**UNIVERSITY OF EASTERN AFRICA BARATON**

**SCHOOL OF HEALTH SCIENCES**

**DEPARTMENT OF NURSING**

**FACTORS CONTRIBUTING TO NON-UTILIZATION OF TUBAL LIGATION SERVICES AMONG WOMEN OF REPRODUCTIVE AGE ATTENDING MCH/FP CLINIC AT KOMBEWA DISTRICT HOSPITAL**

**A RESEARCH PROJECT WRITTEN IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE COURSE NRSG 423 INTRODUCTION TO NURSING RESEARCH**

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**JULY 2015**

# DECLARATION AND APPROVAL

**Declaration by the Candidates**

We declare that this research project is our original work and has not been presented to any other University for a similar or any other degree award. No part of this work should be produced without our consent or the University of Eastern Africa, Baraton

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# TABLE OF CONTENTS

[DECLARATION AND APPROVAL ii](#_Toc424401277)

[ACKNOWLEDGEMENT iii](#_Toc424401278)

[TABLE OF CONTENTS iv](#_Toc424401279)

[List of Tables vii](#_Toc424401280)

[List of Figures viii](#_Toc424401281)

[ABSTRACT ix](#_Toc424401282)

[CHAPTER ONE 1](#_Toc424401283)

[INTRODUCTION 1](#_Toc424401284)

[1.0 Background information 1](#_Toc424401285)

[1.1 Problem Statement 5](#_Toc424401286)

[1.2 Purpose of Study 5](#_Toc424401287)

[1.3 Justification of the study 6](#_Toc424401288)

[1.4 Significance 7](#_Toc424401289)

[1.5 Study objectives 7](#_Toc424401290)

[1.6 Research question 7](#_Toc424401291)

[1.7 Hypothesis 8](#_Toc424401292)

[1.8 Variables 8](#_Toc424401293)

[1.9 Operational definitions 8](#_Toc424401294)

[1.10 Conceptual framework 9](#_Toc424401295)

[CHAPTER TWO 12](#_Toc424401296)

[LITERATURE REVIEW 12](#_Toc424401297)

[2.0 Background 12](#_Toc424401298)

[2.1 Health Service Factors 14](#_Toc424401299)

[2.2 Community/Client Related Factors Knowledge, Attitudes and Perceptions towards Family Planning 15](#_Toc424401300)

[2.3 Community Based Family Planning Interventions 17](#_Toc424401301)

[2.4 Policy Environment 17](#_Toc424401302)

[CHAPTER THREE 20](#_Toc424401303)

[RESEARCH METHODOLOGY 20](#_Toc424401304)

[3.1 Introduction 20](#_Toc424401305)

[3.2 Study Design 20](#_Toc424401306)

[3.3 Study Population 20](#_Toc424401307)

[3.4 Study Area 20](#_Toc424401308)

[3.5 Sample Size Determination 21](#_Toc424401309)

[3.6 Sampling Procedure/Technique 21](#_Toc424401310)

[3.7 Data Collection Tool 21](#_Toc424401311)

[3.8 Data Analysis 21](#_Toc424401312)

[3.9 Ethical Considerations 22](#_Toc424401313)

[3.10 Pre-Testing Of Data Collection Tool 22](#_Toc424401314)

[3.11 Study Limitations 22](#_Toc424401315)

[CHAPTER FOUR 23](#_Toc424401316)

[FINDINGS AND DISCUSSION 23](#_Toc424401317)

[4.1. Introduction 23](#_Toc424401318)

[4.2. Demographic Characteristics 23](#_Toc424401319)

[4.3. Socio-Cultural Factors 29](#_Toc424401320)

[4.4. Knowledge, Attitude and Perceptions 34](#_Toc424401321)

[5.1 Introduction 46](#_Toc424401322)

[5.2 Summary of Findings 46](#_Toc424401323)

[5.2.1 Response Rate 46](#_Toc424401324)

[5.2.2. Demographic Characteristics 46](#_Toc424401325)

[5.2.3. Socio-Cultural Factors 47](#_Toc424401326)

[5.2.4. Knowledge, Attitude and Perceptions 48](#_Toc424401327)

[5.3. Conclusions 50](#_Toc424401328)

[5.3.1. Demographic Characteristics 50](#_Toc424401329)

[5.3.2. Socio-Cultural Factors 50](#_Toc424401330)

[5.3.3. Knowledge, Attitude and Perceptions 51](#_Toc424401331)

[5.4. Recommendations 52](#_Toc424401332)

[REFERENCES 54](#_Toc424401333)

[APPENDICES 55](#_Toc424401334)

[Appendix 1: Information Sheet 55](#_Toc424401335)

[Appendix III: Budget 60](#_Toc424401336)

[Appendix IV: Time Frame 62](#_Toc424401337)

# List of Tables

Table 1: Utilization of Family Planning Methods 6

Table 2: Cross Tabulation of Respondents Level of education and Occupation 27

Table 3: Level of Education and Occupations of Husbands 28

Table 4: s Pearson’s coefficient for chi square test 29

Table 5: Showing Number of Children Wanted 30

Table 6: Cross Tabulation of Number of Children Wanted Against Actual Number of Children 31

Table 7: Pearson’s coefficients for chi square tests 34

Table 8: Knowledge about BTL 34

Table 9: Cross Tabulation of Level of Education and Knowledge on BTL 36

Table 10: Enough Children for Respondents to Consider BTL 37

Table 11: Cross tabulation Marital Status against Preferred Method of Family Planning

40

Table 12: Chi-Square Test on Knowledge of What is done during BTL and Reasons for non-utilization 42

Table 13: Challenges in Accessing Family Planning Services 43

Table 14: Suggestion on How to Overcome Challenges 44

# List of Figures

Figure 1: Diagrammatic Representation Of Conceptual Framework 11

Figure 2: Age of Respondents 24

Figure 3: Marital Status of Respondents 24

Figure 4: Husband’s Age 25

Figure 5: Duration of marriage for Respondents 26

Figure 6: Respondents Religion 26

Figure 7: Number of Children per Respondent 31

Figure 8: Need for husband’s Permission 32

Figure 9: Sources of Family Planning Advice 33

Figure 10: What is done during BTL 35

Figure 11: Perceived Side Effects of BTL 37

Figure 12: Other Family Planning Methods Known to Respondents 38

Figure 13: Preferred Family Planning Method 39

Figure 14: Reasons for Not Using BTL 41

# ABSTRACT

Population management has been a major concern for thinkers for a very long time. Many challenges facing humanity can be directly or indirectly linked to increase in population. For many countries, the population growth rate is higher than the economic growth rate. This implies, production and economic value is not expanding at a fast enough rates to accommodate the growing populations. Maternal and child health care are also directly dependent on family planning. Households have to plan family because it is beneficial for all members. Fewer children reduce economic and health pressure and parents. In return, with planned families, parents are more able to take care of their children thus reducing maternal and infant mortality rates.

Literature shows that family planning uptake is still low in Kenya. Moreover, only 5% of women in Kenya prefer or utilize permanent contraception. This study sought to investigate factors that contribute to non-utilization of permanent contraception. The study focused on factors contributing to non-utilization of tubula Ligation service among women in Seme Sub County.

This study utilized an exploratory study design. The study site was Kombewa District Hospital located in Kisumu county, Seme sub county while the study population were the women of reproductive age attending MCH/FP clinic at the mentioned health facility. A sample of 152 respondents was drawn and data collected from them using a semi-structured questionnaire.

The analyzed data showed that Majority of individuals attending MCH Clinics at Kombewa District Hospital are between ages 25-30. Considering marital status, most of those accessing MCH clinics are married women who have been in marriage for 2 years or less. Majority of the mothers accessing MCH clinics are primary school dropouts and are unemployed. The study established that husbands to the respondents want more children than the women. Considering the number of children the respondents wanted against the children they already have, there are unmet family planning needs that need to be addressed. Further, the study established that there is low awareness about BTL and majority of people have misconceptions about it. Additionally, tests on strength of relationship between demographics, social economic factors, hospital related factors and cultural factors showed that positive significant relationship exists between those factors and uptake of family planning in Seme Subcounty. This study recommends a review of the family planning programmes in order to address needs of youth and involve husbands as well as making family planning a community effort.

# CHAPTER ONE

# INTRODUCTION

## 1.0 Background information

Bilateral tubal ligation is a terminal event in a woman’s life. The decision to undergo bilateral tubal ligation is a major one that affects the family and the community as a whole. While attainment of desired family size is an easy decision to reach for a couple, bilateral tubal ligation is not the first choice contraceptive to many such couples.

As per KDHS 2008-2009, 49% of women interviewed expressed attainment of desired family size, yet only 5% took up BTL. Different factors may affect the decision to undergo BTL such as spousal refusal, level of communication among the couple, socioeconomic standing, and even fear of child mortality. The purpose of this study is to elucidate the factors contributing to the non-utilization of BTL services among women of reproductive age in Kombewa District Hospital.

The current Kenyan population stands at 38 million, while the fertility rate is 4.6 births per woman. The Total Fertility Rate (TFR) in Kisumu is 3.9 children per woman. The highest age-specific fertility rate (ASFR) among women aged 20 -24.This translates to a population of 50 million by the year 2030. Among current users of family planning, 54% of the population in Kisumu accesses their family planning method from public facilities, while 22% seek FP services from private facilities. [www.tupange.or.ke](http://www.tupange.or.ke)

Such a population will be a strain on our economy, considering that only a small proportion of that population will be working. The bulk shall comprise children and unemployed people who will need social support from the government. Indeed, it is but a dream to expect adequate and equitable distribution amongst the Kenyan population if it continues increasing at the current rate. Better healthcare, free education and free healthcare for children below the age of 5 years are some of the factors that are encouraging couples to have many children.

Located in the western side of Nyanza province, Kombewa district hospital is located in Kisumu county, Kisumu west district, south central Seme location. The district has 2 divisions, 8 locations and 37 sub-locations. The divisions are Maseno and Kombewa

According to the Kenya National Bureau of Statistics, a demographic survey done in the year 2009 indicates that Kisumu west district covers an approximated area of about 360.8 km2 with an estimated population of about 144,907.Out of this,76,093 are female, 68,814 are male . Out of the total number of women 20% of them fall under the bracket of women of childbearing age.

According to WHO, the UN millennium development goals aim at combating poverty, hunger, diseases, illiteracy, environmental degradation and discrimination against women by the year 20153. These MDGs are aimed at improving the quality of life worldwide. One of the greatest challenges to attainment of the MDGs is over population with subsequent resource depletion. Indeed, it will be almost impossible to improve maternal health and reduce child mortality if the Kenyan population continues increasing at the current rate. Population growth remains the most important factor in attainment of the MDGs.

It is up to reproductive healthcare providers to advocate for policies aimed at controlling population increase in the country. Such policy would ensure affordable, accessible, and acceptable methods of contraception on one level, and a step towards improvement of quality of life through limitation of family size. While policy on family planning is already in place, uptake of contraceptive methods remains below 50% in Kenya. Furthermore, permanent contraception is still generally not taken up by most couples with less than 5% of women taking up BTL. Bilateral tubal ligation is a terminal event in a woman’s life. It signals an end to a woman’s obstetric career by choice. Bilateral tubal ligation involves surgical disruption of the fallopian tube patency and may be carried out laparascopically, by mini-laparatomy or during caesarian section. When it is performed within six weeks of delivery, it is referred to as postpartum BTL. On the other hand, interval BTL is performed after end of puerperium.

Permanent sterilization should be the ideal choice for couples who have attained desired family size. In addition, it has fewer side effects compared to hormonal contraceptive methods and hence can be used in special cases such as in women with cardiac disease. BTL is an acceptable method of contraception to most communities in Kenya. Unfortunately, it may not be easily accessible to those who have no access to a medical facility with theatre facilities. At the same time, not all health care providers are competent in carrying out interval BTL by mini laparatomy. This creates challenges in accessibility and affordability of the BTL to most women in the rural areas.

Many readily express that they have attained their desired family size but most shy away from choice of a permanent contraceptive. The reasons for this are largely unknown but may be due to interplay of several socioeconomic factors. This study aims at delving into the factors that influence the decision to take up or not to take up BTL as a method of contraception by women who have attained their desired family size.

On World Population day, 11 July 2014, the World Bank reported that the world’s population had hit 7.6 billion. There has been a steady decline in total fertility rates globally with the trend most pronounced in industrialized countries especially western Europe. The total fertility rates in the United Kingdom and United States of America have declined from 2.0 % to 1.9 % Sweden and Norway have had declines of 0.1% to a total fertility rate of 1.9 %. The figures for sub - Sahara Africa are much higher; with Niger having the highest at 7.6%. Nigeria and Uganda also have relatively high total fertility rates at 6.0%. [www.data.worldbank.org](http://www.data.worldbank.org) The total fertility rate for Kenya is at 4.6%. The fertility rate in the Western and Nyanza provinces is 5.5%. [www.bmjopen.bmj.com](http://www.bmjopen.bmj.com)

Rapid population growth plus declining economic performance in sub – Sahara Africa has translated into less income per person with many people living below the poverty line. In 2006, 58% Kenyans lived on less than two dollars a day.[www.prb.org](http://www.prb.org) Birth control policies have to be implemented to rein in this population explosion with some countries like China having very stringent measures like the “one child policy.” According to WHO, family planning allows individuals to control the spacing and timing of births, and to attain their desired number of children. In the short – term this can create the potential for lower maternal and infant mortality rates through fewer unintended pregnancies, and also reduce HIV/AIDS transmission, unsafe abortion practices, and enhance education and employment opportunities for women. Family planning therefore leads to reduced pressure on scarce resources, improves the economy, and empowers women. Dr. John Nduba Director of Reproductive and Child Health at the African Medical and Research Foundation states, “family planning could almost be viewed as a vaccine for the improvement of maternal health.” [www.africaportal.org/blogs/community](http://www.africaportal.org/blogs/community)

## 1.1 Problem Statement

Though much effort has been put forward on the need to use birth control methods, there is still a problem of population growth, which has contributed to birth of unwanted children. Kenya had one of the world’s fastest growth rates in the 1970s and 1980s. The total population rose from 10 million to 15 million by 1978. This rapid population growth and poor economy prompted the government to promote birth control measures to lower fertility rates. The total fertility rate declined from 8.1% in the 1960s to 5.4% in the early 1990s. This according to the UN estimates was because of the gradual acceptance of family planning. By 2007 women, using a contraceptive was 39%, above the average for sub – Sahara Africa (World population Data Sheet, 2007).

The estimated annual growth rate for 2008 – 2030 is 2.4% while contraceptive use for the period 2008 – 2012 is 45.5%. [www.unicef.org](http://www.unicef.org). According to data from Kombewa District Hospital MCH/FP clinic for the past twelve months, there is an average utilization of these services. Even though this is low, it is the non-utilization of sterilization, as a birth control method, which starkly stands out. Out of 1264 clients, none selected sterilization as a method of choice. What factors contribute to this non-utilization of BTL services at Kombewa District Hospital?

## 1.2 Purpose of Study

To explore and describe factors contributing to non - utilization of tubal ligation as a method of choice for women attending MCH/FP clinic at Kombewa District Hospital

## 1.3 Justification of the study

Total fertility rate in Western and Nyanza provinces stands at 5.5%. There is still non-utilization of tubal ligation services as shown Table 1

Table 1: Utilization of Family Planning Methods

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Depo-Provera** | **Pills** | **IUCD** | **implants** | **vasectomy** | **BTL** | **Total** |
| Jan 2015 | 68 | 26 | 2 | 12 | 00 | 00 | 108 |
| Dec 2014 | 52 | 22 | 3 | 18 | 00 | 00 | 95 |
| Nov 2014 | 64 | 34 | 1 | 24 | 00 | 00 | 123 |
| Oct 2014 | 58 | 28 | 1 | 12 | 00 | 00 | 99 |
| Sep 2014 | 50 | 34 | 5 | 18 | 00 | 00 | 107 |
| Aug 2014 | 48 | 36 | 3 | 16 | 00 | 00 | 103 |
| July 2014 | 62 | 26 | 1 | 14 | 00 | 00 | 103 |
| June2014 | 46 | 32 | 0 | 18 | 00 | 00 | 96 |
| May2014 | 38 | 34 | 2 | 22 | 00 | 00 | 96 |
| April2014 | 52 | 26 | 3 | 25 | 00 | 00 | 106 |
| Mar 2014 | 56 | 28 | 2 | 28 | 00 | 00 | 114 |
| Feb 2014 | 48 | 32 | 2 | 32 | 00 | 00 | 114 |
| Total | 642 | 358 | 25 | 239 | 00 | 00 | 1264 |

* Explore reasons why women of reproductive age do not utilize services at KDH.
* No research has been done to establish factors contributing to non-utilization of tubal ligation services at KDH.

## 1.4 Significance

The findings from this research will:-

* Help to establish strategies and programs that will improve utilization of tubal ligation services by women of reproductive age.
* Help the health facility put in place systems that will address the challenges faced by women of reproductive age.

## 1.5 Study objectives

* To identify the factors contributing to non-utilization of tubal ligation services at Kombewa District hospital.
* To explore the level of knowledge on utilization of tubal ligation by women of reproductive age.
* To find out measures that can be put in place to enhance uptake of this services at Kombewa district hospital
* To find out the attitude of women of reproductive age in Kombewa on use of BTL as a method of contraception

## 1.6 Research question

* What are the factors contributing to non-utilization of tubal ligation services?
* What is the level of knowledge on utilization of tubal ligation by women in Kombewa?
* What measures can be put in place to enhance uptake of this service amongst women in Kombewa?
* What is the attitude of women of reproductive age on BTL as a method of contraception?

## Hypothesis

H0- demographic characteristics such as age and marital status have no influence utilization of BTL services among women in Kombewa

H1. Husbands and cultural factors do not significantly influence utilization of BTL by women in Kombewa

H2. Level of awareness about BTL has no significant influence on utilization of BTL as a method of contraception.

## 1.8 Variables

* Independent variable-non utilization of BTL services.
* Dependent variable-factors contributing to non-utilization of BTL services.

## 1.9 Operational definitions

**BTL** Bilateral tubal ligation

**FAMILY PLANNING**  A strategy to prevent pregnancy by spacing births

**KDHS**  Kenya Demographic and Health Survey

**MDGs** Millennium development goals: a set of eight goals set by the UN General Assembly

**TFR**  Total fertility rate: the number of children born per woman

in her child bearing age

**WHO**  World Health Organization

**WRA**  Women of reproductive age i.e. from 15 years to 49 years

## 1.10 Conceptual framework

Millennium development goals (MDGs) are achievable only if poverty is combated, hunger eliminated, disease epidemics reduced, literacy enhanced, environment protected, and women empowered. None of this can be attained if the population is greater than what the environment can sustain. In our Kenyan set up, an over population coupled with high maternal and child mortality rates has created a vicious cycle whereby none of the MDGs can be achieved by the year 2030 as envisioned.

Communication between husband and wife may be instructional whereby a wife is treated as a daughter, especially when the wife is much younger. A couple that has open communication about their family planning options will reach an amicable agreement on their choice. At the same time, a wife who is instructed by the husband will continue conceiving as long as the husband demands and as such will not take up a permanent method of contraception. Indeed, most men do not involve themselves with their wives’ choice of contraceptive. At the same time, women will fear taking up a permanent method such as BTL without informing the husband. This is interrelated with the couples beliefs, religion and experiences.

Socioeconomic factors such as poverty greatly affect the choice of whether or not a woman will take up BTL. Poverty is directly tied to the number of dependents in the house compared to the income available. A survey done in Kenya showed that poor rural women with many children opted for more long-term contraceptives. This was closely related to the education level, which in turn affects health-seeking habits. A poor couple with low education level will more often than not have a higher number of children but have little or no access to contraceptives in a health centre. At the same time, access to a health center, which offers family planning services, may be out of reach for many rural women. This may be due to distance from the health centre or poor infrastructure and transport. Poor information on available options for family planning and their availability may influence the choice of contraceptive a woman takes up.

Most women get their information on contraception from their friends and relatives who may not have the correct information. This coupled with lack of access to a health facility means that a couple may base their decision on wrong information and end up avoiding BTL. At the same time, the health centre may not have the necessary resources to carry out BTL.

These factors will all be looked into in this study in order to explore how they influence a woman’s decision to take up BTL. This in turn will help in creating a better approach that will encourage a woman to have permanent sterilization. As a result, we can improve maternal and child mortality and morbidity and thus achieve our millennium development goals. This is simply explained by the fact that once a woman has BTL performed on her, she no longer can conceive and thus can concentrate on her family. It is important to involve the whole family and community so that a woman is able to plan her family and get permanent contraception once desired family size is achieved. The diagrammatic representation of the conceptual framework is as shown in figure 1

**Figure 1: Diagrammatic Representation Of Conceptual Framework**

**Socio-economic factors**

* Poverty
* Education
* Source of income
* Occupation

**Spousal factors**

* Communication level
* Age difference
* Spouse also accepts BTL

Low uptake of BTL

High Maternal and child morbidity and mobility

Increased uptake of BTL

**Socio-demographic factors**

* Age
* Location
* Education
* Marital status

**Socio-cultural factors**

* Fear of unprecedented outcome
* Polygamy
* Multiparity Herbal contraceptive
* Achieve MDGs
* Reduced maternal mortality and morbidity
* Reduced child mortality and morbidity
* Better resource utilization

**Intervention**

# CHAPTER TWO

# LITERATURE REVIEW

## 2.0 Background

Family planning is an important strategy in promoting maternal and child health. It improves health through adequate spacing of birth, avoiding pregnancy at high-risk maternal age and high parity. It is often used as a synonym for birth control, however. It does have a wider view, dealing with birth control, reproductive health, as well as premarital and pre-conception counseling. Unexpected or unplanned pregnancy poses a major public health challenge in women of reproductive age, especially in developing countries. It has been estimated that of the 210 million pregnancies that occur annually worldwide, about 80 million (38%) are unplanned, and 46 million (22%) end in abortion (Monjok et al 2010)

Contraceptive prevalence rates have correlated with maternal mortality and it has been shown that countries with low contraceptive prevalence rates are also countries with very high maternal mortality ratios (Okonofua, 2003). Bilateral tubal ligation is a terminal event in a woman’s life. It signals an end to a woman’s obstetric career by choice. Bilateral tubal ligation involves surgical disruption of the fallopian tube patency and may be carried out laparascopically, by mini-laparatomy or during caesarian section. When it is performed within six weeks of delivery, it is referred to as postpartum BTL. On the other hand, interval BTL is performed after end of puerperium (Decherny et al., 2003).

The current Kenyan population stands at 38 million, while the fertility rate is 4.6 births per woman (KDHS 2008 - 2009). This translates to a population of 50 million by the year 2030. Such a population will be a strain on our economy, considering that only a small proportion of that population will be working. The bulk shall comprise children and unemployed people who will need social support from the government. Indeed, it is but a dream to expect adequate and equitable distribution amongst the Kenyan population if it continues increasing at the current rate. Better healthcare, free education and free healthcare for children below the age of 5 years are some of the factors that are encouraging couples to have many children (KDHS 2008 -2009). According to WHO, the UN millennium development goals aim at combating poverty, hunger, diseases, illiteracy, environmental degradation and discrimination against women by the year 2015. [www.who.int/topics/millennium\_development\_goals/en](http://www.who.int/topics/millennium_development_goals/en)

These MDGs are aimed at improving the quality of life worldwide. One of the greatest challenges to attainment of the MDGs is over population with subsequent resource depletion. Indeed, it will be almost impossible to improve maternal health and reduce child mortality if the Kenyan population continues increasing at the current rate. Population growth remains the most important factor in attainment of the MDGs. In this context, family planning and limitation of family size constitute the basis for population growth control and hence the epicenter in achieving MDGs.

While policy on family planning is already in place, uptake of contraceptive methods remains below 50% in Kenya. Furthermore, most couples do not, generally, take up permanent contraception with less than 5% of women taking up BTL (KDHS, 2009). Permanent sterilization should be the ideal choice for couples who have attained desired family size. In addition, it has fewer side effects compared to hormonal contraceptive methods and hence can be used in special cases such as in women with cardiac disease. BTL is an acceptable method of contraception to most communities in Kenya. Unfortunately, it may not be easily accessible to those who have no access to a medical facility with theatre facilities. At the same time, not all health care providers are competent in carrying out interval BTL by mini laparatomy. This creates challenges in accessibility and affordability of the BTL to most women in the rural areas (Division of reproductive Health, Ministry of Health, Kenya. National family Planning Costed Implementation Plan 2012-2016.)

Studies have shown that the demand for tubal ligation is low, but is commonly accepted in conjunction with another surgical procedure, such as a cesarean section or laparotomy for repair of uterine rupture. (Monjok et al 2010). Female sterilization by tubal ligation is not a common or acceptable contraceptive choice in Kenya. The reasons for these are largely unknown but may be due to interplay of several socioeconomic factors. Many factors can influence decision-making about sterilization , including religion, ignorance, and superstition based on ancient beliefs, even among more influenced by the high cost of the procedure, scarcity of skilled providers (especially in rural areas), and fear of surgical complications.

## 2.1 Health Service Factors

A major goal of family planning programmes is to help couples achieve their reproductive intentions. To assist clients to achieve these goals family planning services should be tailored to meet clients’ needs. Effective delivery and uptake of modern family planning methods depends a lot on the competency and attitudes of the providers particularly for the long acting and permanent methods. According to Kasedde (2000), some of the constraints observed in family planning delivery include lack of trained staff or transfer of trained and motivated staff resulting in decrease of commitment of the remaining staff. In addition, there is poor information provision ranging from poor display of education and communication materials, to limited disclosure of methods and counseling about modern FP methods especially the long term and permanent ones (Kasedde, 2000). Also documented are the negative attitudes of service providers, poor accessibility to services, and inadequate family planning supplies at the health facilities (Mbonye, 2003). Other service factors that may also hinder FP service utilization include: long waiting times, unofficial fees in the public sector, and limited quantity of information provided during care (Jitta. 2008).

Family planning services can be made more accessible and convenient to clients if they take into account other service needs of the potential clients. Integration of FP services for female clients with frequently used Maternal and Child Health (MCH) and reproductive services would lower costs to clients and reduce missed opportunities for service delivery (Katherine W 2010)

## 2.2 Community/Client Related Factors Knowledge, Attitudes and Perceptions towards Family Planning

Individual knowledge about contraceptive methods is closely linked to the use of the methods (Mbonye, 2003; Agyei, 1995). According to Kamande and Mutombo (2014), Women’s level of knowledge about benefits of family planning is quite low and may be the reasons why fertility is still high in western Kenya. Knowledge of family planning is almost universal at 95% for women of reproductive age with male condoms, injectables and pills. Family planning programmes need to focus on communicating the benefits of family planning in this region. Women with knowledge about contraceptives and the benefits are more likely to use contraceptives as they are enabled to make informed choices.

**Demographic and Socioeconomic factors**

The Kenya Demographic and Health Survey 2008-2009 found that 75% of women with five or more children did not want another child2. Rural women were found to have attained desired family size more than the urban women have. This was mainly because women in rural areas had more children than their urban counterparts. This shows that the number of living children a woman has will be a factor in determining whether she has attained desired family size or not. Attainment of desired family size was not related to the age of the respondents. It was found that many young respondents who had five or more children did not want any more children. However, the survey found that respondents with higher education level and wealth index had attained desired family size early. Among married women with 3 children, 23% with no education desire no more children compared to 71% with secondary school education.

Couples who desired another child were less likely to use contraceptives than couples who wanted no more children. Couples where both partners reported spousal communication about family planning were more likely to use family planning services. According to a study in Nepal, a husband’s education has a greater influence on contraceptive use than the wife’s education. Two studies conducted in Ghana concluded that the greater the age difference between spouses, the lower the probability of contraceptive use, and partners’ adherence to different religions was positively associated with method use (Laili, Ilene, and Fotso, 2014).

According to studies conducted in Uganda, post-primary education and urban residence were strong predictors of knowledge and favorable attitudes towards FP services (Nattabi, 2011). The presence of the spouse in the household and discussion of family planning with spouse were also found to strongly influence contraceptive use. However, child mortality did not have any impact on uptake of FP services (Nattabi, 2011) The wealthy were found to have more knowledge about FP methods and with a higher Contraceptive Prevalence Rate (CPR) compared to the poorest; consequently the richest had a Total Fertility Rate (TFR) of 4.3 far less compared to the poorest of 8 (UDHS, 2006).

**Practices**

According to the KDHS 2008 – 2009 survey, contraceptive prevalence rate among married women by modern methods has barely improved from 32% in 2003, to 39% in 2008. The use of modern methods has slowed somewhat, while use of traditional methods declined between 2003 and 2008.Injectable contraceptives are the commonly used method among married women because they are long lasting, convenient to them, and can be used without the knowledge of the male partners who may not agree to family planning use (MoH., 2000b). The contraceptive mix changes with the sexually active unmarried women; with condom use being the highest at 27% followed with injectables at 13% (Shane, 2008)

## 2.3 Community Based Family Planning Interventions

Community-based distribution (CBD) of family planning provides a way of reaching the rural underserved populations in developing countries. Studies have documented that community based health workers can safely provide injectable contraceptives and subsequently increase contraceptive coverage (Brunie, 2007; Ndola, 2011).

## 2.4 Policy Environment

There are a number of challenges to improving access to family planning information and services. Efforts to increase access must be sensitive to cultural and national contexts, and must consider economic, geographic and age disparities within countries. Poorer women and those in rural areas often have less access to family planning services. Certain groups – including adolescents, unmarried people, the urban poor, rural populations, sex workers and people living with HIV – also face a variety of barriers to family planning. This can lead to higher rates of unintended pregnancy, increased risk of HIV and other STIs, limited choice of contraceptive methods, and higher levels of unmet need for family planning. Particular attention must be paid to promoting their reproductive rights, access to family planning, and other sexual and reproductive health services*.* [www.unfpa.org](http://www.unfpa.org)

An effective policymaking and implementation process is the foundation of scalable and sustainable health programs including those that integrate FP. To achieve the balance between the population growth rate and economic development, efforts must be made to lower morbidity and mortality; reduce incidence of high-risk births; and attain a family size that will enhance the health and welfare of the family.

The UN considers lowering this high population growth rates to be a priority in order for the MDGs to be achieved by 2015. In order to curb the high population growth rates seen in developing nations, the UN passed a resolution to: urge governments to prioritize universal access to reproductive healthcare including family planning, provide access to a variety of family planning methods and to fund family planning methods (UN, 2009). BTL is thus a key pillar in the reduction of population growth rates and consequently the achievement of MDGs.

There is a national drive to strengthen family planning services in order to have a substantial decline in fertility. BTL would be a permanent solution to our already high maternal mortality rates. Encouraging uptake of BTL amongst women who have attained desired family size should be a key pillar in achieving the MDGs. According to the United Nations, the current world population is estimated to be 7 billion as at 2011. The population growth for the world from 2000 to 2005 was 383 million with 92 million being in Africa only. Africa was found be the second most populated continent after Asia. Population growth rate in developing nations such as Kenya was 2.3% annually compared to that of developed nations at 1.2%13. With such high growth rates in the developing countries achievement of the MDGs is impended (WHO, 2015)

[www.who.int/topics/millennium\_development\_goals/maternal\_health/en/index.htl](http://www.who.int/topics/millennium_development_goals/maternal_health/en/index.htl)

None of the MDGs can be achieved with an unsustainable population. At the rate Kenya’s population is growing, by 2030 the country will have swollen to 50 million stretching resources beyond manageable levels. Most of the Kenyan population resides in rural areas and has a high fertility rate despite having fewer resources than their urban counterparts have. According to the KDHS 2008-2009, total fertility rate in rural areas was 5.2 per woman while TFR in urban areas was 2.92. KDHS 2008-2009 also found that 73% of people in the rural areas were below the middle wealth quartile compared to the urban population where 78.5% were in the highest wealth quartile2. The KDHS 2008-2009 survey also found that women in the rural areas used contraception less than their urban counterparts use and generally had more children. The MDGs cannot be achieved if the status quo remains in the rural areas. The situation will only get worse.

One of the MDGs aims at promoting gender equality and empowering women. This aims at empowering women to be able to make decisions on their own without male dominance. In most homes, the choice of whether to take up a contraceptive method can be vetoed by the male head of the house. According to National Policy, unmet need for family planning amongst married women in Kenya is 24% and this is partly attributed to low involvement of males26. Thus a key priority area in increasing uptake of family planning, especially permanent contraception, is to increase the involvement of men in FP. At the same time, strategies aimed at improving the uptake of BTL in Kenya involve correcting misconceptions and addressing fears associated with long-term contraception.

# CHAPTER THREE

# RESEARCH METHODOLOGY

## 3.1 Introduction

This chapter explains the research design that was used for the study. It further describes the population, sample size, and sampling techniques. The research technique is also described. It also describes the data gathering and statistical treatment of data.

## 3.2 Study Design

Explorative research design was used to establish the factors contributing to non-utilization of BTL among women of reproductive age in KDH. It was based on quantification of data and generalization of the results to the sample population of interest; the women of reproductive age in Seme sub county.

## 3.3 Study Population

The study population was women of childbearing age of Seme Sub County who attended MCH/FP clinic at Kombewa District Hospital. The target population of Kombewa District Hospital is 23, 300; out of this women of reproductive age are 4660{20% of the population}.

## 3.4 Study Area

It was conducted in Kombewa District Hospital located in Kisumu county, Seme sub county. It focused on the women of reproductive age attending MCH/FP clinic at the mentioned health facility.

## 3.5 Sample Size Determination

This was the portion of the population selected to represent the whole population. To obtain the sample size, the formula developed by Yamane (1967) cited by Kothari (2004) was used.

In the formula n is the sample size, N is the population size, and e is the level of precision (Kothari, 2004). The level of precision is determined by choosing the desired confidence level. If the confidence level of 95% is assumed, the level of precision was 0.05%. The total target population is 4660 and when the formula is applied, the sample to be drawn is 152, which is 33% of the total population

## 3.6 Sampling Procedure/Technique

To obtain the 152 sample, convenience-sampling method was used to save on time and other resources. Convenience sampling involves choosing elements to include in the sample population based on availability, accessibility and other logistical considerations.

## 3.7 Data Collection Tool

Data was collected by use of a semi-structured questionnaire. Both open and close-ended questions were asked. For those not able to read and write, face- to –face interview was conducted. An interpreter was available for those clients with language barrier.

## 3.8 Data Analysis

This research gathered information that helps to describe the general characteristics of the respondents. This information was analyzed through generation of frequency distributions and measures of central tendency. The main statistics to be relied on were percentage, mean, mode, median, and standard deviation. The research sought to test four hypotheses. These hypotheses are associative considering that they anticipate measure of strength of relationship between variables. Considering most of the variables were string rather than numerical variables, chi square tests were used to correlate the variables i.e. measure the strength of relationship between variables. For easy analysis of data, SPSS software i.e. statistical package for Social Sciences was used.

## 3.9 Ethical Considerations

The researcher obtained approval, permission, and guidance from the respective authority by the head of nursing department in order to conduct the study within the hospital premise.

The respondent’s name was not required to avoid any fear and to show confidentiality to the respondent. In addition the participants were given an information sheet and consent form which included an explanation on the purpose of the study and the study design. Consent was obtained from the participants before they participated in the study. This was after reading and understanding the consent form well.

## 3.10 Pre-Testing Of Data Collection Tool

The researchers pre-tested the data collection tool before conducting the study by administering it at the institution at different dates to ensure that the same respondents did not participate in the actual study. Necessary corrections of the data tool were made before data collection.

## 3.11 Study Limitations

* Inadequate research equipment and funds to carry out the research successfully.

# CHAPTER FOUR

# FINDINGS AND DISCUSSION

# 4.1. Introduction

This chapter presents and explains information gathered from the field with structured questionnaires. The information is analyzed and presented in a manner that captures the responses from respondents using various forms of graphical representations. The main objective of this study was to explore and describe factors contributing to non - utilization of tubal ligation as a method of choice for women attending MCH/FP clinic at Kombewa District Hospital. The specific objectives of the study were to explore the level of knowledge on utilization of tubal ligation by women of reproductive age, to find out measures that can be put in place to enhance uptake of this services at Kombewa district hospital and to find out the attitude of women of reproductive age in Kombewa on use of BTL as a method of contraception The research findings were presented according to the research objectives.

# 4.2. Demographic Characteristics

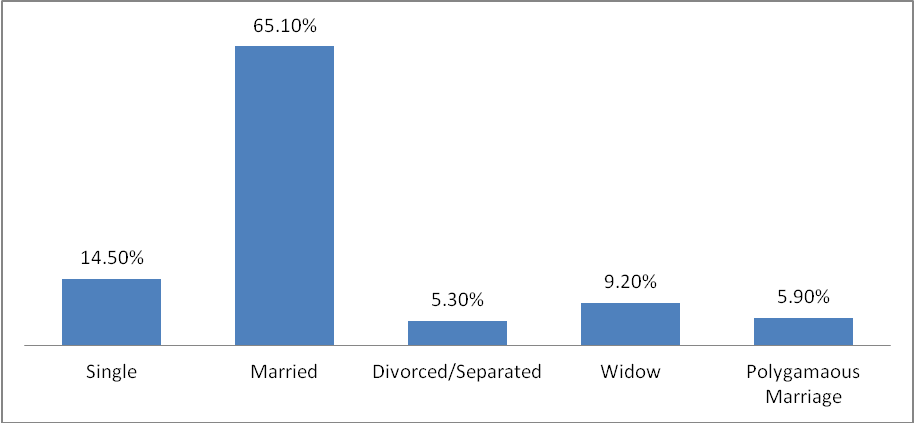
The data presented in this chapter was collected from 152 women of reproductive age attending MCH/FP clinic at Kombewa District Hospital. Considering convenience sampling was used to target, women who came to the facility at regular intervals, the research achieved a 100% response rate. This was achieved through proper early preparation, liaising with the nurses in charge and alerting respondents early about intent to engage them. The first section of the questionnaire helped in gathering the demographic characteristics of the respondents. The first demographic considered was age and the distribution of respondents according to age is as provided in Figure 2.

***Figure 2: Age of Respondents***

Source: Field Data (2015)

Majority of the respondents (40.1%) were in the 25-30 years age bracket. They were followed by those in the 20-24 years age bracket (25%) then the 15-19 and the above 30 years age bracket were 17.1% and 17.8% respectively. All the respondents were within the reproductive age bracket. The study established the marital status of the respondents and the findings are as presented in Figure 3.

Figure 3: Marital Status of Respondents



Source: Field Data (2015)

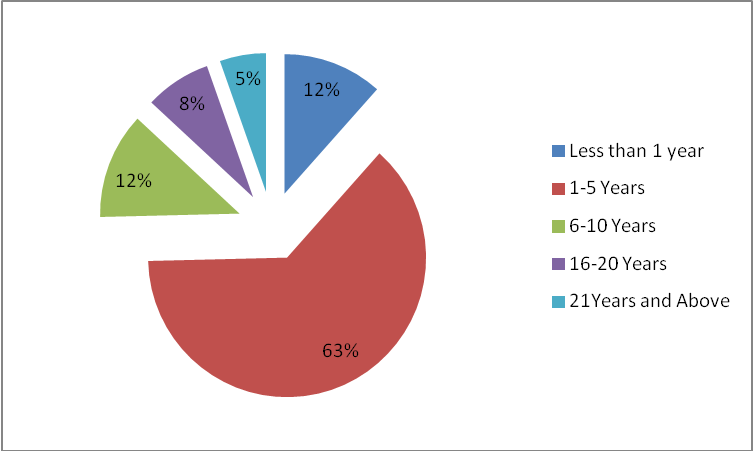
The findings on marital status show that most (65.1) of the women of reproductive age who attend MCH/FP clinic at Kombewa District Hospital are married. The singles attending MCH/FP clinic at Kombewa District Hospital are 14.5%, those divorced or separated are 5.3%, and those widowed are 9.2% while those in polygamous marriages are 5.9%. The respondents were asked to indicate the husbands’ age, and the results are as summarized in figure 4

***Figure 4: Husband’s Age***

Source: Field Data (2015)

As the histogram (figure 4) shows, majority of the husband are below 25 years. The average age of the husbands is 36.43 with a standard deviation of 10.27, which is indicative of high variance in the age of the husbands. This means that there are extreme values in the mean: as shown in the curve, many husbands are between age 20 and 40 but there are some who are over 40years of age. For those who had been in marriage, the study sought to determine for how long they had been married. The distribution on duration of marriage is as provided in Figure 5.

***Figure 5: Duration of marriage for Respondents***



Source: Field Data (2015)

As shown in figure 5, most of the respondents were young in marriages; 63% had been married for 1-5 years while 5% had been married for less than a year by the time of the study. Those who had been married for 6-10 years were12%, those married for 16-20 years were 8% while those married for over 20 years were 5%. Religion plays a role in utilization of family planning services. The respondents were asked to state their religion and the findings on religion are as presented in Figure 6.

***Figure 6: Respondents Religion***

Source: Field Data (2015)

Majority of the respondents (82.2%) were Christians followed by Muslims who were 10.5%. Despite the relative young age, interestingly, 7.2% of the respondents indicated that they ascribe to traditional religion. Apart from religion, education helps to shape individuals minds and their earning powers. The study sought to determine the level of education and their occupations. The findings are as presented in Table 2.

***Table 2: Cross Tabulation of Respondents Level of education and Occupation***

| Level of Education | Occupation | | | | | Total |
| --- | --- | --- | --- | --- | --- | --- |
| Employed | Unemployed | Self Employed | Farming | Housewife |
| Primary | 0 | 17 | 0 | 7 | 4 | 28 |
| Secondary | 27 | 12 | 27 | 10 | 11 | 87 |
| College | 4 | 6 | 6 | 0 | 0 | 16 |
| University | 2 | 0 | 6 | 0 | 0 | 8 |
| No Formal Education | 0 | 0 | 0 | 0 | 13 | 13 |
| Total | 33 | 35 | 39 | 17 | 28 | 152 |

Source: Field Data (2015)

Considering occupations, out of 152 respondents, 33 were formally employed, 35 were unemployed, 39 were self-employed, and 17 were engaged in farming while 38 were homemakers. Considering level of education, 28 respondents had primary level of education, 87 were secondary school leavers, 16 had college education, 8 had university education while 13 had no formal education. Out of the 33 employed, 27 had secondary school education while 4 and 2 had college and university education respectively. All those (13) who had no formal education were homemakers. The study also investigated into the level of education and occupations of spouses to the respondent and the findings are provided in Table 3.

***Table 3: Level of Education and Occupations of Husbands***

| Husband's Level of Education | Husband's Occupation | | | | Total |
| --- | --- | --- | --- | --- | --- |
| Employed | Unemployed | Self Employed | Farming |
| Primary | 3 | 3 | 6 | 18 | 30 |
| Secondary | 0 | 10 | 11 | 19 | 40 |
| College | 11 | 0 | 6 | 17 | 34 |
| University | 12 | 0 | 13 | 0 | 25 |
| Total | 26 | 13 | 36 | 54 | 149 |

Source: Field Data (2015)

Twenty-three respondents were single and hence only 149 respondents indicated what their husbands’ level of education and occupation was. As shown in Table 5, 30 respondents indicated their husbands were primary school leavers, 40 were secondary school leavers, 34 were college graduates while 25 respondents indicated their husbands were university graduates. Out of the 149 husbands, 26 were formally employed, 13 were reported unemployed, and 36 were self-employed while 54 were identified as farmers. Out of 34 college graduates, 11 were formally employed while out of 25 university graduates, 12 were employed. The first hypothesis of the study Personal characteristics such as age and marital status do not significantly influence utilization of BTL services among women in Kombewa. To test this hypothesis, a correlation analysis using the chi-square test was done and the results are as presented in Table 4.

***Table 4: s Pearson’s coefficient for chi square test***

|  |  |  |
| --- | --- | --- |
| Factor | Number of children | Heard About BTL |
| Age | 0.000 | 0.000 |
| Marital Status | 0.000 | 0.000 |
| Duration of Marriage | 0.000 | 0.000 |
| Level of education | 0.000 | 0.002 |
| Religion | 0.000 | 0.001 |
| Occupation | 0.000 | 0.000 |

Source: Field Data (2015)

The findings presented in table 4 are indicative a strong relationship between the various personal characteristics of respondents and the number of children they have as well as whether they have heard about BTL or not. The tests show that the relationship is positive and significant at the 0.05 significance level. This means that personal or demographic characteristics have a strong impact on uptake of BTL.

# 4.3. Socio-Cultural Factors

This study sought to know the social and cultural expectation on mothers about the number of children they should have. Such expectations are manifested in terms of the number of children the women want against the number of children the husband has and then the number of children they finally get to have. The women were asked to indicate the number of children they wanted and the number of children their husbands wanted. The comparisons are as presented in Table 5.

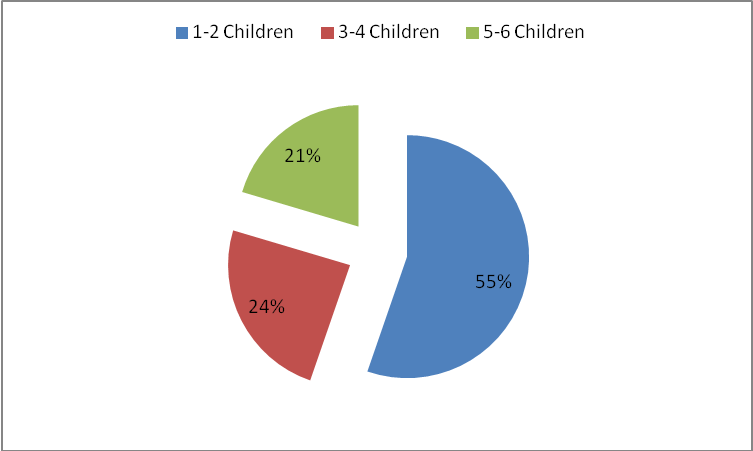
***Table 5: Showing Number of Children Wanted***

| Children Wanted by Woman | Children Husband Wanted | | | | Total |
| --- | --- | --- | --- | --- | --- |
| Singles | 2 or Less | 3-5 | More than 5 |
| 2 or Less | 13 | 13 | 7 | 0 | 33 |
| 3-5 | 7 | 0 | 75 | 31 | 113 |
| More than 5 | 0 | 0 | 0 | 6 | 6 |
| Total | 20 | 13 | 82 | 37 | 152 |

Source: Field Data (2015)

Data presented in Table 5 shows the number of children the respondents wanted against those the husbands wanted. The single respondents who answered the question were 20 out of which 13 want 2 or fewer children while 7 want 3-5 children. Out of 152 respondents, 33 want 2 or less children, 113 want 3-5 children while 6 want more than 5 children. Considering the husbands 13 want 2 or fewer children, 82 want 3-5 children while 37 want more than 5 children. The findings show that more men want more than 5 children. Half the men, when compared to women want 2 or less children. The respondents were asked to indicate the actual number of children they have and their responses are as presented in figure 7.

***Figure 7: Number of Children per Respondent***



Source: Field Data (2015)

All the women in the study had children. Out of 152 respondents 55% had 1-2 children, 24% had 3-4 children while 21% had 5-6 children. The range of number of children per woman was a minimum of 1 and a maximum of 6. Considering that the fertility rate for Kenya is 4.6 births per woman and the Total Fertility Rate (TFR) in Kisumu is 3.9 children, the number of children the women have is within the national and local total fertility rate range. However, that is not to mean there are no unmet family planning needs. To understand the unmet family planning needs, the children the women wanted was compared with the number of children they have and the findings are presented in Table 6.

***Table 6: Cross Tabulation of Number of Children Wanted Against Actual Number of Children***

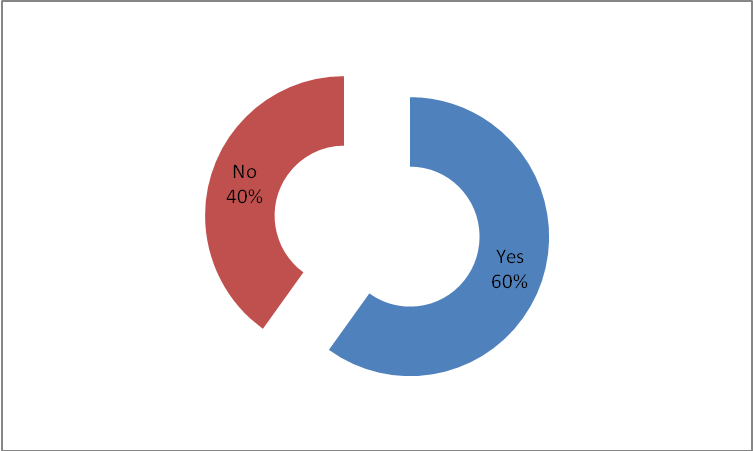
| Children Wanted | Number of Children | | | Total |
| --- | --- | --- | --- | --- |
| 1-2 | 3-4 | 5-6 |
| 2 or Less | 30 | 3 | 0 | 33 |
| 3-5 | 49 | 33 | 31 | 113 |
| More than 5 | 5 | 1 | 0 | 6 |
| Total | 84 | 37 | 31 | 152 |

Source: Field Data (2015)

As shown in Table 6, thirty-three respondents wanted 2 or fewer children and at the time of the study 30 respondents who had less than two children actually had 2 or less. Three of the respondents had wanted 2 or fewer children but had 3-4 children. Additionally, 113 respondents wanted between 3-5 children but 31 out of the 113 already had 5-6 children. Only 6 respondents wanted more than 5 children; however 31 respondents already had 5-6 children.

In the Luo culture, like many other patriarchal societies, the husband is the head of the household or family. Consequently, the women have little or no space in decision-making. This study sought to know whether women have the freedom to attend family planning clinics or whether such a decision is subject to the husband’s discretion. The findings are as shown in Figure 8.

***Figure 8: Need for husband’s Permission***



Source: Field Data (2015)

Figure 8 show that 60% of the women require the husbands’ permission before they can attend family planning clinics. If the husbands do not give permission, it means the women are not in a position to seek family planning services. According to The KDHS 2008-2009 survey, there are more women with unmet family planning needs in rural areas partly due to men denying them permission to access such services.

In most Kenyan communities, men still dominate their wives and are responsible for reproductive health decisions by the women. Husbands are just one player; other players when it comes to uptake of family planning services include religion, health workers, media, and relatives/friends. The respondents were asked to indicate from whom they source information on family planning and the findings are as presented in Figure 9.

***Figure 9: Sources of Family Planning Advice***

Source: Field Data (2015)

Individuals often have many sources of information on a given issue. The respondents in the study were asked to name the main source of information or advice on family planning that they rely on. Out of the 152 respondents, 59.2% indicated that they rely on advice of health workers, 9.9% rely on the church (religious leaders), and 14.5% rely on media while 16.4% rely on relatives and friends. The second hypothesis in this study was that Husbands and culture significantly influence utilization of BTL by women in Kombewa. To test this hypothesis, chi square tests were done to test relationship between husband and cultural factors on utilization of BTL and the results are as shown in Table 7

***Table 7: Pearson’s coefficients for chi square tests***

|  |  |  |  |
| --- | --- | --- | --- |
| Factor | Number of children | Heard About BTL | Needs Permission to attend FP Clinic |
| Husband’s Age | 0.000 | 0.000 | 0.001 |
| Source of Information on FP | 0.000 | 0.000 | 0.000 |
| Children Husband Wanted | 0.000 | 0.017 | 0.000 |
| Husband’s Level of education | 0.000 | 0.000 | 0.000 |
| Husband’s Occupation | 0.000 | 0.000 | 0.001 |

Source: Field Data (2015)

The findings presented in table 7 are indicative a strong relationship between the various personal characteristics of respondents and the number of children they have as well as whether they have heard about BTL or not. The tests show that the relationship is positive and significant at the 0.05 significance level. This means that personal or demographic characteristics have a strong impact on uptake of BTL.

# 4.4. Knowledge, Attitude and Perceptions

The respondents were asked questions to help ascertain their knowledge, attitude, and perception of BTL as a family planning option. The study sought to determine if the respondents had heard anything about BTL and the findings are as presented in Table 8.

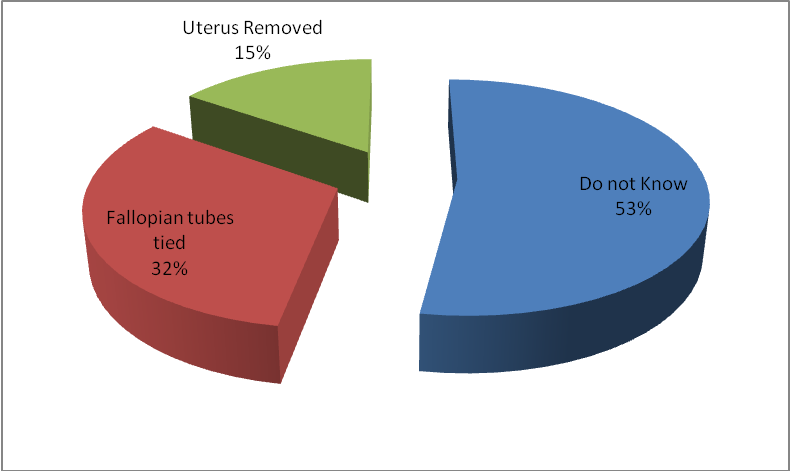
***Table 8: Knowledge about BTL***

| Heard about BTL | Frequency | Percent |
| --- | --- | --- |
| Yes | 110 | 72.4 |
| No | 42 | 27.6 |
| Total | 152 | 100.0 |

Source: Field Data (2015)

Majority of the respondents (72.4%) indicated that they had heard about BTL. Those that had heard about BTL were asked to indicate what happens during BTL. The responses are as presented in Figure 10.

***Figure 10: What is done during BTL***



Source: Field Data (2015)

While 72% of the 152 respondents indicated that they had heard about BTL, 15% of them thought the uterus is removed during BTL, 53% admitted to not knowing what happens during BTL while 32% indicated that Fallopian tubes are tied during BTL. This means that only 34.21% of the 152 respondents actually understand what goes on during the BTL process. Lack of knowledge about BTL is not surprising because it is uncommonly used as a birth control method (Monjok et al., 2010). It is not just in Kenya, according to Monjok et al. (2010); the uptake of BTL is generally low across the world. The uptake and understanding of family planning services is dependent on level of education. To test this, a cross tabulation of level of education against understanding of what happens during BTL was done and the results are as presented in Table 9.

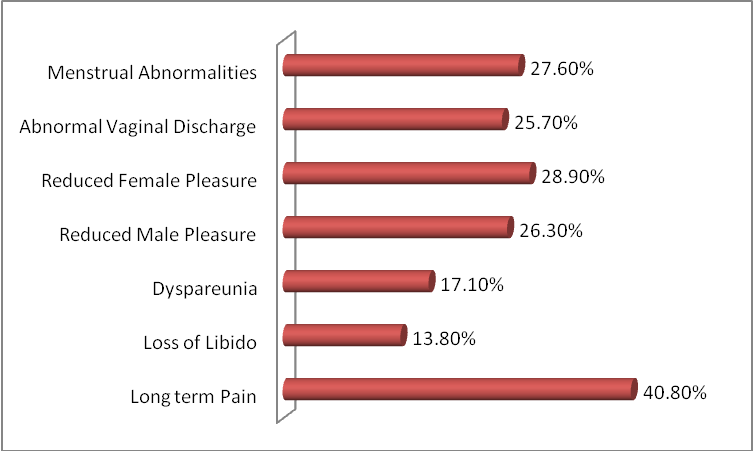
***Table 9: Cross Tabulation of Level of Education and Knowledge on BTL***

| Level of Education | What is Done during BTL | | | | Total |
| --- | --- | --- | --- | --- | --- |
| No Response | Do not Know | Fallopian tubes tied | Uterus Removed |
| Primary | 0 | 18 | 0 | 10 | 28 |
| Secondary | 2 | 45 | 27 | 13 | 87 |
| College | 0 | 3 | 13 | 0 | 16 |
| University | 0 | 0 | 8 | 0 | 8 |
| No Formal Education | 0 | 13 | 0 | 0 | 13 |
| Total | 2 | 79 | 48 | 23 | 152 |

Source: Field Data (2015)

Nattabi (2011) established that level of education is a strong indicator of FP services appreciation and uptake. The findings presented in table 9 show clearly that there is a link between level of education and understanding of family planning services. All without any formal education got the answer wrong while most college and all university graduates got the answer right. The respondents were asked to indicate what they thought are the side effects of BTL. The responses are presented in Figure 11.

***Figure 11: Perceived Side Effects of BTL***



Source: Field Data (2015)

Out of the many perceived side effects of BTL, many of the respondents (40.8%) associated BTL with long-term pain. The fear of long term pain is followed by perception that BTL reduces female pleasure during sex (28.9%), 27.6% of the respondents associate BTL with menstrual abnormalities, which is followed closely by 26.3% of the respondents who think BTL reduces male pleasure during sex. Additionally, 25.7% think BTL leads to abnormal vaginal discharge, 17.1% think it leads to Dyspareunia while 13.8% think BTL leads to loss of libido. The respondents were asked to indicate the number of children they would have for them to consider BTL. The responses are presented in Table 10.

***Table 10: Enough Children for Respondents to Consider BTL***

| Enough Children to Consider BTL | Frequency | Percent |
| --- | --- | --- |
| Can not consider it | 9 | 5.9 |
| 2 or Less | 13 | 8.6 |
| 3-5 | 80 | 52.6 |
| More than 5 | 50 | 32.9 |
| Total | 152 | 100.0 |

Source: Field Data

As shown in table 10, 5.9% of the respondents would not consider BTL. A very small number (8.6%) would consider BTL after having 2 or fewer children, 52.6% would consider BTL after having 3-5 children while 32.9 would only consider BTL after having more than 5 children. Considering, that apart from BTL, there are other family planning methods, the respondents were asked to indicate the ones they know about and the findings are as presented in Figure 12.

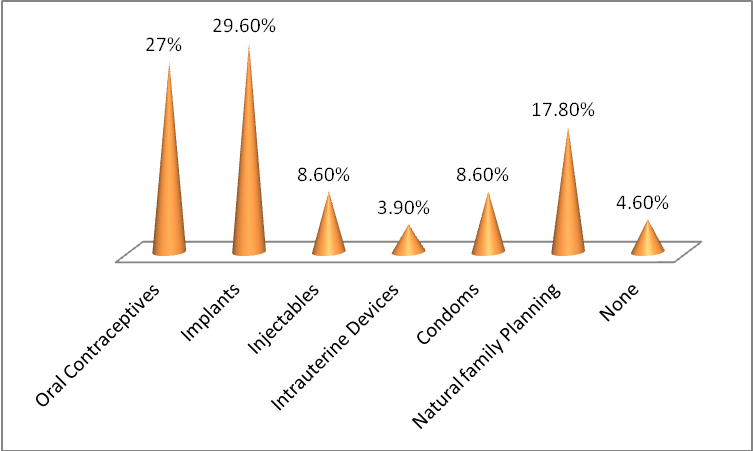
***Figure 12: Other Family Planning Methods Known to Respondents***

Source: Field Data (2015)

All respondents knew about condoms as a family planning method. Another method that was highly known among respondents was injectables (82.9%), followed by oral contraceptives at 78%, Implants at 53.3%, natural family planning at 48.7%, Intrauterine device at 48% while only 17.1% knew about traditional family planning methods. The levels of knowledge about given family planning methods are encouraging.

However, knowing about different family planning methods does not translate into use. Kamande and Mutombo (2014) established that women’s level of knowledge about benefits of family planning is quite low and may be the reasons why fertility is still high in western Kenya. According to Kamande and Mutombo (2014) the Knowledge of family planning is almost universal at 95% for women of reproductive age. This means that the women know about family planning methods but they do not appreciate them enough as to take them up. The respondents were asked to indicate the one they preferred and the results are as shown in Figure 13.

***Figure 13: Preferred Family Planning Method***

******

Source: Field Data (2015)

As shown in figure 13, the three most preferred family planning methods are Implants (29.6%), Oral Contraceptives (27%) and Natural family planning (17.8%). They are followed by Injectables and condoms both at 8.6%, and Intrauterine devices at 3.9%. This finding is supported by what Kamande and Mutombo (2014) found out in Western Kenya. Most women of reproductive age knew about and used male condoms, injectables and pills.

The only difference is that in this study, implants turned out to be the most favored family planning method. A minimal number (4.6%) out of the respondents indicated that they do not have any family planning method that they prefer. According to Shane (2008), family planning methods differ depending on marital status. Cross tabulation was used to determine whether there was any significance difference on FP method preference based on marital status. The responses are provided in Table 11.

***Table 11: Cross tabulation Marital Status against Preferred Method of Family Planning***

| Marital Status | Preferred FP Method | | | | | | | Total |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Oral Contraceptive | Implants | Injectables | Intrauterine devices | Condoms | Natural Family Planning | None |
| Single | 10 | 6 | 0 | 0 | 6 | 0 | 0 | 22 |
| Married | 19 | 34 | 13 | 6 | 0 | 27 | 0 | 99 |
| Divorced/Separated | 3 | 5 | 0 | 0 | 0 | 0 | 0 | 8 |
| Widow | 0 | 0 | 0 | 0 | 7 | 0 | 7 | 14 |
| Polygamous Marriage | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 9 |
| Total | 41 | 45 | 13 | 6 | 13 | 27 | 7 | 152 |

Source: Field Data (2015)

The cross tabulation of marital status shows that there is a direct relationship between marital status and type of family planning method preferred. Single women prefer oral contraceptives (pills), implants, and condoms. Married women prefer injectables and natural family planning followed by oral contraceptives and implants. This finding interesting tends to confirm Shane (2008) that married women prefer more long-term methods of family planning while the single women are more into pills and condoms. All the respondents were asked to indicate why they would not consider using BTL and the responses are as summarized in Figure 14.

***Figure 14: Reasons for Not Using BTL***

Source: Field Data (2015)

Considering the reasons for not using BTL, 25% could not use it because they thought they were still too young. Out of 152 respondents, 19.7% could not use BTL because religion does not allow, 13.2% could not use it because they were afraid of negative consequences, and 12.5% felt they had not achieved the number of children they desire. Additionally, 11.2% thought the husband would not allow, 9.2% feared that if they use BTL the husband would marry another wife while 4.6% apiece indicated that they could not use BTL because their culture did not allow and they were comfortable with other family planning methods.

People who feel they are still young might not be sure about the demand of the future. Some may fear that they may take up BTL only for the need to have a child arising in the future. For instance, a divorce may arise leading to re-marriage. Alternatively, disaster may befall household leading to need to procreate. Religion is an important factor when it comes to family planning uptake. Just like Laili, Ilene and Fotso (2014) found out, religious beliefs define whether people consider family planning methods or not. In this study, the second highest number of responded that they would not consider BTL because of religious consideration. The final hypothesis in this study was that Level of awareness about BTL significantly influences utilization of BTL as a method of contraception. To test this hypothesis, knowledge of BTL was correlated with reasons for non-utilization and the findings are as presented in table 12.

**Table 12: Chi-Square Test on Knowledge of What is done during BTL and Reasons for non-utilization**

|  | Value | df | Asymp. Sig. (2-sided) |
| --- | --- | --- | --- |
| Pearson Chi-Square | 69.246a | 21 | .000 |
| Likelihood Ratio | 73.313 | 21 | .000 |
| N of Valid Cases | 152 |  |  |
| a. 20 cells (62.5%) have expected count less than 5. The minimum expected count is .09. | | | |

Source: Field Data (2015)

The findings in the table 12 shows that there is a strong relationship between what the respondents know about BTL and the reasons for not utilizing BTL. The responds were asked to indicate the challenges they face when accessing family planning services and their responses were as summarized in Table 13.

***Table 13: Challenges in Accessing Family Planning Services***

| **Challenges in accessing FP** | Frequency | Percent |
| --- | --- | --- |
| Lack of Consistent Service | 34 | 22.4 |
| None | 33 | 21.7 |
| No Youth friendly services | 23 | 15.1 |
| No Proper Health Education | 21 | 13.8 |
| My husband does not allow | 13 | 8.6 |
| Condoms not easily accessible | 7 | 4.6 |
| Inadequate counseling | 7 | 4.6 |
| Few Health workers available | 7 | 4.6 |
| many health workers are rude | 7 | 4.6 |
| Total | 152 | 100.0 |

Source: Field Data (2015)

As shown in table 13, there are several challenges that affect women in accessing family planning services. The major challenge as per the study respondents was lack of consistent services, lack of youth friendly services, and lack of health education. Others include condoms not being easily accessible, inadequate counseling services, few health workers being available and health workers being rude when handling women seeking FP services.

The identified challenges seem to confirm the observations by Kasedde (2000); who identified lack of trained staff, transfer of trained and motivated staff resulting in decrease of commitment of the remaining staff, poor information provision ranging from poor display of education and communication materials, to limited disclosure of methods and counseling about modern FP methods especially the long term and permanent ones as major constraints in FP services delivery. The findings on challenges also confirm issues identified by Mbonye (2003); who pointed out that negative attitudes of service providers, poor accessibility to services, and inadequate family planning supplies at the health facilities are major challenges to FP services uptake. The respondents were asked to share suggestions on how the identified challenges can be tackled. The suggestions are summarized in Table 14.

***Table 14: Suggestion on How to Overcome Challenges***

| **Overcoming Challenges** | Frequency | Percent |
| --- | --- | --- |
| Education and creating awareness for public | 60 | 39.5 |
| None | 27 | 17.8 |
| Have enough health workers | 21 | 18.4 |
| Introduced community or home services | 13 | 8.6 |
| Improve supply of condoms | 7 | 4.6 |
| Provide more time for counseling sessions | 7 | 4.6 |
| Need to Improve Health Worker's Attitude | 7 | 4.6 |
| Sensitize health workers on Youth Service and Needs | 3 | 2.0 |
| Total | 152 | 100.0 |

Source: Field Data (2015)

Majority of the respondents (39.5%) emphasized the need for public education and awareness creation in dealing with family planning challenges. Equally, a higher fraction (18.4%) suggested the need to increase health workers in health facilities to enhance access to family planning services. In line with increasing health access, 8.6% of the respondents suggested introduction of community or home services to enhance uptake of family planning services. Improving supply of condoms, improving counseling services and improving health workers attitude were suggested by 4.6% of respondents each.

A very small fraction (2%) indicated that there is need to sensitize health workers on unique needs of the youths towards making family planning services more youth friendly. While a very small percentage suggested making services youth friendly, it is a very poignant suggestion. Katherine (2010) advised that family planning services can be made more accessible and convenient to clients if they take into account other service needs of the potential clients. Health care providers have to look beyond MCH services to consider other avenues through which they can integrate FP services in a manner appealing to the youth. Most crucially, as Mbonyo (2003) indicated, the health workers have to have a positive attitude towards clients such as youth to avoid stigmatizing them or making them shy away.

**CHAPTER FIVE**

**SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMENDATIONS**

# 5.1 Introduction

This chapter presents a summary of findings of the study, the conclusions, and recommendations. The purpose of this study was to explore and describe factors contributing to non - utilization of tubal ligation as a method of choice for women attending MCH/FP clinic at Kombewa District Hospital. .

# 5.2 Summary of Findings

## 5.2.1 Response Rate

This research achieved a 100% response rate. Given the target population were in health facility, the researcher achieved a 100% response rate through liaising with nurses to ensure women who visit for clinic services are included in the sample. Using convenience sampling, the researcher relied on women available at the hospital; who had come for hospital services to ensure target sample size is realized.

## 5.2.2. Demographic Characteristics

This study considered the age of respondents and their spouses, the marital status, the education level, and the occupation level of the respondents and their spouses. The study further considered the number of children the respondents had against the number of children they wanted (wife and husband). Findings on age were that majority of the respondents (40.1%) were in the 25-30 years age bracket. All the respondents were within the reproductive age bracket. Considering marital status, out of 152 respondents, 14.5% were single, 5.3% were divorced or separated, and 9.2% were widowed while 5.9% were in polygamous marriages. Out of those who had been married, 63% had been married for 1-5 years while 5% had been married for less than a year by the time of the study. Those who had been married for 6-10 years were12%, those married for 16-20 years were 8% while those married for over 20 years were 5%. Majority of the respondents (82.2%) were Christians followed by Muslims who were 10.5% while 7.2% of the respondents indicated that they ascribe to traditional religion.

Out of 152 respondents, 33 were formally employed, 35 were unemployed, 39 were self-employed, and 17 were engaged in farming while 38 were homemakers. Considering level of education, 28 respondents had primary level of education, 87 were secondary school leavers, 16 had college education, and eight had university education while 13 had no formal education. Out of the 33 employed, 27 had secondary school education while four and two had college and university education respectively. 30 respondents indicated that their husbands were primary school leavers, 40 were secondary school leavers, 34 were college graduates while 25 respondents indicated their husbands were university graduates. Out of the 149 husbands, 26 were formally employed, 13 were reported unemployed, and 36 were self-employed while 54 were identified as farmers. Out of 34 college graduates, 11 were formally employed while out of 25 university graduates, 12 were employed.

## 5.2.3. Socio-Cultural Factors

On the number of questions the respondents wanted, the single respondents who answered the question were 20 out of which 13 want 2 or fewer children while 7 want 3-5 children. Out of 152 respondents, 33 want 2 or less children, 113 want 3-5 children while 6 want more than 5 children. Considering the husbands 13 want 2 or fewer children, 82 want 3-5 children while 37 want more than 5 children. The findings show that more men want more than 5 children. Half the men, when compared to women want 2 or less children. All the women in the study had children.

Out of 152 respondents 55% had 1-2 children, 24% had 3-4 children while 21% had 5-6 children. Moreover, 33 respondents wanted 2 or fewer children and at the time of the study, 30 respondents who had less than two children actually had 2 or less. Three of the respondents had wanted 2 or fewer children but had 3-4 children. Additionally, 113 respondents wanted between 3-5 children but 31 out of the 113 already had 5-6 children. Only 6 respondents wanted more than 5 children; however, 31 respondents already had 5-6 children. 60% of the women indicated that they required the husbands’ permission before they can attend family planning clinics. Out of the 152 respondents, 59.2% indicated that they rely on advice of health workers, 9.9% rely on the church (religious leaders), and 14.5% rely on media while 16.4% rely on relatives and friends.

## 5.2.4. Knowledge, Attitude and Perceptions

Majority of the respondents (72.4%) indicated that they had heard about BTL. While 72% of the 152 respondents indicated that they had heard about BTL, 15% of them thought the uterus is removed during BTL, 53% admitted to not knowing what happens during BTL while 32% indicated that Fallopian tubes are tied during BTL. The study established that there is a link between level of education and understanding of family planning services.

Many of the respondents (40.8%) associated BTL with long-term pain. The fear of long term pain is followed by perception that BTL reduces female pleasure during sex (28.9%), 27.6% of the respondents associate BTL with menstrual abnormalities, this is followed closely by 26.3% of the respondents who think BTL reduces male pleasure during sex, 25.7% thought BTL leads to abnormal vaginal discharge, 17.1% think it leads to Dyspareunia while 13.8% thought BTL leads to loss of libido.

Asked about when they can consider using BTL, 10, 5.9% of the respondents would not consider using BTL. A very small number (8.6%) would consider BTL after having 2 or fewer children, 52.6% would consider BTL after having 3-5 children while 32.9 would only consider BTL after having more than 5 children. All respondents knew about condoms as a family planning method, injectables are known to 82.9%, followed by oral contraceptives at 78%, Implants at 53.3%, natural family planning at 48.7%, Intrauterine device at 48% while only 17.1% knew about traditional family planning methods. The three most preferred family planning methods are Implants (29.6%), Oral Contraceptives (27%) and Natural family planning (17.8%). They are followed by Injectables and condoms both at 8.6%, and Intrauterine devices at 3.9%. Further analysis revealed that there is a direct relationship between marital status and type of family planning method preferred.

Considering the lessons for not using BTL, 25% could not use it because they thought they were still too young, 19.7% could not use BTL because religion does not allow, 13.2% could not use it because they were afraid of negative consequences, 12.5% felt they had not achieved the number of children they desire, 11.2% thought the husband would not allow, 9.2% feared that if they use BTL the husband would marry another wife while 4.6% apiece indicated that they could not use BTL because their culture did not allow and they were comfortable with other family planning methods.

There are several challenges that were reported as affecting women in accessing family planning services. The major challenge as per the study respondents was lack of consistent services, lack of youth friendly services, and lack of health education. Others include condoms not being easily accessible, inadequate counseling services, few health workers being available and health workers being rude when handling women seeking FP services.

Majority of the respondents (39.5%) emphasized the need for public education and awareness creation in dealing with family planning challenges. Equally, a higher fraction (18.4%) suggested the need to increase health workers in health facilities to enhance access to family planning services. In line with increasing health access, 8.6% of the respondents suggested introduction of community or home services to enhance uptake of family planning services. Improving supply of condoms, improving counseling services, and improving health workers attitude were suggested by 4.6% of respondents each. A very small fraction (2%) indicated that there is need to sensitize health workers on unique needs of the youths towards making family planning services more youth friendly.

# 5.3. Conclusions

## 5.3.1. Demographic Characteristics

* Majority of individuals attending MCH Clinics at Kombewa District Hospital are between ages 25-30. This means that family planning interventions targeting younger women cannot be channeled through the MCH program.
* Considering marital status, most of those accessing MCH clinics are married women who have been in marriage for 2 years or less.
* Majority of the mothers accessing MCH clinics are primary school dropouts and are unemployed. This is indicative of women that require more support structures in order to make empowered reproductive health decisions

## 5.3.2. Socio-Cultural Factors

* Single mothers want 2 or less children while most of the married want 3-5 children
* More men than women want more than 5 children. Half the men, when compared to women want 2 or less children.
* Considering actual number of children against the number of children the respondents want, there are unmet family planning needs. For instance, 113 respondents wanted between 3-5 children but 31 out of the 113 already had 5-6 children. Only 6 respondents wanted more than 5 children; however, 31 respondents already had 5-6 children.
* Husbands play an important role in determining whether women seek family planning services or not. 60% of the women indicated that they required the husbands’ permission before they can attend family planning clinics.
* While a majority 59.2% indicated that they rely on advice of health workers, media, religious leaders, relatives and friends play an important role as sources of information for women on family planning

# 5.3.3. Knowledge, Attitude and Perceptions

* Only 32% of the respondents understood what happens during BTL. Despite low awareness, all the respondents associated BTL with some negative side effects. This means that more awareness for such long-term family planning options is needed. The study established that there is a link between level of education and understanding of family planning services.
* Majority of respondents can only consider BTL after having more than 5 children.
* Condoms, Oral contraceptives, injectables, Implants, and natural family planning are the most known methods of family planning. However, Implants, Oral Contraceptives and Natural family planning are the most preferred methods of family planning.
* There is a direct relationship between marital status and type of family planning method preferred.
* Majority of the respondents fear to use BTL because they are still very young but also equally important because of religious considerations
* The major challenges as per the study respondents was lack of consistent services, lack of youth friendly services, and lack of health education.
* Majority of the respondents emphasized the need for public education and awareness creation in dealing with family planning challenges.

# 5.4. Recommendations

* While universal family planning programmes integrated in MCH are good, such services ought to be customized to address context and age bracket specific need.
* Family programs have to include men in their programming because husbands determine or contribute significantly to reproductive decisions by women. Therefore, family planning programmes ought to target men or husbands as well to encourage them towards make pro-women decisions
* There are unmet family planning needs, which can be addressed if family planning is mainstreamed just as gender and disability issues have been mainstreamed. Everyone needs to play a role in promoting planned families.
* There is very little knowledge about BTL known, especially to the not highly schooled population. There is a need therefore, to introduce and encourage interest in learning more about long term family planning methods in schools (primary and secondary)
* For the purposes of programming, BTL should be promoted for people who have more than 5 children.

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# 

# APPENDICES

## Appendix 1: Information Sheet

Investigation: Sarah Harriet Nesoba and Angela Audrey Makotsi

Dear Respondent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We are nursing students pursuing Bachelor of Science in Nursing at the University of Eastern Africa, Baraton, conducting this research study on factors contributing to non – utilization of Bilateral Tubal Ligation among women of reproductive health as partial fulfillment of the course NRSG 431: Nursing Research Project.

Procedure to be followed:

You are requested to fill questionnaires, which will take around 15 minutes of your time by putting a tick in the boxes or writing out your response.

* You are free to ask for any clarification where necessary
* Participation in this study is voluntary and you are under no obligation to participate.
* You have the right to withdraw if you feel uncomfortable about the study.
* Therefore, respond appropriately to the questions given below express your views freely and please take note that information given will be confidential.

Thanks in advance.

**Appendix 2: Questionnaire**

SOCIO - DEMOGRAPHIC DATA

1. Your age is

15 - 19 years 20 – 24 years 25 – 30 years Above 30 years

1. Your marital status is

Single Married Divorced/ separated

Widow Polygamous marriage

1. Duration of marriage to current partner

˃1 year 1 – 5 years 6 – 10 years

11 – 15 years 16 – 20 years ˃ 21 years

1. Your education level is

Primary Secondary College

University No formal education

1. Your religion is

Christian Muslim Traditional

Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Your occupation is

Employed Unemployed Self employed

Farming Housewife

SPOUSE DETAILS

1. Your husband’s level of education is?

Primary Secondary College

University No formal education

1. Your husband’s occupation is

Employed Unemployed Self employed Farming

1. The age of your spouse is \_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIO - CULTURAL FACTORS

1. How many children do you have

1 – 2 3 – 4 5 – 6

7 – 8 Above 9

1. How many children did you want?

˂ 2 3-5 ˃5

1. How many children did your husband want?

˂ 2 3-5 ˃5

1. Do you need permission from your partner to attend Family Planning Clinic?

Yes No

1. Where do you get advice on available family planning options?

Health worker Church Media Relatives

KNOWLEDGE, ATTITUDE AND PERCEPTIONS

1. Have you ever heard about BTL?

Yes No

1. If yes, what is done during BTL?

Don’t know Fallopian tubes tied Ovaries removed Uterus removed Other, state\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Indicate which side effects may come as a result of BTL

|  |  |  |
| --- | --- | --- |
| **Perceived side effect** | Yes | No |
| Long term pain |  |  |
| Loss of libido |  |  |
| Dyspareunia |  |  |
| Reduced male pleasure |  |  |
| Reduced female pleasure |  |  |
| Abnormal vaginal discharge |  |  |
| Menstrual abnormalities |  |  |

1. How many children are enough for you to consider BTL?

˂ 2 3-5 ˃5

1. Which other FP methods do you know?

Oral contraceptives Implants Injectables

Intrauterine devices Condoms Traditional

Natural family planning None

1. Which one do you prefer to use?

Oral contraceptives Implants Injectables

Intrauterine devices Condoms Traditional

Natural family planning None

1. Why don’t you like to use BTL?

|  |  |
| --- | --- |
| **Reason for not using BTL** |  |
| I have not achieved the desired number of children |  |
| I am too young |  |
| My husband will marry another wife |  |
| My religion does not allow |  |
| My culture does not allow |  |
| My husband does not allow |  |
| I am afraid |  |
|  |  |
|  |  |

1. What are the challenges/barriers you find when trying to access and use FP services
2. How can such challenges/barriers be overcome?

## Appendix III: Budget

|  |  |  |  |
| --- | --- | --- | --- |
| **Item description** | **Quantity** | **Cost per unit** | **total** |
| 1. **Stationary**  * Foolscaps * Pens * Pencils * plastic folder * A4 envelopes | 1 ream  20  20  4  3 | 400/=  15/=  15/=  60/=  15/= | 400  300  300  240  45 |
| 1. **Internet use**  * Browsing * printouts | 1000 minutes  50 copies | 3/=  10/= | 3000  500 |
| 1. **Printing**  * Questionnaire-pilot study printing * Photocopy * Final questionnaire printing * Photocopy * Proposal * Photocopy of proposal * Binding of proposal * Project * Binding | 1 copy x 4 pages  15 copies x 4 pages  3 pages  152 copies x 3 pages  30 pages  30 pages  1  70pages  1 | 10/=  3/=  10/=  3/=  10/=  3/=  100/-  15/=  100/= | 40/=  180/=  30/=  1368/=  300/=  90/=  100/=  1050/=  100/= |
| 1. **Research assistants**  * Emolument * Transport | 2 pax  2 x 10 days | 1500/=  200/= | 3000/=  4000/= |
| 1. **statistician**  * Charges |  |  |  |
| 1. **Miscellaneous** |  |  | 2000/= |
| 1. **Contingency (10 %)** |  |  | 3700/= |
| 1. **GRAND TOTAL** |  |  | 37350/= |

## Appendix IV: Time Frame

|  |  |  |
| --- | --- | --- |
| **DATE** | **ACTIVITY** | **TIMING** |
| 27th Jan – 27th March 2015 | Proposal Writing | 2 Months |
| 30th March 2015 | Hand in Proposal | 1 day |
| 31st March 2015 | Presentation of Proposal | 1 day |
| 22nd May 2015 | Preparation of questionnaire and pretesting | 2 days |
| 9th June – 19th June 2015 | Data collection | 10 days |
| 23rd June - 29th June 2015 | Data analysis | 1 Week |
| 14th July 2015 | Handing in Research Project | 1 day |
| 21st July 2015 | Presentation and defense | 1 day |