ABSTRACT

Family planning is conscious and deliberate process of determining the number and interval between the children one bears. It incorporates reliable methods of contraception combined with the use of fertility awareness methods. In Namibia, family planning services are freely available in all public health facilities throughout the country.

Although widely understood and used, family planning has not yet produced the desired results of reducing unwanted and high-risk pregnancies.

It is against this background that the researcher interviewed women attending family planning services in Otjiwarongo district to explore and describe their experiences when utilising these services. This study is relevant and significant because it will supply managers at all levels of health care delivery with valuable information about the quality of the services being provided.

The study was qualitative in nature and descriptive in design to facilitate eliciting the experiences women have with family planning services over a period of time. To be included in the sample, women had to be long-term users of family planning services as evidenced by continual visits to health care facilities.

This study revealed wide variations of women's experiences with, and perceptions of the family planning services offered in Otjiwarongo district. Despite the fact that some women were generally satisfied with the friendly atmosphere and the respect that they received, some women expressed their dissatisfaction about the services.

Most women in the study expressed satisfaction with regard to information and mechanisms to ensure continuity, the availability of contraceptive supplies and the fact that services were offered free of charge.

However, findings from this study further revealed that health care workers sometimes do not receive the women, especially the youth in friendly manner and treat them with disrespect. Some women indicated that they were not given chances to express their feelings about contraceptives and family planning in general. It was also revealed that women attending family planning services did not receive adequate information regarding different contraceptive methods, their contra-indications and side effects. Also featuring prominently in this study were reports that respect for privacy and confidentiality was not observed by health care workers, while some expressed dissatisfaction with long waiting hours at clinics.

Based on these findings, the researcher recommends that a client-centred orientation and adolescent friendly family planning services be adopted as the most effective approach to counselling and providing information to clients. To ensure informed choice, health workers should provide accurate, clear and useful information and advice about reproductive health, family planning and correct use of contraceptives methods, while taking privacy and confidentiality in consideration.

Family planning services should be part of an integrated and comprehensive sexual and reproductive health programs. To ensure maximum access to all, a community-based distribution should be introduced to deliver family planning services to communities in remote areas.

DECLARATION

I hereby declare that "The study of the experiences of women utilising family planning services in Otjiwarongo district, Namibia", is a true reflection of my own research, and that this work, or part thereof has not been submitted before for a degree in any other institution of higher education.

Vaino Tauya Date:……

ACKNOWLEDGEMENT

Above all I wish to thank almighty God for granting me strength throughout my studies that has sustained me until their completion.

Secondly, I would like to extend my gratitude to my research supervisors, Prof. A. van Dyk and Dr. K. Hofni - //Hoebes, for their tireless guidance during all stages of this study.

I finally would like to express my appreciation to the Ministry of Health and Social Services, in particular the Research Unit under the Subdivision, Management Information and Research, in the Directorate of Policy Planning and Human Resource Development, my colleagues and the Directorate: Otjozondjupa Health Directorate for helping to make this research a success.

DEDICATION

This thesis is dedicated to my wife, Niita Tunomua Hileni Tauya, for her love, encouragement and support during the compilation of this document.

I also dedicate this work to my parents, Aina and Erkky Tauya, to my children Magano, Etuhole, Niilo and Natangwe for their love, emotional support and tolerance.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CDC	Center for Disease Control
CHW	Community Health Workers
HIV	Human Immunodeficiency Virus
DHS	Demographic and Health Survey
FHI	Family Health International
GRN	Government of the Republic of Namibia
ICPD	International Convention on Population and Development
IUCDs	Intrauterine Contraceptive Devices
KAP	Knowledge Attitude and Practice
LAM	Lactation Amenorrhea Method
MCHC	Maternal and Child Health Care
MOHSS	Ministry of Health and Social Services
NDHSS	Namibia Demographic and Health Survey
PMTCT	Prevention of Mother to Child Transmission
STIs	Sexual Transmitted Infections
UNFPA	United Nations Food and Population Fund
ASAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

This chapter presents background information, makes a statement of the problem, states the purpose of the study and identifies the objectives, significance and operational definitions used in the study.

1.2 Background

Family planning programmes help individuals acquire the information and services they require to plan the timing, number and spacing of pregnancies effectively. Around the globe, couples have for generations found ways to avoid pregnancy until they chose to have a child. In fact, most African cultures have a history of awareness of the detrimental effects of producing children too close to one another. Nearly 400 million women in developing countries use family planning to prevent unwanted pregnancies (World Health Organization, 1998, p. 5).

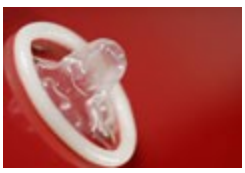
In Namibia, modern contraceptive methods of family planning were officially introduced by the government in the early 1970s. Subsequently, family planning services were gradually expanded and offered in clinics after professional and semi-professional nurses had been trained in 1979 (Ministry of Health and Social Services,

1997, p.1). Today, family planning services are freely available at all public health facilities and through outreach services throughout the country. For instance, the Namibian Demographic and Health Survey (DHS) conducted in 2000 revealed that the level of knowledge in the population concerning family planning is very high. Nearly 97% of women surveyed had heard of at least one method of contraception The survey also revealed that 63% of all women between the ages of 15 and 49 have used a contraceptive method at some time in their lives. Furthermore, the most commonly used method in Namibia is by injection (39% of all women, aged 15–49), followed by male condoms (28%), while oral contraceptives are rarely used (MOHSS, 2003, p. 57).

Most studies revealed that women prefer longer-acting injections and implants over the shorter-acting ones. A qualitative study conducted in Mexico revealed that women considered injections to be less troublesome than oral contraceptives based on perceived effectiveness, convenience, and absence of side effects (Hardon, 2005, p. 68).

Family planning choices are, in part, dependent on the effectiveness of the contraceptive method in preventing an unplanned pregnancy, availability of the method and medical eligibility (WHO, 2004, p. 5). Common family planning methods are:

- Barrier methods



Barrier methods include condoms, spermicides, diaphragms and cervical caps that prevent fertilisation by blocking the physical union of sperm and egg.

- Oral contraceptives

Oral contraceptives come in the form of tablets, often referred to as “pills”, and prevent fertilisation by thickening the mucus produced by the cervix so that sperm cannot pass.

- Injectables

Injectable contraceptives contain progestogen and are administered every two to three months, depending on the type. They prevent pregnancy by producing changes in a woman's body similar to those caused by oral contraceptives.

- Intra-uterine contraceptive devices (IUCDs)

IUCDs are plastic or copper devices that are inserted in the womb through the vagina for a period of time to prevent pregnancy. An IUCDs is a highly effective contraceptive method and may be used for long periods of time.

- Sterilization

Female sterilization, or tubal ligation, is a surgical procedure that permanently prevents fertilization. It involves cutting each fallopian tube into two and tying or burning the ends separately.

- Natural methods

Are all those that do not involve taking a drug or using a device to prevent pregnancy. Methods include breastfeeding, the calendar rhythm, the cervical mucus test, the body temperature test, and withdrawal (coitus interruptus).

Each contraceptive method has advantages and disadvantages and no single method is suitable for everybody. The more methods available, the more likely it will be for every woman to find one that will be suitable for her. In addition, the availability of a range of methods will enable a woman to change methods as her circumstances change. Diversity has real benefits, and availability will motivate a woman to space pregnancies and limit the number of children she bears as awareness of the advantages grows (Cubbins, Brewster & Tanfer, 2002, p. 12).

A family planning programme that endeavors to cater to a client's contraceptive needs is expected to be flexible, allowing methods to change as a client's needs change. The difference between a woman's needs and a couple's needs will affect the choice that the woman makes. For example, a woman who wishes to space her pregnancies requires a different contraceptive than one who wishes to stop having children altogether (Hardjanti, 2005, p. 6). Factors such as convenience and previous experience also play an important role in determining the type of contraceptive a

woman chooses. Although new contraceptives have been introduced, demographic and health surveys in most countries indicate that the pill is still the most popular contraceptive method (Hardon, 2005, p. 68).

The aim of family planning services should be to contribute to the health and well-being of women, their children and their families, by reducing the frequency of maternal deaths and illnesses resulting from unwanted or high-risk pregnancies. It is widely known that the number of children a woman bears will have an impact on her health and on the likelihood of her children growing up healthy and educated. In addition, it has been proven that family planning produces benefits related to gender equality, child survival, reduction of poverty, promotion of economic growth and improvement of family well-being by lowering fertility (United Nations Population Fund, 2005, p. 41). Robey and Upadhayay (1999, p. 2) stated that family planning provides many and diverse benefits for individual users as well as their countries. Some of these benefits are:

- **Saving women's lives**. By using contraceptives, women avoid unsafe abortions. This is a relevant issue in Namibia, where it was discovered that 17% of maternal deaths were caused by abortion-related complications.
- **Saving children's lives**. An infant's chances of survival can be improved by about 50% if its mother spaces her pregnancies at least two years apart. In addition, women who limit childbearing to their healthiest reproductive years (age 20 to 40 years) are much less likely to bear children who die during infancy.

- **Offering women more choices**. Women who have access to family planning can make reproductive choices such as delaying motherhood until they have completed their education. Through family planning, women become motivated to bear only the number of children they can afford to care for properly, avoiding the depletion of resources they require to maintain a family.

According to UNFPA (2005, p. 41), family planning provides proven benefits in terms of gender equality, reduction of maternal deaths, and improvement of child survival. According to the United States Agency for International Development (USAID) (2006, p. 7), governments would vastly improve the health and quality of life for millions of women, girls, and families if they helped citizens achieve their desired fertility through family planning. In addition, the immediate personal benefits of quality family planning services include, among others, safety and effectiveness, client satisfaction, longer continuation and wider use of contraception (William, 2006, p. 4).

Consideration of the aims and proven results of family planning services reveals clearly how important these services are. A high standard in family planning services should be maintained to ensure that women of child-bearing age (15 to 49 years) will be able to meet their reproductive health needs safely and effectively (Bogart & Thornburn, 2006, p. 3). The success of family planning depends, among other things, on the quality of the service itself, since quality will influence whether a woman continues its use or not (Kols & Sherman, 1998, p. 3). The perception of being cared for can be the most crucial factor for clients who want to avoid

pregnancy but who are ambivalent about the service. Uncertainty about a family planning service is a negative perception of the service itself.

Although tremendous advances in the development of safer and effective contraceptives have been made, millions of individuals and couples around the world are still unable to practice family planning according to their wishes (WHO, 2004, p.5). Some causes of this unaddressed need are poor quality services, including inadequate interaction between clients and providers, substandard technical competence of providers and inadequate information. Other causes are technological issues such as limited availability or inappropriate choices regarding methods. Still another cause is the fear of side effects on the part of clients (WHO, 2007, p.7). One thing that has been learned in other countries is that the introduction of each new method of contraception attracts new users and consequently increases the prevalence of contraception (WHO, 2002, p. 5).

The quality of health care, and family planning in particular, has been defined in many ways, both from a provider's and a client's perspective (Gorbach, Magnani & Veney, 2005, p. 8). In the current study, focus will be on the experience of family planning from the female client's perspective. From this point of view, aspects of privacy and confidentiality are just as important as the technical quality of the service, as is competent counseling, friendly personnel and the opportunity to make an informed choice about contraceptive methods (Bryant, Piotrow & Salter, 1998, p. 12).

Kols and Sherman, (1998, p. 4) recommended a model, widely known as the Bruce-Jain framework, that identifies six factors for measuring the quality of care in a family planning service. These factors are choice of method, information supplied to clients, demonstrated competence, interpersonal relationship, mechanisms to encourage continuity and an appropriate constellation of services.

Between March and June of 2002, a study was conducted in Malawi to identify barriers to the utilisation of and access to family planning methods. This study revealed that key barriers to the use of family planning services are: unavailability of contraceptive supplies, lack of method counseling to help people make informed choices and poor client-provider relations (Dwyer & Jezowski, 2000, p. 16).

The high incidence of unplanned pregnancies, teenage pregnancies and abortions in Namibia is a clear indication that the family planning services provided in health facilities needs to be improved. The situation is exacerbated by the fact that pregnancy is particularly risky for very young females, for older women with several children and for women with health problems. Furthermore, teenage mothers are more likely to suffer from severe complications during delivery (MOHSS, 2003, p. 36).

Regarding teenage pregnancies, a publication of the Ministry of Health and Social Services reported that approximately one in seven teenagers in Namibia have bore a child (MOHSS, 2003, p. 54). Another report indicated that 22% of women in Otjiwarongo district (Otjozondjupa region) who use antenatal care facilities for the first time are between 15 and 19 years of age (MOHSS, 2006, p. 27). The 2001

Population and Housing Census indicated that teenage females comprised 11% of the total fertility in this region (National Planning Commission, 2003, p. 63).

The *Hospital Based Study on Abortion*, conducted in Namibia in July 2000 to determine how many abortions are reported by hospitals, found that the number of abortion-related problems was alarming and might be attributable to unwanted pregnancies (MOHSS, 2000, p. vii). The study recommended that the ministry consider strengthening provisions for family planning services as a means of reducing the number of abortions and the severity of consequences of abortion (MOHSS, 2000, p. 29).

Technical competence involves factors such as competence in applying clinical techniques for service delivery, the observance of protocols and provisions for asepsis required to deliver clinical methods such as the insertion of an intrauterine contraceptive device (IUCD) or the performance of sterilisation (Junhong, 1999, p.9). Health workers providing family planning services should possess adequate and appropriate skills and be able to communicate their knowledge to clients to help them make informed choices, to ensure the safety of their female clients and to maintain a high standard of medical care.

Women judge the technical competence of the services they receive in a personal way. For example, clients surveyed in Chile based their judgment on the cleanliness of the clinic, while in Kenya and Zambia women judged competence based on how they were examined. In general, one may say that clients measure demonstrative

competence according to whether their needs are met and their problems are resolved (Jejeebhoy, 1998, p. 10).

1.3 Problem statement

Despite the fact that policies and guidelines for rendering family planning services exist, how women experience the manner in which these services are administered by health care staff has yet to be evaluated. Findings of studies on family planning services suggest that, although widely understood and used, family planning has yet to produce desired results in reducing unwanted and high-risk pregnancies.

Women of reproductive age will not use family planning services if they don't feel comfortable about them, and this rejection can result in a higher incidence of unwanted pregnancy. According to MOHSS, unwanted pregnancies are common, with 23% of the women interviewed admitting they had fallen pregnant when they did not want to (MOHSS, 2003, p. 56). There are also frequent reports of unwanted babies being discarded by mothers. The large numbers of street children, as well as national statistics on child neglect, also indicate that some families cannot feed the children they produce.

Many factors may contribute to either negative or positive perceptions of family planning, which in turn could influence a women's inclination to visit a family planning clinic. The attitude of attending health workers, as well as the degree of professionalism in which they conduct interviews or provide advice on contraceptives, could be crucial. According to King (2000, p. 42), health care

providers are often criticized for either planning or giving care that does not take clients' perceived needs, wishes or expectations into consideration.

It is against this background that the researcher has explored and described the experiences of women utilising family planning services in Otjiwarongo district.

1.4 Purpose of the study

The purpose of the study was to investigate and describe the experiences of women of child bearing age who took advantage of family planning services in Otjiwarongo district.

1.5 Objectives

The objectives of this study were:

(a) to describe the experiences that women of reproductive age report regarding the family planning services they receive in Otjiwarongo district; and

(b) to submit recommendations how family planning services could be improved.

1.6 Significance of the study

The study would provide relevant and significant information to managers at all levels of health care delivery about the quality, appropriateness and completeness of

family planning services. Further, the study could provide information whether a lack of availability or choice of contraceptive methods might contribute to problems experienced by women using family planning services in Otjiwarongo district and indicate that such services are of poor quality. The results should also expose any deficiencies in technical competency or poor attitudes, such as a lack of sensitivity towards clients on the part of staff, as well as provide information about whether the constellation of services is adequate.

As mentioned by Bender and Santader (1999, p. 14), policy makers and service providers are now placing greater emphasis on assessing the quality of services provided. Consequently, the importance of understanding family planning services from the point of view of end users has grown. Although the knowledge, attitudes and practices (KAP) of users have received much attention, few studies have investigated the problems that prevent people from utilising family planning services (Gangopadhyay & Das, 1998, p. 1).

1.7 Operational definitions

Experience: The Concise Oxford Dictionary defines experience in several ways: "Actual observations of, or practical acquaintance with, facts or events; a process of gaining knowledge or skill acquired from seeing or doing something; an event or activity that affects one in some way; or an activity that has given one a feeling of pain, pleasure, difficulty or hardship" (Allen, 1998, p. 411).

This study will focus on actual observations of women attending family planning services, and specifically on those observations that relate to interaction with health workers.

Utilizing: The Concise Oxford Dictionary defines utilizing as to put to use, or to make practical or profitable use of something. In this study utilisation refers to women who make practical or profitable use of family planning services (Allen, 1998, p. 710).

Family planning service: A conscious, deliberate process of determining the number and interval between the children one bears (Shryock & Siegel, 1998, p. 30). It is usually applied to the circumstances of a monogamous female-male couple that wishes to limit the number of children they conceive or to control the timing of pregnancy. Family planning incorporates reliable methods of contraception combined with the use of fertility awareness methods.

These services include clinical assessment and screening of clients to determine eligibility, counseling on methods and the provision of a contraceptive method. Family planning services are available free of charge at all public health facilities on a daily basis.

1.8 Summary

This chapter presented the general background of the thesis and a statement of the problem to be addressed by the survey. It also covered the purpose of the study and its objectives, significance and the operational definitions used.

The following chapter will focus on the research design and methodology.

CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1 Introduction

This chapter focuses on the research design and method, target group and the criteria used for the selection of respondents, on sampling procedure and how data was generated. It also indicates where the study took place, highlights the strategies used to ensure that it was conducted effectively, how data was analysed and the ethical considerations involved.

2.2 Design of the study

2.2.1 Qualitative approach

The study was qualitative in nature. A qualitative research may be defined generally as a study conducted in a natural setting in which the researcher, using an interview schedule for data collection, gathers words or pictures, analyses them inductively, determines the meaning of participants' responses, and describes a process that is both expressive and persuasive in language (Mensah, 2000, p. 6).

For this reasons, the qualitative research was adopted because it provides insight into people's "lived" experience, discovering how people interpret the world around them and how this interpretation influences their behaviour (Bryman, 1998. p. 29).

2.2.2 Descriptive approach

The study utilized a descriptive design, as it is directed towards describing the experiences of women utilizing family planning services. The researcher got information from these women when describing their experiences, thereby helping in making recommendations how family planning services should be improved. Descriptive study gives information that help health service providers and planners to revise services and allocate resources effectively (Joubert, Karim & Katzenellenborg, 1997, p. 66).

2.2.3 Explorative approach

The objective of exploratory research is to gather preliminary information that will help define problems and suggest further studies. The aim of the researcher in this study was to gather information, gain insight and generate meanings regarding the experiences of women utilising family planning services.

This approach method was selected because it supports the exploration of subjective experiences that are recorded through a series of in-depth interviews with users. Another advantage of the approach is that it generates data that enhances insight into the phenomenon itself rather than merely provide representative information (Bowling, 1997, p. 338).

2.2.4 Contextual approach

The study was limited to a specific context of Otjiwarongo district in Otjozondjupa region, therefore, the results applied only to this district. Women in other districts may have different experiences. The study was conducted on women who made multiple visits to family planning clinics as they have broader experiences.

2.3 Population

Population refers to all elements or subjects that possess the attributes addressed by a given study (Brynard & Hanekom, 2006. p. 55). The target population for this study was all women of child bearing age who used family planning services at Orwetoveni clinic in the Otjiwarongo district. One thousand, one hundred women utilised family planning services in the district in 2007 (MOHSS, 2007, p. 20).

2.4 Sample and sampling

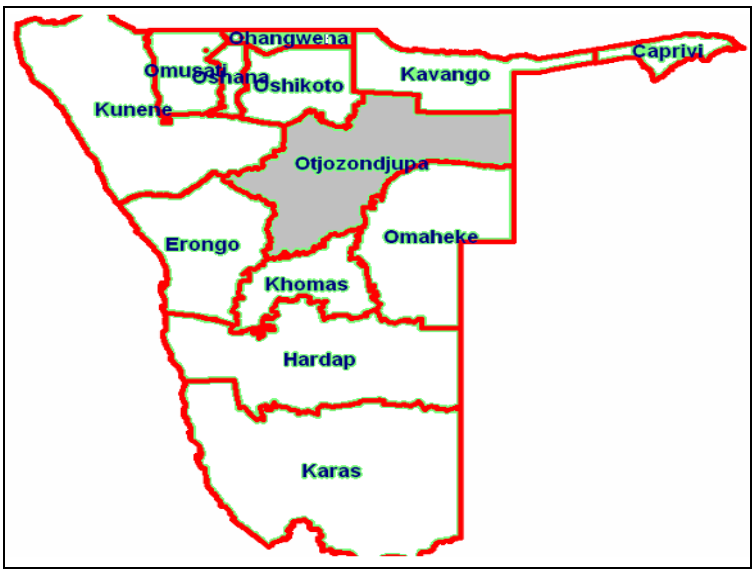
A sample is a subset of the population that participates in the study. The researcher used a non-probability sampling method to select participants from women visiting the family planning clinic. A purposive sampling method was used to select participants from the population attending family planning services during the year 2007. Participants were selected for the study, till data saturation was reached. That was after 45 participants were interviewed.

Women who were included (inclusion criteria) in the sample made multiple visits to the family clinic as they have a broader experience using the family planning service.

2.5 Setting for the study

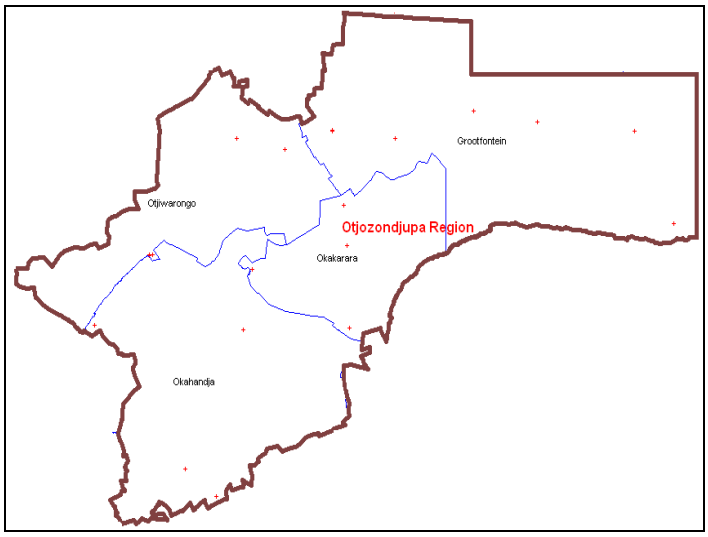
The study was carried out in the Otjiwarongo district of Otjozondjupa region. The area of the region is 105,185 square kilometers, and has a population of approximately 145,000 (MOHSS, 2006, p. 4). The region is in the central part of the country and is bordered by Kunene, Oshikoto and Kavango regions in the north, Erongo region in the west, Khomas region in the south and Botswana in the east (refer to figure 2.1 below).

Figure 2.1 Map of Namibia showing regions



The region is divided into four health districts, Otjiwarongo, Grootfontein, Okakarara and Okahandja and contains four district hospitals; two health centers and 21 clinics (refer to figure 2.2 below).

Figure 2.2 Map of Otjozondjupa region showing health districts



Otjiwarongo district contains one district hospital, Otjiwarongo State Hospital, one health center (at Otavi) and three clinics (Orwetoveni, Kalkfeld and Osire). All these facilities routinely provide family planning services free of charge. All commonly used contraceptive methods, including injectables, pills and condoms are generally available at these facilities. Contraceptives are also provided through outreach services. However, IUCDs and sterilization are only provided at the district hospital when doctors are available to carry out the procedures involved.

2.6 Pilot testing

A pilot study, also referred to as a "feasibility" study, is a small version of a full-scale study. It also refers to specific pre-testing of a particular research instrument such as a questionnaire or interview schedule (Peat, Mellis, Williams & Xuan, 2002, p. 8). An advantage of a pilot study is that it can give advance warning of possible failure of the main project, indicate where research protocols might not be followed, or whether proposed methods and instruments are inappropriate or too complicated.

A pilot test of the interview was conducted with five participants at Kalkfeld clinic in Otjiwarongo district. This facility was not included in the main study. After pilot testing was conducted, critical aspects of how questions should be posed were noted and then implemented during the main study.

2.7 Data collection

Data was collected using unstructured interviews. This approach encourages participants to speak freely about personal experience and their feelings about family planning services (Kruger & Welman, 2001, p. 188). Unstructured interviews have the advantage of offering a wide range of responses that also help capture nuance in people's answers, at the same time avoiding influence of the outcome that would result by pre-determining specific responses (Beiske, 2002, p. 1). Participants had the opportunity to reveal relevant information in a natural way, to qualify their answers and to explain underlying meanings or reasons for their responses.

Interviews are more suited to elicit people's perceptions and underlying feelings. The approach also allows a researcher to rephrase questions and get clarifications on responses. During interviews, data was also gathered using less structured methods, such as by observation, to generate rich descriptions of experience (Bamberger, 2000, p.25).

In-depth, privately conducted interviews gather information in such a way that it is less likely to influence responses based on group dynamics and social conformity than would a focus-group setting. Conversation during interviews was free flowing, enabling the interviewer to follow up questions or to pursue new information that might spontaneously arise. The interviewer took notes during the interviews. Responses to questions and other comments were analysed and reported in the context of common themes, in addition to any insights gained through interviews with single individuals.

Interviews are frequently used when it is difficult to organise a focus group, if the subject is potentially embarrassing or when participants may resist making candid comments in a group setting. Interviews are more effective when the information sought is of a confidential nature. A total of 45 interviews were conducted, each lasting until data was saturated and no additional information from a respondent was forthcoming.

2.8 Interview venue

Interviews were conducted at the main health facility, Orwetoveni clinic, which provides family planning services on a daily basis. Encouraging participants to feel confident in conversation and to share their experiences, was essential in developing a mutual trusting relationship. A place situated at the exit of the facility was selected and prepared to conduct the interviews. This secluded area helped participants feel at ease during the interview process. According to Merriam (1998, p. 3) qualitative research generally takes place in the field and often involves face-to-face encounters with subjects.

In prelude to interviews, participants were received in a friendly manner, the procedure was explained and their permission was obtained for participation (see ethical considerations on page 21). Interviews were not conducted as question-and-answer sessions but were held as a conversation during which participants were encouraged to freely express their views. The researcher took field notes of all responses given during interviews. No audio recordings were made. Field notes are comprised of detailed observations made by the interviewer of everything that is said during an interview (Kruger, Mitchel & Welman, 2005, p. 198). The initial question posed to each participant was: "Describe to me your experience when you utilise family planning services." The question was followed by in-depth discussion and additional questions posed based on the responses from individual participants.

2.9 Data analysis

Qualitative data analysis is a process of systematic organisation of field notes to ensure that information derived from them addresses the subject of the research comprehensively (Bailey, 1997, p. 25). Qualitative research is often reported in the form of rich narrative style in order to reconstruct meaning by giving participants "a voice" (Akpo, 2005, p. 271). This manual processing ensured that a good grasp of the original data is retained (Bowling, 1997, p. 344).

To ensure quality, information was analysed for completeness and consistency throughout the process. Inductive analysis was used to sort data into categories that provided descriptive information in the context of the study. Transcripts of the interviews were reviewed and related topics were identified as themes and sub-themes, through the process of open coding. Open coding involves the naming and creation of categories and themes pertaining to certain segments of the text through close examination of the data (De Vos, 2007, p. 338). Data analysis continued throughout the entire process and interpretations were re-written a number of times to produce confidence in the findings, ensuring that they faithfully represented the reality constructs of the participants.

2.10 Strategies to ensure trustworthiness

Guba and Lincoln (as cited in Moss, 2001, p. 28) have projected an alternative set of criteria to establish trustworthiness for a study. Guided by the constructivist

paradigm as conventional criteria for credibility, transferability, dependability and conformability. According to Marie (2003, p. 2) these criteria play an important role in building and enhancing trustworthiness of a study. The strategies used in this study to achieve trustworthiness are explained in the following table:

Table 2.1: ***Application of strategies to ensure trustworthiness***

Strategy	**Criteria**	**Application**
Credibility	Prolonged engagement	✓ The researcher had 10–15 minutes with each subject to explain purpose and ethical considerations, and then a 30–40 minute interview. These steps initiated the researcher's engagement with participants. ✓ Repeated re-reading of interview transcripts was the major factor to produce prolonged engagement with participants' perceptions of family planning services. ✓ Being a member of the Otjiwarongo community and a professional nurse facilitated the process.
Transferability	Dense description and sampling	✓ Precise and sufficiently detailed description of the setting, participants, data collection and analytical procedures will be presented to the reader. ✓ For this study a purposeful sampling procedure guided by emerging insights from relevant findings was chosen. Participant responses have been cited as direct quotes, enabling the reader to form an accurate understanding of their context. This thick description will hopefully facilitate application of the findings to different clinical contexts and enable judgments

		regarding integrity and similarity.
Dependability	Dense description	✓ Research methodology was clearly and fully described. ✓ Step-by-step replication, meaning in each interview the same steps were followed.
Confirmability	Bracketing	✓ The researcher used bracketing to note non-verbal responses such as smiling and other gestures.

2.11 Ethical considerations

An ethical approach to research implies that respondents' comments and opinions will be treated confidentially and would in no way be used against them. Ethical considerations are very important for safeguarding the rights of participants.

2.11.1 Quality of research

To ensure that the study was methodologically rigorous, operationally sound and in full compliance with acceptable ethical standards, the researcher sought approval from the Office of the Permanent Secretary of the Ministry of Health and Social Services through the Research Management Committee before commencing with the study. This procedure was also necessary to ensure that the research would later be used as a management tool for decision making (MOHSS, 2003, p. 2).

2.11.2 Consent to conduct the study

The nature of the study was explained to each participant before they were requested to give informed, verbal consent. Participants were informed that they could withdraw from the study at any time and could refuse to answer any question without negative consequences.

They were also assured that access to health care services in the future would not depend on their willingness to participate in the survey. No risks or incentives, financial or otherwise, were accrued from participating in the study and a decision to participate was entirely voluntary.

Written permission to conduct the survey was obtained from the national Regional Unit and Regional research Committee.

2.11.3 Confidentiality, privacy and anonymity

Confidentiality means that information supplied by participants will not be made public. To ensure confidentiality and privacy of every participant, no name or any form of identification was recorded during interviews. Verbal guarantees of their rights and wishes were given to participants so that they would express themselves freely and without inhibition. The anonymity of participants was protected through the absence of any link between recorded data and specific respondents and no names were recorded anywhere in the survey findings.

2.12 Summary

This chapter outlined the descriptive design and qualitative methods used in the study and their respective advantages. It identified the population, the sampling method, data collection technique and ethical considerations involved in the implementation of the study. How data was analysed and how trustworthiness was ensured were also described.

CHAPTER 3

ANALYSIS OF DATA AND LITERATURE CONTROL

3.1 Introduction

The previous chapter discussed research design and the method of data collection. This chapter will address analysis of the data and literature control using a narrative writing style. A purposive sample of 45 participants was selected from clients visiting selected clinics for family planning services during repeated visits made between October 2007 and December 2007. These women were interviewed.

The purpose of the study was to explore and describe the personal experiences reported by women of child bearing age who use family planning services in Otjiwarongo district, and to make recommendations how these services could be improved.

Women describe their experiences with family planning services from different perspectives. According to Family Health International (FHI) (2000, p. 15) various researchers indicate that women often view family planning in broad terms — identifying family planning as a long-term activity that affects the quality of diverse aspects of their life: their psychological health, their domestic lives, their ability to participate in the work force and their ability to join in community activities.

The themes and sub-themes of the study were developed after an initial analysis of the data. In a qualitative study data is analysed by systematically organizing and interpreting information using categories, themes and motifs that identify patterns and relationships (Patton, 2002, p. 10). See table 3.1 for identified themes and sub-themes.

Table 3.1: ***Themes and sub-themes***

Themes	**Sub themes**
1. Interpersonal relationships between health workers and clients need to be strengthened.	1.1 Reception of clients by health workers not always friendly 1.2 Lack of open communication between health workers and clients.
2. The quality of information provided to clients utilising family planning services needs to be improved.	2.1 Health workers do not always provide information with regard to methods and choices of contraceptives 2.2 Contraindications and side effects to contraceptive usage are sometimes not explained 2.3 Encouragement for continuity of services are lacking 2.4 Importance of breast feeding not always emphasized 2.5 Protection against sexually transmitted infections is not well communicated
3. A conducive environment is needed for family planning services.	3.1 Clients waiting too long to be attended to 3.2 Family planning services not always readily available due to long distance to health facilities. 3.3 Availability of stock and other related services influenced utilization. 3.5 Lack of privacy and confidentiality during discourage women to attend family planning services.

3.2 Discussion of results

Results of the study in the context of the themes and sub-themes identified in table 2 above are discussed below.

3.2.1 Main theme 1: Interpersonal relationships between health workers and clients need to be strengthened

Good interpersonal relationships between providers and clients are the cornerstone of providing quality services. Clients who feel welcome, are treated with respect and encouraged to ask questions are more likely to be satisfied contraceptive users. That is to say, a client's satisfaction with family planning services and their continued use depends significantly on the behavior of health workers. As mentioned by Darabi (2003, p. 8), good interpersonal relationships between women and their health care providers can improve the quality of services rendered by increasing the likelihood of continued follow up.

In this study, interpersonal relationships were assessed by asking respondents questions about how they were received by health workers, whether they were allowed to ask questions and whether they were shown respect. In addition, enquiry was made concerning their perceptions and experience of the general behaviour of health care workers. Many studies have revealed that health care workers often treat women in an insensitive manner, not regarding their concerns or by treating them rudely, particularly if they arrive late for scheduled appointments or do not comply with to

health care workers' requests (Agyei, 1999, p. 3). Effective interpersonal relationships is necessary for quality health services and are based on mutual trust and respect between health care providers and receivers.

Responses from the women interviewed in this survey revealed marked contrasts in the way they were treated, some expressing happiness and some expressing dissatisfaction with regards to interpersonal relationships with their health care workers.

3.2.1.1 **Sub-theme 1.1: Reception of clients by health workers not always friendly**

Clients judge their experience of family planning services every time they come into contact with these services. Most women are perceptive, recognising a warm reception and courtesy when they experience it. They certainly know when they are treated badly (Oddens, 1999, p. 5). A visit to a health care facility, especially the first one, for family planning is very important for building good rapport between health workers and clients. During this contact, health workers should welcome women in a friendly manner and make them feel as comfortable as possible.

While some women in this study expressed satisfaction with the reception and behavior of health workers, the majority of respondents expressed disappointment with the way they were received and treated. In fact, some women reported that their

health workers were always helpful and friendly and demonstrated understanding for their concerns.

One such comment was: *"Those nurses at the clinic are so helpful. I remember one thing, when I came last month my supervisor brought me with her car and told me to hurry up because we have a lot of work to do at the shop. At first I was very afraid to talk to the nurse because there were many people who came before me. I just went inside and explained to the nurse and surprisingly she just helped me. I was so happy; I really did not expect that because people in the location used to say that nurses are very rude. Even my supervisor was so happy."*

Another comment was: *"I received* good *reception when I visited the clinic for the first time and that encouraged me to come again for the second time today."*

Another woman responded: "*You know what, I am originally from Windhoek and this is my first time to come to this clinic and I can tell you there is a lot of difference between nurses here and those in Katutura clinic. Nurses here really showed respect for others. The nurse greeted me, offered me a chair and even asked me whether I experienced problems with my contraception. It is the first times to experience such treatment. In Windhoek it was so bad, maybe because they are overworked, I hope I will bring them here to see how patients are being treated".*

Clients value individualised service and prefer providers who make extra efforts to understand their particular situation and needs (Forrest & Frost, 1999, p. 26).

Previous interactions with health care professionals offer clients the possibility of comparing the quality of different services and have been shown to be a strong predictor of the propensity of a client to utilise family planning services (Sullivan, 2001, p. 3).

Regarding the behavior of health care workers, this study indicates they do not always treat women well. Comments from some women confirm that health care workers often make impatient or inappropriate remarks to their clients.

One woman indicated: "*When I entered the injection room, I found the nurse already sitting down on the bed and her face looked unfriendly. I didn't even know what to say first, but I greeted her using my mother language and she replied that, 'You Hereros do not want to learn other languages because you are so proud of our language.' I know for sure that she understood my language very well. Maybe she was just overworked and frustrated".*

The behaviour of some health care staff, though not excusable, often reflects their very difficult working conditions (WHO, 2002, p. 9). When health care workers are perceived to be hostile or unfriendly, many women will turn to relatives or friends for advice about family planning instead. These people might provide them with inaccurate information. Such an experience may account for a situation in which a woman delays seeking accurate and appropriate family planning services from professionals.

Another woman indicated: "*Why are these nurses asking question like: 'Why do you have sex at that young age, didn't you know that you would become pregnant?' It is not their business to worry about my personal life."*

Another young woman said: *"I am not particularly happy with these older nurses who are treating us young people very bad. Why should a nurse tell me that I am just coming for family planning to make it easy for me to continue having unprotected sex?...it is not fair, I know why I came for family planning."*

To a great extent, young people have been excluded from benefiting from the family planning revolution. A variety of traditions, institutional and myths about sexuality have made it difficult to develop effective programmes that provide accurate reproductive health services for young people. Many people believe providing family planning services to youth will promote promiscuity, even though there is no evidence to support this view (Lodewijckx, 1999, p. 7).

Various studies have revealed that health care workers often treat women in an insensitive manner, often rudely, without acknowledging their concerns. On the other hand it has been shown that positive interactions between health workers and women build confidence and compliance in these clients (WHO, 2003, p. 9).

Women are more likely to use family planning if they have a positive relationship with service providers. Research shows that health care providers' attitudes and

treatment of clients often determine which health services women will use and even whether women will seek services at all (Hossain & Schuler, 1998, p. 1).

According to Berhane, Fantahun and Genna (2006, p .4) clients must have access to quality, client-oriented services and receive reliable information regarding them. In client-oriented services, a client's needs should be considered above all other factors at every point in planning, implementing and evaluating service delivery (Premchand 2006, p. 9). Women value individualised services and prefer providers who make an effort to understand their particular situation and needs. Treating women with respect will build their confidence and self esteem and, in turn, will strengthen their autonomy and ability to make a variety of decisions for themselves (Robey & Upadhayay, 1999, p. 2).

3.2.1.2 Sub-theme 1.2: Lack of open communication between health workers and clients

Encouraging clients to speak freely and ask questions concerning their health situation fosters a friendly relationship between clients and health care workers based on trust. Inadequate or misunderstood instructions about how to use a programme of family planning can lead to illogical application of the method, and sometimes elicit unintended or even dangerous results. Effective communication in family planning services improves usage by creating awareness, increasing knowledge, building approval and encouraging healthy behaviour (Phyllips, 2005, p. 5).

However, most women interviewed indicated that they were not given a chance to ask questions or express their feelings about contraception. A young woman who wanted to find out whether she was pregnant before continuing, was not happy with the response she received from the nurse: *"You know, today is Friday and we are so busy. You can see how many patients are still waiting to be helped. If you think you are pregnant why can't you just wait to see whether you will miss your period? You know that this contraception is not one hundred percent effective, so if you become pregnant it is not the problem."*

Women need to be treated with respect and prefer health care workers that make and effort to understand their particular situation and needs. They expect health workers to listen to them, to explain options in terms they can understand, and to ensure their problems are addressed and solved.

Other women responded: "*If you find yourself in a situation whereby a nurse from whom you are receiving assistance from is not open enough to talk to you, she doesn't want to hear anything from you, how will I, as a patient, be free to express my opinions? This means that this person is not ready to serve the people."* According to Costello, Jain and Lacuesta (2001, p. 12), interactions with clients are structured by service providers in a manner that imposes the provider's view on clients without giving adequate attention to their needs. To ensure that the interaction between a health care worker and the client is conducive to a good relationship between them, the health care worker must elicit basic information from the client, such as her reproductive intentions, previous experience with

contraception, and family circumstances. Only with this basic knowledge in his or her possession, will a health care worker be able to help the client with any problem.

One woman commented that health care workers in family planning do not encourage open communication with their clients: "*When I went to the clinic for antenatal care, all pregnant women were grouped together in a room and the nurses explained a lot of things concerning HIV and this medicine to prevent babies from getting HIV. We asked a lot of questions and they answered them nicely. It was very good… I think that the nurses who are providing family planning should also do the same. We also want to ask questions. They must go for training."*

Being communicative and providing counseling for women are very important components of a family planning service. Quality education and counseling can sometimes make the difference for a woman between using or rejecting family planning. Through counseling, clients and providers meet face to face, discuss choices and build a relationship of trust that will foster confidence in women and ensure their successful use of family planning services (Center for Disease Control (CDC), 1999, p. 561).

3.2.2 Main theme 2: The quality of information provided to clients utilising family planning services needs to be improved.

During family planning services, women should receive enough information to enable them to make an informed and voluntary choice for a contraceptive method. As a minimum, this should include information on different types of contraceptive

methods, the effective and correct use of each method, common side-effects and contra-indications, health risks and benefits, signs and symptoms that would necessitate a visit to the clinic and information on protection against sexually transmitted infections (STI) (WHO, 2004, p. 4). FHI (2007, p.13) stated that when clients have adequate information about contraceptive methods and have several to choose from, they are more likely to be satisfied.

Elements vital to family planning education that women need to be informed about by their health workers can be easily remembered under the acronym GATHER (CDC, 1999, p. 561). These elements are:

- G: Greet women in a friendly and helpful manner
- A: Ask women about their family planning needs
- T: Tell women about available family planning methods
- H: Help women decide what method is suited for them
- E: Explain how to use the chosen method
- R: A return visit should be planned at each session

3.2.2.1 Sub-theme 2.1: Health workers do not always provide information with regard to methods and choices of contraceptives

Diverse methods for family planning are available at health facilities. Not all methods are suitable for every client. For this reason, health care workers have a responsibility

to provide reliable information to help each woman make the most suitable choice for herself.

In the current study, women were asked to name the different types of contraceptives that nurses explained to them during family planning sessions. The findings of this study clearly reveal that women attending family planning services did not receive adequate information regarding methods available. *"That young new nurse explained to me that there are different types of contraceptives such injections, pills and condoms,"* responded one woman.

In a 1993 survey conducted in India, a total of 125 female users of family planning were interviewed. They were asked to reveal how they selected contraceptive methods and to evaluate the quality of services they received. Findings suggested that considerable responsibility rests on the shoulders of health care workers because, when selecting a method, a large number of users depended on information provided by these professionals. Furthermore, the survey indicated that 80.8% of the respondents had received information only about IUCDs, while only 16% had been offered all four methods available at the health care facility.

In the current study, another woman visiting the clinic for the first time responded that the health care worker had informed her only about the two methods available at that specific clinic, pills and injections. Afterwards the client was shown the two methods. She continued: "*The nurse put the pills in the plastic envelope and told me to finish them and return to collect the other".*

This study indicated that health care workers predominantly explained only pills and injections as methods of contraception available to women. However, informing them about the wide range of methods available enables clients to make a better choice for themselves. Although a successful family planning programme will explain and provide as many methods as possible, making only one or two methods available is at least better than not providing any at all. In this connection, despite the call of the International Convention on Population and Development (ICPD) for universal access to a full range of family planning methods, it has been determined that only one or two methods dominate in most countries (UNFPA, 2005, p. 43). This situation prompted the Programme of Action of the 1994 International Conference on Population and Development (ICPD) in Cairo to urge a more a client-centered approach to the delivery of family planning services (Bulatao, 1999, p. 3).

Questions were also posed to women regarding their current choice of contraceptive and about choices they had made in the past. Responses indicated that, while some women made a choice even before visiting a clinic, most of them chose a method only after a health care worker had presented them with options.

One such woman commended: *"When I visited the clinic for the first time to get my contraceptives, the nurse explained to me different types of contraceptives. I feel I was really well informed to enable me to make a choice."*

Another young woman indicated she preferred the injection method because all her schoolmates who use contraceptives were on injection. The reason she gave was the fact that injection is the only method that will prevent parents from discovering they are using contraceptives. A study in Nigeria similarly revealed that influencing factors in the choice of contraceptive methods included advice from friends and family members, intended duration of use and information from the media (Konje, Ladipo, Oladini & Otolorin, 2000, p. 18).

Another woman expressed that she felt it is important for health care workers to make decisions on the type of contraceptive one should take because, "*they are trained and they know exactly what type of contraceptive a woman must be given."*

Another young woman said, "*When I entered the injection room, I found already injections filled with contraceptives on the table and the nurse just told me to turn back and injected me on my buttocks."*

The experience related above, perceived negatively by current standards, reveals a common occurrence in which a contraceptive method is designated by a service provider, rather than by the client herself. A study in Togo found that 46 % of clients in family planning clinics played a minimal role in determining the contraceptive method they would use (FHI, 2000, p.13). This study revealed that unplanned pregnancies were twice as common among women (22 %) in areas with poor services, as they were among women (11 %) in areas with services of a high standard (FHI, 2000, p.15).

Another deficiency on the part of health care workers is often a lack of professionalism when interviewing a potential client to identify problems. One woman who had visited a small clinic responded: "*Nurses at Kalkfeld clinic explained all types of contraceptives to us when I took my younger sister for family planning, but here at this clinic nurses are not explaining, but I think it is because there are too many patients and they don't have enough time."*

Negative factors may also determine the choice of a contraceptive method. For example, information about the side effects of one method may have relevance when a choice is made for new method because of its perceived benefits. In Uzbekistan, the majority of women rely on IUCDs as a single contraceptive method. It is not clear, however, whether this choice reflects the existence of constraints or is simply evidence of a widespread preference (Barret & Buckly, 2007, p. 19).

A study of family planning services in Tanzania found that provider bias regarding method preference, and age restrictions against the use of some methods, lead to barriers to contraceptive use (Hennink & Stephenson, 2004, p. 8). UNFPA (2007, p. 10) indicated that a lack of counseling about choices, correct method use and distinguishing myth from fact, are all key barriers to effective use of family planning services. The widespread preference for injections and pills is also a clear indication that nurses predominantly inform women about these two types of contraceptive.

Research suggests that people make choices from available options by balancing perceived gains against perceived losses, significantly when these choices relate to the experience of others. Other evidence indicates that women make choices based on the effectiveness of the method, the balance of beneficial and adverse effects, the impact of daily living and the degree to which a prescribed method conflicts with personal values or underlying beliefs about health (Walsh, 1998, p. 6).

In many instances women are reluctant to participate in selecting a contraceptive method because they are intimidated by health care providers whom they perceive as rude and insensitive. Consequently, these women feel pressured to make choices they perceive to be in conflict with their own ideas about health or fertility goals (WHO, 2000, p. 5).

This problem was evident in the current study from the comment of a woman who indicated: *"When I changed from the injection to the pill, these nurses were complaining too much… she actually said that I am wasting the government's medicine because she had already opened the bottle before I informed her that I want to change to the pills. At that moment I wanted to change again to the injection, because I don't want to be pregnant in the near future, but I don't know how I will tell this same nurse again… even today I wanted to inform her but… hey, when I look in her angry face…"*

Studies on family planning have been conducted in Zimbabwe, Egypt, Philippines, India and Mali (FHI, 2000, p. 12). In Zimbabwe, it was found that both men and

women regarded family planning as an essential component of "quality of life", because they feel it improves both physical and psychological wellbeing. Women, however, regarded restricted choices regarding contraceptives to be an impediment to the continuation of family planning services. They had strong opinions about how these services could be made more acceptable to women, recommending that a variety of methods be made available. To assist new clients select the most appropriate family planning method, it is essential that providers ask them about their fertility intentions (Mogotlane, 2005, p. 25).

In the current study women were also asked what type of information they expected to receive from health care workers when attending family planning services. The usual response was that they want information about different methods, about how each method works and the possible side effects. One woman said, *"I would have liked to be informed about all the methods of family planning, how each method works so that I can choose the one that I like. Now we are just using these injections and pills, but maybe there are also some other methods that are easy to use."*

In Egypt, more than half of all married women use some form of family planning. However, unplanned pregnancies are a still major concern. Sixty two percent of women in that country who reported an unplanned pregnancy, said they became pregnant while using contraceptives, including oral contraceptives and intrauterine devices. Because these methods are highly effective, failure is probably due to a lack of information regarding how to use them.

In addition, more than one-third of Egyptian women with unplanned pregnancies tried to terminate them through abortion. Because abortion is illegal in Egypt, these women were often forced into opting for unsafe procedures.

The women in that survey also said that unplanned pregnancies affected their ability to look after their health, brought financial burdens, and allowed them less time with their other children. These findings clearly illustrate the importance of providing women with adequate information about the correct and consistent use of contraceptives (FHI, 2006, p. 8).

3.2.2.2 Sub-theme: 2.2 Contraindications and side effects to contraceptive usage are sometimes not explained

Women using contraceptives, especially injections and pills, may experience unpleasant side effects such as light bleeding, irregular periods (or no periods at all) and weight gain resulting from increased appetite (MOHSS, 1997, p. 19). These effects can be irritating and cause some discomfort, especially if women are not informed about them in advance. United States Urgency for International Development (USAID) (2005, p. 10) stated that conveying information about side effects should be included when screening a client regarding personal factors that would reasonably affect their choice of a contraceptive. This potentially delicate communication can only be accomplished successfully when the health worker is well trained. Appropriate technical training in clinical procedures as well as knowledge of contraceptives are fundamental to the delivery of safe and accessible family planning services.

In a number of studies it has come to light that women sometimes reject family planning services out of fear of side effects, the limited variety of methods available, or even a lack of general knowledge about contraceptives (Roy & Verma, 1999, p. 3). By providing adequate information, health care workers can help clients gain maximum benefits from a family planning programme. Inadequate or misunderstood instructions for usage of a contraceptive can lead to wrong application of the method with sometimes unintended or dangerous consequences (Boikanyo, Gready, Klugman, Rees & Xaba, 1999, p. 25).

A significant finding of the current study was that nearly all the women interviewed did not mention that health care workers informed them about side effects, contraindications or the advantages and disadvantages of different methods. Although women were informed to different degrees about the possible side effects of contraceptives, almost all women had not received sufficient information from health care workers about the side effects and contraindications before they had selected the methods they were using.

Another concern raised by women regarded their experiences with physical symptoms that they attributed to contraceptive use. These included weight gain, headaches and irregular menstrual periods. Although most women expressed concern about physical symptoms they were experience, most of them said they would continue taking contraceptives because the consequences of an unwanted pregnancy would be more serious than the symptoms. For example, one village

woman said: "*I am not really satisfied with my body overweight… but if I don't use contraceptives, I will have too many children and I will struggle to feed them, send them to school, because I am not employed and all these things are very expensive, I am really happy that this service is available."* (This resigned attitude regarding side effects contrasts to findings of the Mali study that revealed many women who use contraceptives had been counseled that amenorrhea was a possible side effect of injectables, and they found this side effect made the method unacceptable (FHI, 1998, p. 5).

When the researcher in the current study probed further, asking women specifically whether health care workers had informed them about side effects, the majority said that they had not received any information. One woman said, *"After the nurse did all the investigation, like checking blood pressure and weight, she gave me three packets of pills and said I must come back if anything happened to me, but did not mention a specific problem."*

Another woman indicated: *"I read in a paper that was brought by my daughter from school that some contraceptives such [as] pills and injections can cause problems like overweight and heavy bleeding, but I have never experienced them since I have been using injection for the past three years. For sure I cannot remember a case where nurses discussed these things with me."*

There could be several reasons why the side effects of contraceptive use are not explained to women. Health care workers may fear that mentioning side effects

might cause women to lose confidence in them personally or discourage clients from continuing contraceptive use. Studies in Kenya indicated that 80 % of women discontinued using pills after twelve months. They also discovered that some women worried that side effects of a contraceptive might limit their ability to work, creating reluctance to either initiate or continue contraceptive use (FHI, 2000, p. 14).

In the current study, women who had changed from one method to another were asked to reveal the reason for their decision. The main reasons women gave were side effects, dislike of their partners for a particular method and advice from friends or relatives against a method. One woman responded: *"I have been using injections since I started family planning about five years ago. After a year or so I started developing skin rashes on my face and chest and when I told the nurses what the injection wase doing to me, they told me that it was not caused by the injection. Maybe it is due to a skin lotion that I am using. I went to another clinic in order to change to the pills. Since then, I see that there is slight improvement."*

Information about the side effects of a contraceptive should always be shared with a client. Knowledge would help the user anticipate changes in her daily routine that might be necessitated by side effects. Accurate information would also counter persistent myths and dispels anxiety caused by rumours. It would also help the client differentiate between physical changes caused by side effects and those that may indicate a health problem.

Another comment was: *"When I came for my first family planning visit in 2003, the nurse gave me an injection and I continued with it, but after about three months I experienced heavy and painful menstruation. I was so afraid and thought that maybe I will never become pregnant if I want to. My husband advised me to consult the private doctors because he trust them so much and he also believed that nurses at state clinic gave me wrong injections. Due to lack of money to pay private doctors, I just went back to the clinic and described my problems to the nurse there. The nurse did some investigations on me (urine test, pregnancy test etc.) and without even the advice from the doctor she gave some treatment and changed me from injection to pills. Since that day, you know it was in 2004, till now I don't have any problem with my periods."*

If a woman is not informed about the possible side effects of a contraceptive, she may not realise the problems she encounters are caused by that method. It is crucial to counsel anyone who is considering the use of a contraceptive about what side effects they might encounter and how to deal with them.

The current study also indicated that information regarding contraindications was totally omitted by health care workers when providing family planning services. General information relating to contra-indications includes information about sterilisation for young women who still want to bear children, about IUDs for women who have several sexual partners, and about hormonal methods containing estrogen for mothers who are breastfeeding (Berkow, 1997. p. 1121). Other contra-indications are medical conditions such as circulatory and liver diseases. The

unacceptably high risk of serious complications from these diseases makes the pill an inappropriate method for women suffering from them (Sellers, 1992, p. 885).

One woman responded: *"Nurses never informed me whether there [are] some contraceptives that cannot be offered to women with specific health conditions."*

Another woman responded: *"If there are some medical conditions that prevent a woman from taking contraceptives, then nurses must always ask woman if they are suffering from such conditions. It is really very serious, because a person can easily lose their life."* Recommending a contraceptive to a woman with medical problems is a complicated issue because of the limitations her condition may impose regarding methods that are safe for her. Women with medical problems require special attention and counseling to guide their choice of an appropriate contraceptive (FHI, 2006, p. 5).

An obviously angry woman shared the following experience. **"***After the delivery of my second baby, I asked the nurse to give me contraceptives. The nurse immediately grabbed two packets of pills and said I must finish them and come back when finished. When I went home I showed the pills to my neighbor, who is a retired nurse, but she told me that those pills are not good for breastfeeding mothers and advised me to take them back. Unfortunately, I did not know the nurse who gave me wrong pills, but after I explained my problem to the nurse, she understood and gave me another type of pills. I was really unhappy with the previous nurse because she was even supposed to examine me and ask if I am breastfeeding… What if something*

happened to my baby? ... I feel that's wrong, there might be some women who will not notice this or don't have anybody to advise them!"

A study conducted in Senegal in 1998 revealed that more than one-third of breastfeeding women said during their exit interviews that they had accepted combined oral contraceptives. Only about one-eighth of breastfeeding women received pills containing only progestin, indicating those breastfeeding women, and probably those who gave them the pills, were insufficiently educated about the importance of avoiding contraceptives containing estrogen during lactation (Measham, Stein & Winikoff, 1998, p. 3).

3.2.2.3 Sub-theme 2.3: Encouragement for continuity of services to be strengthened

Contraceptive methods, such as pills and injections, require the user to return to the clinic for periodic examinations and to replenish their supply of contraceptives. Clients should be confident that they will always receive quality reproductive health care when they visit their clinic. They need to know when they should return on a routine basis and they must have access to services whenever they are needed (Askew, 2004, p. 4). Continuity of care is provided when health care workers encourage clients to return as often as necessary to receive appropriate care and support. It is very important for a woman's safety to visit the health facility

regularly, allowing her to change her contraceptive if she is unhappy and to build a trusting relationship with the service provider (Boikanyo et al., 1999, p. 31).

Little is known about the things women experience while using contraception. It is therefore difficult to say with certainty why some discontinue their use of family planning services. Kols and Sherman (1999, p. 5) stated the following reasons may explain why clients discontinue their method or stop using contraceptives altogether:

- if a method is inadequately explained and an unintended pregnancy occurs;
- if possible side effects are not explained before use of a contraceptive;
- if the service programme runs out of supplies of contraceptives;
- if the service provider treats clients rudely; and
- if clients cannot get the method they want.

Various studies indicate, however, that quality service encourages people to continue using family planning when they wish to avoid pregnancy (Sherman & Kols, 1999, p. 4). Women who use family planning judge a service favorably based on various factors. Mechanisms employed to encourage continuity should be based on those factors.

A mechanism such as consistent scheduling of forward appointments encourages continuity by engaging well-informed users to manage their own family planning programme. Home visits by health care workers also encourage continuity.

Encouragement can also be built into the programme itself through planned actions, or may result naturally from a relationship of trust between the client and her service provider (Junhong, 1999, p. 11).

Another important mechanism to encourage continuity would be action based on a correct evaluation of why a woman remains with her family planning programme despite having discontinued a specific method of contraception. Correct understanding of this situation would provide valuable information about clients' reactions to side effects and the influence of other personal factors. This information could be used to improve service delivery.

In the current study, women were asked whether any mechanisms were introduced to ensure they continue with family planning services, either by the programme or by themselves. Responses suggested that formal mechanisms implemented through the programme were more influential than their own actions, with most women indicating entry in their health passports of an appointment for the following visit was important for maintaining continuity. *"Nurses always write the dates of the next visit in my passport, so I don't have a problem of knowing when to come back,"* indicated one woman. Another comment was: *"That is actually one of the best things that nurses are doing, they always encourage us to come back to get another injection, they inform us that if we come too late there is always a possibility of pregnancy"*.

On the other hand, some women commented they don't rely on nurses to inform them about their visits because they feel it is their own responsibility to manage family planning. *"I made a decision to take contraceptives in order to prevent unwanted pregnancy and I make sure that I don't miss my appointments. I have already four children; I will never make that mistake of not coming for my injection on time"* said one woman.

Junhong (1999, p. 10) stated that mechanisms to encourage continuity may involve users managing their own programme of family planning or may be created by service providers who introduce formal mechanisms. The latter should include utilization of community media to distribute information and encouragement, specific follow-up action, such as reminding clients of their appointments in writing, and home visits made by health workers or peer groups.

Figure 3.1 Providing information through a peer group

Courtesy of WHO, 2004

Figure 3.1 above illustrates a peer group providing important information to women in remote areas. The peer group visit is a formal approach that may reduce the number of women who discontinue family planning services since peer education has proven effectiveness in reaching identified target populations (Gorgen, Kloss-Quiroga & Pochanke-Alff, 2000, p. 69).

Frequently women were informed about their follow-up visit because an appointment had been made in advance. In the current study, this provision emerged as a consistent feature of family planning programmes, indicated by the fact that most women spoke about it.

To ensure that women continue family planning services, health care workers should not only focus attention on their new clients, but should also take diligent care of their existing clients, always seeking to identify their changing contraceptive needs.

Clients who are satisfied with a contraceptive usually return to have their supply replenished (Stover, 1998, p. 1). The most common reasons why women discontinue contraceptives are, either they become pregnant or they are intolerant to side effects. It is therefore very important that health care workers enquire about their clients' experiences with a contraceptive and explain that they have the right to change it if they are not satisfied for any reason.

Clients of family planning services should also be informed about other health facilities near their place of residence where they can either renew supplies of their contraceptive or apply for another kind. This possibility would also encourage continuity by making services more easily accessible (Beckman et al., 1999, p. 15).

3.2.2.4 Sub-theme 2.4: Importance of breastfeeding not always emphasised

Many women in developing countries name breastfeeding as their method of contraception. Although women may believe that breastfeeding is contraceptive, in fact studies show that its use according to the Lactation Amenorrhea Method (LAM) of family planning is only of limited value (UNFPA, 2002, p. 7).

To effectively practice LAM, a mother must fulfill three criteria. She must use breastfeeding exclusively; she must be less than six months postpartum; and her menstruation cycle may not have resumed. If a sexually active woman does not meet all the criteria, she is not practicing LAM correctly and, despite breastfeeding, is at

risk of becoming pregnant, unless of course she is using another contraceptive method at the same time (UNFPA, 2002, p. 9).

Breastfeeding is commonly believed to offer protection against pregnancy. Apart from its benefit for the health of a newborn child, breastfeeding, under the right conditions, may provide a natural method of contraception. However, responses from women who were interviewed in the current study clearly revealed that the effectiveness of breastfeeding as a contraceptive method was not emphasised by health care workers.

For example, upon direct questioning one woman indicated: *"I will never trust that breastfeeding can prevent pregnancy. The nurses in this hospital advised a friend of mine while we were in the hospital that if she does not want to use contraceptives, she can strictly breastfeed her baby for her not to become pregnant immediately. You know what, I also followed that advice and that is how I became pregnant while my first baby was still very small".* This response clearly indicates that health care workers had not provided adequate information about how breastfeeding may be used to prevent pregnancy.

Breastfeeding may sometimes act as a contraceptive for the breastfeeding mother. However, it is not a reliable method of contraception. Each woman is unique and the amount of protection from pregnancy that breastfeeding offers is completely unknown. Even if her baby is only one month old and is being breastfed, the mother can still become pregnant (Baraister, Cowley, Dolan & Fettiplace, 2002, p. 7).

Family planning programmes can promote better infant and child health by encouraging women to breastfeed fully, and may advise mothers how to practice the lactation amenorrhea method correctly (LAM) to space births. This advice may also encourage women to breastfeed their babies even if they do not choose LAM as a contraceptive method.

3.2.2.5 Sub-theme 2.5: Protection against sexually transmitted infections is not well communicated

Family planning programmes can play an important role in preventing sexually transmitted infections (STI's), including HIV. To facilitate the prevention of STI's, providers of family planning services can encourage clients to delay the initiation of sexual activity, advise couples to remain faithful and promote the role of condoms.

It is known that hormonal contraceptives have greatly improved the well-being of women. However, as the HIV pandemic continues unabated, scientists seeking to identify factors that contribute to the spread of the virus have raised the possibility of a connection between hormonal contraception and HIV infection (FHI, 2007, p. 11).

It is therefore very crucial that health care workers provide information about the prevention of STI's when making different types of contraceptives available to women. Meanwhile, women using contraceptives who are HIV positive and wish to switch methods, should receive counseling about effective contraceptive options, such as intrauterine devices and sterilisation. Such information is particularly

important because contraceptive use plays an important role in preventing mother-to-child transmission of the HIV virus (FHI, 2007, p. 8). There is some concern, however, that antiretroviral therapy (ARV) drugs may alter the metabolism of oral contraceptives, thus requiring an adjustment in dosage or a change of the contraceptive (Best, 2004, p. 23).

Most young women receive information on how to protect themselves against sexually transmitted infections, most importantly from the HIV virus. The majority who are using injections and pills as contraceptive methods were also given condoms and advised to use them as a preventative measure against STIs. "*Nurses always encourage us to use condoms to protect ourselves from diseases. A nurse specifically told me that I am too young to take contraceptives (injection, because I will be at risk of getting HIV, but after I explained to her that I might become pregnant if raped, she eventually injected me and gave me a lot of condoms",* said one young woman.

Oral contraceptives, injections, IUCDs and sterilisation are highly effective means of preventing pregnancy. Condoms, on the other hand, when used correctly and consistently, are known to fulfill the double function of protecting women against the risk of pregnancy and infection by the HIV virus (Bazant, Kim, & Storey, 2006. p.8).

Another woman said: *"Since I started with family planning in 2002, I have never heard nurses discussing STI's or even HIV issues with us. I think it is very important for them to remind especially young ladies who are coming for family planning to be*

careful about contracting these diseases." Evidence from studies conducted in Mexico suggests that providing information to contraceptive users on both subjects, family planning and the risk of contracting sexual transmitted infections, has a significant effect on their subsequent choice of a contraceptive method (Rosser, 2000, p. 3).

According to FHI (1998, p. 22), clients are more likely to be satisfied with and continue family planning if they have adequate information about contraceptive methods. Ideally, users should receive information about all types of contraceptives, how each method works to prevent pregnancy, how to use each method, contra-indications and possible side effects, what to do if they appear and how to prevent STIs.

Family planning can help achieve HIV prevention goals and improve the health of mothers and their children. Likewise, services tailored specifically to assist people living with HIV can help increase access to family planning services. Family planning and HIV programmes often serve similar populations, particularly in countries where the HIV pandemic is driven by heterosexual transmission. When programmes and services meet a variety of client needs, satisfaction with the health system increases and scarce resources are better utilised (USAID, 2006, p. 26). According to FHI (2006, p.22), there is enough evidence that contraception is a potentially powerful and cost-effective HIV prevention strategy, enabling HIV-infected women to prevent undesired pregnancies, thereby eliminating the problem of mother-to-child HIV transmission.

3.2.3 Main theme 3: A conducive environment is needed for family planning services

A study conducted in India about women's experiences with and perceptions of family planning services, used five indicators to determine the value of various constellations. These indicators were: the average travel time to the clinic, the average waiting period for a consultation with a health care worker, clinic office hours, a doctor's availability and the availability of medicines. A long travel time to a clinic and long waiting periods to see a health care worker are discouraging factors to clients and negatively affect their full utilisation of family planning services. On the other hand, easy access to health care workers and the availability of resources, such as equipment and medication, can serve as motivating factors to use the services. It is important that family planning facilities not only offer quality services but are also accessible in terms of distance, cost and operating hours. Seen in the widest possible context, factors such as distance to health care facilities, operating hours, condition of the waiting area, toilet facilities, availability of health care workers, equipment and supplies and related health services, play a determining role whether women use those services or not.

Another factor that will affect a client's assessment of the services provided is the appropriateness of their configuration. An appropriate constellation of services is one that is convenient and acceptable, responds to client concerns and meets their current health needs (Roy & Verma, 1999, p. 8).

Although most of the women interviewed in the current study had no complaints regarding travel distance to their clinic and were satisfied with the availability of medicine, this study identified some degree of dissatisfaction with the constellation of family planning services, long periods of waiting for service and unavailability of health care workers being the main concerns, as discussed in the following sub-themes.

3.2.3.1 Sub-theme 3.1: Patients waiting too long to be attended to

Long waiting time at the clinic can be a major barrier to the utilisation of government services (Roy & Verma, 1999, p.11). Clients and potential clients regard long waiting time as an obstacle to family planning. While a certain amount of time spent waiting is acceptable to clients, waiting periods in excess of one or two hours are one of the most important explanations for relatively high dropout rates in family planning programmes and discontinuation of contraceptive methods. This factor may also play a role in discouraging potential clients from taking advantage of services (Miller & Wolff, 1998, p. 40).

Long waiting time was also in evidence in the current study and long waiting periods was the main problem encountered by clients of family planning services at the clinic. *"I know that the clinic is supposed to open at eight o'clock in the morning, but here it is always a problem ...even when I came today at half past eight the clinic was not yet open. Some nurses even arrived after me. I really do not want to blame*

the nurses so much. It seems the problem lies with cleaners because they start to clean at eight o'clock so we have to wait for them," said one woman.

Another woman said sympathetically: *"I like to come to this clinic because it is near to my house but the biggest problem is that there are not enough nurses to serve the people immediately. Most of the time there are only three nurses to do all the work like immunizing children, giving out medicine, caring for pregnant women etc. I came here at nine o'clock but now it is almost one o'clock, I feel pity for these nurses really. They even told us that women who came for family planning should wait to be helped later because they are not sick. They are not entirely wrong to say that, how can they divide themselves then?"*

Long periods of waiting are common in family planning and other health care programmes and the solutions to the problem vary from one facility to the next. A study conducted in Kenya revealed that problems of time management began at the beginning of each day, care being delayed while providers prepared the clinic for business and conducted group discussions (Kols & Sherman, 1998, p. 30).

Another woman commented: *"When someone is planning to go to the clinic for family planning or any other service, you must expect to stay there the whole day. You have to make sure that there is someone to take care of your house and children. Sometimes I had to close my shebeen in order to get to the clinic. If you do not have someone, that means you cancel the visit to the clinic, as a result pregnancy can happen".* "One of the greatest barriers to health care for the poor is the time it takes

to get treatment. For many, time is a resource, since time away from work may mean lost income" (Aplogan & Hutington, 1999, p. 6).

3.2.3.2 Sub-theme 3.2: Family planning services not always readily available due to long distance to health facilities

For the individual woman, the ability to utilise family planning fully depends on several factors, the most important being service within convenient reach, in terms of both distance (including travel time) and the cost. As challenging at it is to meet the contraceptive needs of women in urban areas, it is even more difficult in rural areas, where the majority of women in developing countries live. Rural women often live at a great distance from health care or family planning services (FHI, 1998, p. 7).

In most rural areas, one in three woman lives more than five kilometers from the nearest health care facility. The scarcity of vehicles, especially in remote areas, and poor road conditions can make it extremely difficult for women to reach even relatively nearby facilities (WHO, 1998, p. 1). Access to service means it is within the reach of women who need it — in terms of being able to get to a facility in the absence of barriers, either of cost for that service or the distance to the facility that provides it.

Regarding the cost of services, none of the women interviewed reported that they were requested to pay for the services they received, a fact that was well appreciated. One woman said that, although the service was free of charge, she had to pay for

transportation to the clinic since she lives a distance from the town: "*I know that the government did something good by not allowing us to pay for family planning, but I still believe that they can make transport available to visit nearby farms and locations just the way they visit farms that are far away from the town, because there is not much difference in what we pay for transportation."*

Economic access is achieved when the cost of obtaining services is within the financial means of potential users. Costs are also indirect and include the amount of time required to access services. These costs must also be affordable to the majority of clients (FHI, 2002, p.32). The finding of the current study emphasises the importance of maintaining cost-free family planning services that are physically and economically accessible to all women.

Another factor that determines whether a woman will continue using family planning services is her ability to reach the facility that provides those services in terms of distance and access to transportation (WHO, 1998, p. 23).

One woman said, "We are lucky that o*ur clinic in Otjiwarongo is situated in the location, where most people are situated and we don't find it difficult to reach there. It is a good idea if the new clinic can be built at Tsaragaibes (informal settlement) because these people find it difficult to reach the clinic."* Offering family planning services in locations close to the residential areas of their potential clients will ensure that a large number of eligible people have access and that travel to the health care facility is shorter and quicker.

Credibility for this view was provided by demographic health surveys (DHS) conducted in some countries. In Zimbabwe, where the mean travel time to a health care facility is 31 minutes, the prevalence of family planning use stands at 45%. In Uganda, where the mean travel time is 60 minutes, the prevalence of use is only 5% (Ross, Stover & Willard, 1999, p. 69). In Namibia, most people living in remote areas still do not have convenient access to health care facilities (Brule, Forster, Lejars, Mendelson, & Obeid, 2001, p. 22). Despite a mean travel time to the nearest health facility of 64 minutes, the prevalence in family planning use in Namibia stands at 37% (MOHSS, 2003, p. 186).

A woman indicated: *"For us, who are staying at farms it is very difficult to stick to the programme… we rely so much on the nurses who visit us during outreach services and they don't always come as they promised. Sometimes we wait for three to four months after the due date is over and then what can you do in that situation? Even our men don't want to use condoms; it is one of the reasons why many ladies become pregnant at farms. One day I ask them why they can't give us extra pills to take in case they will not come back and they said that we need to be examined regularly before taking more pills."*

In most countries surveyed, even where prevalence of contraceptive use is high, unfulfilled need is greater in rural areas than in cities, a fact suggesting that access to family planning services is inequitable (Bryant, et al, 1998, p. 6). Physical access is

improved when service delivery points are conveniently located and can be reached easily by a large segment of the population, including hard-to-reach populations.

As mentioned by Khan (2001, p. 7), clients of family planning want easy access to services and supplies of contraceptives, as well as a convenient delivery location and prompt service.

3.2.3.3 Sub-theme 3.3: Availability of stock and other related services influenced utilization.

It does not matter how many contraceptive methods exist, people will not be able to use them unless supplies are available when they are needed. Supply shortages cause people to become dissatisfied and even to discontinue the services (Crozet, 2000, p. 8). Findings of this study suggest that stock availability is not perceived as a problem to most women in the sample. This perception is indicated by the following two responses:

"I heard people complaining of lack of medicines at hospitals and clinics, but when it comes to contraceptives I have never experience such a problem since I started with family planning".

"I remember only once last year when I came to collect my pills and the nurse gave me only one packet instead of two because there was not enough in stock. She told

me to come after a week to get the other remaining packets, which I did and got the rest".

Providing quality service to family planning clients, personnel in charge of managing stocks of contraceptive supplies must take care that adequate supplies are on hand, that the contraceptives have not expired and that a complete range of contraceptive methods are available (Binzen, 1998, p. 1). Having the sufficient supplies and types of contraceptives available builds confidence in the service and ensures that clients will always return to the clinic. The availability of related reproductive health services including vaccinations, nutritional services, prenatal and post-natal care and medical treatment for diarrhea is also important. Women who apply for family planning services should also be given an opportunity to discuss their problems as well as other health issues and health care workers should be flexible enough to accommodate these issues. Programmes such as voluntary counseling and testing (VCT) for HIV/AIDS can be entry points for family planning as they are complimentary. Family planning provides opportunity for strengthening VCT because it offers an opportunity for emphasising the dual protection role of condoms in preventing both pregnancy and HIV infection (WHO, 2005, p. 4).

One of the most important aspects of quality family planning services is that other routine services, especially those concerned with reproductive health, should be offered at the same facility so that clients are not required to travel unnecessarily to take advantage of them. One woman commented: *"One advantage of coming to the clinic is that once you inform the nurse that you are having a problem, for example*

malaria or anything like diarrhea, the same nurse will treat you immediately. But I suffered one day when I went to the hospital. There the nurse referred me to another one who did not do much and I had to wait in a long line of other patients. After she asks me some question she referred me again to the doctor. I left the hospital very late that day."

Another comment was: *"If you come for family planning, nurses will never ask you if you have any other problem. They just concentrate on that. If you tell them that you are sick then they tell you to go and pay first at the ticket office and go back to that long queue."*

Another woman complained about lack of integrated health services as follows: *"Last week I brought my child for immunisation at this clinic, and at the same time I also realised that I need to get a papsmear. I was in the queue for the whole morning as there were many children that day, when I finished with the immunisation it was almost one o'clock. I asked the nurse to do a papsmear to me and her response was that I am late because it was already done during the morning hours. That means I had to go back again this week. Why didn't they inform me earlier, I could have used my time well to do papsmear in the morning while waiting for immunizations."*

In general, women regard a programme more appealing if all their family planning and reproductive health needs are met at one place and during a single visit. For example integrating voluntary counseling and testing (VCT) into family planning services can help prevent mother to child transmission (PMTCT) by simultaneously

preventing pregnancy and infection of women who are not pregnant (Best, 2004, p. 5).

3.2.3.4 Sub-theme 3.4: Lack of privacy and confidentiality during discourage women to attend family planning services.

Women want to be treated with respect and in a friendly manner. They interpret courtesy, confidentiality and privacy as signs that health care workers take them seriously and consider them as equals.

However, some negative experiences were also reported by some of the women interviewed. One woman described her visit to the clinic as follows: " *I arrived at the clinic at 08H30 to get my contraceptives before I went to work, and the cleaner, who was just standing with a broom at the entrance, informed me that she cannot allow me inside because I am not a patient (not sick). She further said that nurses informed her that only patients are to be seen first, while those who came for family planning will be seen later in the afternoon. I was so embarrassed because even the cleaner already knew that I came for family planning, which means these nurses are discussing our secrets with cleaners… I was not happy at all."*

Figure 3.2 Lack of privacy at a family planning service

Courtesy of Goosen and Klugman, 1997, p. 298

Some of the women interviewed also expressed dissatisfaction with the way they were treated by health care workers who did not respect their right to privacy, an important aspect of quality service. Figure 3.2 above illustrates the absence of privacy at a family planning clinic. A lack of privacy causes embarrassment for women and loss of dignity (Goosen & Klugman, 1997, p. 298).

"One thing that I really don't like with this clinic is the fact that it is too small. There is only one room for injections and all of us have to sit in a queue like animals, just imagine I am almost fifty years old and how can someone expect me to share an injection room with those school kids who like to spread stories in the location?" complained one woman. She continued by saying, "*I think it is advisable*

for these people to divide the days for young people and older ones so that we can be free to mention our problems".

Another woman reponded: "*I tell the nurse that I am sick and she instructed another young nurse to test my urine for pregnancy, but this was in full view of all the people who were sitting there. Now everyone in the location will know that I am pregnant even though I am sure that I am not, I think that women who are coming for family planning services should be treated like all other people who are coming for treatment."*

Problems related to violation of privacy were articulated mostly by women residing at farms. These locations are served by mobile teams. The women are usually made to stand in queues outdoors and receive their pills and condoms in full view of others. They were also required to expose themselves when getting injections. One woman commented, *"I am staying at a farm in Outjo and outreach team used to visit us although for a long time they did not come. But my biggest concern is that during outreach service nurses are just treating us under the trees, there is really no safe place to get an injection."*

"I don't think there is enough confidentiality at clinics or hospital and the problem comes both from nurses and also from other patients, but I believe that nurses are more of a problem than patients. Sometimes it is only you and a nurse discussing problems but after few days you will hear these problems in the location. Even me, I know many people with HIV and those who made abortions, how is that an ordinary

community member, like me, know that someone made an abortion? No, it is only nurses who are spreading these stories, especially women…" (Laughter).

Situations created in family planning programmes, during which clients felt free to speak openly and frankly with a health care worker, were considered to be lacking in privacy. This finding is substantiated by data from interviews in villages of West Nigeria, where only 39 percent of women surveyed believed that clinics had provided adequate personal privacy (Roy & Verma, 1999, p. 8).

3.3 Summary

This chapter provided detailed findings from the study and discussions based on those findings. The next chapter considers the limitations of the study, makes a conclusion and offers recommendations.

CHAPTER 4

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

4.1 Introduction

The previous chapter provided findings and discussions of the study. This chapter provides conclusions, recommendations and study limitations.

The purpose of the study was to investigate and describe the experiences women of child bearing age have in family planning services offered in Otjiwarongo district, Otjozondjupa region of Namibia, and to make recommendations how those services could be the improved.

The objectives of the study were:

(a) To describe the experiences that women of reproductive age report regarding the family planning services they received in Otjiwarongo district.

(b) To submit recommendations how these services could be improved.

4.2 Conclusions

This study revealed wide variations of experience with, and perceptions of, the family planning services offered in Otjiwarongo district. While some women have positive experiences and were pleased with services, some women expressed their dissatisfaction with them.

The following conclusions have been drawn based on the objectives and major themes that emerged from the study as were described in the previous chapter:

Main theme 1: Interpersonal relationships between health workers and clients need to be strengthened.

Concerning interpersonal relationships with health care workers, it can be concluded that women had both positive and negative experiences. Some women indicated they were generally satisfied with workers. This satisfaction was based on the friendliness of staff and the respect they received from them. By treating women with respect, workers in family planning programmes help clients build self esteem and confidence, strengthening their autonomy and ability to make informed decisions (FHI, 2002, p. 25).

On the other hand, some participants in the study indicated they experienced problems when interacting with health care workers during family planning services. Incidents marked by poor communication and insensitivity to clients' needs were

revealed by the study. In addition to the fact that women reported rudeness and negative behaviour on the part of health care workers, some felt that health care staff gave them no opportunity to ask questions. Some women expressed the view that negative traits or behaviour observed in health workers are a reflection of other problems affecting them, such as overwork due to staff shortages (WHO, 2007, p. 11).

Women are usually reluctant to use health care services if they perceive health care providers to be rude and insensitive, behaviour that is humiliating and discouraging them from expressing themselves. On the other hand, it has been found that positive interactions between women and health care workers lead to confidence and compliance (Kols & Sherman, 1998, 6).

This study provided strong evidence that treating clients with respect not only leads to their feeling positive about the service, but actually fosters more openness to discuss concerns on their part. It is also possible that poor relationships between health care workers and their clients are partially to a lack of training regarding the needs of women. Poor interpersonal relationships with clients can also be caused by a lack of respect for them.

Main theme 2: The quality of information provided to clients utilising family planning services needs to be improved.

It was concluded that most women who came for family planning services had not received sufficient information about different types of contraceptives, their use, side effects and contra-indications. Limited access to reliable information and a lack of compassionate counseling exposes women to dangers related to unwanted pregnancy and unsafe abortions (FHI, 2002, p. 14) . It was also evident that three contraceptive methods (pills, injections and condoms), were promoted by health care workers over others.

None of the women interviewed mentioned, unless specifically questioned, that health care workers had informed them about the possible side effects and contraindications of contraceptive use. While most women said they had been offered condoms during their visits to family planning services, general information regarding the prevention of STI's had not been given.

Findings from the study also revealed that health care workers did not advise women regarding the importance of their breastfeeding status when making the choice of a contraceptive. Incorporating the subject into discussions of contraceptive choice would have promoted the importance of breastfeeding.

Theme 3: A conducive environment is needed for family planning services.

It was concluded that some women were satisfied with the availability of family planning supplies and easy access to health care facilities. In contrast, women from remote areas expressed concern about the scarcity of services due to lack of health care facilities in their area. Due to high costs of transportation to urban centers, the only option left many women is to wait for outreach services. These are not always available or regular. One of the notable discoveries of the study was the prevalence of long waiting times that most women experienced when coming to a facility for family planning services. The likelihood that a woman will continue using a service depends on several factors, among them the distance she has to travel, waiting times at a health care facility, access to health care workers and the availability of contraceptives.

The majority of participants in the study said they were dissatisfied with the lack of privacy and confidentiality they experienced during discussions and examinations. Lack of confidentiality is a matter of concern with serious consequences for women. This serious problem needs to be addressed. The experience of some participants in the study that health care workers did not respect their need for privacy is a matter of concern with serious implications for the reproductive health of many women.

Women have also expressed their dissatisfaction with a lack of integration of health care services at facilities and the impact on them. Not all women can afford to make repeated trips to health care facilities.

4.3 Recommendations

Various issues were identified by the study and, based on the findings; the following recommendations are made with reference to the specific themes that emerged.

Main theme 1: Interpersonal relationships between health workers and clients need to be strengthened.

To make family planning services more attractive to individuals and couples, more effort should be exerted to make women feel welcome and as comfortable as possible when applying for and accepting these services. This implies that health care workers should structure services to cater for different kinds of people, especially the needs of young people and single mothers. Adolescent friendly family planning services should be introduced where young people can discuss their concerns about reproductive health needs comfortably and openly.

The United Nations General Assembly, as part of a broader resolution reflecting on progress in reproductive health, urged government s to recognize that sexual active adolescent will require special family planning information, counseling and health services ((Bryant, Piotrow & Salter, 1998, p. 10).

Main theme 2: The quality of information provided to clients utilising family planning services needs to be improved.

More attention should be placed on informing women about the range of contraceptive methods available. The study revealed that health care workers usually recommend pills or injections. It is unclear, however, whether focus on these methods is due to a lack of confidence to discuss other methods, or to the fact that other methods are not available.

Health workers should be encouraged to explain all methods of contraception that are available, including IUDs, male and female sterilization, periodic abstinence, caps, diaphragms and implants, to help users make informed choices about contraceptive methods that are most suited for them. This study reveals that in most cases, health workers only mentioned injections, pills and condoms. For family planning programs, encouraging women to make informed choices about reproductive health is a cornerstone of good quality (FHI, 2000, p. 8).

A broadly based approach to counseling and distributing information is needed that functions effectively on several levels, ensuring that women receive basic information, understand their rights and are empowered to make informed choices. This may include family planning messages that are publicised through radio, television and newspapers that convey information about contraceptive methods.

Often, women receive information from classmates or friends and they may be ill informed, contributing to the spread of misconceptions among users. To help users better understand methods of contraception, Family Health Division might introduce and establish peer groups and programmes of community-based distribution of contraceptives. The latter could utilise experienced contraceptive users, who after

being trained, could counsel new users by relating their personal experiences with methods and side effects, and sharing their coping strategies. These trained women could also be employed to follow up with contraceptive users in remote areas after they have begun a new method or if they have problems or concerns.

Because side effects play such a pivotal role in women's choice of methods, health care workers must emphasise correct and consistent use of contraception. They should also receive additional training on counseling techniques and learn how to assist clients manage side effects.

It is important that health care workers suggest long-term methods in order to reinforce the likelihood of their continuation, especially for women who might be prone to drop out of a programme, such as teenagers and people living far from health care facilities that provide the services. Health care workers can also create registers at their facilities in which clients are listed and their personal programmes recorded. Introducing a family planning register, health care workers could follow client schedules and remind them when a visit is due. A system of appointment reminders would be worked out in consultation with the client, to ensure that it would be suitable for her.

In order to meet the needs of breastfeeding women, health care workers must have accurate information about the appropriate use of contraceptive methods during lactation. To ensure that women receive the full benefits of breastfeeding, i.e. protection against pregnancy and better infant health, health care workers should

counsel mothers to breastfeed fully and advise them how to practice the lactational amenorrhea to space births.

Theme 3: A conducive environment is needed for family planning services.

A recommendation that would make family planning services more accessible and effective is to make them part of an integrated health care model that links them with other services such as immunizations, Voluntary Counseling and Testing (VCT), Prevention of Mother to Child Transmission (PMTCT) of HIV, pregnancy tests, STI prevention and pap smears. Integrated health care would be the most satisfactory way of meeting women's diverse reproductive health care needs.

An integrated service should be available to women admitted to hospitals, especially those who come for deliveries or abortions. Many women leave hospitals after treatment for complications associated with unsafe abortions without having received either information or counseling on how to prevent future pregnancies. For obvious reasons, family planning should form an integral part of general health care education provided to women during antenatal visits and should be followed by individual counseling during postnatal visits to a health care facility.

To address the problem of long waiting periods at family planning clinics, health care workers could develop a simple form that would record each client's arrival time, when she is receive by a health care worker and the length of time spent with that worker to facilitate a client flow analysis. This analysis would help staff to determine how and when the longest delays occur. The time women spend waiting

for family planning services could be used beneficially by providing them information on different kinds of contraceptives in the form of brochures, posters or videos that they could review while they wait.

Causes of long waits, and their solutions, vary from one place to another. In two Kenyan clinics studied, problems started at the beginning of each day when care was delayed while health workers prepared the clinic. Part of the solution was to reorganise the clinic schedule to match client flow which was heaviest in the morning and slower in the afternoon (Kols & Sherman, 1998, p. 30).

To improve access to family planning services for rural populations, the services must be offered in their vicinity. This is a crucial issue. A way to bring service delivery to them is to introduce community-based programmes in which trained Community Health Workers (CHW) provide information on contraceptives and supply condoms and pills. Alternatively social marketing could be introduced that would distribute contraceptives, especially condoms and pills, free of charge or sell them through commercial outlets at subsidized prices.

To ensure privacy and confidentiality, those involved in providing family planning services must show respect for the client's opinion and for the need for confidentiality. A system can be introduced where a woman is given a card which tracks the purpose of her visit on it, so that when she arrives she can hand the staff her card without having to say the reason for her visit out loud in the waiting room.

4.4 Limitations of the current study

Weaknesses can usually be pinpointed in the design or methodology of most studies. In the current study, limitations in the accuracy of findings can be attributed to the size of the population sample and the data collection technique.

4.4.1 Data collection technique

It is generally acknowledged that many participants in studies tend to express views that are consistent with socially accepted norms, rejecting contradictory views as unacceptable. The bias of social acceptability may influence respondents to self-censor their actual views (Becker & Felton, 2001, p. 9).

Similarly, a respondent may harbour a biased attitude towards a researcher based on the researcher's background. The researcher in this study is familiar to some of the respondents as a health care worker. This knowledge could influence respondents to conceal their negative experiences with health care providers.

4.5 Summary

This chapter dealt with the purpose and achievement in meeting the objectives of the study. Limitations were also indicated as well as recommendations on the findings. In my opinion as a researcher in this study I have been able to highlight the problems encountered by women if they come to utilize family planning services. I have been able to create a data base that can be utilized by health service providers when dealing with problems related to utilization of family planning services.

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ANNEXURE A: PERMISSION LETTER FROM UNAM RESEARCH COMMITTEE

UNIVERSITY OF NAMIBIA
Private Bag 13301, 340 Mandume Ndemufayo Avenue, Pionierspark, Windhoek, Namibia

FACULTY OF MEDICAL AND HEALTH SCIENCES

Letter of permission:
Post graduate students

UNIVERSITY OF NAMIBIA
Faculty of Medical and Health Sciences
OFFICIAL
2007 -08- 02
PRIVATE BAG 13301,
WINDHOEK, NAMIBIA
OFFICE OF THE DEAN

Date: 2·8·2007

Dear Student: V Tauya

The post graduate studies committee has approved your research proposal.

Title: The experiences of women utilizing family planning services in Otjiwarongo District. Namibia

You may now proceed with your study and data collection.

It may be required that you need to apply for additional permission to utilize your target population. If so, please submit this letter to the relevant organizations involved. It is stressed that you should not proceed with data collection and fieldwork before you have received this letter and got permission from the other institutions to conduct the study. It may also be expected that these organizations may require additional information from you.

Please contact your supervisors on a regular basis.

Faculty representative on Post graduate committee

A van Dyk

Prof A van Dyk

ANNEXURE B: LETTER OF APPROVAL FROM THE MINISTRY OF HEALTH AND SOCIAL SERVICES

ANNEXURE C: INTERVIEW SCHEDULE

Interviewee No: 26

Age: 34

Main question:

1. Describe to me your experience when you utilize family planning services.

"I am now using these contraceptives for a long time and I am happy with the services

- **Can you explain to me why you are happy with the services?**

Those nurses at the clinic are so helpful.

- **Are there any specific examples of how nurses are helpful?**

I remember one thing, when I came last month my supervisor brought me with her car and told me to hurry up because we have a lot of work to do at the shop. At first I was very afraid to talk to the nurse because there were many people who came before me. I just went inside and explain to the nurse and surprisingly she just

helped me. I was so happy; I really did not expect that because people in the location use to say that nurses are very rude. Even my supervisor was so happy.
I heard people complaining of lack of medicines at hospitals and clinics, but when it comes to contraceptives I have never experience such a problem since I started with family planning. I remember only once last year when I came to collect my pills and the nurse gave me only one packet instead of two because there was not enough in stock. She told me to come after a week to get the other remaining packets, which I did and got the rest

- **What did the nurses tell you about different types of contraceptives?**

Nurses at Kalkfeld clinic (smaller clinic) explained all types of contraceptives to us when I took my younger sister for family planning, but here at this clinic nurses are not explaining, but I think it is because there are too many patients and they don't have enough time. Here some of them show different types, but I only know about pills and injections.

- **In your opinion what experiences can you describe as not good?**

When I changed from the injection to the pill, these nurses were complaining too much…she actually said that I am wasting the government's medicine because she had already opened the bottle before I informed her that I want to change to the pills. At the moment I want to change again to the injection, because I don't want to be pregnant in the near future, but I don't know how I will tell this same nurse

again…even today I wanted to inform her but…hey…when I look in her angry face… If you find yourself in a situation whereby a nurse you are trying to receive assistance from is not open enough to talk to you, she doesn't want to hear anything from you, how will I as a patient be free to express my opinions. This means that this person is not ready to serve the people.

I remember one day when I came with my friend they ask me funny questions like: Why do you have sex at that young age, didn't you know that you would become pregnant"? It is not their business to worry about my personal life.

What I also don't like is that *I am not really satisfied with my body (overweight)… ..[but] if I don't use contraceptives, I will have too many children and I will struggle to feed them, send them to school, because I am not employed and all these things are very expensive, I am really happy that this service is available.*

- **What encourages/motivate you to come to family planning again?**

I made a decision to take contraceptives in order to prevent unwanted pregnancy and I make sure that I don't miss my appointments. I have already four children; I will never make that mistake of not coming for my injection on time

- **Did you receive information about sexual transmitted diseases at any time during your visit?**

"Since I started with family planning in 2002, I have never heard nurses discussing STI's or even HIV issues with us. I think it is very important for them to remind especially young ladies who are coming for family planning to be careful about contracting these diseases."

- **In your opinion how would you like to be treated by the nurses**

"When someone is planning to go to the clinic for family planning or any other service, you must expect to stay there the whole day. You have to make sure that there is someone to take care of your house and children. Sometimes I had to close my shebeen in order to get to the clinic. If you do not have someone, that means you cancel the visit to the clinic, as a result pregnancy can happen".

*I don't think there is enough confidentiality at clinics or hospital and the problem come both from nurses and also from other patients, but I believe that nurses are more of a problem than patients. Sometimes it is only you and a nurse discussing problems but after few days you will hear these problems in the location. Even me I know many people with HIV and those who made abortions, how is that an ordinary community member, like me, know that someone made an abortion? No it is only nurses who are spreading these stories, especially women"…… (*Laughing).

ANNEXURE D: VERBAL CONSENT FROM PARTICIPANTS

I, Vaino Tauya, a student at UNAM conducting a study to describe the experiences that women of reproductive age report regarding the family planning services they receive in Otjiwarongo district. The study would provide relevant and significant information to managers at all levels of health care delivery about the quality, appropriateness and completeness of family planning services

The participants for this study are all women attending family planning and you are therefore requested to participate in this study. As a participant, you are allowed to withdraw from the study at any time and could refuse to answer any question without negative consequences.

To ensure confidentiality, the names of the participants will not be recorded and, that information will not be made public or available to others.

Written permission to conduct the survey was obtained from the University of Namibia and the Ministry of Health and Social Services.