Attitudes Toward Tubal Ligation among Acceptors, Potential Candidates, and Husbands in Zaire

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Attitudes toward Tubal Ligation among Acceptors, Potential Candidates, and Husbands in Zaire

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Twenty-nine focus groups were conducted among men and women in five regions of Zaire to identify motivations for and obstacles to voluntary surgical contraception (VSC) for women. Both male and female participants believe that VSC is justified only for medical reasons related to difficulties with pregnancy or childbirth, and not for economic hardship. Women feel great pressure, especially from the husband's family, to produce many children, and fear they might be abandoned after being sterilized, even if their husband had previously consented to VSC. Men also perceive the major consequence of VSC to be marital conflict and dissolution. However, women who had had the procedure—primarily for medical reasons—expressed high levels of satisfaction with the operation. At the same time, they stress the need for confidentiality, suggesting that VSC remains controversial. Also examined are reasons for introducing VSC programs in a country such as Zaire. (STUDIES IN FAMILY PLANNING 1989; 20, 5: 273–280)

Voluntary surgical contraception (VSC) accounts for one-third of all contraceptive practice and has been accepted by over 90 million couples of reproductive age around the world (Philliber and Philliber, 1985). In a number of developing countries, VSC is the most widely used of all contraceptive methods (London et al., 1985). The majority of VSC acceptors are women, although there are a number of successful vasectomy programs in Asia and, more recently, in Latin America.

One exception to these generalizations is sub-Saharan Africa. VSC programs have been established in at least 18 sub-Saharan countries to date, but most are pilot efforts and/or still in their infancy. In part, this can be seen simply as a reflection of the lower levels of family planning effort in Africa as compared to other regions of the developing world. However, there is evidence to suggest that the cultural implications of fertility regulation are markedly different in Africa.

One such pilot effort was begun in Zaire in 1986 by the Association for Voluntary Surgical Contraception (AVSC) in collaboration with the Projet des Services des Naissances Desirables (PSND). The objective of the project was to set up six VSC model sites, three in urban areas (Kinshasa, Lubumbashi, and Bukavu) and three in rural health zones (Kimpese in the Bas Zaire region, Kaziba in the Sud Kivu region, and Nyankunde in the Haut Zaire region). In connection with this service delivery effort, the current research was conducted in an effort to better understand the motivations for and barriers to VSC for women in Zaire.

The findings are based on a total of 29 focus groups carried out in five of the eleven regions of Zaire among both men and women. This information is being used in training sessions for VSC counselors to better acquaint them with the realities of VSC in this society. At the same time these findings provide insights into attitudes and values underlying the decision for VSC, which may be applicable in other African countries, as well.

Although hundreds of studies have been conducted on social and psychological correlates of VSC from numerous countries around the world, almost no research has been done on VSC in sub-Saharan Africa. This is particularly evident in the VSC review article by Philliber and Philliber (1985); with one small exception, no data are available from any African country in the numerous summary tables presented. As such, this study constitutes one of the first attempts to look at VSC from the African perspective.
Methodology

Focus groups are a qualitative methodology that allows the researcher to obtain in-depth information on attitudes, beliefs, perceptions, and values of a given population with regard to a specific subject. While they cannot be said to be representative of the larger population, they are, nonetheless, often considered superior to quantitative sample surveys in obtaining attitudinal data, especially on sensitive topics (Bellenger et al., 1976; Kumar, 1986).

The study was designed to obtain data from three categories of people at each of the six sites included in the project. These categories included:

— Acceptors: women who had undergone tubal ligation (TL) within the three-year period prior to the focus groups; excluded from this group were women who had had cesarean sections, since there may not have been any choice involved in their decision.

— Potential candidates: women who had at least five children and had been using a reversible method for at least one year. The women in this category are labelled “potential candidates,” not because of a declaration on their part but rather on an assumption by the researchers that future acceptors of VSC might conform to this profile.

— Husbands: men married to a woman who had at least five children and who had been using a reversible method for at least one year. These were not the husbands of the women above but rather of other active users. This was done in an attempt to obtain as many independent viewpoints as possible.

For each of the six sites, five focus groups were to be conducted, for a total of 30 groups. The five groups per site included one for acceptors, two for potential candidates, and two for husbands. (No groups were conducted among nonusers, who were judged unlikely candidates for tubal ligation.) However, there were difficulties in conducting one of the husband groups in Kinshasa; thus, the results are based on 29 groups.

The methodology and discussion guide were developed by the authors in the capital city of Kinshasa; the first author was then responsible for overseeing the data collection in all six sites. Because the focus groups were to be conducted in the local language of the site (for a total of four languages in six sites), a single set of moderators could not be used throughout. Rather, the study coordinator (first author) travelled to each site, identified an appropriate individual to be trained as a moderator, conducted this training (including practice sessions), and proceeded to organize the actual groups.

The selection of participants in the discussions was done by randomly selecting from the registers of the local hospital and/or health center names of TL clients and of active users who fulfilled the criteria for selection. The latter served as the basis for identifying participants for both the active user and husband groups.

The groups, each consisting of eight to twelve persons, were conducted by a moderator of the same sex. Although the moderators followed a pre-established discussion guide, they tried to maintain spontaneous, free-flowing discussions of the subject. The sessions, which generally lasted 90–120 minutes, were taped, transcribed into the local language, and then translated into French. The French transcripts served as the basis for this report.

In the description that follows, the term “tubal ligation” is used throughout; in fact, “tubal occlusion” would be more accurate since VSC procedures have been performed in Zaire using both cauterization and clips. However, the VSC procedure for women is known locally as ligature des trompes, and thus we have adopted this term.

Results

The results from the focus groups are presented in two parts: (1) for TL acceptors, and (2) for active users and husbands. In the case of the latter, both the questions asked and the responses obtained were similar for the two types of groups.

Acceptors: Women Who had Undergone Tubal Ligation

In Zaire the prime reason for undergoing tubal ligation is not child limitation, but health. At least half of the acceptors had either experienced complications with previous pregnancies and/or were advised to avoid another pregnancy for health reasons, often because of high parity. In a much smaller number of cases, the women selected this method to avoid further childbearing at the point they became grandmothers; to have children at the same time as their own children were doing so would be “shameful.”

Economic hardship was not seen as sufficient grounds for having a tubal ligation. Even the women who underwent sterilization and were satisfied with their operation felt it should be done for medical/health reasons only. As one woman said, “If I knew someone
who was sick all during her pregnancies or had problems delivering, I would recommend that she have the operation, since she risks dying and leaving her children behind... But if she tells me that her husband is unemployed, that they don't have a house, that they are incapable of taking care of their children, then I could not recommend it."

Nonetheless, a few women admitted that they had been motivated by economic factors. "My husband died and he left me with the children. I saw that it wasn't worth it to keep having children when there is no one to help me raise them."

Sources of Information and Period of Deliberation

Most of the women had learned about the operation from health personnel at the local hospital, who talked about this option either during prenatal sessions or at the time of delivery (in cases of high parity or obstetrical complications). A smaller number of women had learned about the operation from friends, missionaries, or family planning educators.

In general, these women had known about the operation for a considerable period of time (often several years) before having it done, except where the woman accepted the operation at the time of delivery for compelling medical reasons. The response of one woman was not atypical: "I first heard of this method when I had nine children. At that time the doctor proposed that I have the operation, but I refused. It was only after my eleventh that I accepted."

Fear of the operation (for example, of dying and leaving behind one's children) often caused women to postpone the decision. Others needed time to convince their husbands to consent.

Individuals Influential in the Decision

Who made the decision? In at least half the cases the doctor recommended and the couple accepted this method for medical reasons. Less frequently, the husband suggested it because he felt they had enough children. In a handful of cases it was the woman's children who persuaded her to have the operation, because they were already beginning to have their own children.

There was total consensus among the women who had undergone this procedure that it should be a confidential matter, suggesting that tubal ligation is still very controversial in Zaire. "The neighbors don't have anything to say about it, they can't interfere in the problems of another family. Even the [extended] family members don't have any say in the matter if you and your husband are in agreement from the start."

Those who had undergone the operation for health reasons felt that this decision was acceptable to their families. By contrast, women who had had the operation for other reasons (too many children, financial hardship) felt they were open to criticism by others; they could be accused of having bad intentions (prostitution, wanting to steal others' husbands) or lack of intelligence (letting their husbands trick them into this).

Consequences of Tubal Ligation

The majority of respondents reported their health to be the same or improved following the operation, in part because they were free of pregnancy-related health problems. However, there were widespread complaints of back pain, abdominal pain, and menstrual irregularities (especially heavy bleeding or periods "twice a month"). A few women attributed all subsequent ills to the operation.

Of the women participating in the sessions, none had become pregnant since the operation; however, there was general concern that the rumor might be true that the tubes can reopen after a certain time. A few women feared that the reason they had been invited to the session was to be told they were no longer protected or that the operation was to be reversed.

It was unclear from the groups what the effect of the operation had been on marital relations. Most claimed that there was no change, while a few mentioned a change for the better now that fear of pregnancy was removed. However, the participants offered very little elaboration on this point (in contrast to most other topics).

A potential problem with tubal ligation in Zaire is that the husband may give his consent to the operation (especially if it is for medical reasons); however, afterwards, he often wants to have more children, and looks for another wife to produce them. Of the women who participated in the sessions, only one mentioned this experience: "In my case all our neighborhood made fun of me when they learned I'd had a tubal ligation, more so because my husband took another woman to give him children, even though he'd agreed to my operation because of the difficulties I had in giving birth. Some time after the operation he took another woman without warning me or even telling me. I have even heard my friends say that it's good, that I was too proud. Now my co-wife has become their friend. But I say let them mock me. My five children are enough for me."
Satisfaction with the Operation

Almost all of the sterilized women had no regrets over the operation. This was especially true among those with seven or more children. However, those who considered they had too few children and had accepted the operation for medical reasons expressed some remorse, even though they recognized that the operation may have saved their lives.

In spite of widespread satisfaction with the operation, most of these same women reported that they would be afraid to recommend it to others, for fear of becoming a source of conflict in that household. Also, such a recommendation could be construed as jealousy on the part of the sterilized woman: “If you recommend the operation to others, they’ll say that because you have already killed the children in your womb, you want them to do the same.” Because of these attitudes, there was a general consensus that others should learn about this method directly from health personnel.

Active Users of Reversible Methods and Husbands of Users

The majority of men and women participating in these groups were strongly convinced of the benefits of family planning. Some used reversible methods because they intended to have other children, while others expressed interest in ceasing childbirth. A number of women were taking DepoProvera in the hope that this would eventually result in sterility.

As was the case among the groups of sterilized women, the active users and the husbands felt that the one, unquestioned justification for tubal ligation was for medical reasons. Women who had difficulties with pregnancy or deliveries should, they said, resort to this method rather than risk severe health consequences or death. There was also agreement that one should avoid having children at the same time as one’s own children.

Among the active users, at least some women felt that tubal ligation was justified if one had too many children and insufficient means to care for them, although this was a minority viewpoint. Men, on the other hand, strongly objected to tubal ligation for economic reasons. As one man stated, “The high cost of living can in no way cause a couple to limit their births. Whoever would yield to this program of tubal ligation is incapable of taking responsibility, because our parents who had less resources than we do managed to raise us relatively well.”

A few women who had five or six children expressed an interest in tubal ligation. However, it was more often the case that tubal ligation was considered acceptable once a woman had more than five or six children; the numbers mentioned were eight, nine, and eleven to thirteen.

Obstacles to Tubal Ligation

Even among those who did not want any more children, many expressed the desire to continue using reversible methods rather than undergoing tubal ligation. The reasons they gave included the following:

— Fear of being abandoned by the husband afterwards. This argument came up in the majority of women’s groups. One woman recounted an experience within her family: “One of my brothers, who saw that his wife was sickly and that they already had six children, agreed to her having a tubal ligation. But the wife refused, because she was afraid he would take another wife and then not take care of her. Despite this, the husband obliged the wife to accept his point of view…. Once his wife was sterilized, he proceeded with his plan to marry someone else.”

— Pressure from the husband’s family for continued childbearing. This reason was also cited frequently. As one woman explained, “The members of the husband’s family will come to complain that you aren’t having any children and to influence him toward a divorce. They are going to keep bothering him until he gives in. They will obliged him to take a second wife, even though the two of you were in agreement about the operation before it was done.”

— Desire for more children. The pronatalist views of this society were reflected in such comments as “One can never have enough children. One simply rests between births.” One man explained that in the eyes of the extended family, “It is the number of children that determines if the marriage has succeeded or failed.”

— Fear of infant mortality. The desire for a large family is reinforced by the fear of infant and child mortality. “Tubal ligation is not yet possible for us, because… you can have four children and death comes to take them all away from you. We aren’t like the whites in Europe that can be assured [of having their children live].

— Fear of dying from the operation. A number of women voiced their fear of surgery. “Many women would like to undergo the operation, but they are afraid of dying simply because
they don’t want any more children. Because of this, they prefer to take Depo.”

— Fear of becoming sexually unappealing. This argument was less frequently cited than those above. However, there were those who believed that “women who have a tubal ligation undergo certain changes in their body and they no longer attract men.”

Perceived Consequences of and Reactions to Tubal Ligation

The participants who knew someone who had undergone tubal ligation were favorable about the general state of her health after the operation. Some stated this in very general terms; others referred to the fact that she had gained weight (seen as positive).

However, there was frequent mention—especially among women—of three particular side effects that women who undergo tubal ligation are likely to have: back pain, abdominal pain (especially around the time of menstruation), and heavy menstrual flow. In fact, these parallel closely the complaints of the women who had undergone tubal ligation, although there is no known medical basis for these complaints.

The other perceived consequence was marital conflict. The woman’s role within the marriage is to produce children, and a deliberate cessation of this could result in a loss of the husband’s affection and/or dissolution of the marriage. One man explained, “It is very difficult for a sterilized woman to be respected as a wife, since she can’t have children anymore; she becomes jealous and suspicious of her husband.”

It was generally believed that the families of the couple involved would not agree to a tubal ligation except for medical reasons. Usually, it was the husband’s family that was seen as most resistant. One woman said, “It’s the husband who must decide…but he may be influenced by the members of his family. If the woman undergoes tubal ligation without informing her in-laws, even if the husband is in agreement, that could create a lot of problems within the family.”

One male participant explained, “Both families aspire to numerous progeniture. If we decided on tubal ligation, my wife’s family could interpret that I didn’t love my wife and was looking for a way to have children outside of marriage…. My own family would be tempted to believe that I am dominated by my wife and that she is the one who commands in the household.”

Another man explained that if his wife had medical problems related to childbirth, his family would approve without hesitation the idea of ceasing childbearing. But he added, “It is possible that after this approval, they would force me to take a second wife.”

The role of the extended family with regard to childbearing may be explained by the fact that in five of the six sites in which the groups were conducted, a patriarchal system of lineage is in effect. All children belong to the husband, not to the couple jointly, and by extension to the husband’s family or clan. At the time of marriage, the husband’s family pays a dowry to the family of his bride, which compensates for the expenses related to her upbringing and for the loss of her services to her own family. In return, they expect her to contribute to the husband’s family, both in terms of the labor she performs and the children she bears. To voluntarily cease childbearing without good reason is seen as the wife’s failure to comply with her end of the agreement.

In relatively few cases did the women feel that the family did not have to be informed about sterilization. “It’s the husband who must give his consent; the others don’t have anything to say in the matter.”

Misconceptions regarding Tubal Ligation

There were two main misconceptions regarding tubal ligation that surfaced in a number of the groups of potential candidates (not to be confused with women who actually underwent the operation). First, there were some women who were not sure if it is a permanent or temporary method. In part this seemed to stem from a surprising number of “cases” (described by the participants) in which the operation had failed. It is unclear if in fact there have been a considerable number of failed operations (possibly due to an inappropriate operating technique in earlier days of the program), or if this is simply a rumor that is used to discredit the operation.

The second misconception involves the operating procedure and what exactly is done to the woman. The commonly used term for sterilization in the different regions (and in different languages) is “reversing the uterus,” which may lead many to imagine that the uterus is somehow manipulated or repositioned. In a few cases the women seemed to confuse tubal ligation with hysterectomy. Since many of these participants may not have a clear idea of female reproductive anatomy, these misconceptions are not surprising.

Reaction to a Wife’s Request to Undergo Tubal Ligation

One additional question, asked only in the sessions with men, was: “What would be your reaction if your wife wanted to have a tubal ligation?” This question produced more heated responses than any other in the sessions.
The answers reflected two different, though not unrelated, attitudes. First, the fact that the wife would want a tubal ligation was seen as highly suspicious in almost all the groups. "Such a request on the part of a wife is very suspect. If the husband sees that there is no problem with childbirth, he can't accept it. One must then believe that the woman has other intentions— debauchery, for example."

The second attitude that emerged from this line of questioning was that such a request on the part of the woman would put in question the husband's role as decision-maker. One man reported, "For my part, after the marriage, my wife is my property. It's not for her to give the orders in the house."

**Regional Differences in Attitudes toward Tubal Ligation**

The 29 focus groups were conducted in five of the eleven regions of Zaire: Kinshasa, Bas Zaire, Sud Kivu, Haut Zaire, and Shaba. While the sessions conducted in specific cities or towns cannot be considered representative of the region as a whole, there is a striking pattern in the results that offers further insight into the acceptability of tubal ligation in Zaire.

Among the groups of active users and husbands, the responses were very similar in five of the six sites included in this study. Kimpese (in the region of Bas Zaire) was the exception. While some of the same arguments surfaced, there was a far greater acceptance of tubal ligation as a contraceptive method in this location than in the other five. As one woman from a village on the outskirts of Kimpese said, "If you sent us the means to have the operation right here, many would accept."

One possible reason for the difference in attitudes is that, in Bas Zaire, there are elements of the matrilineal system of lineage, in which the children of the couple belong to the family of the wife (specifically the wife's older brother). Local sociologists contend that there is a certain ambiguity regarding the system of lineage in Bas Zaire, and that practices may differ from one area to another. Nonetheless, it would be in keeping with a matrilineal system of lineage (although large families are also the rule in this region).

This difference is evident from comments both from the men and women who participated in these sessions. For example, when one male participant from Kimpese was asked what his reaction would be if his wife asked for a tubal ligation, he replied, "There are men that are not regarded well by the families of their wives for having taken this initiative (tubal ligation). But if it's the wife herself who declares she wants the operation, then I'd support the idea entirely." Several male participants from Kimpese spoke favorably of tubal ligation, but lacked the funds to have it done. One explained, "It's the money that's lacking. If not, she'd already have had the operation."

**Summary and Conclusions**

The results of this study indicate that at the present time in Zaire, health and medical problems related to pregnancy and childbirth are the only widely acceptable reasons for a woman to undergo tubal ligation. There is widespread consensus that one should cease childbearing once one's own children start to reproduce, although many women prefer to continue using reversible methods until menopause rather than undergo tubal ligation. While economic hardship was seen as an acceptable motivation for child-spacing and even limitation at high levels of parity among some of the women, it was less acceptable to men.

From the woman's point of view, the major obstacles to undergoing tubal ligation are: (1) pressure from the husband's family to have a large number of children; (2) fear that the husband might look for another wife if one could no longer produce children, even if he had given his consent to the operation; (3) fear that one's own children could die, leaving one childless; and (4) fear of the operation itself.

The obstacles to a greater acceptance of tubal ligation among males relate to the prevailing attitudes that: (1) it is the wife's duty to produce a large number of children, in part to repay the dowry; (2) one's existing children could die, leaving one childless; (3) a husband who allows his wife to undergo a tubal ligation for nonmedical reasons is dominated by her; and (4) women who have been sterilized risk becoming either sexually promiscuous or unduly jealous or suspicious of the husband.

The main consequence of tubal ligation, perceived both by men and women who had not undergone the procedure, is marital conflict and dissolution, related to the wife's inability to have more children. In fact, one VSC acceptor was abandoned by her husband after she had the procedure, but this was not the experience of the majority of VSC acceptors. Most participants who knew someone who had undergone the operation felt that her general state of health was good, although specific complaints included back pain, abdominal pain (especially at the time of menstruation), and heavy menstrual bleeding.

A number of the potential candidates and husbands were unclear whether the operation is permanent or
reversible. This confusion may stem from the fact that many claimed to know someone who had gotten pregnant after it was done. VSC acceptors believed that the operation was permanent, though they were concerned that rumors regarding method failure might be true.

The attitudes expressed through these focus groups reflect the desires for high fertility that continue to be the rule in most of sub-Saharan Africa. Caldwell and Caldwell (1987) contend that traditional African religious values have sustained high fertility in two ways. First, they have acted directly to equate fertility with virtue and spiritual approval and to associate reproductive failure or cessation with sin. Second, they have placed both positive and negative sanctions on filial piety and material homage to the older generation so that high fertility is rarely disadvantageous.

Frank (1987) also describes the universally high childbearing desires found at this time in sub-Saharan Africa. Contraception, and even sterilization, are used within the framework of these high fertility desires; sterilization is generally performed on older women of high parity, such that few potential births are averted. According to Frank, sterilization conforms with expected “stopping” patterns rather than suggesting unusual limitation.

The fact that tubal ligation is relatively uncommon in Zaire is confirmed by the findings of a number of surveys on contraceptive prevalence in different sites of this country. In the vast majority, 1 percent or less of women of reproductive age have had a tubal ligation; in two areas where the operation was relatively accessible, 5–6 percent had had this operation (Bakutuvvudi et al., 1985; Bertrand, 1989). These surveys show a strong preference for traditional methods (withdrawal, rhythm, and abstinence) compared to modern contraceptives.

In light of this, one might question the relevance of a VSC program in Zaire. However, there are several factors that would argue in favor of this type of program. First, in a society where high parity is the rule, the percent of women at risk of obstetrical complications is high (Otolorin et al., 1987). Thus, VSC represents an important component of any public health effort aimed at improving maternal/child health.

Second, while the participants in the Zaire focus groups tended to accept VSC “for medical reasons only,” this has been the case in the early phases of most VSC programs, especially in Africa. The most striking case is Kenya (see the following report in this issue by Bertrand et al., 1989), where the first AVSC-supported service program was initiated in 1981. Such programs started with very modest results, but currently AVSC-supported programs perform over 8,000 VSC procedures a year (AVSC, 1987). While this number may be small in comparison to well-established programs from other regions of the world, it nonetheless suggests that VSC may become culturally acceptable in sub-Saharan countries.

Third, while VSC programs may not have a significant impact on fertility at this time, their existence may well influence the next generation of women. As Frank (1987) points out, family planning programs introduce the notion of cessation of childbearing, and daughters who will experience less child loss (than their mothers) may see its purpose at earlier stages.

Fourth, the acceptance of permanent contraception is a step-by-step process that begins with a few women at risk of pregnancy complications and eventually spreads to younger, lower-parity women. While the former want complete confidentiality regarding the procedure, the latter group tend to discuss VSC more freely and become the best promoters of the program (Dwyer, 1988). Since this process takes several years (as it has in Kenya during the 1980s), there is an argument to be made for introducing the program as early as possible, with the expectation that public acceptance of it may follow several years later.

Fifth, it has been found in other African countries (for example, Kenya and Nigeria) that in the early stages of VSC programs, service providers may have negative attitudes toward the program that create a barrier for clients interested in the method. The best way to change these attitudes has been the actual introduction of services.

Sixth, most hospitals in Africa currently provide female VSC for at least the women at risk of serious complications with future pregnancies and extremely high parity. However, the majority are performing laparotomy with general anesthesia, which increases the risk of complications from anesthesia and requires hospitalization for five to seven days due to the large incision. By contrast, the current VSC programs are designed to train and equip physician/nurse teams to do minilaparotomy with local anesthesia, which can be done on an outpatient basis. This results in increased safety, reduced fear of “an operation,” and increased confidentiality, because the woman does not have to explain why she was in the hospital. Moreover, it reduces the burden on already overcrowded hospitals, which improves the attitudes of service providers.

At the same time the findings from this study indicate certain factors that should be taken into account in implementing the VSC program in Zaire (and possibly in other sub-Saharan countries). Tubal ligation may have more far-reaching social consequences in this society than in other regions of the world where it is now widely accepted by the population. Thus, VSC...
personnel need to be sensitive to this in counseling potential clients. In contrast to many information, education, and communication (IEC) programs for VSC in other countries that focus on the economic hardship of having large families, IEC efforts in Zaire should concentrate on the health benefits of the operation or, conversely, on the risks associated with high parity.

Whereas word-of-mouth has been an effective means of communication in many other programs, the Zaire program should expect to use health professionals associated with the operating facility to educate the population about this method, at least in the early stages. There is considerable fear surrounding operations in general, which extends to tubal ligation as well; the IEC efforts need to alleviate this fear to the degree possible in the minds of potential clients. Acceptors and potential acceptors also need assurance about the permanent nature of the operation, in light of rumors that the tubes can reopen.

Finally, there is need to guard complete confidentiality regarding the procedure (although women obviously have the prerogative to reveal that they have been operated on, if they so choose). Sterilization for reasons other than medical necessity is still viewed with strong suspicion, and acceptors should be protected from this type of criticism.

References


