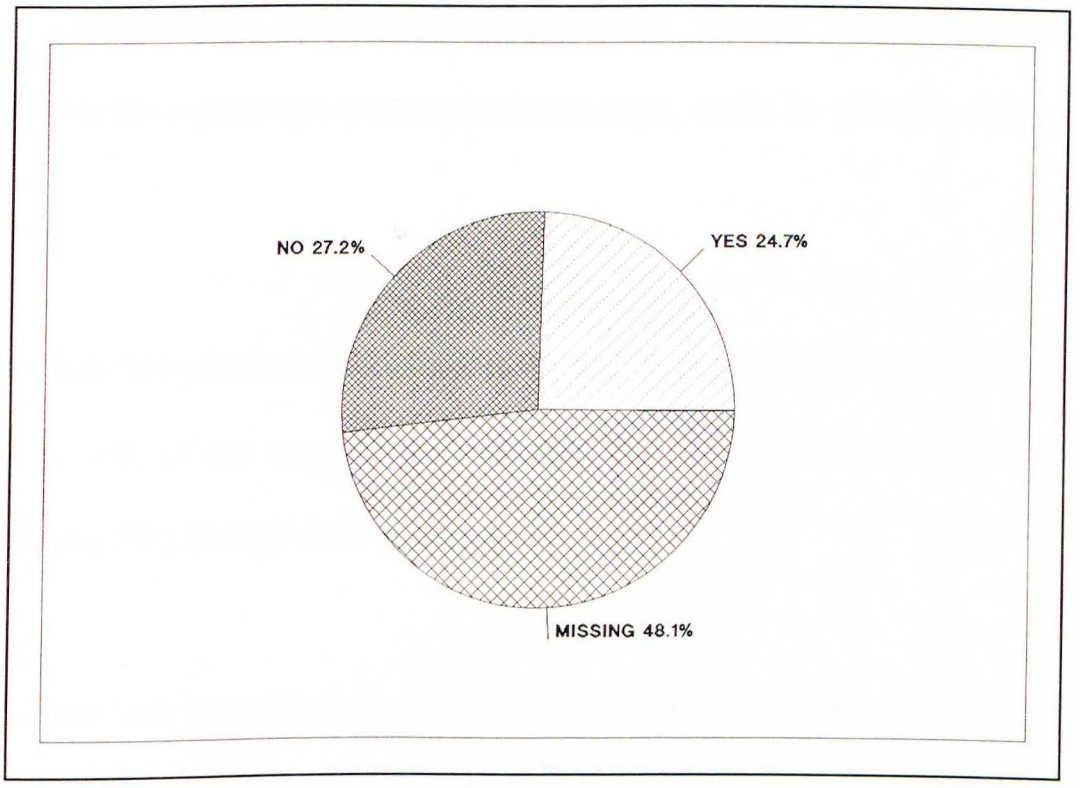

Figure 4 shows that 20 (24.7%) of the respondents were positive about receiving family planning information at health care facilities 22 (27.2%) indicated that they did not receive any information on family planning while 39 (48.2%) did not respond. If you take the consequences of poor family spacing and unwanted pregnancies into consideration the findings do not positively contribute to health education with specific reference to family planning.

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planning [illegible] world

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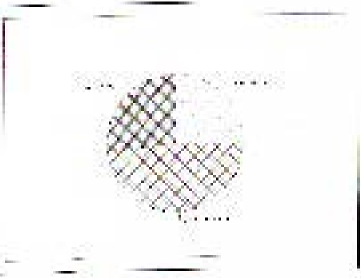

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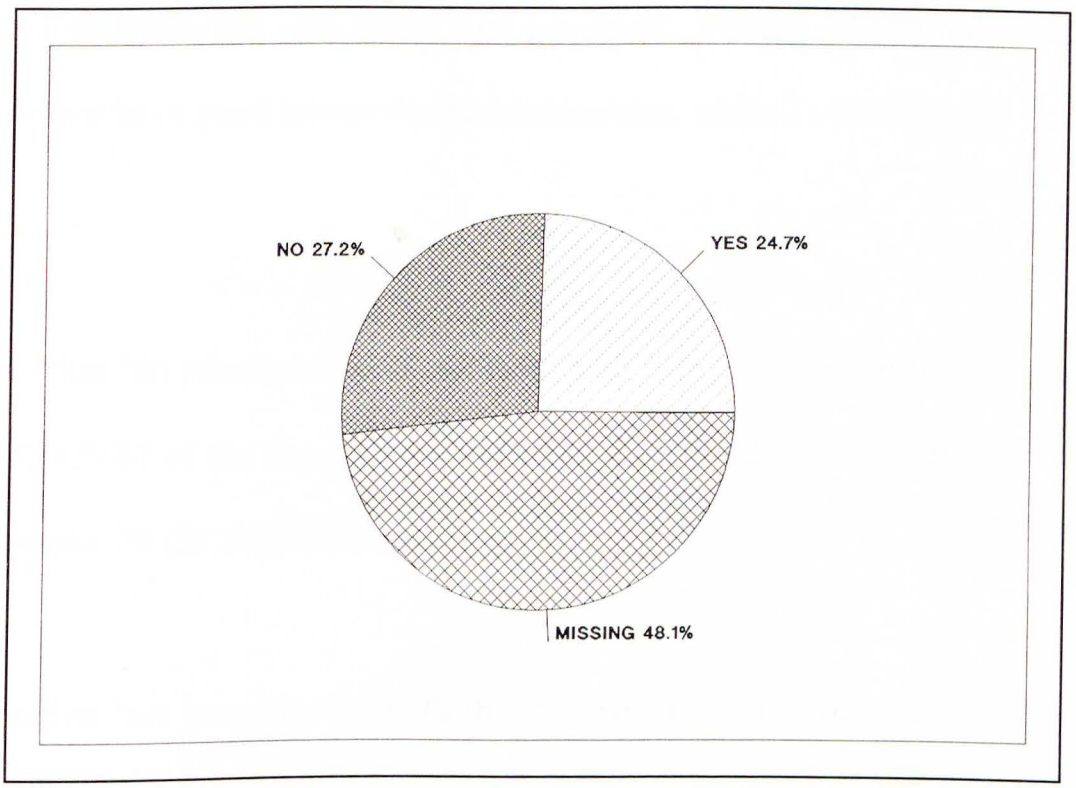

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Even if respondents do not have children yet every woman should be well informed about available facilities to be able to utilize them at a later stage.

Item 8,9,10 and 11 dealt with interpersonal relationships and attitudes of health care providers. Thirty (37%) of the respondents indicated that they have good interpersonal relationships with health care providers. Twenty (25%) indicated that they do not have good interpersonal relationships, while 31 (38.2%) did not respond.

On the question "do you feel free to ask the health care provider for help when needed", 30 (37%) of the respondents indicated they do, 22 (27.2%) indicated they do not and 29 (35.8%) were missing.

On the question "are you satisfied with the attitudes of the health care provider towards you", 27 (33.3%) of the respondents indicated that they are satisfied with the attitude, while 26 (32.1%) of the respondents are not satisfied with the attitude and 28 (34.6%) are missing. It was found that 26 (32.1%) of the respondents indicated that their problems with regard to family planning are dealt with by health care providers, 29 (35.8%) indicated that their problems are not dealt with, while 26 (30.1%) did not respond on the question.

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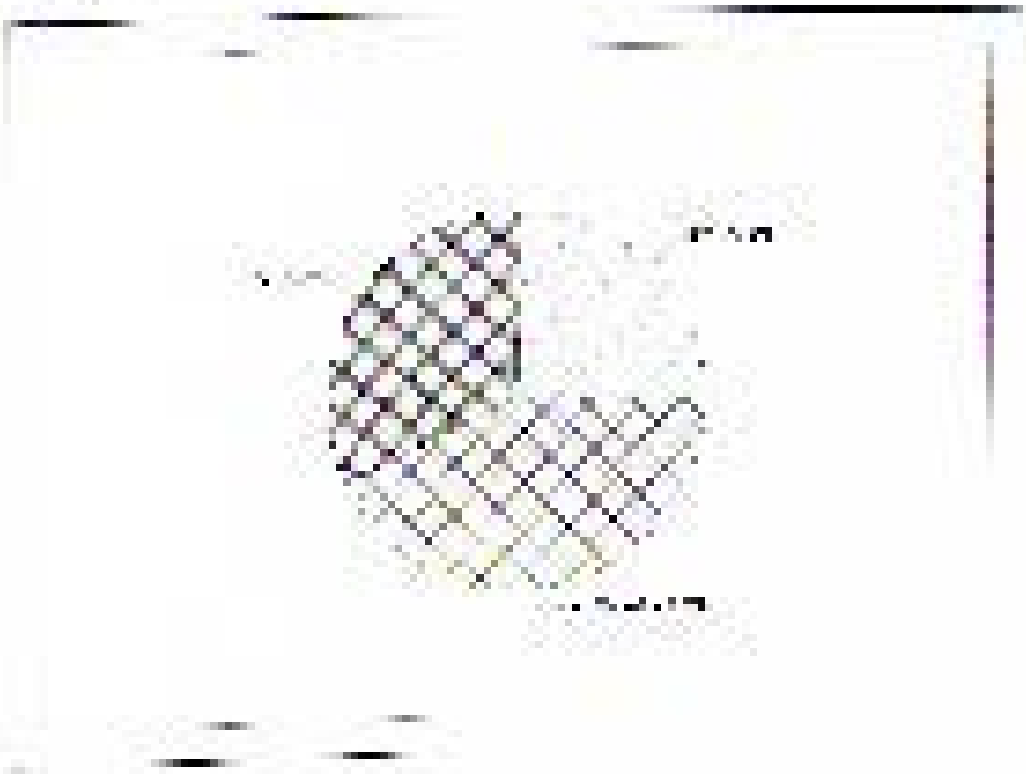
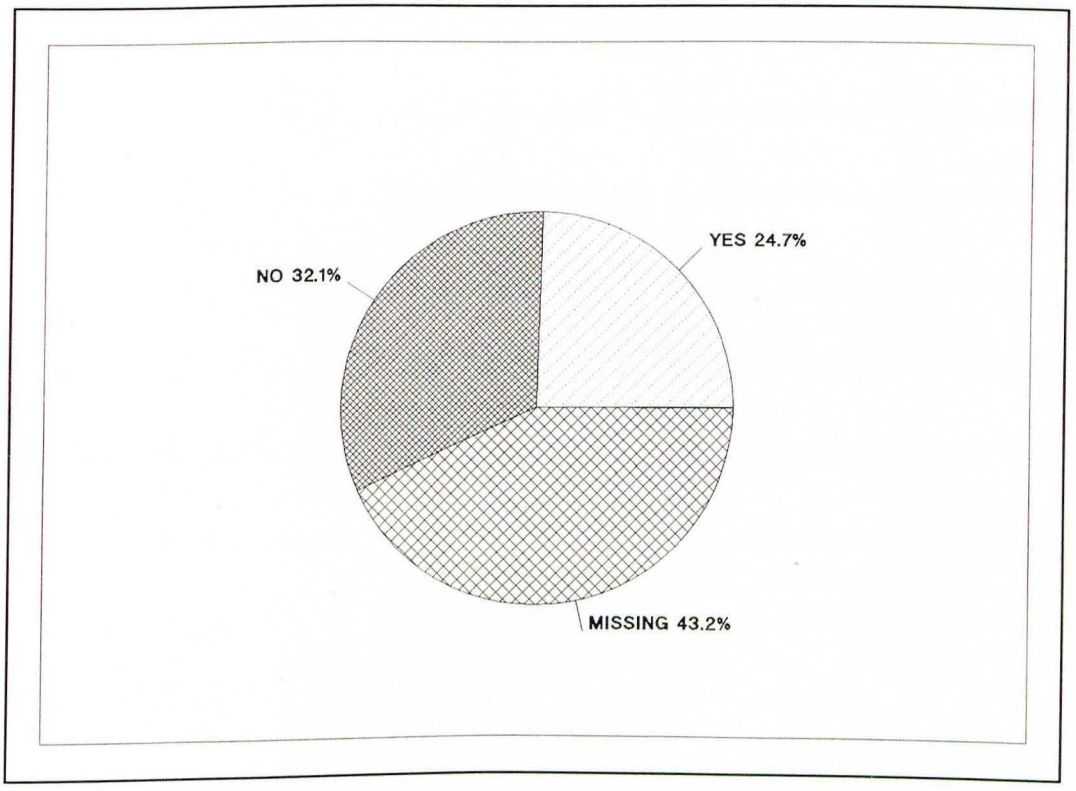


The attitudes of the health care provider is of utmost importance when rendering health services to the public and specifically concerning contraceptive use. If the health provider's attitudes are destructive an array of problems appear to give ground to prejudice against and rejection of contraceptive use. Justifiable fears concerning risks are overrated due to lack of instructions for contraceptive use and supportive counselling on the potential side effects (Ahrenson-Pandikow, H., 1992: 42).

Item 12 - Are you aware of new developments in family planning?

Figure 5 Information about new developments in Family Planning methods (N=81)



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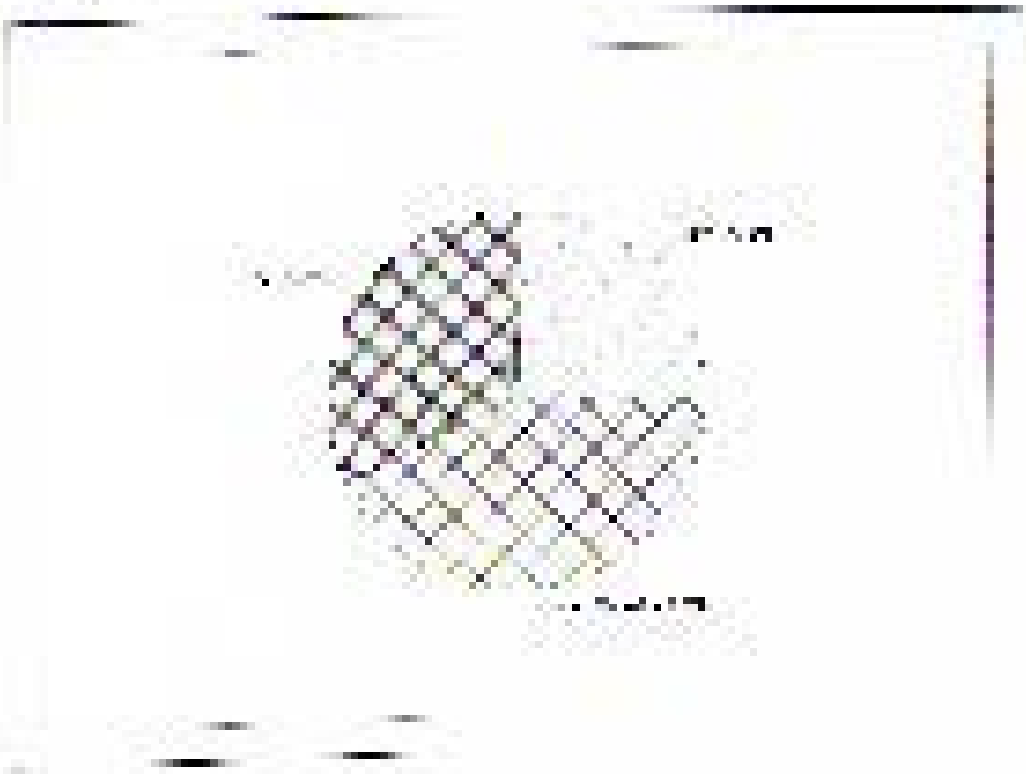

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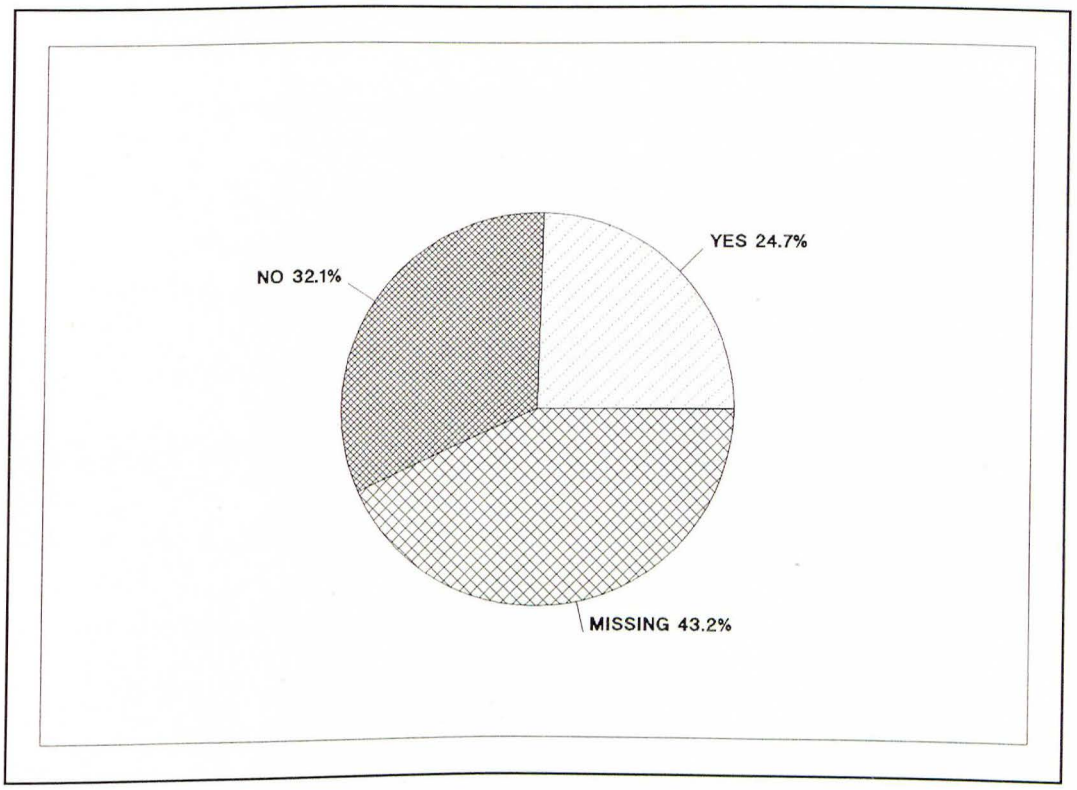

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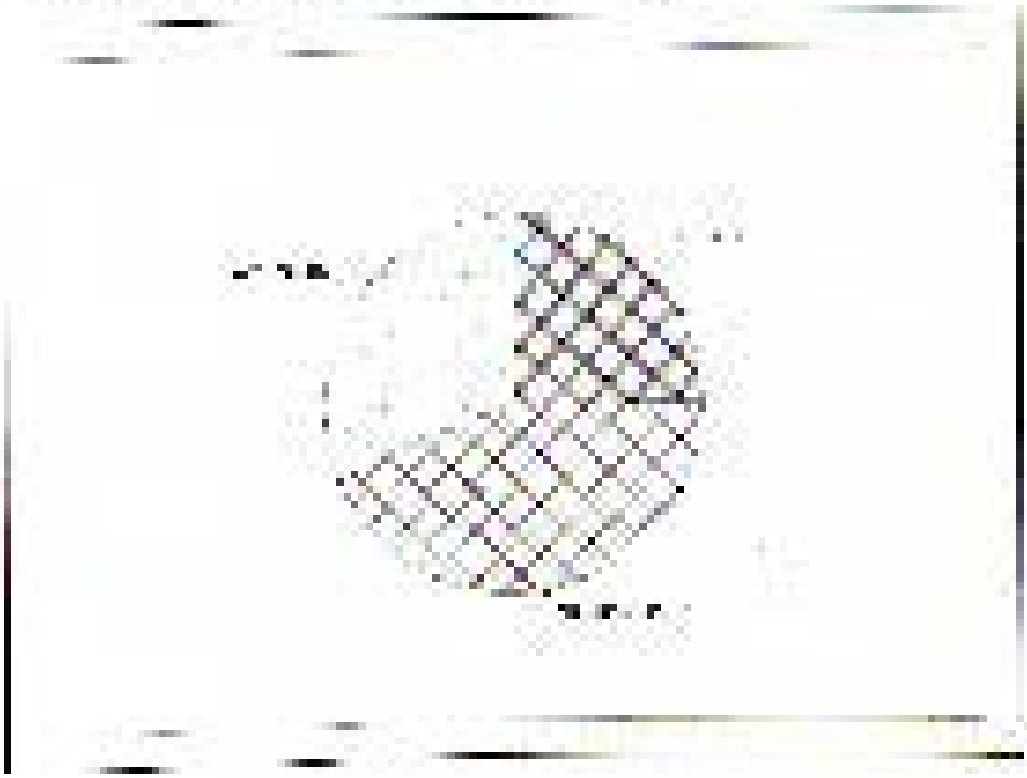
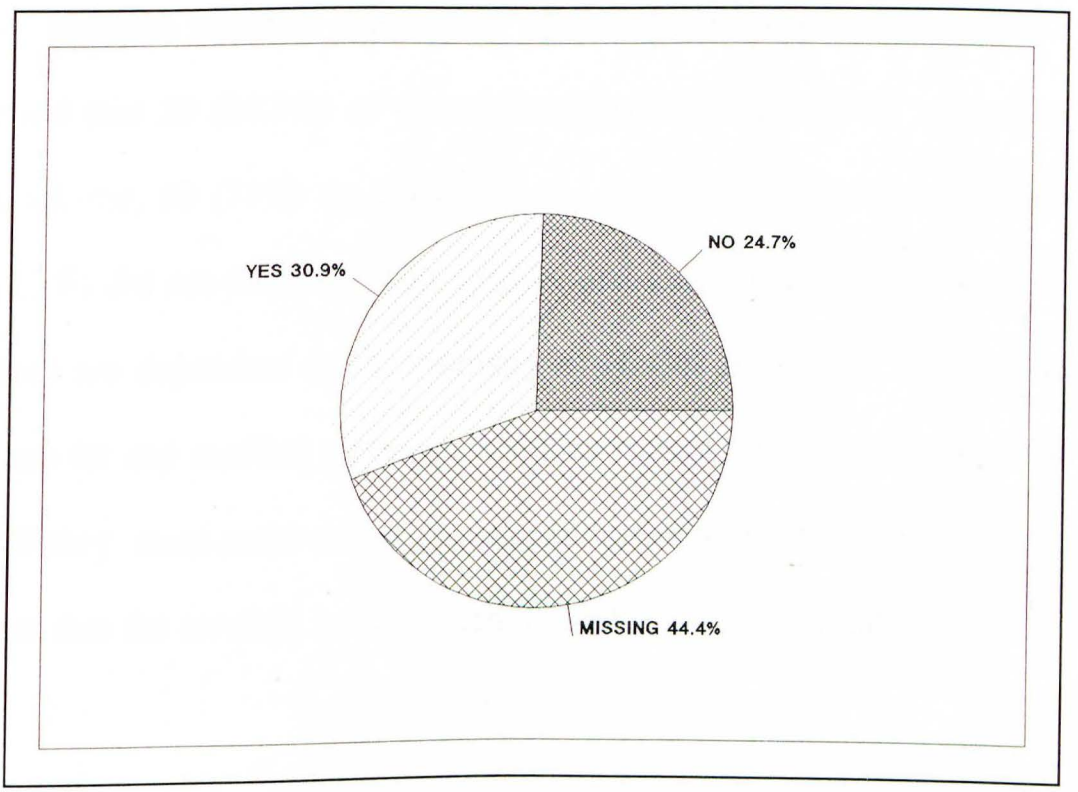


Figure 5 shows that 20 (24.7%) of the respondents are aware about new developments in family planning while 6 (32.1%) of the respondents indicated that they are not aware of new developments in family planning. Thirty five (43.2%) did not respond. Even if women in child bearing age do not make use of family planning services it should be expected that they at least know of new developments in contraceptive use.

Item 13 - Does the health care provider give you opportunity to take your own decisions with regard to family planning?

Figure 6 Opportunity for own decision-making (N=81)



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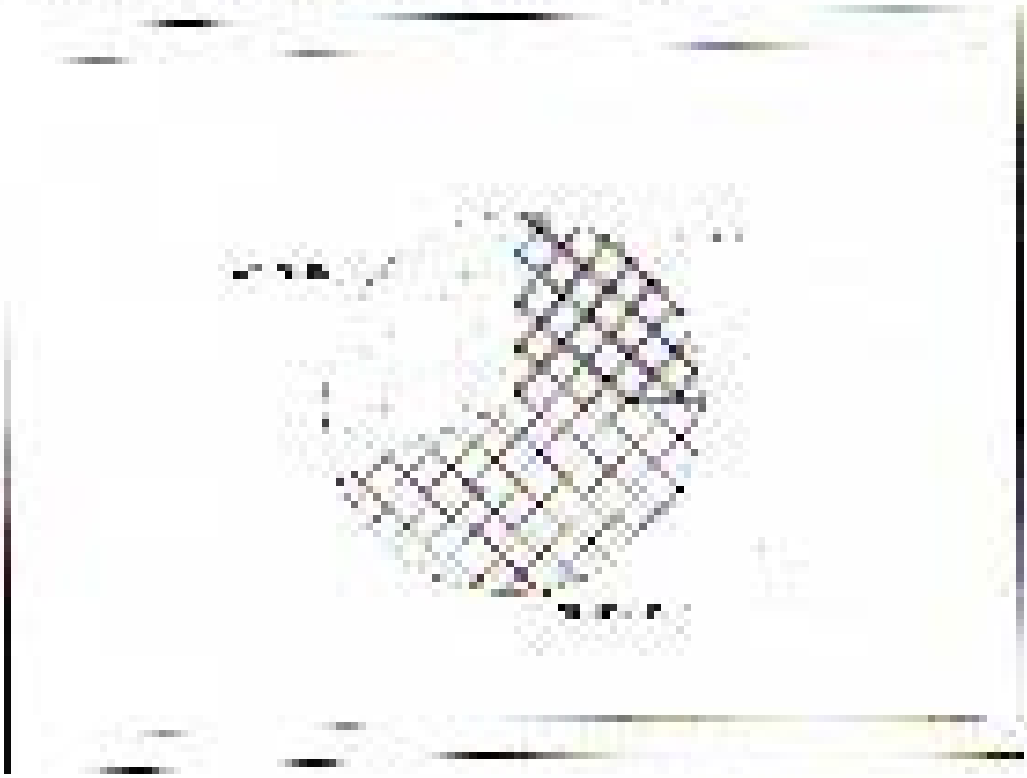

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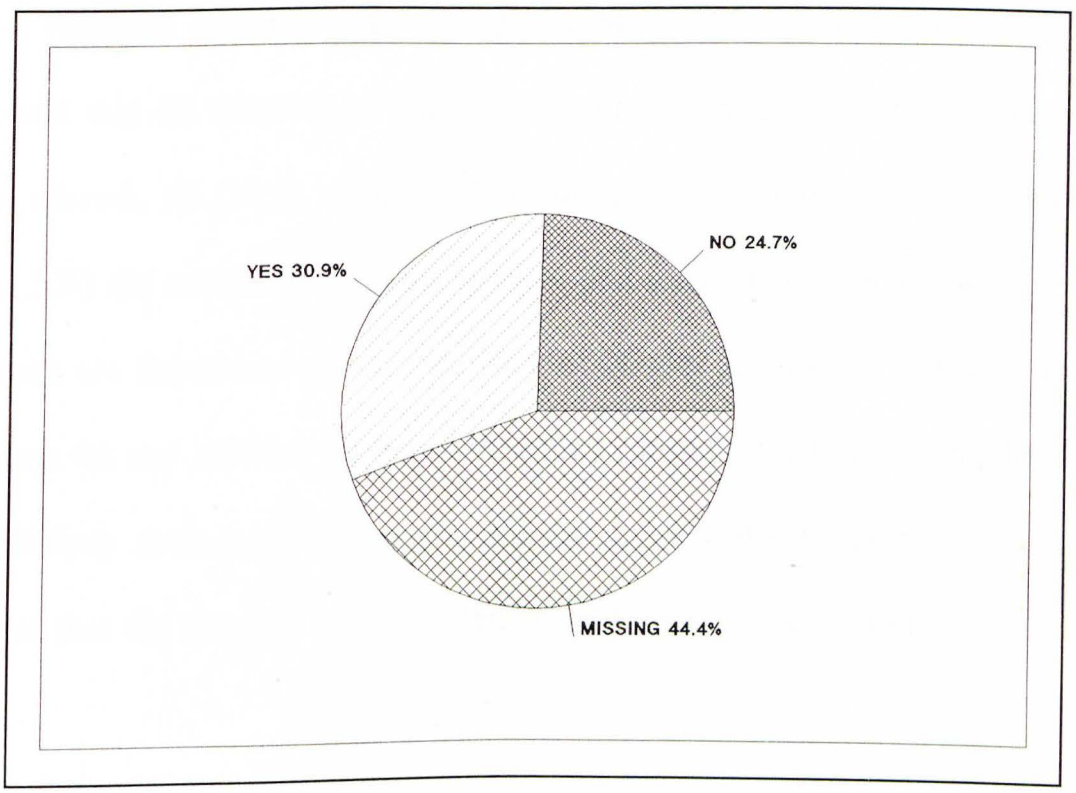

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From figure 6 it is clear that only 25 (30.9%) of the respondents had the opportunity to make their own decisions with regard to family planning matters while 20 (24.7%) did not have the opportunity to make their own decisions. Thirty six (44.4%) did not respond. The poor state of women's health in Namibia could be due to the fact that women are denied their right to control their own fertility, and right to health and health care. As suggested by Cook, R.J., 1993: 46-50 women should be treated with dignity and respect and be provided with information in order to make informed decisions on particular courses of treatment like family planning.

4.2.4 SECTION 4 - THE ATTITUDE OF THE EMPLOYER TOWARDS THE HEALTH OF THE EMPLOYEE/WORKER

Item 1 - Indicate whether you belong to a medical insurance scheme

It was found that 20 (24.7%) of the respondents are members of a medical insurance scheme, 60 (74%) do not belong to any medical insurance scheme while 1 (1.3%) did not respond. This implies that most of the female workers in Windhoek are dependent on the Ministry of Health and Social Services as state patients for any medical services since they cannot afford private medical services. If they must make use of government services due to their income it is important that the services be user friendly and improve accessibility.

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Item 2 - If your answer is "yes" indicate the type of medical insurance

Responses from item 12 indicate that only ten (12.3%) of the respondents belong to a private medical scheme, probably because they are married and are part of their husband's medical insurance coverage.

Ten (12.3%) of the respondents belong to a compulsory medical insurance scheme from the industry in which they are employed. Sixty one (75,4%) of the respondents do not belong to any medical insurance scheme.

Most medical insurance schemes cover maternal and health services and those who do not belong to such schemes could use the facilities offered by the Ministry of Health and Social Services as family planning services are free of charge.

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[illegible]

[illegible]

[illegible]

Item 3 - Does the employer allow personnel from the Ministry of Health and Social Services to give health education sessions at the workplace?

Figure 7 Health education allowed from Ministry of Health and Social Services (N=81)

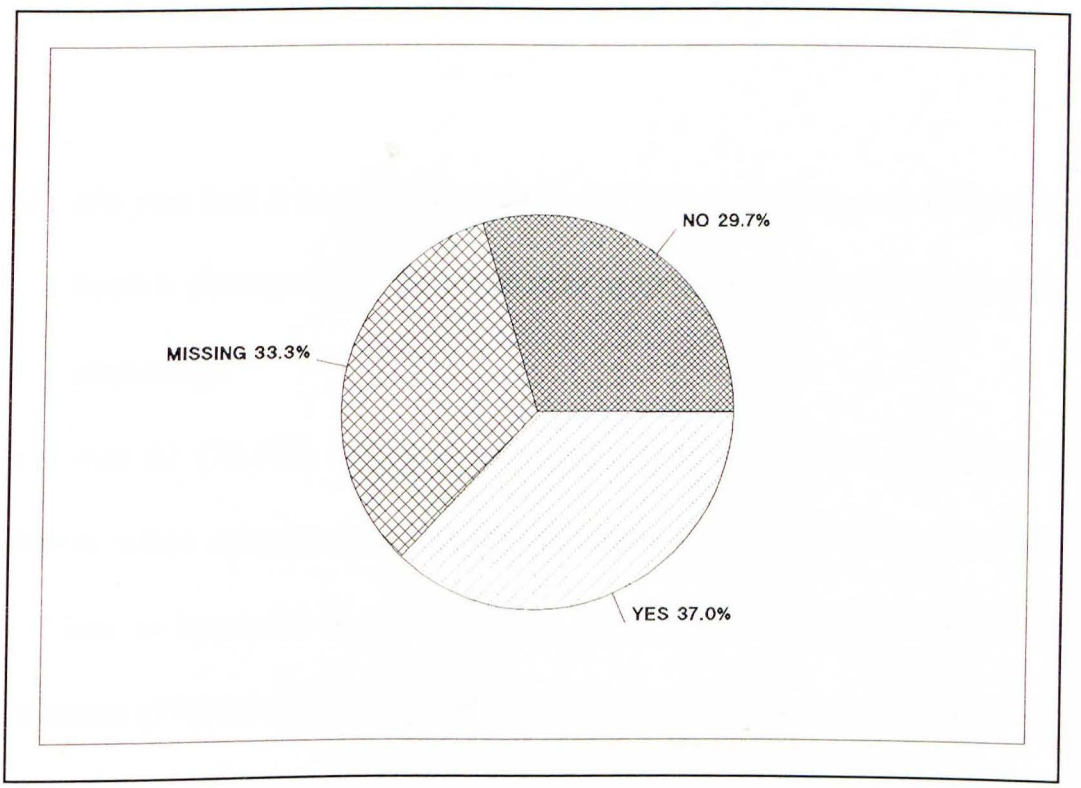

Figure 7 shows that 52 (64.1%) of the respondents have indicated that the employer allows personnel from the Ministry of Health and Social Services to give health education talks at the workplace. Twenty four (29.6%) of the respondents indicated that health education talks from the Ministry of Health and Social Services are not allowed at their workplace, probably due to fear of

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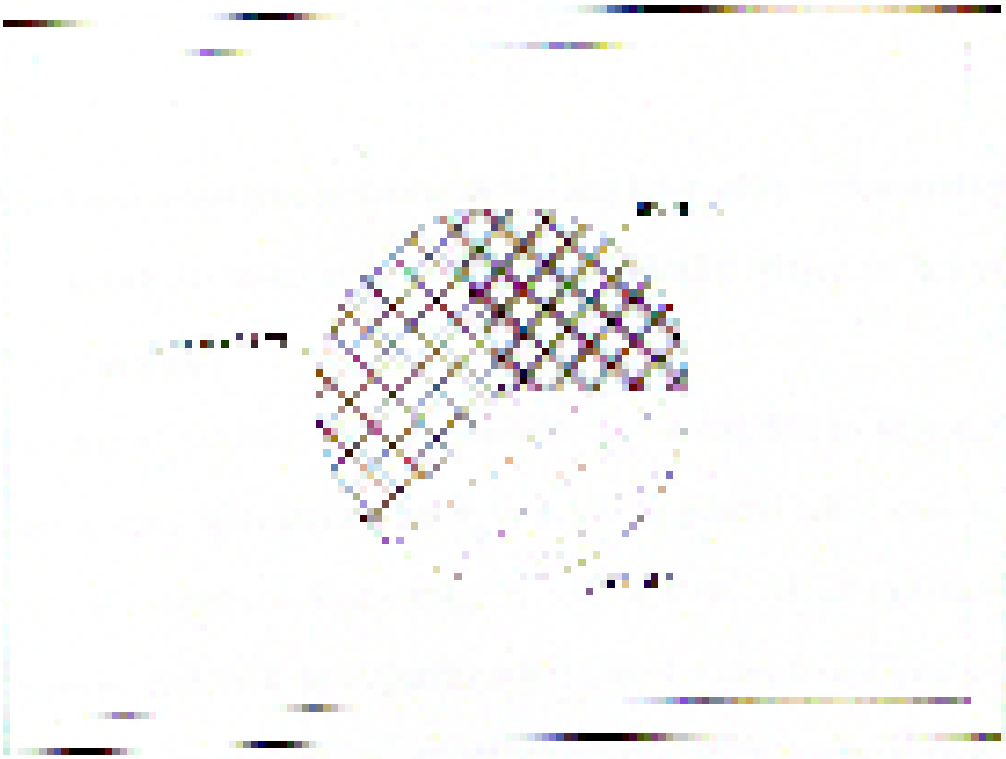

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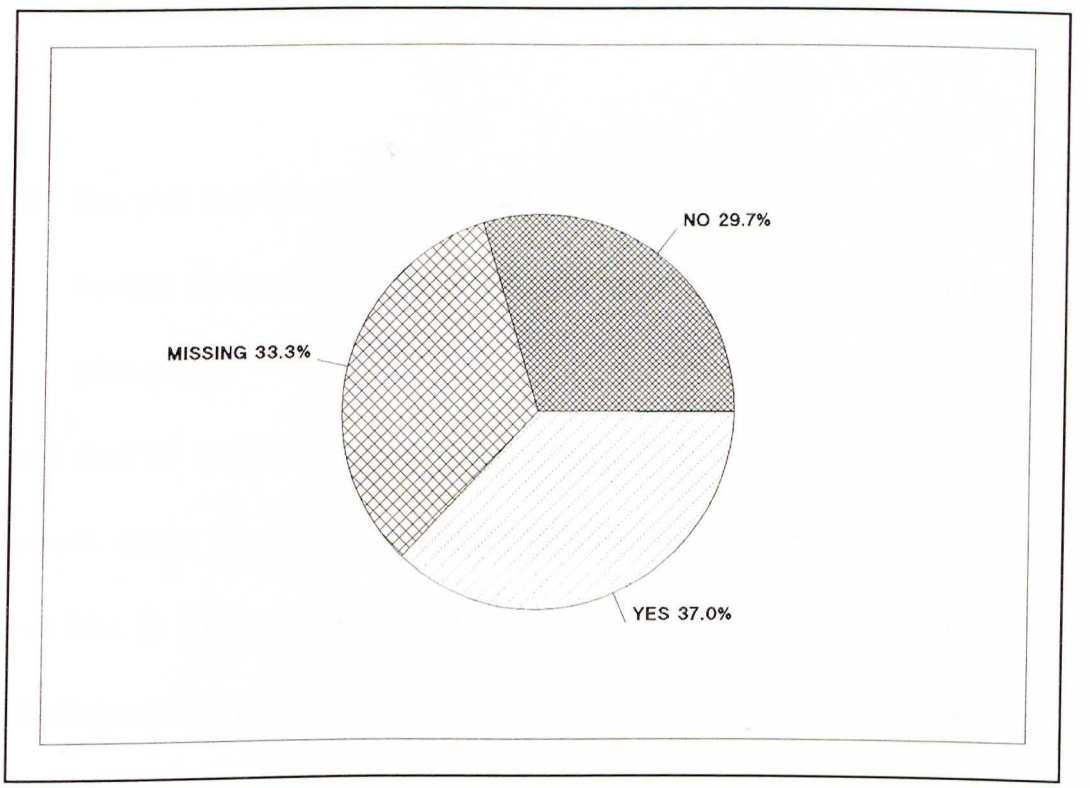
Figure 7 Health education allowed from Ministry of Health and Social Services (N=81)



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production loss during these sessions, while 5 (6.3%) did not respond.

This implies that those workers who are not allowed to visit health facilities during working hours and also fall in the category of those who do not receive any health education sessions from the Ministry of Health and Social Services are totally denied access to health facilities and information.

Item 4

4.1 and 4.2 - Do you feel free to approach the employer when encountering health problems in general and specifically related to family planning?

It was found that 62 (76.5%) of the respondents do not feel free to approach their employers when encountering health problems in general while only 36 (44.4%) feel free to approach their employers with problems related to family planning. Sixteen (19.8%) of the respondents indicated that they do not feel free to approach their employers when encountering health problems in general while 13 (16%) would not approach their employers with regard to family planning problems. This implies that the respondents might view family planning problems as very personal to discuss with their employers.

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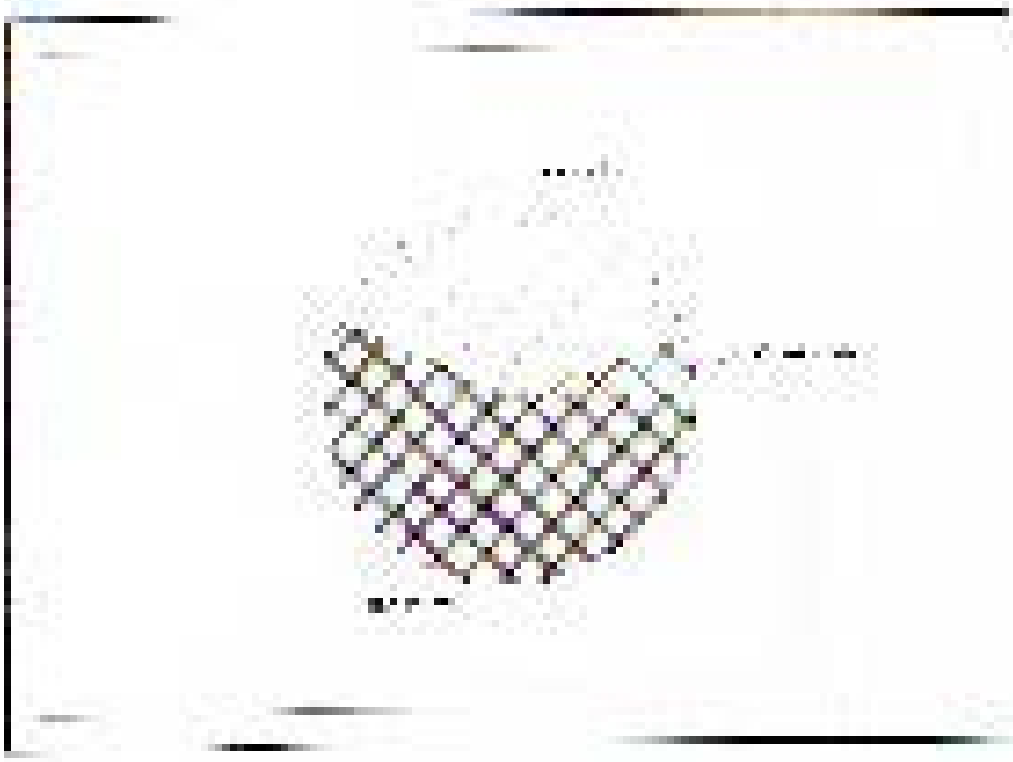

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Item 5 - Does the employer give you opportunity to visit health facilities during working hours?

Figure 8 Visit during working hours (N=81)

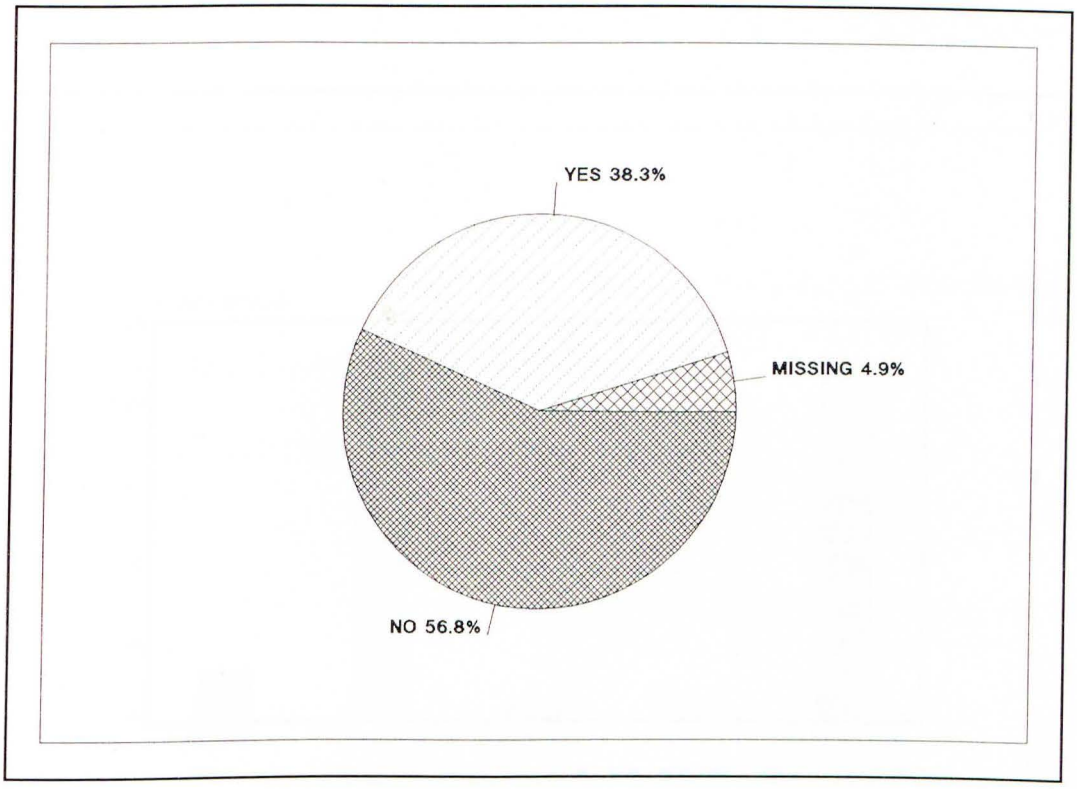

Figure 8 reveals that 31 (38.3%) of the respondents are allowed to visit health facilities during working hours while 46 (56.8%) of the respondents indicated that they are not allowed to visit health facilities during working hours, 4 (4.9%) did not respond.

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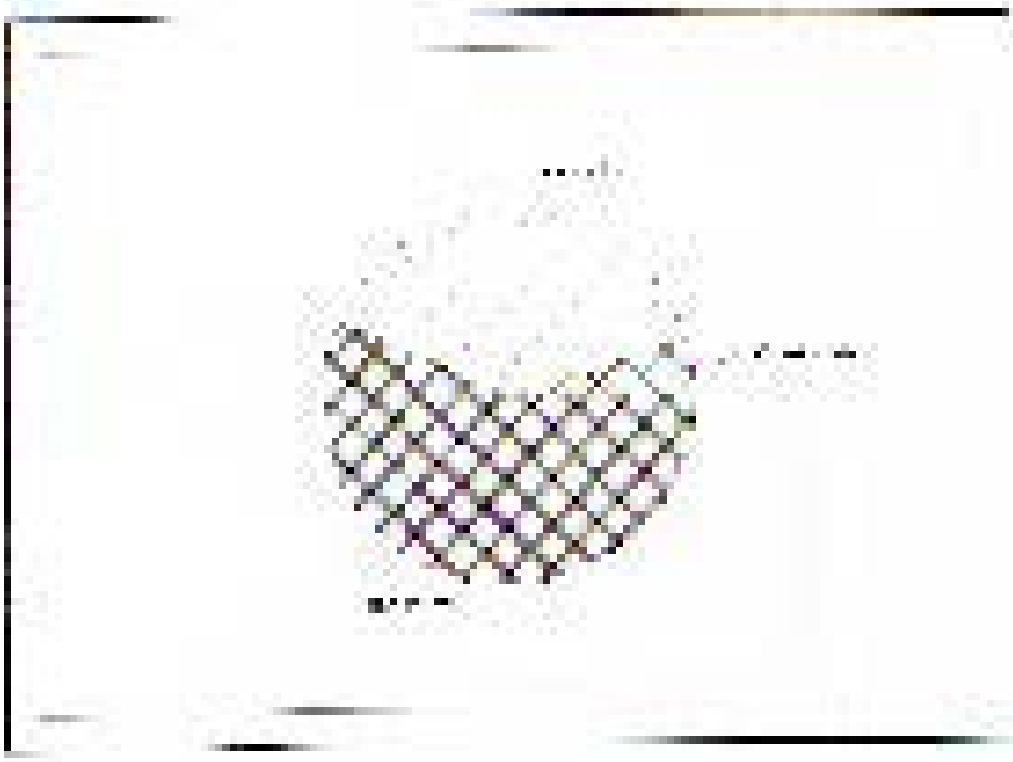

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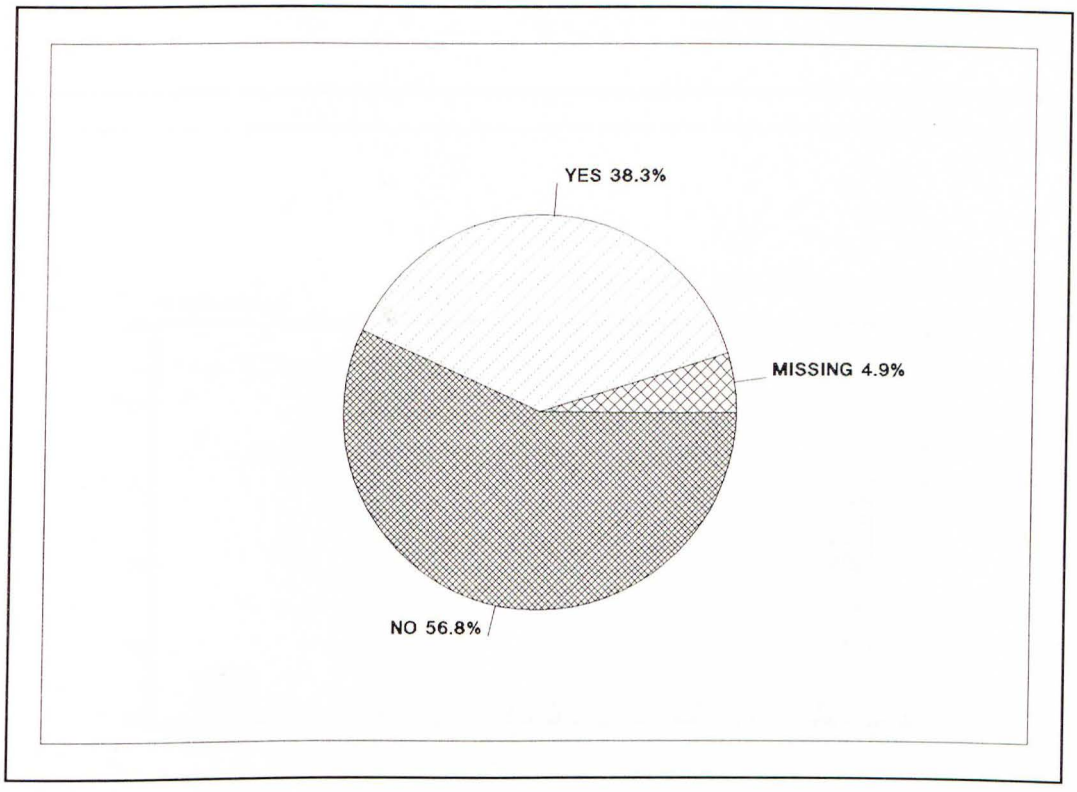

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Figure 2 [illegible] [illegible] [illegible] [illegible] [illegible]

Item 6 - How often are you allowed to visit health facilities during working hours?

Figure 9 Number of visits allowed to health facilities during working hours (N=81)

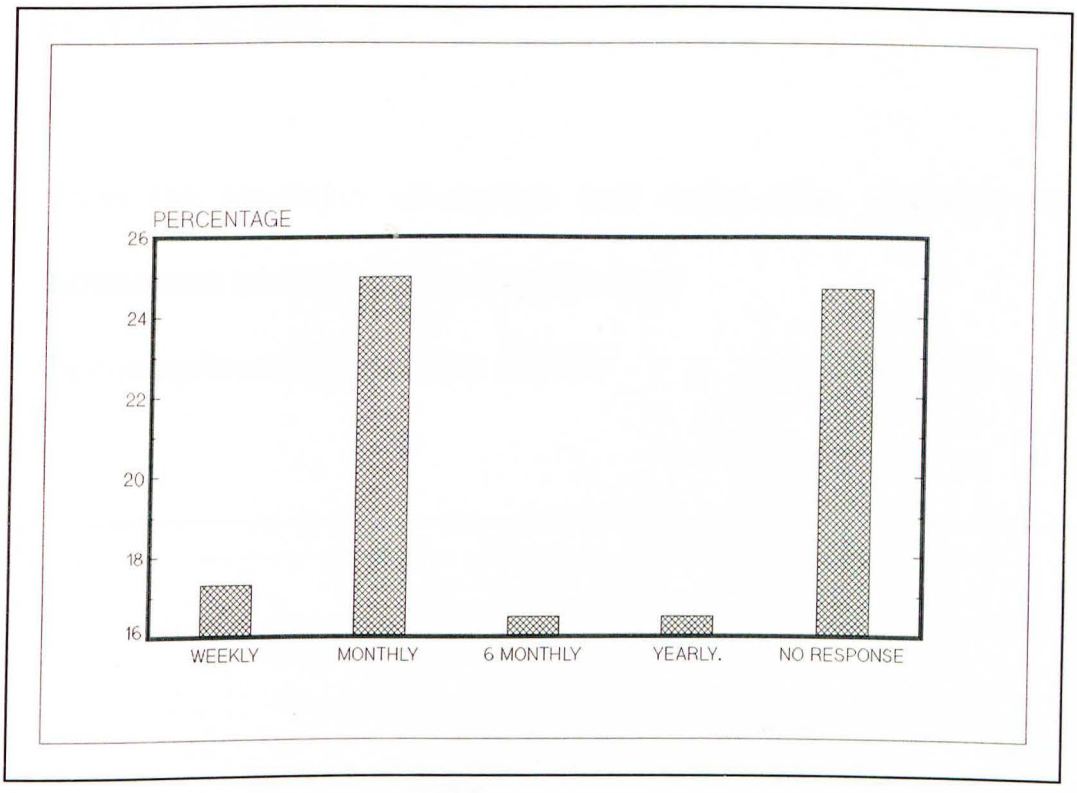

Figure 9 displays a graphic presentation of visits allowed to health facilities. When encountering problems employers have different periods on which employees are due to visit such facilities.

[illegible] Are [illegible] to [illegible] [illegible] with [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]?

Figure 2 [illegible] [illegible] [illegible] [illegible] [illegible]

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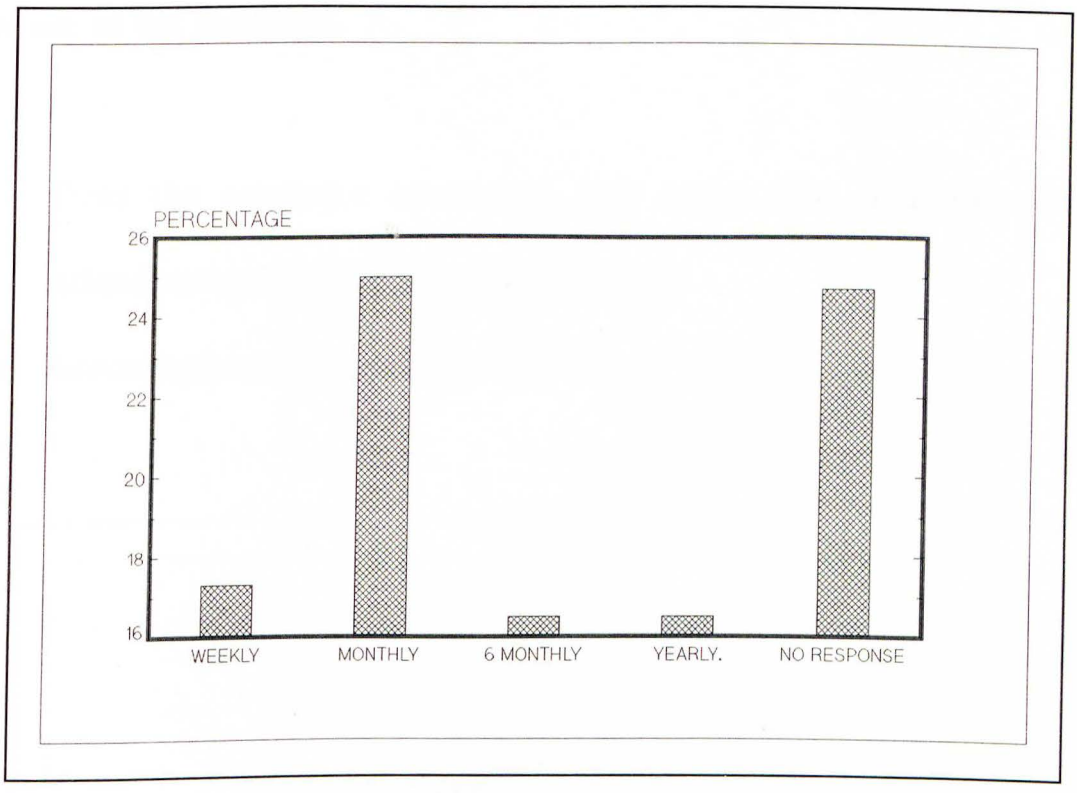

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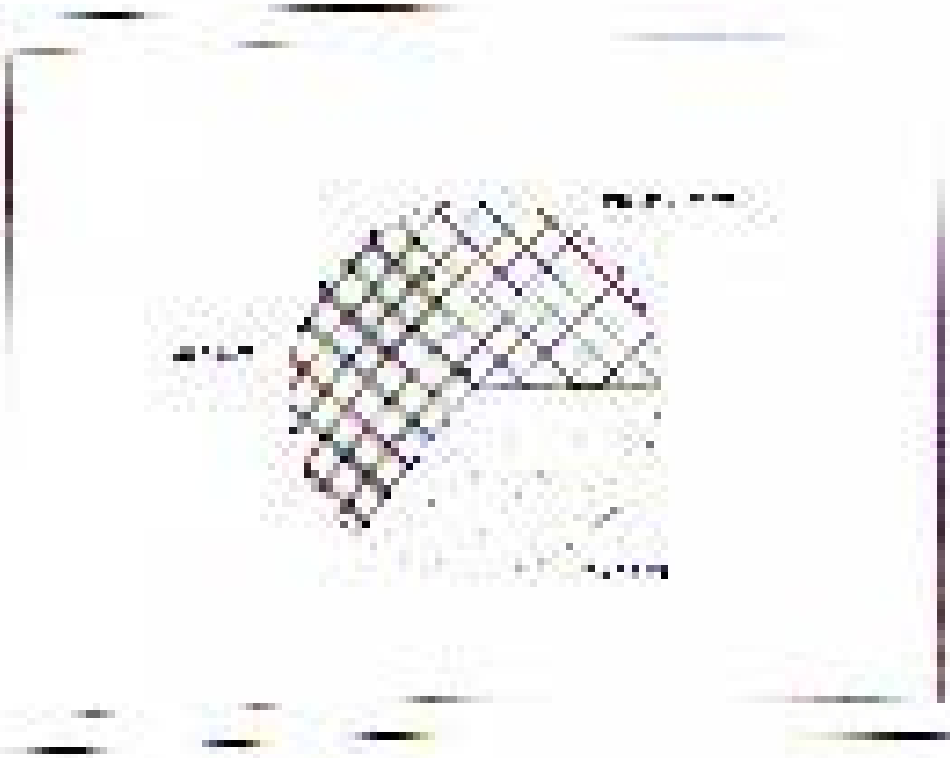
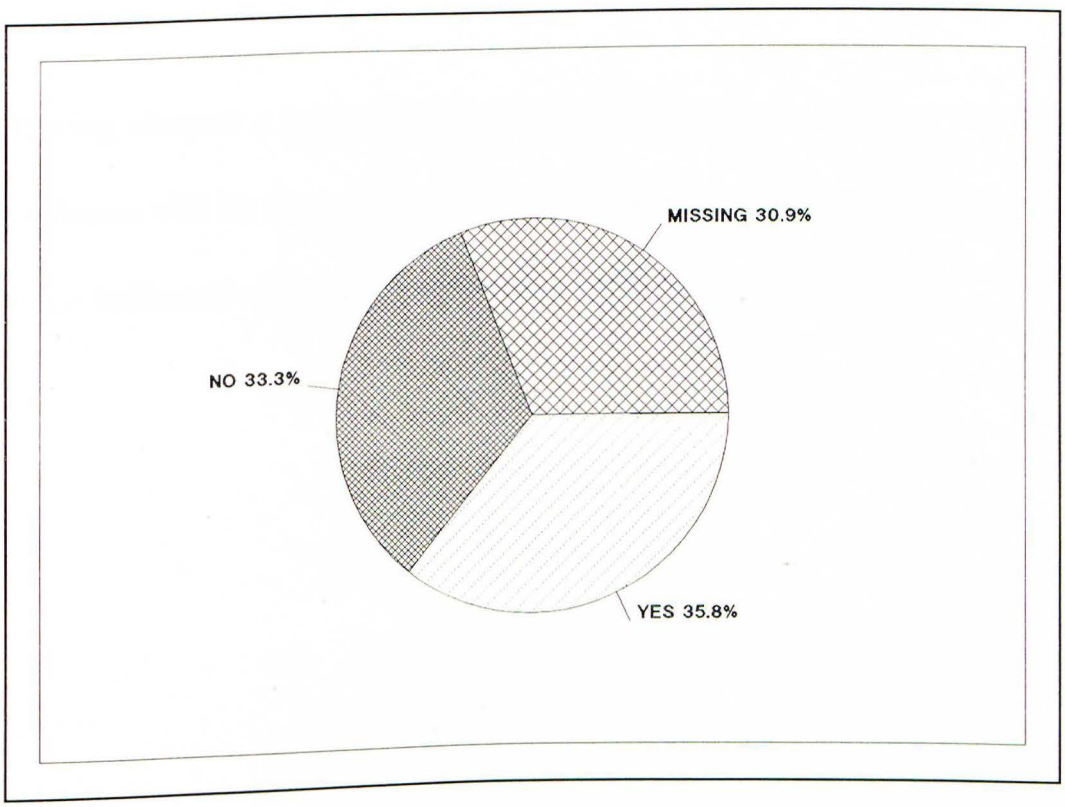


Fourteen (17.3%) of the respondents indicated that they can visit health facilities on a weekly basis, 21 (25.(%) on a monthly basis, 13 (16.5%) on a six monthly basis and 13 (16.5%) on a yearly basis. Twenty (24.7%) did not respond possibly because they do not feel free to approach the employer with health problems especially those concerned with family planning or because they do not make use of the facilities.

Item 7 - Does the employer encourage and make time available for attendance at family planning services?

Figure 10 Encouragement by employer (N=81)



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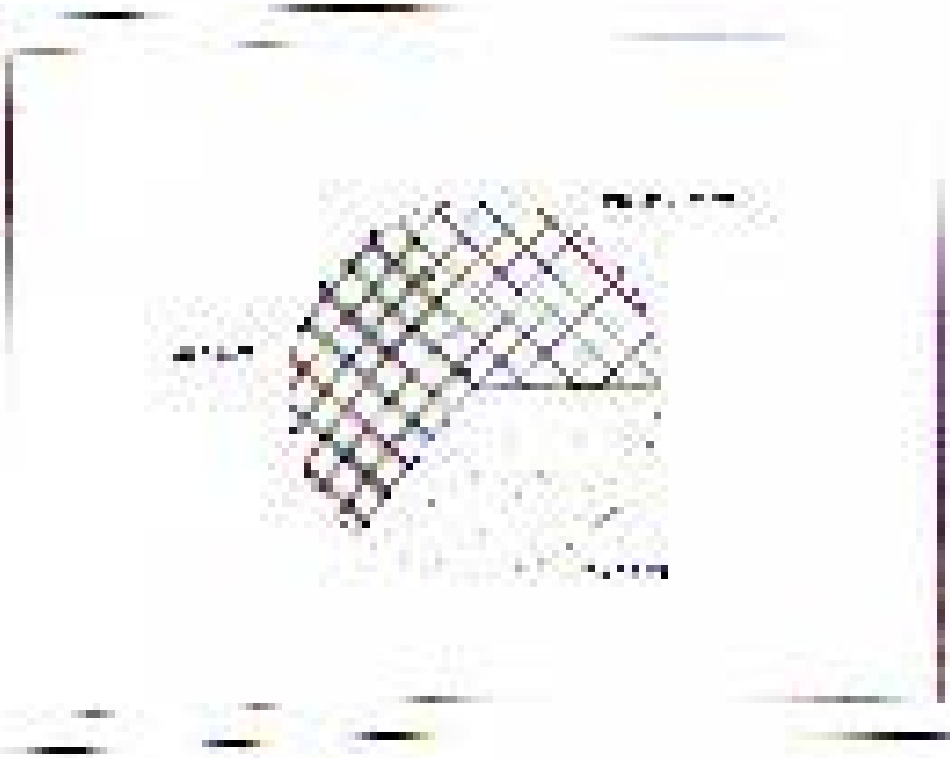

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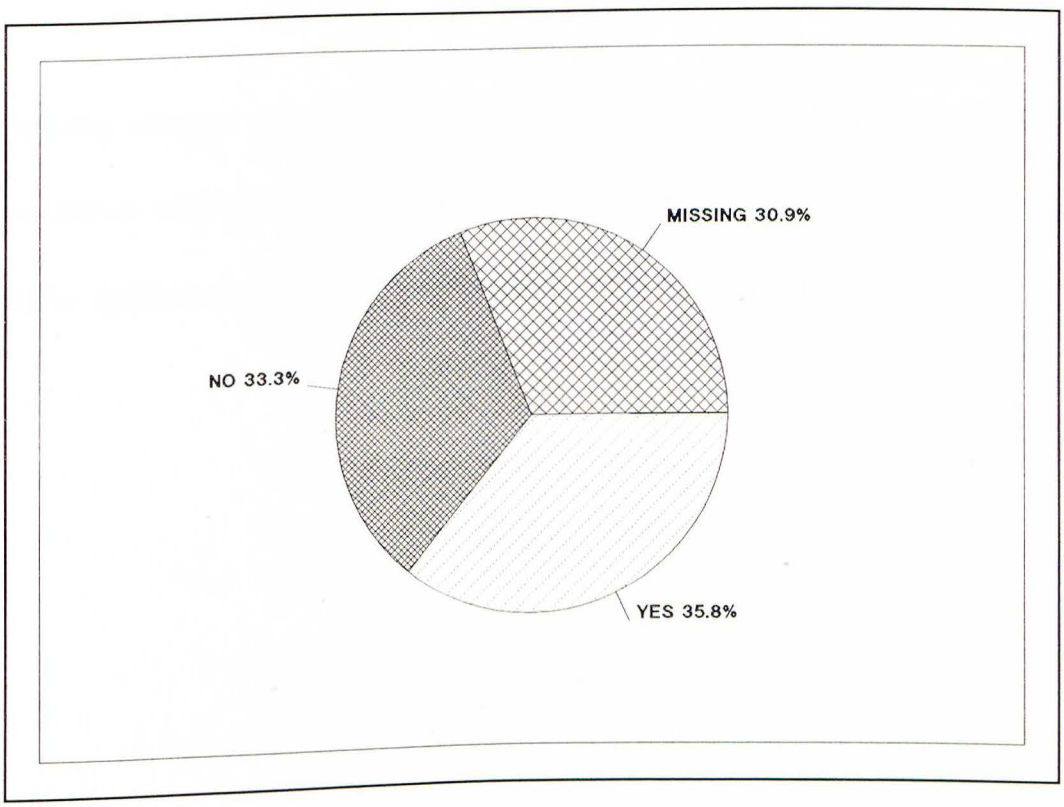

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Figure 10 reveals that 29 (35.8%) of the respondents indicated that their employers do encourage and make time available for them to visit family planning services, 27 (33.3%) indicated that they are not encouraged or given time for attendance of family planning services while 25 (30.9%) did not respond.

4.3 CONCLUSION

By using different techniques for statistical analysis information regarding utilization of family planning services by working women was processed.

In the following chapter a summary of the most significant findings and the conclusions drawn will be discussed. Limitations identified during the research project will be indicated and recommendations will be presented.

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CHAPTER 5

SUMMARY OF FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

[illegible]

5.2 SUMMARY OF FINDINGS

[illegible]

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5.1 INTRODUCTION

In this chapter research questions are answered by summarising the most significant findings and conclusions of this study. Limitations which were identified during the study will be discussed and recommendations will be made.

5.2 AIM AND METHOD OF THE STUDY

The aim of the study was to determine and describe the facilities and arrangements available at different industries for working women of child bearing age in Windhoek. The study was also aimed at determining factors that influence the utilization of these facilities.

In the analysis of the research problem certain aspects are identified which could be important in the utilization of family planning services. The study is, thus, aimed at the following:

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selected registered industries;

- to determine the attitudes of employers towards the health of their employees;
- to determine the knowledge of working women concerning the use of family planning and also to determine the number of working women of child bearing age who utilize family planning services as well as reasons for non-utilization.

In order to achieve this aim the researcher delivered questionnaires at different industries in Windhoek. The questionnaire consisted of four sections. The first section of questions concerned personal data of the respondents. The second section comprised of questions regarding data on knowledge and utilization of family planning services. The third section of the questionnaire consisted of questions regarding data on available family planning services while the fourth section was concerned with questions on the employer's attitude as experienced by the employee.

5.3 LIMITATIONS IDENTIFIED DURING THE STUDY

Almost one third (27.2%) of the respondents indicated that they did not have children yet and did not respond to most of the questions asked in sections 2 and 3. Some respondents considered some of the questions too private and were, thus, reluctant to respond. By implication it is difficult to generalise some of the findings.

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5.4 FINDINGS, CONCLUSIONS AND RECOMMENDATIONS OF THE STUDY

The findings and conclusions of the survey are summarized according to the research questions asked in chapter one. The discussions will be presented as follows:

- General findings and conclusions
- Findings, conclusions and recommendations with regard to the research questions and objectives

5.4.1 SECTION ONE - **General findings and conclusions**

Aim

To describe all the respondents with special emphasis on their biographic profile.

Age

Approximately 80.2% of the respondents fell in the age group 15-29 years while the age group 30-45 years was represented by 19.8% (Item 1 Table 5). The fact that 80.2% of the respondents fell into the 15-29 year age category, which is normally a period of active sexual drive with a further 19.8% still in the child bearing category indicates the need for available family planning education and the availability of affordable, accessible and acceptable family planning services.

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Occupation

Since only working women were considered for this study, it can be concluded that all respondents were occupied for at least eight hours per day (Item 2, Table 6).

Period in present occupation, qualification and salary

The majority of respondents 64 (79%) had held their posts for less than five years, which means that they were in most circumstances inexperienced workers in the specific job, with limited possibilities for promotion (Item 3). Promotion possibilities are also influenced by the highest school qualification which in this study seems to be very low as 70 (86.4%) have only grade 10 or lower (Item 4). The above-mentioned factors contribute to the low salary scales that most of the respondents received. Only 11.1% were on salary scales higher than N$1000-00 (Item 7, Table 8).

Marital status and housing

Sixty two (76.5%) of the respondents were single women who could not afford to have more children. Considering the fact that they were on minimum wages it is obvious that these women would not financially be able to support a larger household and suitable housing (Item 6, Table 7).

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4. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS WITH REGARD TO THE [illegible]

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Type of family

Although extended families are widely found in Namibia, most of the urban families have taken on a more westernized style of living. The majority, 32 (39.5%) of respondents came from nuclear families (Item 9, Table 10).

Hours away from home and child care arrangements

Although 93.9% of the respondents are away for eight hours or more, only 38,2% (Item 10) arranged for their children to be cared for.

One could arrive at the conclusion that those others who have children did not arrange for child care during their absence (Item 10).

5.4.2 FINDINGS, CONCLUSIONS AND RECOMMENDATIONS WITH REGARD TO THE STUDY QUESTIONS AND OBJECTIVES

5.4.2.1 SECTION TWO - **Findings, conclusions and recommendations**

Items covered in this section of the questionnaire were aimed at answering the following questions:

HOW MUCH KNOWLEDGE DO THE WORKING MOTHERS OF CHILD BEARING AGE HAVE ON THE METHODS OF FAMILY PLANNING?

Discussion of family planning, pregnancy and with whom

Only 30 (37%) of the respondents indicated that they were informed about family planning and pregnancy by their parents, nurses and other sources.

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The majority (63%) (Table 12) indicated that they did not have information of modern family planning methods and pregnancy. This implies information on pregnancy and family planning methods is not conveyed to the community, whether it be by parents, health care personnel or other sources.

Number of children

Twenty two of the respondents indicated before answering the questionnaire that they did not have children and did not see the necessity for answering these questions. They were later convinced by the researcher that the questionnaire was not only meant for those respondents with children. They then agreed to participate. Fifty nine (72.5%) of the respondents had children ranging from one to more than six. This information shows that since only 16 (19.8%) (Item 1, Section 1) of the respondents were above the age of 29 years most of the women with children were still in their most fertile years, of life and need to know more about family planning methods and the utilization thereof (Item 3, Section 2).

Given birth to child who died later and how many

A very low percentage of respondents had live children who died later that is, 6 (7.3%). This factor needs further investigation in the light of the general infant mortality rate (Item 4, Section 2).

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Previous use and current use of family planning methods and the type preferred (Item 8, Figure 1)

Since the majority of respondents did not respond to this item it can be concluded that only a limited number of women of child bearing age use contraceptives in Windhoek. From those who have indicated that they use or intend to use contraceptive methods, most of them preferred injectable methods, probably because of its effectiveness or because this particular method is widely known in Namibia. Since 22 respondents have indicated that they do not have children yet one could conclude that they are part of those 25 (30.9%) who still intend to have children (Item 13, Section 2).

Partners approval of using family planning methods (Item 13)

From the answers to this item it is obvious that the partners of those who have indicated the use of family planning methods do approve of the use thereof. Twenty two (27.2%) of the partners still do not approve of the use of family planning methods probably because of cultural factors or because of limited knowledge on contraceptive methods. On the other hand, the already high population growth of Namibia, could be increased.

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This will add to the burden of scarce natural resources which attributes to malnutrition, unemployment and housing problems. Excessive reproduction also carries risks for both mother and child as rising parity increases maternal and child mortality. It is a well known fact that the larger the family size the greater the ill health.

The final conclusion to this section is that the working women of child bearing age do not have enough knowledge on family planning methods.

Recommendations arising from section two of the study

The most important recommendations for this section are given below.

Firstly, there is a need to develop educational programmes on family planning. These programmes should be provided in the context of felt health needs rather than population education because it will then be likely to be more understandable and acceptable.

Secondly, everything that is possible should be done to help women to raise their literacy levels. The result will be that the constraints of poverty will be improved and mothers will be enabled to fulfil their important role in motherhood.

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Thirdly, there is need to sensitize the population at large. The population needs to be made aware of the resulting problems of high population growth like malnutrition, unemployment, teenage pregnancies causing high school drop-outs, high maternal and child mortality and morbidity rates caused by unplanned and unwanted pregnancies.

Fourthly, it is important to get the involvement and participation of non-governmental organizations and private practitioners in the distribution of information on contraceptive use and the availability thereof.

Fifthly, there is need to increase the choice of modern family planning methods of all health facilities in Namibia as well as to ensure that the message of how, when and what to use gets across to the population, especially to those members who are employed and do not always have the opportunity to visit health facilities very often. The functioning hours of community health services should be adjusted by the Ministry of Health and Social Services to accommodate those mothers who are not able to attend family planning services during working hours.

5.4.2.2 SECTION THREE - **Findings, conclusions and recommendations**

This section is divided into two parts since questions asked were directed at gathering data on:

Part one (Items 1 to 5)

Thirdly, there is need to sensitize the population at large. The population needs to be made aware of the resulting problems of high population growth like malnutrition, unemployment, teenage pregnancies causing high school drop-outs, high maternal and child mortality and morbidity rates caused by unplanned and unwanted pregnancies.

Fourthly, it is important to get the involvement and participation of non-governmental organizations and private practitioners in the distribution of information on contraceptive use and the availability thereof.

Fifthly, there is need to increase the choice of modern family planning methods of all health facilities in Namibia as well as to ensure that the message of how, when and what to use gets across to the population, especially to those members who are employed and do not always have the opportunity to visit health facilities very often. The functioning hours of community health services should be adjusted by the Ministry of Health and Social Services to accommodate those mothers who are not able to attend family planning services during working hours.

5.4.2.2 SECTION THREE - **Findings, conclusions and recommendations**

This section is divided into two parts since questions asked were directed at gathering data on:

Part one (Items 1 to 5)

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WHETHER THE FAMILY PLANNING SERVICES ARE SUFFICIENT FOR WORKING WOMEN OF CHILD BEARING AGE

AND

Part two (Items 6 to 14)

THE ATTITUDE OF HEALTH PERSONNEL TO THE DELIVERY OF FAMILY PLANNING SERVICES

Findings and conclusions - Part One

Supplies (Item 1 Figure 3)

From those respondents who use family planning methods the majority receive their supplies from the Ministry of Health and Social Services, though the percentage of users remain low. Other services like private practitioners contribute very little, if at all, while occupational health services are non-existent.

Accessibility of services (Item 2)

It has been shown that those respondents who make use of family planning services have easy access to these services. It could possibly be that those who do not make use of available services experience some problems with accessibility.

WHETHER THE FAMILY PLANNING SERVICES ARE SUFFICIENT FOR WORKING WOMEN OF CHILD BEARING AGE

AND

Part two (Items 6 to 14)

THE ATTITUDE OF HEALTH PERSONNEL TO THE DELIVERY OF FAMILY PLANNING SERVICES

Findings and conclusions - Part One

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Some industries are situated some distance from the city centre where public transport is not regularly enroute.

Functioning hours (Item 3 and 4)

The possibility of visiting health facilities during working hours does exist for some workers, 31 (38.3%) but does not for the majority, 50 (61.7%). Some female workers do experience problems in utilizing family planning services during working hours.

Occupational health services (Item 5 Table 16)

It was found that occupational health services do not exist at the majority of industries in and around Windhoek. By implication it means that people have to leave the work place during working hours to visit health facilities.

The final conclusion to this section is that family planning services for working women of child bearing age must be made available more readily.

Recommendations arising from part one

The following recommendations are made with regard to the availability and accessibility of family planning services:

Some industries are situated some distance from the city centre where public transport is not regularly enroute.

Functioning hours (Item 3 and 4)

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Recommendations arising from part one

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* The identification of strategic places where services could be made more accessible and user-friendly to clients;
* Modern family planning methods and the outlet thereof should be increased;
* Individuals should be made aware of their rights with regard to family planning issues;
* The training of health care providers in family planning should be reinforced and made compulsory in all health curriculae;
* Information on modern contraceptive methods should be made available at all major industries, especially where female workers are employed by the Ministry of Health and Social Services; and
* The delivery of family planning services should not be restricted to medical practices and governmental health facilities but should go beyond that to private health sectors and employer-supported services.

Findings and conclusions - Part Two

Almost one third of the respondents did not respond to items 7 to 14 of section three, probably because they do not make use of family planning services as indicated already while another third of the respondents gave negative responses on the attitude, guidance and problem-solving abilities of health care providers. It was also found that the respondents were not satisfied with the manner in which their individual needs were dealt with.

* The identification of strategic places where services could be made more accessible and user-friendly to clients;
* Modern family planning methods and the outlet thereof should be increased;
* Individuals should be made aware of their rights with regard to family planning issues;
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Reasons for client dissatisfaction could be due to ignorance of health care providers or because health care providers are not always well prepared and skilled to fulfil their role in the provision of family planning services. Another reason could be staff shortage as most health facilities do not have sufficient professional personnel to meet the demands of an ever growing society.

The conclusion reached for section two is that the attitude of health care providers are not satisfactory in the delivery of family planning services.

Recommendations arising from part two

* Much stronger interest and motivation is needed from health care personnel towards family planning services.
* The importance of skills and knowledge with regard to family planning matters should be observed by all health care providers who are directly involved in rendering family planning services.
* Health care providers should realize that acceptance and utilization of health services are greatly influenced by interpersonal relationships.
* The family planning policy of Namibia should be adhered to in all circumstances and clients should be given due respect.

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5.4.5 SECTION FOUR - **Findings, conclusions and recommendations**

Questions in this section were aimed at

DETERMINING THE ATTITUDE OF THE EMPLOYER TOWARDS THE HEALTH OF THE EMPLOYEE/WORKER

Findings and conclusions

Medical Insurance Scheme (Items 1 and 2)

It was found that only 20 (24.7%) of the respondents belong to medical insurance schemes from which 10 (12.3%) were private medical insurance schemes to which the respondents belong by personal choice and only 10 (12.3%) were compulsory medical schemes from the industry. This implies that some working women have to make use of the health services offered by the Ministry of Health and Social Services since occupational health services are almost non-existent.

Some employers also do not allow personnel from the Ministry of Health and Social Services to give health education sessions at the workplace. Neither do they give the workers time off to visit health facilities. That means that working mothers forfeit the opportunity to benefit from available health services.

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This violates the Principles of Women's Right to Health of the World Health Organization which states that:

> "obstruction of available health services and non-provision of reasonable access to otherwise unavailable health services deny women the right to health care...." (Cook, R. 1993: 44)

It is thus concluded that the attitude of some employers are not satisfactory and encouraging towards the health of their employees.

Recommendations arising from Section four

Although maternal and child health services are not included in the Labour Code as compulsory occupational health services to employees, comprehensive health and safety programmes are needed at the workplace to change the focus from illness care to health promotion and risk reduction. It is, thus, important to ensure a healthy and safe working environment. Employers should become more sensitive to the health needs of working women, as healthy, well informed workers can only be beneficial to the company in a number of ways. There is a need to develop guidelines for the legal promotion of women's health, particularly at the workplace.

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5.5 RECOMMENDATIONS FOR FURTHER RESEARCH

This study has proved that research in the following areas would contribute to improve the delivery of maternal and child health services and the utilization of family planning services in Namibia:

* An investigation of Women's Right to health care within the occupational milieu
* A survey to determine how the use of family planning services can reduce maternal and child mortality and morbidity

5.6 CONCLUSION

The study has shown that the real focus of integration of family planning services should occur at the level of the individual. Every contact of the mother/woman with the health care provider should be an opportunity to be utilized to promote all priority components of maternal and child health care and family planning.

For family planning to make a meaningful impact on maternal mortality in Namibia, it must be integrated into maternal and child health services at all levels of health care.

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APPENDIX

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APPENDIX A

LETTER TO ASK PERSONNEL MANAGER FOR

PERMISSION TO DISTRIBUTE

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APPENDIX A

LETTER TO ASK PERSONNEL MANAGER FOR

PERMISSION TO DISTRIBUTE

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Annexure A

TO: The Personnel Manager

FROM: Ms S Black
Faculty of Medical and Health Sciences
University of Namibia

DATE: April/May 1994

RE: M. NSc: A SURVEY TO DETERMINE FACTORS THAT INFLUENCE THE UTILIZATION OF MATERNAL AND CHILD HEALTH FACILITIES/SERVICES BY WORKING WOMEN OF CHILD BEARING AGE (15-45 YEARS) WITH SPECIFIC REFERENCE TO FAMILY PLANNING

With regard to the high population growth rate in Namibia, I have considered to undertake a study to determine the following factors:

- What employees know about family planning methods
- Whether employes know about existing facilities with regard to family planning
- Whether the existing family planning services are utilized satisfactorily

I would thus appreciate if permission could be granted by your industry to distribute my questionnaires among your employees.

Thank you

.....
MS S BLACK

Annexure A

TO: The Personnel Manager

FROM: Ms S Black
Faculty of Medical and Health Sciences
University of Namibia

DATE: April/May 1994

RE: M. NSc: A SURVEY TO DETERMINE FACTORS THAT INFLUENCE THE UTILIZATION OF MATERNAL AND CHILD HEALTH FACILITIES/SERVICES BY WORKING WOMEN OF CHILD BEARING AGE (15-45 YEARS) WITH SPECIFIC REFERENCE TO FAMILY PLANNING

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APPENDIX II

Q 1520-1-1-1

APPENDIX B

QUESTIONNAIRE

APPENDIX B

QUESTIONNAIRE

[illegible]

[illegible] [illegible]

[illegible] [illegible]
[illegible]
[illegible]

[illegible] [illegible]

[illegible] [illegible] PROPOSAL TO IMPROVE [illegible] TREATMENT [illegible]
[illegible]
[illegible]
[illegible]
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Annexure B

TO: The Employee

FROM: Ms S Black
P O Box 10322
KHOMASDAL

DATE: April/May 1994

RE: M. NSc: A SURVEY TO DETERMINE FACTORS THAT INFLUENCE THE UTILIZATION OF MATERNAL AND CHILD HEALTH FACILITIES/SERVICES BY WORKING WOMEN OF CHILD BEARING AGE (15-45 YEARS) WITH SPECIFIC REFERENCE TO FAMILY PLANNING

The employee has an important contribution to make in the determination of factors which hamper the utilization of existing family planning services.

It would, thus, be appreciated if you could complete the attached questionnaire as soon as possible.

Please note that all information will be kept confidential and also that no name or address needs to be submitted to me.

Your co-operation is appreciated.

Thank you

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MS S BLACK

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MS S BLACK

[illegible]

[illegible]

[illegible]

[illegible]

QUESTIONNAIRE

THIS QUESTIONNAIRE SHOULD BE COMPLETED BY THE EMPLOYEE

SECTION 1

PERSONAL DATA (Biographical data)

Your personal data is important to determine whether all respondents have the same personal/biographic characteristics.

Please indicate your answer with a cross [x].

Example:	15-25 yrs	x
Indicate your age	26-35 yrs	

1. Indicate you age.

15-25 yrs	
26-35 yrs	
36-45 yrs	

2. Indicate your present occupation.

Professional	
Clerical	
Supervisor	
Cleaner	
Other	

3. How long have you held your present job?

0-5 yrs	
5-10 yrs	
10 yrs and more	

QUESTIONNAIRE

THIS QUESTIONNAIRE SHOULD BE COMPLETED BY THE EMPLOYEE

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Other	

3. How long have you held your present job?

0-5 yrs	
5-10 yrs	
10 yrs and more	

[illegible]

[illegible]

[illegible]

[illegible]

4. Your highest Academic qualification is:

Standard 6	
Standard 8	
Standard 10	
Degree	
Other	

5. Can you read and write?

Yes	
No	

6. Indicate your marital status.

Married	
Divorced	
Single	

7. What is your income per month?

N$ 200-399	
N$ 400-599	
N$ 600-799	
N$ 800-999	
N$1000-1199	
N$1200-1399	

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Standard 6	
Standard 8	
Standard 10	
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Other	

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No	

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N$ 400-599	
N$ 600-799	
N$ 800-999	
N$1000-1199	
N$1200-1399	

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

8. Indicate your place of residence.

Katutura	
Khomasdal	
Other	

9. Indicate the type of family within your home.

Mother, father and their children	
Parents, children, aunt uncle, grandmother, grand-father	
Single parent with children	
Other	

10. Indicate how many hours you are away each working day.

8 hours	
More than 8 hrs	
Less than 8 hrs	

11. Indicate whether you have any day care arrangements for your children while you are at work.

Yes	
No	

8. Indicate your place of residence.

Katutura	
Khomasdal	
Other	

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Yes	
No	

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

SECTION 2

DATA ON KNOWLEDGE AND UTILIZATION OF FAMILY PLANNING SERVICES

1. Before you became pregnant for the first time, did your parents or anybody else discuss pregnancy and family planning with you?

Yes	
No	

2. If "yes" who discussed family planning with you for the first time?

Parents	
Nurse	
Other	

3. Indicate how many children you have.

- to 0	
1 to 3	
4 to 6	
7 to 10	
More	

4. Have you ever given birth to a child who was born alive but died later.

Yes	
No	

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No	

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Other	

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- to 0	
1 to 3	
4 to 6	
7 to 10	
More	

4. Have you ever given birth to a child who was born alive but died later.

Yes	
No	

5. If "yes" how many?

1	
2	
3	
4	
more	

6. Are you pregnant presently?

Yes	
No	

7. Have you ever used any method to avoid/delay pregnancy?

Yes	
No	

8. What have you used?

Injection	
Pill	
Other	

9. How many living children did you have when you first started to use family planning methods?

1-4	
5-9	
10 and more	

5. If "yes" how many?

1	
2	
3	
4	
more	

6. Are you pregnant presently?

Yes	
No	

7. Have you ever used any method to avoid/delay pregnancy?

Yes	
No	

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[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

10. Are you currently using any method to avoid pregnancy?

Yes	
No	

11. Which method are you currently using?

Injection	
Pill	
Other	

12. Would you like to have more children?

Yes	
No	

13. Does your husband/partner approve of couples using contraceptives?

Yes	
No	

QUESTION 14

ANSWER BY WRITING SENTENCES IN THE SPACE GIVEN BELOW

14. Indicate in not more than (3) three sentences why you are not using family planning methods.

    1.
    2.
    3.

10. Are you currently using any method to avoid pregnancy?

Yes	
No	

11. Which method are you currently using?

Injection	
Pill	
Other	

12. Would you like to have more children?

Yes	
No	

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Yes	
No	

QUESTION 14

ANSWER BY WRITING SENTENCES IN THE SPACE GIVEN BELOW

14. Indicate in not more than (3) three sentences why you are not using family planning methods.

    1.
    2.
    3.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

SECTION 3

AVAILABILITY OF FAMILY PLANNING SERVICES

This information is important to determine whether there are family planning services available within easy reach and also to find out whether the services rendered are to the satisfaction of its consumers.

1. Indicate from where you receive your family planning supplies.

Hospital	
Community health nurse	
Occupational health services	
Private doctor	

2. Indicate whether the services used are easy to reach.

Yes	
No	

3. Indicate whether there is regular transport available to health services.

Yes	
No	

4. At what times does the service function?

During working hours	
After working hours	

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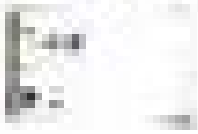

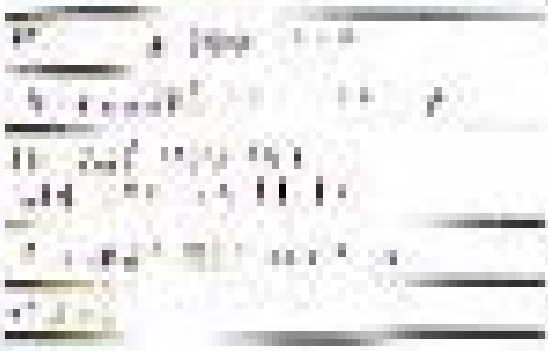

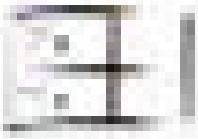

5. Are there any occupational health services available at your working place?

Yes	
No	

6. Indicate whether there is anything you particularly disliked about these services.

Waiting too long	
Personnel unfriendly	
Method you want to use not availabe	
Privacy not observed	
Other	

7. Indicate whether there is information available on family planning methods at the service.

Yes	
No	

8. Is there good interpersonal relationship between you and the health care provider?

Yes	
No	

9. Do you feel free to ask the health care provider for help when needed?

Yes	
No	

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[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

10. Are you satisfied with the attitude of the health care provider towards you?

Yes	
No	

11. Are your problems with regard to family planning dealt with by the health care provider/s?

Yes	
No	

12. Are you aware of new developments in family planning?

Yes	
No	

13. Does the health care provider give you opportunity to take your own decisions with regard to family planing?

Yes	
No	

SECTION 4

THE ATTITUDE OF THE EMPLOYER TOWARDS THE HEALTH OF THE EMPLOYEE/WORKER

Information in this section is important to determine the attitude of the employer towards the health of the employee/worker.

10. Are you satisfied with the attitude of the health care provider towards you?

Yes	
No	

11. Are your problems with regard to family planning dealt with by the health care provider/s?

Yes	
No	

12. Are you aware of new developments in family planning?

Yes	
No	

13. Does the health care provider give you opportunity to take your own decisions with regard to family planing?

Yes	
No	

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[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

1. Indicate whether you belong to a medical insurance scheme.

Yes	
No	

2. If your answer is "yes". Indicate the type of medical insurance.

Private	
Compulsory for all workers	

3. Does the employer allow personnel from the Ministry of Health and Social Services to give health education sessions at the workplace?

Yes	
No	

4. Do you feel free to approach the employer when encountering health problems?

4.1 In general

Yes	
No	

4.2 Specifically related to family planning

Yes	
No	

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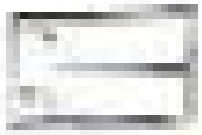

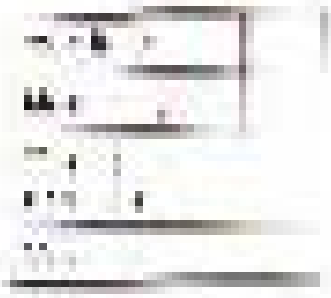

5. Does the employer give you opportunity to visit health facilities during working hours?

Yes	
No	

6. How often are you allowed to visit health facilities during working hours?

Weekly	
Monthly	
Every 6 months	
Yearly	

7. Does the employer encourage and make time available for attendance at family planning services?

Yes	
No	

5. Does the employer give you opportunity to visit health facilities during working hours?

Yes	
No	

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