

UNIVERSITY OF MALAWI
KAMUZU COLLEGE OF NURSING

**FACTORS THAT INFLUENCE WOMEN OF
CHILDBEARING AGE TO STOP CHILDBEARING
AT KAMUZU CENTRAL HOSPITAL, LILONGWE**

**A RESEARCH DISSERTATION SUBMITTED TO
THE UNIVERSITY OF MALAWI, FACULTY OF
NURSING, IN PARTIAL FULFILLMENT FOR THE
AWARD OF THE BACHELOR OF SCIENCE IN
NURSING**

**PRESENTED
BY**

MISS VERONICA NKHATA

**SUPERVISED
BY**


MRS C.G CHITSULO

10 DECEMBER, 2010.

DECLARATION

I hereby declare that this proposal is solely my own work and has not been submitted for any degree program at any other institution.

Candidate name: VERONICA NKHATA

Signature..........Date.....10/12/2010.....

Supervisor: MRS. C. G CHITSULO

Signature.....Date.....

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DEDICATION

I dedicate this proposal to the Almighty God, my mum and my late dad for the financial and psychological support and encouragement they rendered to me throughout my academic year.

ACKNOWLEDGEMENT

First and foremost I thank the almighty God for the gift of life, strength, wisdom, guidance and perseverance. May his name be praised for ever. Amen.

I would like to express my heartfelt gratitude to my supervisor, Mrs C.G. Chitsulo for the continuing support, guidance and concrete criticism.

I thank my research lecture for the theoretical information he provided, which guided me in finding a better topic for conducting a research.

Many thanks should also go to all my classmates and the librarians who provided me with information i needed for my research as well as internet and secretariat services respectively.

Finally i thank my family members for the continuing support they provided.

ABSTRACT

The aim of the study was to find out the factors that influence women of childbearing age to stop childbearing. A qualitative descriptive study design was used for generating rich descriptive data on the factors that influence women of childbearing age to stop childbearing. The study was conducted at family planning clinic at KCH in Lilongwe since it was accessible to the researcher. In addition the women of childbearing age who wanted to access family planning services were found there. A minimum of 10 women within the childbearing age were recruited using convenience sampling. An in depth interview guide was used for data collection. Thereafter the data was analyzed manually using content analysis and the emerging themes were presented in subthemes, patterns and categories that gave meaning.

The results indicated that 90% (n=9) of women had a positive attitude towards limiting family size. The women were able to explain the benefits of limiting family size. This showed that the women would be able to limit family size willingly. However 10% (n=1) of women indicated a negative attitude toward limiting family size. The reasons included inability to reach at an agreement with their spouse on the number of children to have due to conflicts. On cultural beliefs affecting limiting family size, the women indicated that they tied a rope around their waists in order to prevent conception for five years. This improper method of family planning has no scientific basis such that it does not have direct positive impact on limiting family size. Therefore although this was the women's culture, it could contribute to an increase in birth rate hence predisposing the women to complications associated with childbearing. It could also lead to unwanted pregnancies hence an increase in the number of abortions. The findings further indicated that the women could not make decisions about family planning on their own hence they would be motivated to continue bearing many children.

DEFINITION OF TERMS

Factors: A circumstance that contributes towards a result.

Influence: Force that can affect action. It can be in positive or negative sense (Webster's Reference Library Concise Edition Dictionary & Thesaurus, 2006).

Childbearing age: This is the reproductive age ranging from 15 to 49 years.

Childbearing: Childbearing is referred to as the process of giving birth. It is also referred to as the pregnancy, labour, and delivery (Olds, London & Wieland Ladenwig, 2000).

Total Fertility Rate: This rate estimates the number of children, a hypothetical cohort of 1000 women in the specified population would bear if they all went through their childbearing years experiencing the same age specific birth rates for a specified time period (Winson & McDonald, 2005).

Tubal Ligation: This is a permanent contraception for women who will not bear any more children. A small incision is done in the abdomen in order to block off or cut off the two fallopian tubes (Hatcher, Rinehart Blackburn, Geller & Shelton, 1997).

LIST OF ABBREVIATIONS

KCH: Kamuzu Central Hospital

KCN: Kamuzu College of Nursing

HBM: Health Belief Model

TFR: Total Fertility Rate

TL: Tubal Ligation

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CHAPTER ONE

1.1 Introduction

Childbearing is referred to as the process of giving birth. It is also referred to as the pregnancy, labour, and delivery (Olds, London & Wieland Ladenwig, 2000). In Malawi childbearing age ranges from 15 to 49 years. Childbirth as a component of childbearing is referred to as the process whereby the foetus makes its way from the womb down the birth canal to the outside world. It includes labour (the process of birth) and delivery (the birth itself).

Childbirth usually occurs spontaneously following about 40 weeks after conception but it may be started by artificial means if the pregnancy continues past 42 weeks gestation. Delivery between 37 and 42 weeks of gestation is considered normal and full term. Labour is signalled by regular painful uterine contractions. The average length of labour is about 14 hours for a first pregnancy and about 8 hours in subsequent pregnancies (Beischer, Markay, & Coldtz, 1997).

Currently the fertility rate in Malawi is 6.0 births per woman and on average a Malawian woman bears 6 children. However the Malawi Demographic Health Survey (2004) indicated that there was a higher proportion of men (71%) who prefer having four children compared to females (67%). An ideal family size of four children per couple was established. The ability to monitor the fertility levels has an impact on the reproductive health of women. This is referred to as the state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters related to the reproductive health system and to its functions and processes (Olds, London & Wieland Ladenwig, 2000).

For most women in Malawi having children is an essential part of life. Childbearing in our society is perceived at different angles. People perceive it as having a sense of pride or prestige when one has many children in the family. Other people perceive it as being rich since the children will help them in future when they attain old age. The perception of people towards childbearing is determined by the sex and the number of the children. This is because the parents especially the father, prefer having male children for their surnames to be sustained when they die. Therefore the family would want to have many male children hence increasing the family size to a level they cannot manage to support. However if women in the society are childless they are perceived as being bewitched by other people and they are stigmatised by community members.

Changes in the demand for children and greater accessibility to contraception are important conditions for fertility transition. During the transition period, the main concern is usually confined to the health of women of childbearing age during pregnancy and childbirth. This is because women suffer severe and permanent damage to their health as a result of pregnancy and childbirth. People from different cultures have different beliefs towards childbearing. For instance pregnant women are deprived of food such as eggs, pork with an aim of maintaining their health. Although this is the case the health of women before pregnancy very much determines the subsequent reproductive performance. Postponing the first child, spacing between births and limiting the number of births do have a bearing on the health of women and children (Kinati, 1990).

People are able to have a satisfying sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so. In Malawi family planning health services are available for the people to have access to it. Outreach family planning services from almost each Health Centre are also provided for the people who are living at a far distance from the hospital to have access. Men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility as well as access to health care for safe pregnancy and childbirth (Kinati, 1990). In order for the women of childbearing age to be able to limit the family sizes, they need to have the desire to do so. This is influenced by several factors. In view of this the researcher wants to find out the factors that influence women of childbearing age to stop childbearing.

1.2: Background

Malawi is a small country in Southern Africa bordered by Tanzania, Mozambique, Zambia and Lake Malawi. The population of Malawi is 13 million with nearly 75% of the population living in rural areas and at least 25% living in urban areas. There are 6.4 million males and 6.7 million females. Of all the districts Lilongwe has the highest population of 260,000. Population growth rate of Malawi is 2.2 % (Von Bothmer, 2009).

According to the Malawian Demographic Health Survey (2004) the Total Fertility Rate (TFR) is 6.0 births per woman. An average woman in Malawi bears 6.0 children in her lifetime. Despite that, the Malawian Demographic Health Survey (2000) indicated that there was a higher proportion of men (69%) who prefer having four children than females (64%). In 2004 it also indicated that there was a higher proportion of men (71%) who prefer having four children compared to females (67%). An ideal family size of four children per couple was established.

However, among sub Saharan countries Malawi is seconded by Uganda which has the highest fertility rate. This shows that Malawians consider childbearing as a necessity in one's life. There is a substantial regional variation in the TFR between central and the other two regions. The TFR in the central region is 6.4 births per woman while in the southern and northern region it is 5.8 and 5.6 births per woman respectively. In Lilongwe the TFR is 5.7 births per woman. This indicates that although a lot of women in the central region have the desire to limit their family sizes, they are not motivated to do so, this is shown by a higher fertility rate in the central region compared to the other regions.

Higher population growth rate results in increased demand for resources such as natural resources for example agricultural land and water. There is also increased pressure for public and social services such as educational facilities, health services and social services. The government can incorporate family planning programmes in the media to motivate the people to limit their family sizes in order to reduce the population growth to a manageable level depending on the available resources. It can also be done by making the family planning health services available, accessible and affordable. The family planning health services include, long term use of depo provera, oral contraceptives and tubal ligation (TL).

At Kamuzu Central Hospital (KCH) the statistics indicated that from January to December (2008), out of 4717 women who attended family planning clinic, 105 women went for TL representing a percentage of 2.23%. However from January to December (2009) the statistics indicated that, out of 5493 women who attended family planning clinic, 140 women went for TL representing a percentage of 2.55%.

This shows that there is an increase in the number of women who go for TL indicating that family planning health services are accessible, affordable and available to most women of childbearing age..

Thereafter, from January to early June (2010), out of 1440 women who attended family clinic, 102 women went for TL representing a percentage of 7.08%.

1.3: Problem statement

According to Malawi Demographic Health Survey (2004) there was a high percentage of women (45%) in the central region who wanted to stop childbearing than in the northern and southern region representing a percentage of 38% respectively. It also indicated that in the urban areas, there was a high percentage of women (43.2%) who wanted to stop childbearing as compared to women who were living in the rural areas (40.4%). The proportion of women who wanted to stop childbearing among the districts ranged from 46% in Lilongwe to 29% in Mangochi. In other districts such as Blantyre, Kasungu, Salima, Thyolo, Mzimba and Mulanje, the proportion of women who wanted no more children ranged from 40% to 44%. This showed that many women in Lilongwe had the desire to stop childbearing as compared to any other district. In view of the above, the researcher is interested to find out the factors that influence the women of childbearing age at Kamuzu Central Hospital in Lilongwe to stop childbearing.

1.4: Significance of the study

The proportion of women who want to limit childbearing is of fundamental importance because it has direct impact on the population growth and it designates a segment of the population that may be at risk of having unwanted pregnancy.

The findings of the study will provide information that health personnel can use to motivate women of childbearing age to stop childbearing. This can reduce complications associated with childbearing if the women bear more children consistently.

The findings of the study will also provide input to policy makers for formulating and implementing population and family planning policy.

1.5: Broad objective

To find out the factors that influence women of childbearing age to stop childbearing at Kamuzu Central Hospital in Lilongwe.

1.6: Specific objectives

To assess the perception of women on limiting family size

To identify perceived benefits of women on limiting family size

To explore beliefs of women towards limiting family size

To identify problems encountered before limiting family size

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Literature review has been defined as an exhaustive, systematic and critical examination of publications relevant to the research topic (Wood & Harber, 2006). It provides the researcher with relevant information about what is known about the topic of study and the relationship between and among dependent variables. Literature review helps to develop a comprehensive picture of the state of knowledge on the topic and acquaints the researcher with what has already been done in relation to the study and thereby minimizing unintentional duplication (Polit & Beck, 2006). It also provides a summary of a series of articles and therefore creating a structure upon which further research can be based. This chapter will provide information on the studies that were done by other researchers in relation to the topic of study. These will include those that were done worldwide, in Africa as well as Malawi.

2.2 Induced abortions as a contributing factor to limiting family size

Bankole, Singh & Hass (1998) did a study to find out the reasons why women had induced abortions internationally. The study indicated that worldwide the most reported reason women cited for having an abortion was to postpone or stop childbearing. The second most socioeconomic concern included disruption of education or employment, lack of support from father, desire to provide schooling for the existing children and poverty as well as unemployment or inability to afford additional children. In addition relationship problems with a husband and partner and a woman's perception that she was too young to constitute other important categories of reasons were also reasons the women gave for having an induced abortion. Women's characteristics were associated with their reasons for having an abortion with few exceptions. Older women and married women were the most likely to identify limiting family size as the main reason for abortion. Overall the combined proportion of married women in the age group of 15-49 years who wanted to postpone the next birth or to stop childbearing at any given point in time ranged from 39% in the Central African Republic to 89% in Japan. This proportion was greater than 50% in 48 of the 51 countries for which data was available. It was concluded that the reasons women gave for why they sought abortion was often far more complex than simply not intending to become pregnant.

Similarly Bardenhost (2005) conducted a study worldwide whose aim was to investigate the reasons given by women for choosing to terminate a pregnancy over other alternatives to deal with an unwanted pregnancy. The findings indicated old age, employment status, gestation period, ideal family size, sexual behaviour and contraceptive use as some of the reasons why women terminated pregnancy. Some of the respondents indicated that they initially considered having the baby and raising the child but due to a change in circumstances, they decided to terminate the pregnancy. It was concluded that there was a relationship between employment status, financial affordability and being too young in such a way that there exist intricate links.

Khokhar & Gulati (2000) conducted a study in an urban slum of Delhi. The aim of the study was to find out the factors related to women undergoing an induced abortion. The findings indicated that out of 440 ever married women, 70(15.9%) had undergone one or more induced abortions. 31.4% of the women had undergone two or more induced abortions. Maximum (51.4%) of the total induced abortions occurred in the age group of 25-29 years. Women who were gainfully employed were more likely to undergo an induced abortion. 52.08% of the husbands consented to their wives decision to abort and also husband's literacy status was observed to be associated with abortion status of their wives. Unplanned pregnancy was stated as a reason for abortion by 85.7% of the women and low socio-economic status (71.4%). This indicated that a large number of women resorted to an induced abortion once their desired family size was reached.

2.3 Factors influencing women's childbearing intentions

Jaime (2006) conducted a study on the factors influencing Filipino couples' desired family size and contraceptive use in the Philippines. The findings indicated that increasing age of couples diminished the odds for a small family size. Young couples tend to prefer 2 or fewer children. husbands and wives married at an older age significantly favoured 2 or fewer children. Urban area, education and catholic affiliation were strong covariates for small family norm but not for family planning which was associated with higher fertility. Catholic couples, urban women and wives who desired small family size were more likely to use contraceptives. It was concluded that age, education, family planning discussion with spouse and mass media exposure to family planning messages on television were important for contraceptive use.

Unger and Molina (2010) conducted a study on educational differences in desired family size and attitudes towards childbearing in Latina women. The results indicated that attitudes towards childbearing and desired family size influence women's reproductive choices. Attitudes of women with and without a high school education were compared. Respondents without a high school education desired a mean of 3.1 children while those with high school education desired a mean of 2.7. Women without a high school education endorsed more attitudes favouring large families. Among women without a high school education, those who wanted to have son to carry on the family name tended to desire large families. Therefore it was concluded that the desire for large families among the Latina women with low education may result from traditional cultural attitudes.

Ryerson (2010) conducted a study on beliefs about simple approaches that are mistakenly believed to hold promise of a quick fix to the population problem. The result indicated that people have large number of

children out of fear that some of their children will die before reaching maturity. It was also assumed that if infant and child mortality rates are reduced, people will quickly understand the reduced risk and adjust their fertility patterns accordingly.

The results also indicated that the relationship between education and percentage of women who want more children is positive in several of the countries but weak or non-existent in many others. In fact the data gave the impression that the intention to terminate childbearing is similar across educational levels. In conclusion there are some of the steps that can be taken to bring about accelerated progress in reducing population growth. Many of these steps have to do with addressing personal beliefs and cultural norms with regard to the status of women, ideal family size and age of initiating childbearing. Many of these issues revolve around the concept of personal motivation.

Ali (2000) conducted a study on the effect of selected socio demographic characteristics on desire for additional children among couple in Bangladesh. The findings revealed that women who have more daughters and sons are more likely to desire additional children than women who have equal number of sons or daughters and more sons than daughters. Similarly the desire for additional children decreases with the increasing number of children. The findings also showed that the desire for additional children is greater among the women who live in rural areas, who are Muslims, have no media exposure, are not members of any social organisations and the husbands are educated. It was then concluded that wife's education and occupation and husband's occupation have no significant effects on desire for additional children.

Duze and Muhammed (2006) conducted a study on male knowledge, attitudes and family practices in northern Nigeria. The results indicated that there is high knowledge of contraceptives, a generally negative attitude towards limiting family size for economic reasons and consequently low rates of contraceptive use. Respondents who were willing to use contraceptives were more willing to use them for child spacing purposes than explicitly for limiting family size. Path-analytic decomposition of the effects of predictor variables show that education has largest direct and total effects on contraceptive use while specific knowledge of contraceptives has the smallest direct and total effect. Most importantly attitudes have the largest direct effect on contraceptive use with a standardised co-efficient value of 0.781. Therefore it was concluded that family planning progress that continue to focus solely on women will continue to achieve only limited successes in Northern Nigeria.

Romea, Berensornb and Segarsc (2004) conducted study a sociocultural and religious influence on there normative contraceptive practices of Latina women in the United States. The results showed that Spanish speaking women were more consistent contraceptive users than their English speaking counterparts suggesting that acculturation negatively impacts contraceptive use. However Spanish speaking women with longer United States residency were more likely to be consistent contraceptive users than Spanish speaking women who had lived in for briefer period, suggesting an effect of acculturation. Religiosity and education were associated with family size but not contraceptive use. It was therefore concluded that women who were married and had fewer children were more likely to plan their current pregnancy indicating that Latina women take family size and marital status into consideration when actively dealing to become pregnant.

Save, Erbaydar, Kalaca, Harmanci, Cali and Karavus (2004) conducted a qualitative study on resistance against contraception or medical contraceptive methods on women and men in Istanbul. The findings indicated that most people attending the focus groups in the study were against having 'too many' children. Economic constraints appear to be a leading influencing factor for limiting the number of children. Urbanisation also seems to have a strong influence on people's knowledge and attitude towards contraception. Culture and religious beliefs were not found to be major barriers to contraception in general but they would influence the type of a certain contraceptive method. More specifically culture and religious beliefs were barriers to use of medical methods and they were the main reasons for use of withdrawal method which is the most common method used in Turkey. It was concluded that men and women are not resistant to contraception, but they are reluctant to use of medical methods. The provision of contraceptive services with special attention to cultural and religious beliefs and values and the inclusion of appropriate counselling and education sessions during service delivery may give clients new options and increase the use of medical methods.

Dibaba (2005) conducted a study in Oromia, regional state Ethiopia to examine factors that influence women's intention to limit childbearing. He found that a greater intention to limit childbearing was associated with older age, large number of living sons and daughters, being wealthier, no previous child death, knowledge and use of family planning and exposure to media. The findings further indicated that 12.9% of married women wanted a child within two years, 33.9% of married women wanted a child after two years (child spacing) and 3.40% of married women wanted to stop childbearing but they were not sure. In addition, he found that 46.8% of currently married women wanted to stop childbearing.

It was concluded that a high proportion of women desired to limit childbearing but there was a large unmet need for contraceptives. Thus improving access to family planning services to women who had achieved their family goals would be important.

Oladenji (2008) conducted a study in Ibadan, Nigeria on the relationship of couples' reproductive decision making on mater regarding contraceptive use, family size birth spacing, breastfeeding, extramarital sexual behaviours among couples. The results indicated that the 6 independent variables (gender roles and norms factors) when taken together were effective in predicting reproductive behaviour, relationship and decision making among couples involved in the study. Furthermore the findings indicated that significant relationships existed between extramarital sexual partners, family size, prenatal care, contraceptive use and breastfeeding as well as reproductive behaviour. However no significant relationship existed with birth spacing practices. In addition, the results indicated that a combination of the independent variables significantly predicted reproductive behaviour and relationship. Therefore there was a need for those in the health related profession to design intervention programmes for couples on reproductive behaviour.

Mbaye (2007) conducted a study on the sexual behaviour and future childbearing intentions of HIV infected women receiving antiretroviral therapy (ART) in Lilongwe. The results indicated that out of 189 women who were enrolled 66% desired more children and 85% remained sexually active. Condom use was low: 5% of the sexually active women reported consistent condom use; 58% of women did not use condoms because their partners refused. 37% of women used hormonal contraception. Older women (<34 years) were less likely to want more children. Those who had been on ART for < 2 years were less likely to desire more children. Most women on ART desired more children especially during the first 2 years of starting ART. It was recommended that intensified counselling messages on sexual behaviour and family planning should be incorporated into ART education. In addition, family planning services should also be integrated into ART clinics.

Similarly, Taalo, Berry, Tsui, Makanani, Kafulafula, Li, Nkhoma, Kumwenda, Taha & Kumwenda (2008) conducted a study at Blantyre with an aim of finding out the determining fertility intentions of HIV infected and uninfected reproductive age women. The results indicated that the hazard of wanting no more children at baseline to wanting no more children at follow up was 61% lower among HIV infected women compared to HIV uninfected women after adjusting for other factors. However HIV infected women were more likely to wanting no more children. The overall pregnancy rate was 14.9 per 100 person years and did not differ among 102 HIV uninfected women and 100 infected women who became pregnant. It was concluded that HIV infection was the significant predictor of fertility intentions overtime.

2.4 Challenges faced by women before limiting family size

Kamvazina (2007) conducted a study on the factors contributing to high unmet needs for modern family planning at Lungwena . The study revealed that the discussion of family planning between family planning clients and Family planning service providers during the antenatal care of the pregnancy of the first born child (especially for the first pregnancy) was a key to subsequent use of family planning methods and reduction of unmet needs for family planning.

This was explained by the fact that the women who reported that they had discussed family planning with their service provider during the antenatal care of the first pregnancy were many times less likely to have unmet needs for the conception of the last child compared to women who did not discuss family planning with their service provider. It was concluded that interpersonal communication between client and their service provider provided a better opportunity for women to access and obtain family planning information. This was because during one to one discussion the service provider was expected to explain in depth and detail about each method.

2.5 Conclusion

Literature review shows that there are several factors that can influence women to limit their family sizes according to the above mentioned studies. Most of the factors are based on religious beliefs, health status of women, poor planning of the couples on the desired family sizes as well as availability of family planning services. In addition the factors differ in each country depending on the culture of the country, availability of family planning services and even the socioeconomic status. In view of this, the researcher is interested to find out the factors that are influencing the women of childbearing age at Kamuzu Central Hospital in Lilongwe to stop childbearing.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

3.1 Introduction

Conceptual framework is a frame of reference that is derived from an existing theory which provides a general, abstract explanation of the relationships of concepts to be investigated and support the rationale for conducting the study (Clark, 2008). Conceptual framework provides the foundation for the study. When research is performed within the context of the theoretical framework, its findings are significant and are utilised in nursing (Polit & Beck, 2006). Health Belief Model (HBM) was used as a theoretical framework for the study. This chapter will include a description of the model, diagrammatic presentation of the HBM as well as its application to the study.

3.2 Description of the model

The model was developed to help determine what people perceive to be true about themselves in relation to health. It also determines whether an individual is likely to participate in disease prevention and health promotion activities. It is based on motivational theory. The model is a useful tool in developing programs that help people change to healthier lifestyles and develop a more positive attitude toward preventive health measures (Allender & Spradely, 2005).

The health belief model is based on three major components which are:

a) Individual's perceived susceptibility to disease

This is an individual's belief that he or she either will or will not contract a disease. Perceived susceptibility may range from being very afraid of contracting a disease to complete denial that certain behaviours will result in illness.

b) Individual's perceived seriousness of a disease

This involves two factors which are seriousness of the disease and its perceived effect on the person's life style. This component is based on how much the person knows about the disease and can result in a change in health behaviour. Both perceived susceptibility to a disease and perceived seriousness of the disease are part of beliefs about the threat of the disease.

c) Individual's perceived benefits of the action

This is concerned with how effective the individual believes preventive measures will be in preventing illness. It is influenced by the person's conviction that carrying out a recommended action will prevent or modify the disease and the person's perception of the cost and unpleasant effects of performing the health behaviour (as compared to taking no action at all).

Modifying factors of the perceived threat of disease which include age, personality, peer group pressure and knowledge of the disease interact to influence the perceived benefits of preventive action minus the perceived barriers to preventive action. Cues to action are also modifying factors and are provided by activities such as advice from others, mass media campaign and significant other. These cues can either be internal and external. The likelihood of taking a recommended preventive health action depends on the perceived benefits minus the perceived barriers.

3.3 The diagrammatic presentation of Health Belief Model

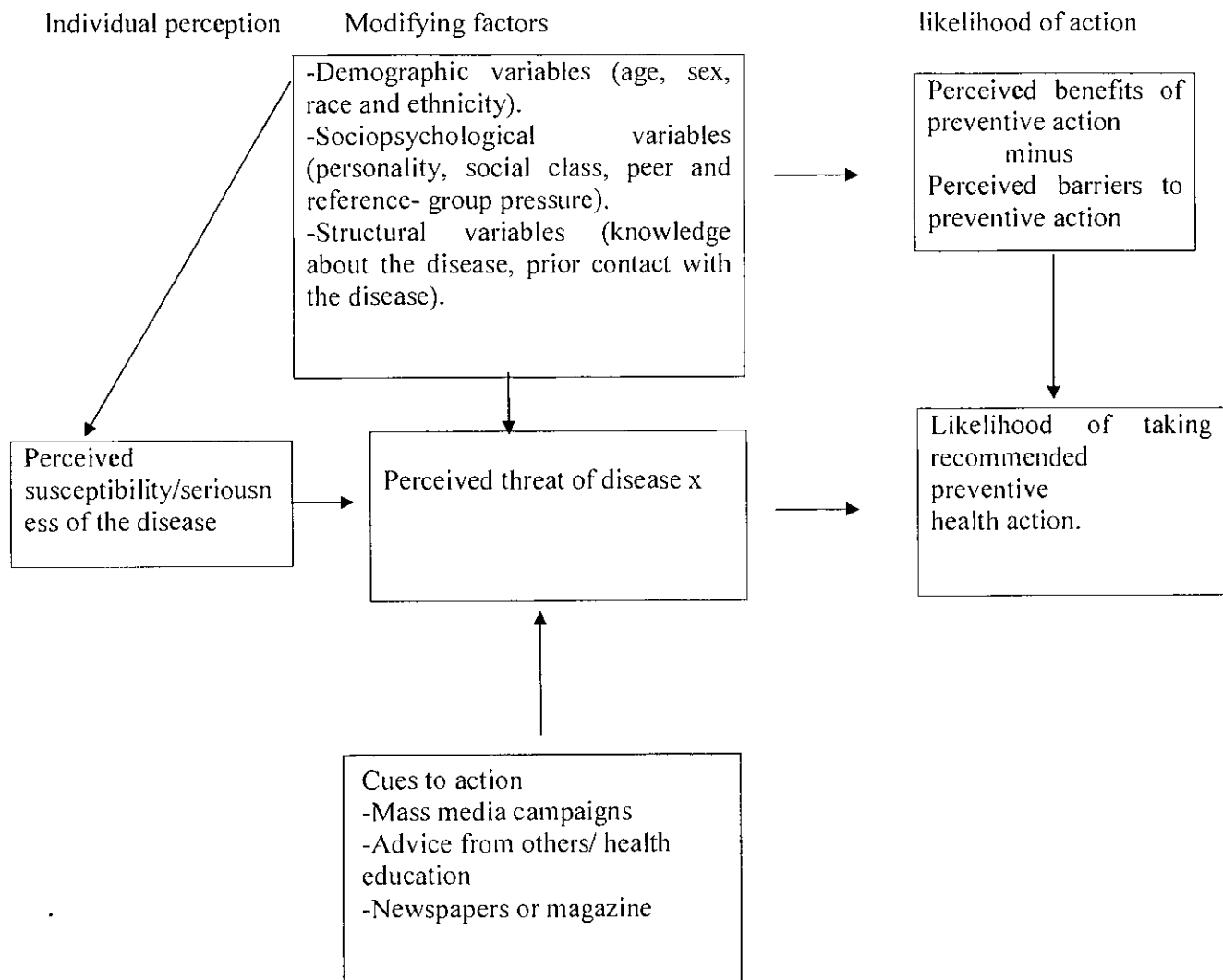


Fig 1: Source: M.H Becker, D.F Haefner, S.V Kasi et al., Selected psychosocial models and correlates of individual health related behaviours, Medical care/1977,15, 27-46

3.4 Application of the model

The health belief model explores factors that influence an individual willingness to take action hence determining decision making in women to stop childbearing. In this study the model helped in finding out the factors that influence women of childbearing age to stop childbearing. Demographic variables such as age, sex and ethnicity (beliefs) were some of the factors that affected childbearing. For example ethnicity played a role in the beliefs women had on limiting their family sizes. Some of the sociopsychological variables which influenced women were pressure from the women's culture to either stop or continue childbearing or their socioeconomic status which could enable them to provide their children with basic needs. Other structural variables which influenced women in decision making of limiting their family sizes included the knowledge they had on the complications that arose due to consistent childbearing, or even malnutrition in children due to lack of food in the family . The knowledge women had was derived from mass media campaigns, advice from others which motivates them to act. The perceived susceptibility, perceived severity, perceived benefit and perceived threat women had on the problem of bearing children consistently, contributed to the likelihood of taking the recommended preventive action of limiting their family sizes.

CHAPTER FOUR

METHODOLOGY

This section will include the methodology that was used for the research. It includes the description of a study design, setting, sampling, pilot study, data collection tool and instrument, data analysis, ethical consideration, limitation of the study and dissemination of results.

4.1 Study design

Research design has been defined as the overall plan for obtaining an answer to the research question or for testing the research hypothesis. A qualitative descriptive design was used in the study. This was because it involved formulating broadly stated questions about human experiences and realities studied through sustained contact with other people in their natural environments (Wood & Haber, 2006). It also involved generating rich descriptive data on the factors that influence women of childbearing age to stop childbearing.

4.2 Sampling and sample size

Sampling refers to the process of selecting a portion of the population to represent the entire population while sample consists of a subset of the units that compose the population (Burns & Grove, 2001). The population of interest were women of childbearing age with or without the desire to stop childbearing. The study used a convenience sampling method. Convenience sampling refers to the use of most readily available persons or objects for use as subjects in a study (Burns & Grove, 2005). This was because the study involved women of childbearing age who wanted to access family planning services at the family planning clinic as the participants during the time of data collection. A minimum of 10 women within the childbearing age were interviewed in order to obtain data.

4.3 Setting

Setting refers to the location for conducting the research (Burns & Grove, 2004). This research was conducted at KCH in Lilongwe at family planning clinic. This was where the women of childbearing age who wanted to access family planning services were found. The setting was also accessible to the researcher hence it was easier to conduct the research.

4.4 Data collection

Data collection is the process of gathering data from subjects in order to address the research question while a data collection instrument is a data collection tool (Burns & Grove, 2004). An in depth interview was used during the data collection. An interview guide containing open ended questions as well as close ended was developed in order to collect the information. Open ended questions were used because they allowed the participants to freely give responses and close ended questions limited responses to predetermined categories. The interviews were conducted on one to one and it was done through verbal communication between the researcher and the participant (Wood & Harber, 2006). Interviews had been considered appropriate since they were the best methods for in depth probing of personal opinions, beliefs and values and very rich in depth information would be collected. They were also very successful at uncovering hidden issues (Burns & Grove, 2004).

4.5 Data analysis

Data analysis has been defined as the systematic organization and synthesis of research data as well as the testing of research hypothesis using the data. The purpose of data analysis regardless of the type of data one had was to impose some order on a large body of information so that some general conclusions could be reached and communicated in a research report (Wood & Harber, 2006). Data was analyzed manually using content analysis. Content analysis is the process of organizing and integrating narrative, qualitative information according to the emerging themes and concept (Polit & Beck, 2006). Therefore responses for each question were analyzed and the emerging themes were isolated and presented in subthemes, patterns and categories.

4.6 Ethical consideration

A proposal was submitted to Kamuzu College of Nursing Research Committee in order to ensure safety of the participants throughout the study. In addition permission was sought from Lilongwe District Health Officer and the Hospital Administrator of Kamuzu Central Hospital before data collection.

The subjects were informed on the purpose of the study, method, procedure for data collection and the benefit of the study to make them aware and obtain an informed consent. This was done in order to ensure protection of human rights. Subject's participation was voluntary and the subjects were informed that they were free to withdraw anytime they felt like doing so without being penalized. They were also assured that no physical risk would be involved in the study.

In addition the researcher explained to the participants the aim of the study in simple terms. Participants were told that there were no direct benefits from the study but indirectly they would benefit.

Those who gave consent to participate in the study were given consent form to sign and those who were illiterate used a thumb stump. Participants were informed that information collected would be kept in confidence by ensuring that interview guides were kept safely in files for at least five years following data analysis. The participants were allowed to give their names to make sure that they remained anonymous instead code numbers would be used. The interviews were held on one to one basis to allow free expression of views and feelings. The interviews were also conducted in a separate room for the maintenance of audio and visual privacy.

4.7 Pilot study

Pilot study is a smaller version of a study proposal. It is conducted to refine the methodology using the proposed study, similar subjects, same setting, same treatment, and same data collection and analysis techniques (Burns & Grove, 2004).

This was done in order to develop and refine a variety of steps in the research process and to determine whether the proposed study was feasible or not thereby pretesting the questionnaires for efficiency and clarity. The pilot study was conducted at Queens Central Hospital at family planning clinic. Only three women were involved in the pilot study.

4.8 Limitation of the study

The study had a small sample size hence the findings would not be generalized. Less time had been allocated for the research since the study was done concurrently with other academic issues. In addition the study was not funded hence it was conducted at a small scale.

4.9 Dissemination of results

The results will be disseminated through research report which will be placed in the KCN library and copies will be made available at Kamuzu Central Hospital.

CHAPTER FIVE

PRESENTATION OF FINDINGS

INTRODUCTION

This chapter presents findings of the study. The purpose of the study was to find out the factors that influence women of childbearing age to stop childbearing at Kamuzu Central Hospital. The main focus of the findings is on demographic characteristics of the participants, perception of women towards limiting family size and cultural beliefs related to limiting family size, benefits of limiting family size and problems encountered before limiting family size.

Table 1: Demographic characteristics of women

Table 1.1: Age of women

Age	Number of responses	Percentage (%)
15-24	3	30%
25-34	7	70%
35-44	-	-
45-49	-	-
	Total=10	Total=100%

A total of 10 women within the childbearing age (15-49) participated in the study. The results indicated that 70% (n=7) of the women were in the age range of 25-34 and 30% (n=3) were in the age range of 15-24 with a mean age of 25.

Table 1.2: Tribe of women

Tribe	Number of responses	Percentage (%)
Chewa	5	50%
Yao	2	20%
Ngoni	2	20%
Tumbuka	1	10%
	Total=10	Total=100%

A majority of women were predominantly of the Chewa tribe representing 50% (n=5), 20% (n=2) were of Yao and Ngoni tribe respectively and 10% (n=2) were of Tumbuka tribe.

Table 1.3: Marital Status of women

Marital Status	Number of responses	Percentage (%)
Married	8	80%
Single	1	10%
Divorced	1	10%
Widower	-	-
Cohabiting	-	-
	Total 10	Total 100%

In terms of marital status, 80% (n=8) were married, 10% (n=1) were single and 10% (n=1) were divorced and none of the women were neither cohabitating nor widowers.

Table 1.4: Parity of women

Parity	Number of responses	Percentage (%)
1-4	6	60%
5-8	4	40%
	Total=10	Total =100%

Sixty percent (n=6) of women had children within the range of 1-4 and 40% (n=4) had children within the range of 5-8.

Table 1.5: Education level of women

Education	Frequency	Percentage (%)
Primary	7	70%
Secondary	3	30%
Tertiary	-	-
	Total 10	Total 100%

Seventy percent (n=7) of women attended primary school education while 30% (n=3) attended secondary education.

Table 1.6: Denomination of women

Denomination	Frequency	Percentage (%)
CCAP	3	30%
Roman Catholic	2	20%
SDA	1	10%
Islam	3	30%
Others	1	10%
	Total 10	Total 100%

Thirty percent (n=3) of women belonged to CCAP Church, and Islam respectively. Twenty percentage (n=2) of the women belonged to Roman Catholic Church, 10 % (n=1) belonged to Seventh Day Adventist and 10% (n=1) belonged to other denominations.

5.2: PERCEPTION OF WOMEN TOWARDS LIMITING FAMILY SIZE

5.2.1: Women's perception towards limiting family size

When the women were asked about their perception towards limiting family size, 90% (n=9) of the women indicated a positive perception towards limiting family size. Ten percent (n=1) of women indicated fear of giving birth as the reason of limiting family size. Ninety percent (n=9) of women explained that, it was good to have few children because they were able to provide their children with basic needs. Ten percent (n=1) of women indicated problems encountered when caring for many children as other reasons of limiting family size. However 10% (n=1) of women were quoted saying:

"I can plan to have few children but others may come unexpectedly".

This indicated that although they may plan to limit family size, they were not sure of whether they would succeed with the plan or not.

The results indicated that one woman (10%) had a negative perception towards limiting family size. This was because they thought that some may die so one may not have children if she bore few children. On the same issue 10% (n=1) of women who had a negative perception towards limiting family size were also quoted saying:

"I think it is not good to bear few children because it may be difficult to reach at an agreement with the spouse."

5.3: BENEFITS OF LIMITING FAMILY SIZE

A variety of the benefits on limiting family size were mentioned. Provision of total parental care was mentioned by 80% (n=8) of the women. In support of this, the women further emphasized on provision of basic needs to their children such as food, clothes, as well as education. Twenty percent (n=2) mentioned of good maternal and child health as the benefit of limiting family size, 10% (n=1) indicated prevention of HIV/AIDS pandemic and 10% (n=1) indicated happy life for the children. Ten percent (n=1) further explained that the children could be taken care of by other people when they were few.

Ten percent (n=1) indicated that they could care for the children when they had divorced as evidenced by one woman (10%) saying:

"I can take care for the children when I am divorced"

5.4: CULTURAL BELIEFS OF WOMEN ON LIMITING FAMILY SIZE

The findings indicated that 30% (n=3) of the participants believed in tying a rope around the waist in order to prevent conception for a period of 5 years. However 30% (n=3) of the participants who believed in tying a rope also revealed that they untie the rope if they wanted to bear more children. Thirty percent (n=3) did not have any beliefs related to limiting family size. Twenty percent (n=2) explained that they took traditional medicine for them to prevent conception. The findings further showed that 20% (n=2) did not allow their husbands to drink beer to avoid conception. This was because they thought that if their husbands were sober they would not have sex with them hence preventing conception.

5.5: MOTIVATING FACTORS TO LIMIT FAMILY SIZE

The findings indicated that 70% (n=7) of the participants had plans to limit family size. A variety of reasons were given for planning to limit family size. Forty percent (n=4) planned to limit family size because of inability to provide total parental care due to low economic status of the mothers. Twenty percent (n=2) of the participants indicated HIV/AIDS pandemic since it could contribute to an increase in the number of orphans. The remaining 10% (n=1) of the participants that had plans to limit family size indicated reasons such as lack of financial support from their husbands during gestation period. However the results indicated that 30% (n=3) did not have any plans to limit their family sizes.

Eighty percent (n=8) of the women had no problems that motivated them to plan on limiting family size. However the findings indicated that only 20% (n=2) had problems that motivated them to plan on limiting family size. Out of the 20% (n=2) that had problems, 10% (n=1) indicated that they were epileptic so their children may be predisposed to injury when having sudden fits. Ten percent (n=1) further explained that they were being abused by their husbands hence they planned on limiting family size.

CHAPTER SIX

DISCUSSION OF FINDINGS

6.1 INTRODUCTION

This chapter discusses the findings on factors that influence women of childbearing age to stop childbearing. The discussion is focused on the themes that emerged from the analysis of data and the rest of findings from similar studies. A conclusion has been drawn and limitations of the study are presented. It has also included recommendations and areas for further study.

6.2 DEMOGRAPHIC CHARACTERISTICS

6.2.1 Denomination

Among the participants it was noted that most of them belonged to catholic as well as Islam. This indicates that most women who belonged to catholic or Islam indicated a positive attitude towards limiting family size, and most of them had children ranging from 1-4. This concurs with Jaime (2006) who found out that catholic affiliation was a strong covariate for small family norm but not with family planning which was associated with higher fertility. So the women might have been abstaining from sex if they were in fertile periods or they might even be using traditional methods of family planning.

6.2.2 Education

All the women were literate (100%). This means that the women would be able to understand the need for limiting family size. The women would also be able to make sound decisions on the family sizes they wanted to have, depending on their ability to care for their children. According to Jaime (2006), education was a strong covariate for small family norm but not with family planning which was associated with higher fertility. Similarly Dibaba (2005) found that knowledge of women was associated with having a greater intention to limit family size. However Molina (2010) found that women without high school education endorsed more attitudes favouring large families. Ali (2000) also argues that wife's education have no significant effects on desire for additional children.

In addition Ryerson (2010) found that the relationship between education and the percentage of women who wanted no more children was positive in several of the countries but weak or non-existent in many countries. The findings gave the general impression that the intention to terminate childbearing was similar across educational levels. According to the Health Belief Model there are demographic factors such as education which influence an individual willingness to limit family size. The women are able to make sound decisions on limiting family size depending on their ability to fend for the children.

The women will also have the ability to understand the need for limiting family size. This would therefore influence the willingness of the women to limit family size.

6.2.3 Marital status

Eighty percent (n=8) of the women were married. Married women would be better placed to plan for their family sizes as compared to single mothers. The women would be assisted by their husbands in planning on the number of children they wanted to have. This concurs with Sergarsc, Berenson & Romoa (2004) who found that women who were married were more likely to plan their current pregnancy. The women take marital status into consideration when actively deciding to become pregnant. However findings from this study shows that women could make decisions to limit family size without agreeing with their spouses.

6.3 PERCEPTION OF WOMEN ON LIMITING FAMILY SIZE

6.3.1 Positive perception of women

The results indicated that 90% (n=9) of women had a positive attitude towards limiting family size. The positive attitude women had, could have a positive influence on women's reproductive behavior. Therefore the women would plan on limiting family size depending on the number of children they have planned to have. This concurs with Unger (2010) who indicated that attitudes towards childbearing and desired family size influence women's reproductive behavior. The women indicated that it was good to bear a few children because they would be able to provide their children with basic needs such as education and food. This concurs with Bankole & Hass (1998) whose results indicated desire to provide schooling for the existing children as the reason women gave in engaging themselves in induced abortion. The findings further indicated that families encountered problems when caring for many children. This was one of the reasons for limiting family size. The problems may include malnutrition due to low economic status hence parents would be unable to provide nutritious food to their children. Fear of giving birth was also given as a reason to limiting family size. This showed that the women had fear of giving birth because of the information they have on complications associated with childbearing such as rectal vaginal fistulas or even death. This would contribute to the negative attitude women had towards childbearing. According to Health Belief Model perceived threat to the disease may lead to the likelihood of taking a recommended preventive health action. This fear of giving birth, the women expressed had contributed to their willingness to limit childbearing.

The women further indicated that although they planned to limit family size, they were not sure of whether they would succeed with their plan or not. The women had doubts despite using family planning methods to limit family size. The family planning health service providers probably did not give adequate information to women. The women could also have had an experience of being found pregnant while on a family planning method because the women probably were using the family planning methods wrongly.

This could also mean that the women had misconceptions and they did not have enough knowledge on family planning methods hence having doubts on the achievement of their plans about limiting family size. This concurs with Kamvazina (2007) whose results revealed that the discussion of family planning methods between family planning clients and family planning service providers during antenatal care was a key to subsequent use of family planning methods. In contrast Duze & Mohammed (2006) indicated that respondents who were willing to use contraceptive were more likely to use them for childbearing purposes than explicitly for limiting family size. In Malawi most women go for family planning but are reluctant to use the family planning methods.

Although the findings showed that 80% (n=8) of women were married they indicated that it might be difficult to reach at an agreement on the number of children to have. The parents may have conflicts in reaching at an agreement on the number of children to have. The parents may have different suggestions on the number of children they wanted to have depending on the sex and number of the children. This is because in Malawian culture, fathers would prefer to have more male children for their surnames to be sustained when they die. Therefore they would continue bearing many children until they bear enough male children if they started bearing female children. In addition other people prefer having many children as a sense of pride or prestige. This would depend on the culture from which the spouses come from. Malawian culture also gives power to men thus tends to make decisions in reproductive health issues. This concurs with Oladenji (2008) who found out that significant relationship existed between family size as well as reproductive behaviour.

6.3.2: Negative perception of women

Despite that the majority of women (90%) had a positive attitude towards limiting family size, one woman (10%) had a negative attitude towards limiting family size. This was because the woman thought that the children may die hence there may be no children left. This concurs with Dibaba (2005) whose results indicated that having no previous child death was associated with the women having a greater intention to limit family size. Similarly Ryerson (2010) found that people have large numbers of children out of fear that their children will die before reaching maturity.

It is also assumed that if infant and child mortality rates are reduced, people will quickly understand the reduced risk and adjust their fertility patterns accordingly. According to Malawi Demographic Health Survey (2004) from 1995-1999 the infant mortality rate was 112 per 1000 live births and child mortality rate was 84 per 1000 live births giving an overall under five mortality rate of 187 per 1000 live births. It also indicated that from 2000-2004 the infant mortality rate was 76 per 1000 live births and child mortality rate was 62 per 1000 live births giving an overall under five mortality rate of 133 per 1000 live births. This showed that there was a decrease in the infant and child mortality rate although the women still perceive child death as a motivating factor to bear many children.

The findings also indicated that one woman (10%) would not limit family size until God told them to. One participant said (10%):

"Other people prefer having as many children as they can until God tells them not to".

This indicates that religion had an influence on women's decision to continue bearing children. The women may be discouraged to use family planning methods in order to limit family size but they would be encouraged to continue bearing children persistently. This showed that the women did not perceive limiting family size of any benefit to them due to the influence of their religion. On the same issue other women indicated that they would have many children to reduce workload in their homes as one was quoted saying:

"Others enjoy bearing many children because they reduce workload in the homes".

Therefore the women would be motivated to bear many children with an aim of reducing workload in their homes.

6.4 BENEFITS OF LIMITING FAMILY SIZE

When women were asked about the benefits of limiting family size, they indicated a variety of benefits that are discussed under the following themes:

6.4.1 Provision of total parental care

Eighty percent (n=8) of women indicated that they would be able to provide their children with basic needs such as education, food since they will have a limited number of children. This concurs with Bankole, Sigh & Hass (1998) whose results indicated the desire to provide schooling for the existing children as the reason women gave for inducing abortion.

Women also explained about their children having a happy life since they would be able to provide total parental care to their children. In addition to that the women explained that their children would be taken care of by other people when they are few in number. Other women further explained that they would be able to take care of their children when they were divorced. This indicates that ability of the women to

provide total parental care was a determining factor in planning for the number of children the women wanted to have.

6.4.2: Prevention of HIV AND AIDS

Ten percent (n=1) indicated that they will prevent HIV and AIDS pandemic if they were limiting family size. This was because the women associated persistent childbearing with contraction of HIV/AIDS hence the women would be motivated to limit family size. This is a wrong perception since childbearing is being considered as the mode of transmission of the pandemic but rather the women may not be using condoms when having sex with their spouses. This wrong perception could also cause the women not to enjoy sex life in their marriages with their spouses which can make them feel psychologically abused by their spouse. The fear of HIV and AIDS pandemic as a way of limiting family size can not be regarded as a reliable way of limiting family size. This is because there is no direct positive impact on limiting family size.

6.4.3: Good maternal and child health

Ten percent (n=1) further indicated good maternal and child health as the benefit of limiting family size. This is because when the mother bears a small number of children, the risk of being exposed to complications associated with persistent childbearing is minimized. In addition the child can be supported by the parent with all the basic needs it requires.

6.5: CULTURAL BELIEFS OF WOMEN ON LIMITING FAMILY SIZE

The findings indicated that 30% (n=3) believed in tying a rope around the waist in order to prevent conception for a period of 5years. However the participants also revealed that they untie the rope if they wanted to bear more children. The women emphasized that the method was effective unless the rope was untied. This is an improper method of family planning and has no scientific basis such that it does not have a direct positive impact on limiting family size. Therefore although this was the women's culture, it could contribute to an increase in birth rate hence predisposing the women to complications associated with childbearing. This concurs with Unger (2010) whose study was based on educational differences in desired family size and attitudes towards childbearing in Latino women. The results indicated that the desire for large families may result from traditional cultural attitudes.

The results further indicate that 20% (n=2) of the women took traditional medicine for them to prevent conception. Although the beliefs can be effective in preventing conception, the women can be predisposed to infections such as pelvic inflammatory disease e. t. c. In addition 20% (n=2) of the women also explained that they did not allow their husbands to drink beer to avoid conception. This was because they thought that if their husbands were sober they would not have sex with them hence preventing conception. However 30% (n=3) did not have any cultural beliefs related to limiting family size. This would either mean that the women do not believe and do not practice on the cultures or they did not have cultural beliefs related to limiting family size.

6.6: MOTIVATING FACTORS TO LIMIT FAMILY SIZE

Thirty percent (n=3) of women indicated that they did not have any motivators related to limiting family size. However a variety of reasons were indicated by 70% (n=7) of women who indicated that they had motivators related to limiting family size. The reasons indicated are discussed in the following themes:

6.6.1: Inability to provide total parental care due to low economic status of the mothers

This was indicated by 40% (n=4) of women. The women explained that they may not be able to fend for the children since things were expensive. This was because most women further explained that they were not employed but they were doing a small scale business to generate income. This concurs with Save (2004) whose results indicated that economic constraints appeared to be a leading influencing factor for limiting the number of children.

6.6.2: HIV and AIDS pandemic

Twenty percent (n=2) of the women indicated HIV/AIDS pandemic as a motivating factor to limit family size. This could contribute to an increase in the number of orphans. In addition to that it could also lead to incomplete parental care due to poor health status of the mothers of which they may not be able to fend for their children. The pandemic can also cause economic constraints in the affected family such as demand for transportation, even provision of balanced diet to the infected individual. In addition to that it can also cause poor academic performance of children since they are psychologically affected especially if their parents are infected with the pandemic. In contrast Taalo (2008) found that the overall pregnancy rate among HIV infected and HIV uninfected was 14.9% per 100 person. The results further indicated that there was no difference in terms of childbearing among the 102 uninfected women and the 100 infected women. However HIV infected women were more likely to wanting no more children. Therefore it was concluded that HIV infection was the significant predictor of fertility intentions.

However Mbaye (2007) found out that most women on Antiretroviral Treatment (ART) desired more children especially during the first 2 years of starting ART.

The HIV and AIDS pandemic is being viewed as a factor that is being considered when women plan on the number of children. In addition whether the women are infected with the pandemic or not it has an impact on the decisions made in terms of the number of children or even their ability to fend for the children due to the health status.

6.6.3: Lack of financial support

The results also indicated that 10% (n=1) of women had other reasons of limiting family size such as lack of financial support from their husbands during gestation period. The women can engage themselves in risky behaviours such as prostitution in order to generate income for supporting their children. The women can also be motivated to steal from their husbands which can lead to conflicts in the family hence divorce. In addition the women can get financial support from extramarital affairs or their relatives in order to care for the children. This concurs with Bankole (1998) whose study revealed that lack of support from the father was the reason the women gave for having an induced abortion.

6.6.4: Health status of women

The findings further indicated that only 20% (n=2) of women had problems that motivated them to plan on limiting family size. According to the women, their health status was the limiting factor for family size. In support of this the women explained that they were epileptic so their children may be predisposed to injury when having sudden fits. Therefore this would motivate the women to plan on limiting family size. The women further explained that they were being abused by their husbands hence they planned on limiting family size. The women may not have financial support from their husbands to provide total parental care to their children. In addition to that it can predispose the women to divorce hence they planned on limiting family size because they knew that they would be unable to fend for their children.

6.7 CONCLUSION OF THE STUDY

In conclusion the results indicated that 90% (n=9) of women had a positive attitude towards limiting family size. The women were able to explain the benefits of limiting family size. This showed that the women would be able to limit family size willingly. In addition the results indicated that the women could not make a decision on their own concerning limiting family size. The women also indicated the influence of economic status as well as knowledge on family planning methods on limiting family size. The women further explained that low economic status would have a positive impact on limiting family size.

Seventy percent (n=7) of the women were using the traditional family planning methods to limit family size. This would predispose the women to having unwanted pregnancy which would motivate them to have an abortion. This would further predispose the women to life threatening conditions or even death since people use different harmful methods in aborting the unwanted pregnancy. This could cause heavy bleeding (haemorrhage). The main challenge that was noted was that the women could not make decisions on their own hence they would be motivated to continue bearing many children.

6.8: LIMITATION OF THE STUDY

- The study had a small sample size hence the findings would not be generalized.
- Less time had been allocated for the research since the study was done concurrently with other academic issues.
- Lastly the study was not funded hence it was conducted at a small scale.

6.9: RECOMMENDATIONS

6.9.1: Nursing practitioner

- Nurses should apply transcultural nursing theory which states that culture congruent care must be based on transcultural knowledge discovered by examining social structure, cultural values, environment and language. Therefore the nurses should provide adequate information to people using traditional methods on family planning methods to avoid misconceptions. This can be done through health talks.
- Nurses need to sensitize the couples and significant others on the negative effects of using traditional methods of family planning e. g unwanted pregnancies e. t. c.
- Nurses should teach the couples and significant others on the complications related to persistent childbearing.
- Nurses need to be attending to women who have brought their husbands first before helping the others. This will motivate other women to bring their husbands to the family planning clinics. This will help the couples to be able to reach at an agreement on the number of children to have since they will all have the knowledge hence reducing conflicts.
- The information about family planning needs to be explained to women in simple terms for the client to be able to understand.

- The nurses also need to counsel the women that are using traditional family planning methods as well as significant others on the consequences of using the methods for them to be motivated to use the family planning methods.

6.9. 2: Nursing managers

- The nurse managers need to advocate for their fellow nurses to go for training of family planning methods to enhance total provision of family planning services.
- The managers also need to identify the needs of people for them to ensure that the family planning services are meeting the needs of the people
- The nurse managers should influence their fellow nurses to provide health talks in the wards or at the family planning clinics. The health talks can be provided on the complications related to persistent childbearing in order to equip the women with the required knowledge.
- The nurse managers should advocate for the information about family planning to be included in the media such as radio, news papers e. t. c.
- The nurse managers should also develop family planning policies to guide the nurses on the provision of family planning services especially to meet the women's reproductive health needs.

6. 9.3: Nursing educators

- The nurses should teach students about the family planning services and how best they need to be provided. This will enable the women to have adequate information on family planning. It will also help the women to be empowered hence enabling them to start limiting family size since the women are knowledgeable on the benefits of limiting family size. In addition to that the results also indicated that the women had a positive attitude towards limiting family size therefore they can easily plan on limiting family size.
- The nurse should influence their fellow nurses to provide health talks in the wards or at the family planning clinics. The health talks can be provided on the complications related to persistent childbearing to provide the women with the proper information

6.9.4: Nursing research

- Impact of utilization of traditional methods on the reproductive behaviour of women.
- Effect of religion on the willingness to limit family size.
- Availability and effect of traditional methods on family planning.

6.9.5: Policy makers

- The policy makers need to assess how the population and family planning policy is being implemented by health workers. This will enable them to guide the health personnel on the implementation of the policies during the provision of family planning services.
- Policies that incorporate the impact of culture on decision making of women in terms of limiting family size. This is because Malawian culture favours men as the decisions makers in the family hence the policy might enable the women to be involved in decision making.

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APPENDICES

APPENDIX A: TIME TABLE

Activity	JAN- MAR	APR- JUN	JUL- AUG	SEP	OCT	NOV
Topic presentation						
Proposal writing and Submission						
Pretesting and Data Collection						
Data Analysis						
Report Writing						
Submission of Dissertation						
Dissemination of results						

APPENDIX B: BUDGET FOR RESEARCH

STATIONARY

ITEM	QUANTITY	COST (MK)	TOTAL COST (MK)
Plain paper (A4) reams	4	K 900.00	K3600.00
Pencils	5	K 20.00	K 100.00
Pens	5	K 25.00	K 125.00
Flat files	2	K 300.00	K 600.00
Small envelopes	5	K 15.00	K 75.00
Postage stamps	5	K 75.00	K 375.00
Small hard cover	1	K 250.00	K 250.00
Sub total			K5125.00

PRINTING AND BINDING

ITEM	QUANTITY	COST(MK)	TOTAL(MK)
Printing proposal	40 pages/3 copies	K 10.00	K1200.00
Binding proposal	3 copies	150/copy	K 450.00
Printing interview	20(10 pages each)	K 10	K2000.00
Printing dissertation	60 pages/3 copies	K10.00	K1800.00
Binding dissertation	3 copies	K 150.00	K 450.00
Sub total			K 5900.00

TRANSPORT AND ACCOMMODATION

DESTINATION	No OF TRIPS	COST (MK)	TOTAL (MK)
Food and accommodation		K4000.00	K8000.00
Lilongwe for data collection	2	K2000.00	K4000.00
Blantyre pilot study	2	K 2000.00	K4000.00
Sub total			K16000.00
Contingency			K3000.00
Grand total			K30,025.00

JUSTIFICATION OF THE BUDGET

STATIONERY

The papers were used in writing drafts and final copies of the research proposal and dissertations. The papers were also used for writing clearance, application letters and printing letters going to various institutions. The files were used for keeping interview guides for the researcher.

Pens, pencils, and rubbers were used when writing drafts and for recording participants' responses. Envelopes and stamps were used when seeking permission to various organizations and institution.

SECRETARIAL SERVICES

The money was required for secretarial services like printing and binding of the proposal as well and dissertation, letters and interviewers' guide.

TRANSPORT

The money was used for travelling to Lilongwe and Blantyre for data collection. There was also a need for the researcher to travel to Lilongwe to meet the supervisor who was based in Lilongwe.

Contingencies were used whenever there was an urgent need for the phone calls, Internet and emergency travelling so as to avoid inconveniences. They were also be used when inflation has hit the market and prices of items are high.

APPENDIX C: AN INTERVIEW GUIDE

ID CODE.....

Date of interview.....

Place of interview.....

Title: Factors that influence women of childbearing age to stop childbearing at KCH

SECTION A: DEMOGRAPHIC DATA

1. How old are you?

a) 15-24 ☐

b) 25-34 ☐

c) 35-44 ☐

d) 45-49 ☐

2. What is your religion?

a) CCAP ☐

b) Catholic ☐

c) SDA ☐

d) Islam ☐

e) Other ☐

3. Have you been to school?

a) Yes ☐

b) No ☐

4. If yes what is your highest level of education

a) Primary level ☐

b) Secondary level ☐

c) Tertiary level ☐

5. What is your marital status?

a) Single ☐

b) Married ☐

c) Widower ☐

d) Divorced ☐

e) Cohabiting ☐

6. To which tribe do you belong to?

.....
7. Do you have children?

a) Yes ☐

b) No ☐

8. If yes how many?

a) Girls ☐

b) Boys ☐

9. How many are alive or dead?

a) Dead ☐

b) Alive ☐

SECTION B: PERCEPTION OF WOMEN ON LIMITING FAMILY SIZE

10. What are your feelings on limiting family size?

.....

.....

11. What is your desired family size?

.....

.....

12. Do you think it is necessary to limit family size?

a) Yes

b) No

13. If no explain why?

.....

.....

14. What do you think other people say about limiting family size?

.....

.....

SECTION C: PERCEIVED BENEFITS OF WOMEN ON LIMITING FAMILY SIZE

15. Do you feel there are benefits of limiting family size?

a) Yes

b) No

16. If yes what are they?

.....

.....

SECTION D: BELIEFS WOMEN HAVE ON LIMITING FAMILY SIZE

17. What are the beliefs in your culture that are related to limiting family size?

.....

SECTION E: PROBLEMS ENCOUNTERED BEFORE LIMITING FAMILY SIZE

18. Do you have any plans on limiting your family size?

.....
.....

19. If yes what do you think has motivated you?

.....
.....

20. Are there any problems that led you to plan on limiting your family size?

a) Yes

b) No

21. If yes what are they?

.....
.....

SECTION F: ANYTHING TO ADD

-END-

THANK YOU VERY MUCH FOR YOUR PARTICIPATION IN THE STUDY

MAFUNSO A KAFUKUFUKU

NAMBALA YA WOTENGA MBALI:

TSIKU:

MALO:

**MUTU:KAFUKUFUKU WOFUNA KUDZIWA MFUNDO ZIMENE ZIMAPANGITSA AZIMAYI
WOBEREKA KUTI ASIYE KUBELEKA ANA PA CHIPATALA CHA KAMUZU CENTRAL**

GAWO A: MBILI YA MUNTHU

1. Muli ndi zaka zingati?
 - a) 15-24 []
 - b) 25-34 []
 - c) 35-44 []
 - d) 45-49 []
2. Ndinu a chipembedzo chanji?
 - a) CCAP []
 - b) Catholic []
 - c) SDA []
 - d) Islam []
 - e) Zina []
3. Kodi minaphunzilapo?
 - a) Eya []
 - b) Ayi []
4. Ngati eya munalekezela kalasi yanji?
 - a) Primary level []
 - b) Secondary level []
 - c) Tertiary level []
5. Kodi ?
 - a) Simuli pa banja? []
 - b) muli pa banja? []
 - c) banja linatha ? []
 - d) Ndinu mkazi wa masiye ? []
 - e) munangolowana? []
6. Kodi ndinu a mtundu ?

7. Kodi muli ndi ana?

a) Eya ☐

b) Ayi ☐

8. Ngati eya ndi angati?

a) Akazi ☐

b) Amuna ☐

9. Ndi ana angati ali?

a) Amoyo ☐

b) Anamwalira ☐

SECTION B: MAGANIZO ANU PA NKHANI YA NAMBALA YA ANA

10. Mumalingaliro anu pankhani ya nambala ya ana mumawonapo bwanji?

11. Mumafuna mutakhala ndi ana angati?

12. Kodi mukuganiza ndi bwino kukhala ndi ana ochepa?

a) Eya ☐

b) Ayi ☐

13. Ngati ayi fotokozani?

14. Kodi mukuganizapo kuti anthu ena amatipo chani pa nkhani yobereka ana ochepa?

SECTION C: ZOMWE MUMAGANIZA KUTI NDI UBWINO PA NKHANI YOCHEPETSANAMBALA YA ANA

15. Kodi mukuganiza kuti kukhala ndi ana ochepa kuli ndi ubwino?

a) Eya

b) Ayi

16. Ngati eya ubwino wake ndi wotani?

.....

.....

SECTION D: ZIKHULUPILIRO ZOMWE AZIMAYI AMAKHALA NAZO PA NKHANI YOCHEPETA KUBEREKA

17. Mu chikhalidwe chanu pali zikhulupiliro zANJI zimene zimakhudzana ndi kuchepeta nambala ya ana?

.....

.....

SECTION E: MAVUTO AMENE MUMAKUMANA NAWO MUSANAKHALE NDI MAGANIZO OSIYA KUBEREKA

18. Muli ndi maganizo ena ali wonse okhala ndi ana ochepa?

a) Eya ☐

b) Ayi ☐

19. Ngati eya chakupangitsani ndi chain?

.....

.....

20. Munali ndi mavuto ena ali wonse kuti mupange chiganizo chimenechi?

a) Eya ☐

b) Ayi ☐

21. Ngati eya ndi mavuto anji?

.....

.....

GAWO F: ZOWONJEZERA ZILIZONSE

ZIKOMO POTENGAPO MBALI MU KAFUKUFUKUYI

APPENDIX D: LETTERS

University of Malawi
Kamuzu Collage of Nursing
P/ Bag 1
Lilongwe

The Chairperson
KCN Research and Publication Committee
P/ Bag 1
Lilongwe

Dear Sir/ Madam,

APPROVAL TO CONDUCT A RESEARCH STUDY ON THE FACTORS THAT INFUENCE WOMEN OF CHILDBEARING AGE TO STOP CHILDBEARING

I am a 4th year generic student pursuing a Bachelor of Science Degree in Nursing at Kamuzu College of Nursing.

Therefore I write to apply to conduct a research on the above topic as a requirement for the fulfilment of this degree program.

The results of the study will provide information that health personnel can use to motivate women of childbearing age to stop childbearing. This can reduce complications associated with childbearing if the women bear more children consistently. The findings of the study will also provide input to policy makers for formulating and implementing population and family planning policy.

There are no serious risks attached to the study though some questions will cause embarrassment since the topic itself is sensitive. However, all ethical considerations will be strictly observed so as to prevent any violation of human rights.

The study will be done from July to August in the year of 2010.

Your favourable consideration will be greatly appreciated.

Yours faithfully,

Veronica Nkhata (Miss)
Student Researcher

Mrs C.G.Chitsulo
Researcher Supervisor

Kamuzu College of Nursing
Private Bag 1
Lilongwe

The Hospital Director
Queens Central Hospital
P.O Box 95
Blantyre

Dear Sir/Madam,

REQUEST TO CONDUCT A PILOT STUDY AT YOUR INSTITUTION

I write this letter to seek permission to conduct a pilot study on the factors that influence women of childbearing age to stop childbearing.

I am Veronica Nkhata a fourth year student pursuing a Bachelor of Science Degree in Nursing. In partial fulfilment of my degree program, I am required to conduct a research project.

The findings of the study will provide information that health personnel can use to motivate women of childbearing age to stop childbearing. This can reduce complications associated with childbearing if the women bear more children consistently. The findings of the study will also provide input to policy makers for formulating and implementing population and family planning policy.

A sample of 3 women will be taken for interview. This will be done to modify the questionnaire in order to come up with uniform results.

Your consideration will be greatly appreciated.

Yours faithfully,

Veronica Nkhata (Miss)

Student Researcher

University of Malawi
Kamuzu College of Nursing
P/ Bag 1
Lilongwe

The Hospital Director
Kamuzu Central Hospital
Post Office Box 149
Lilongwe

Dear Sir / Madam,

**REQUEST TO CONDUCT RESEARCH AT KAMUZU CENTRAL HOSPITAL ON THE
FACTORS THAT INFLUENCE WOMEN OF CHILDBEARING AGE TO STOP
CHILDBEARING**

My name is Veronica Nkhata, a 4th year generic student, pursuing a Bachelor of Science Degree in Nursing at Kamuzu College of Nursing and as a requirement in partial fulfilment of this degree programme, i am conducting a study on the above topic.

I would like to conduct this study from October to November 2010 at your hospital. Data will be collected from women at the family planning clinic.

There are no serious risks attached to this study though some of the question are sensitive and so will cause embarrassment. However all ethical considerations will be strictly observed in order to prevent any violation of human rights.

I therefore, ask permission from you to conduct this study at your place and I will be very grateful if my application will be considered.

I am looking forward to hear from you.

Yours faithfully,
Veronica Nkhata
Student Researcher

Mrs. C.G. Chitsulo
Research Supervisor

APPENDIX E: CONSENT FORM

CONSENT TO PARTICIPATE IN A STUDY ON THE FACTORS THAT INFLUENCE WOMEN OF CHILDBEARING AGE TO STOP CHILDBEARING AT KAMUZU CENTRAL HOSPITAL

My name is Veronica Nkhata, a 4th year generic student, pursuing a Bachelor of Science Degree in Nursing at Kamuzu College of Nursing and as a requirement in partial fulfilment of this degree programme i am conducting a study on the above topic.

The purpose of the study is to find out the factors that influence women of childbearing age to stop childbearing. The findings of the study will provide information that health personnel can use to motivate women of childbearing age to stop childbearing. This can reduce complications associated with childbearing if the women bear more children consistently. The findings of the study will also provide input to policy makers for formulating and implementing population and family planning policy.

You are being requested to participate in the study in which you will be required to answer questions while the researcher shall be recording and you are chosen because you are within the age group of childbearing age (15-49).

There is no direct benefit that you will obtain to your participation in the study. There are no serious risks involved in the study but rather embarrassment may be expected since the questions that are going to be asked might be sensitive, however you are encouraged to be free.

Participation is voluntary and you are free to withdraw at any time without being penalized. All information provided will be kept in confidence except to the researcher and her supervisor. Privacy will be maintained throughout the study by ensuring that the discussed issues are not shared to any and interviews will be conducted in a private room where only participant and the interviewer will be available.

In addition to this, the study publication will not bear any participant's name instead numbers or codes will be used to ensure anonymity. To maintain confidentiality, interview guides will be kept in files so that no one has access to the information other than the people involved.

Findings will be sent to the related institutions namely Kamuzu College of Nursing and Kamuzu Central Hospital and the information will only be available to those who upon accepting the agreement made will seek for the information to benefit others.

You are therefore requested to make an informed choice without coercion or being forced to participate in the study.

Your participation will be greatly appreciated.

Researcher

Signature.....Date.....

I, the undersigned, have read the above information, understood it fully and wish to give consent to participate in the study.

Signature.....Date.....

**CHILOLEZO CHOTENGAPO MBALI MU KAFUKUFUKU WOFUNA KUDZIWA MFUNDO
ZIMENE ZIMAPANGITSA AZIMAYI WOBEREKA KUTI ASIYE KUBELEKA ANA PA
CHIPATALA CHA KAMUZU CENTRAL**

Dzina langa ndine Veronica Nkhata, wophunzira wa pasukulu ya ukachenjede ya unamwino yotchedwa Kamuzu College of Nursing ndipo ndili kalasi yomaliza. Ndikofunika kuti ndichite kafukufuku ngati gawo limodzi lokwanilitsa maphunziro anga ndipo mutu uli pamwambawu ndiwo mutu wakafukufuku wangayu.

Cholinga cha kafukufukuyi ndi kudziwa mfundo zimene zimapangitsa azimayi wobereka kuti asiye kubereka ana pa chipatala chachikulu cha Kamuzu Central. Zotsatira za kafukufuku, zithandiza adotolo kuti agwiritse ntchito mfundozi pokopa azimayi anzathu kuti asiye kubereka ana zimenezi zichepetsa mavuto amene amabwera kamba kobereka ana mwakathithi. Komanso zithandiza akatswili opanga malamulo azakulera ndi chiwerengelo cha anthu

Ndi pempho langa kwa inu kuti mutengepo gawo mukafukufukuyu m'mene mutayenekere kuyankhapo mafunso pamene ndidzakhala ndikutepa zokambirana zathu.

Palibe phindu limene inu mudzapate mu kafukufukuyi. Palibenso chiophyezo china chilichonse chachikulu komabe mutha kudzachita manyazi popeza mafunso ena ndiwochititsa timanyazi. Koma mukupemphedwa kuti mudzakhale omasuka.

Zonse muzokambirana zathu sizizaululidwa kwa wina aliyense kupatula ine mwini ndi wondiyanganira. Mafunso onse otsogolera ofunsayu ndi tepi yotepera zokambirazi zizasungidwa moyenera ndi kudzawotchedwa zikadzatha kugwiritsidwa ntchito kuti wina wapadera asadzadziwe china chilichonse. Sikudzakhala kololedwa kuti mutchule dzina lanu ndipo mapepala wogwiritsa ntchitowa adzalembedwa manambala panwamba pake ndi cholinga choti musadziwike kuti mwatengapo mbali mu kafukufukuyi ngakhale kwa ine wochita kafukufukuyi.

Zonse zokambirana zathu zizachitikira mmalo woyenera komwe kudzizapezeka ine wofunsa ndi munthu mmodzi wotengapo mbali mu kafukufukuyi. Kutengapo gawo mukafukufukuyi zitengera kufuna kwanu ndipo muli woloredwa kusiya kutengapo mbali pa nthawi iliyonse wosachitidwa kalikonse.

Zotsatira zizatumizidwa ku malo oyenera a Kamuzu College of Nursing ndi Kamuzu Central Hospital.

Mukupemphedwa tsono kuti mundipatse chilolezo chanu kuti mutengapo mbali mu kafukufukuyi. Kutengapo mbali kwanu chidzakhala chothokozedwa koposa.

MWINI KAFUKUFUKUYI

SIGNATURE.....DATE.....

Ine ndasayina pansipa, ndawelenga kalatayi, ndamvetsetsa, ndipo ndapanga chisankho chovomeraza pempho lanu kuti nditengapo mbali mu kafukufukuyi.

SIGNATURE.....DATE.....



University of Malawi
KAMUZU COLLEGE OF NURSING

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

TITLE:

**Factors that influence women of child bearing age to
stop childbearing at Kamuzu Central Hospital,
Lilongwe**

INVESTIGATOR:

VERONICA NKHATA

DEPARTMENT/YEAR OF STUDY:

Year

REVIEW DATE: *08* SEPTEMBER 2010

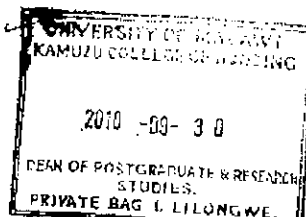
DECISION OF THE COMMITTEE:

SIGNATURE:

[Signature]
CHAIRPERSON, RESEARCH AND PUBLICATIONS COMMITTEE

DATE:

30/09/10



cc Supervisor:

DECLARATION OF INVESTIGATOR(S)

I/we fully understand the conditions under which I am/we are authorized to carry out the above mentioned research and I/we guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/we will resubmit the proposal to the committee.

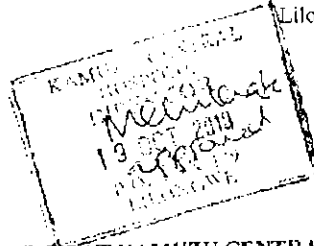
DATE: *30/9/10*

SIGNATURE(S):

[Signature]

University of Malawi
Kamuzu College of Nursing
P/ Bag 1
Lilongwe

The Hospital Director
Kamuzu Central Hospital
Post Office Box 149
Lilongwe
Dear Sir / Madam,



**REQUEST TO CONDUCT RESEARCH AT KAMUZU CENTRAL HOSPITAL ON THE
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Veronica Nkhata
Student Researcher

Mrs. C.G. Chitsulo
Research Supervisor

0888490 945

Kamuzu College of Nursing
Private Bag 1
Lilongwe

The Hospital Director
Queens Central Hospital
P.O Box 95
Blantyre

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Your consideration will be greatly appreciated.

Yours faithfully,

Veronica Nkhata (Miss)
Student Researcher

cel # 0995 490 945

Approved *Graded*
Handwritten signature