CHAPTER 1

INTRODUCTION

1.0 Introduction

This is a study of the role of individual and societal knowledge, attitudes and practices in enhancing or limiting the use of modern family planning methods in Namuwongo, an urban slum located on the out skirts of Kampala city in Makindye division, Bukasa Parish. In this study, utilization of modern contraception is the dependent variable, while accessibility, demographic, socio-economic and environmental factors are the independent variables. This chapter explores the background to the study, the problem statement, general and specific objectives, and research questions, hypotheses of the study, conceptual framework, significance and justification of the study, operational definitions, assumptions and limitations of the study.

1.1 Background to the study

In 2010, the United Nations Population Fund (UNFPA) reported a slight increase in the world's population to 6.9 billion , compared to the 6.8 billion people in 2009. This seems like only a minimal increase, but when it is subjected to projections, the estimate will be nearly eight billion people by the year 2050 and this is only if the world total fertility rate remains at 1.54 (UNFPA, 2009). However, even with this fertility rate that is assumed to be ideal, the environment will not be able to support the population. The high population is greatly attributed to the high fertility rate especially within developing nations. According to Rosenburg (2009), the total fertility rate is 2.3 percent in less developed countries as compared to that of 2.1 percent in developed countries. This calls for efforts to control the birthrates because the consequences of a large population do not only impact on the developing nations but on the world at large.

A country's Contraceptive Prevalence Rate has a bearing on its fertility rate and its population growth rate. In East Africa, Tanzania, with a modern contraceptive prevalence rate of 20%, has a lower fertility rate of 5.47 and hence a lower population growth rate of 2.9%. Kenya, with an even higher modern CPR of 39% has a lower fertility rate of 4.78 and therefore a population growth rate of 2.6% (UNFPA, 2010).

Uganda's fertility rate currently stands at 6.5 children per woman, the third highest in the world according to a recent report by the Population Secretariat (MOFPED, 2011). The high fertility rate coupled with the high poverty levels has crippled the country's development (MoH, 2010). One of the ways of reducing the fertility rate and in turn the population growth rate is by increasing the contraceptive prevalence rate

(CPR). However, for Uganda, the modern CPR at 18% is very low for a country that has had modern contraception promoted since 1957 (Reproductive Health Uganda, 2007). The gravity of this is that country's total population is projected to be 91.3 million people by 2050 (UNFPA, 2010). Increasing the CPR in Uganda may lead to a reduction in the fertility rate and consequently a reduction in the population growth rate.

For Uganda, a developing country, the high population growth rate and increasing poverty levels contribute greatly to the high dependency rate, low economic growth, and rural-urban migration (Byamukama, 2011). With these issues, come the rapid expansion of urban slums which are usually overcrowded, and have poor infrastructure. The country, however, does not have the resources to sustain the ever rising number of immigrants into the city, and this highlights the need to encourage efforts aimed at increasing the contraceptive prevalence rate, in order to bring about a reduction in the overall population growth rate.

Namuwongo is the second largest slum in Kampala and has a population of over 10000 people most of whom are victims of war who have escaped from their homelands over the years (KCC, 2009). As they settle within the community, they gradually invite friends or relatives to join them. This could partly explain the high rate of rural urban migration. Also, there is high population of youths who have left their rural homes and migrated to the cities where they end up in slums employed as casual labourers, motorcyclists, or brewers (Kungu, and Mwesigwa, 2010). Due to their meagre incomes, and the fact that they are living as illegal squatters who are constantly facing the threat of eviction, they have limited, irregular, or no access to family planning services. They are therefore bound to face problems associated with high fertility and uncontrolled population growth.

Various strategies have been used in Uganda with the aim of increasing the use of contraception among the general population. The major intervention has been introduction of modern family planning methods and health promotion of these methods. This has increased access to modern contraception especially in the urban areas where the people have been found to use them more than those in rural areas, that is, 37% and 15% respectively (UDHS, 2006). Nonetheless, there has been increased concern over the reluctance of people to use modern contraceptives, even when they are provided freely in government health facilities. This has resulted in contraceptives getting expired in medical stores because the intended users are not using them even when they are provided freely (Bita, 2010). This may imply that there are attitude and practice factors that need to be addressed in order to increase the uptake of modern contraception.

1.2 Statement of the problem

High population growth poses grave environmental and economic implications for countries. Among these are high levels of poverty, massive environmental degradation, scarcity of land, increased government expenditure, and reduced rate of socio-economic development on the whole. These problems highlight the importance of controlling countries' populations especially through reducing the birth rates which are major contributors to population growth. Birth rates are significant because they are a reflection of a country's CPR and consequently, its population growth rate (Okezie, Ogabo, and Okezie, 2010). The problems associated with high population growth are even more pronounced in less developed nations which tend to have low CPR, and high birth rates per woman, probably because they do not have comprehensive family planning programs, and where they exist, they are ineffective. Uganda is one such country struggling with a high population growth rate and yet with a low contraceptive prevalence.

Uganda's population is estimated to be 32.7 million people and with an annual population growth rate of 3.3%, the population is bound to double in the next two decades (MoH, 2010). With this growth rate comes an increased rate of rural urban migration which usually culminates into a high urban population that requires family planning and other health services. The urban population is 5 million people and 60% of these live in informal settlements, commonly known as slums, as the cost of living in decent environments is very high (MLHUD, 2009). The county's urban fertility rate is 4.4 with people living in congested areas exhibiting a higher fertility which can be attributed to the low modern contraceptive prevalence (SAP, 2009).

The government of Uganda recognises the fact that the high fertility rate has greatly contributed to the high maternal and child mortality and morbidity and slowed overall development for the country. As one of its strategies to improve sexual and reproductive health, the government seeks to increase the contraceptive prevalence rate especially among the adolescents who contribute 23% teenage pregnancies (MoH, 2010). The high rate of rural urban migration has seen many of these young people settling in urban areas where they hope to make a living. Many of them end up in slums where they couple and soon start having children. In Uganda, a lot of effort has been put in addressing sanitation and health needs of people in congested settlements. However, their reproductive health needs have been largely ignored. The contribution of slum populations to the high fertility, given the fact that slum dwellers are mainly young people of reproductive age, should no longer be ignored because of its negative implications.

1.3 General objective of the study

To study the relationship between knowledge, attitudes and practices regarding modern contraceptive use among women and men of reproductive age in Namuwongo.

1.3.1 Specific objectives

1. To estimate the contraceptive prevalence rate among the men and women of ages 15-49 years in Namuwongo between July 1st 2011 to July 31st, 2011.
2. To determine the factors which influence the utilization of modern family contraceptive methods in Namuwongo.
3. To assess the knowledge of the respondents toward modern contraception.
4. To determine the attitude of the people of Namuwongo towards the use of modern contraception.

1.4 Research questions

- What is the contraceptive prevalence rate of Namuwongo?
- What factors accelerate or hinder modern family planning uptake in Namuwongo?
- How knowledgeable are the men and women of Namuwongo with regard to modern contraception?
- What is the attitude of the women and men of reproductive age (15-49) years in Namuwongo regarding modern family planning?

1.5 Significance of the study

This study will generate information that will lead to a better understanding of the attitudes and practices of modern family planning and aid in devising means of re-introducing modern family planning in ways that will be acceptable to the population and hence this may lead to increased utilization of modern contraception and therefore a reduced fertility rate in Uganda

1.6 Justification of the study

Increased modern contraceptive prevalence in Uganda would lead to the reduction in the country's fertility rate and therefore its population growth rate. A reduced population also presents prospects for increasing the country's economic development by reducing the dependency ratio.

The Ministry of Health has put a lot of effort in trying to ensure that utilization of modern family planning methods is widespread amidst political and individual pressures. In areas where MoH has not been able to reach, development partners like Marie Stopes International (MSI), Uganda Health Marketing Group (UHMG), Reproductive Health Uganda (RHU) and others have bridged the gap. The

result of these efforts is that awareness has been created and access to modern contraceptive methods has increased. Despite all these efforts, the CPR is still very low leading to a rapidly increasing population especially in the slums. This may imply that there are other factors that may have hindered the use of modern contraception. Consequently, modern contraception will not be embraced unless the factors that make a large portion of the population to reject it are identified and addressed.

1.7 Assumptions

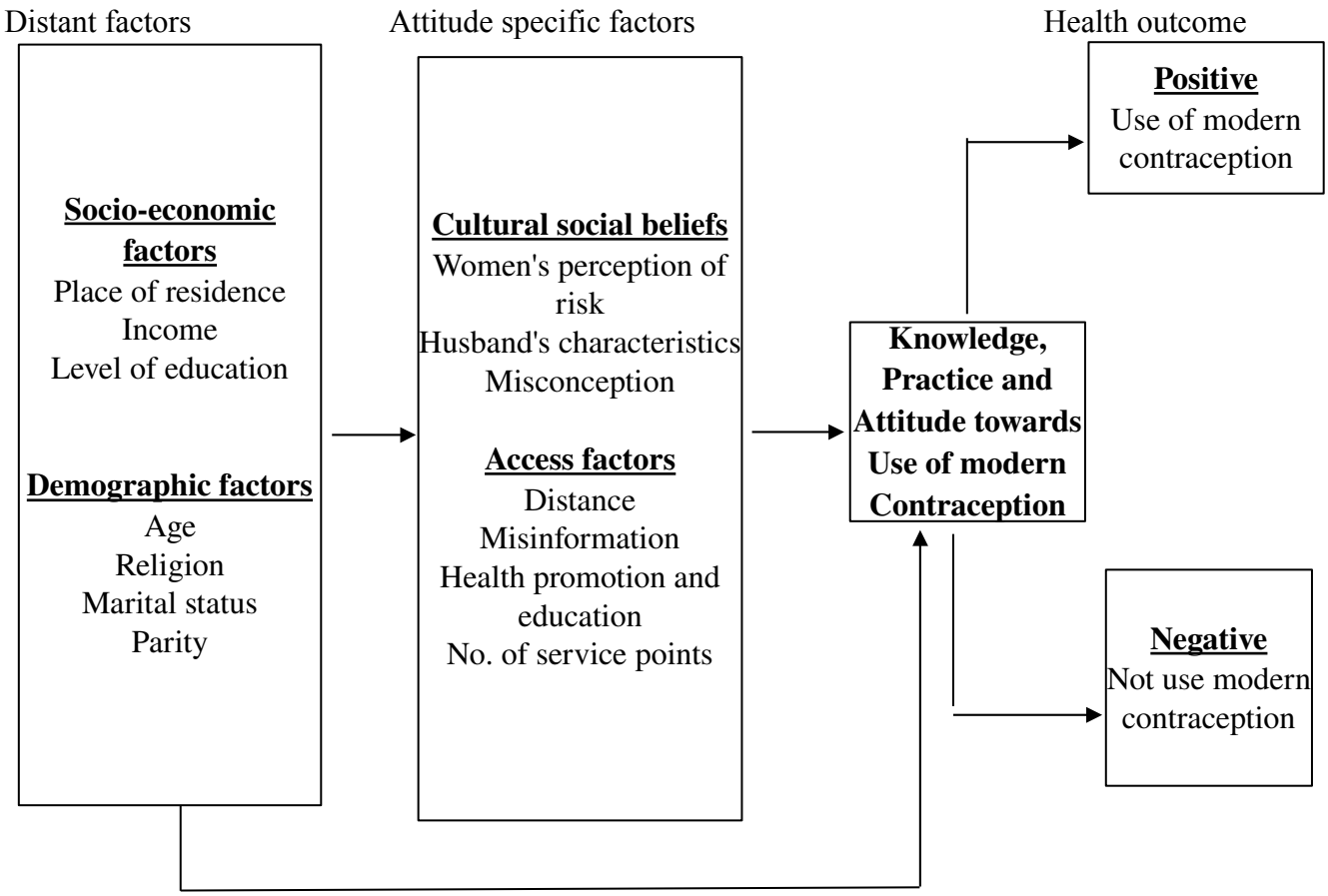
The assumptions are that:

- The knowledge about modern contraception is high among the residents of Namuwongo.
- There has been no prior research done about attitude and practice regarding modern contraception in Namuwongo.
- There is a high population of people of reproductive age in Namuwongo.
- Interpreters will be available to translate the questionnaire.

1.8 Limitation

- The study was done in three zones of Namuwongo, that is, Yoka Zone, Zone B, and Kanyogoga. These zones are mainly residential, while the others are mainly commercial and therefore are inhibited by many people who were not necessarily residents, but were there for trading activities.
- The study excluded residents who do not speak languages commonly used in Namuwongo. This will mean that their opinions may not be considered.
- The study excluded mentally challenged persons as seeking proxy respondents for these may bias the results.

1.9 Conceptual Framework



CHAPTER 2

LITERATURE REVIEW

2.0 Introduction

This chapter explores the various studies that have been done pertaining to the use of modern contraception. These studies have highlighted the various factors that are believed to influence the use of modern contraception. In this chapter are the theoretical review, conceptual framework, and the literature review.

2.1 Background

In 2006, the UN population division estimated that world population would increase from 6.7 billion in 2006 to 9.2 billion in 2050. This increase would however be experienced in developing nations because the population of developed nations was expected to remain unchanged (UN population division, 2006). Much as an increase is expected in developing nations, significant declines have been shown in Asian countries which have been attributed to substantial decrease in their birthrates and consequent increase in their CPR (UNFPA, 2011).

While the world prepares to measure progress towards achievement of the MDGs in 2015, there is an increasing quest to invest resources in measures that would be cost effective, and yet bring about significant, drastic, and sustainable change. The World Health Organisation has identified the following factors as impeding the attainment of these goals: poverty, conflict, which slows down development, and above all, high population growth rate that cripples the set interventions (UNFPA, 2009). Such conditions are not unusual in Uganda, especially the population issue that is currently causing great concern. Family planning, especially the modern methods, has been identified as one of the strategies that could make the achievement of five of the eight MDGs more affordable (USAID, 2009). However, this still faces resistance in Uganda, as in many developing countries, as people shun it due to various factors. This has greatly contributed to the high fertility rates that the world is currently experiencing.

For the decline in the fertility rate to occur, access to voluntary family planning has to be increased. This implies that family planning should focus on the needs of the users considering the aspect of informed choices, education for the girl child, and providing economic opportunities for the women. A new approach should therefore be taken to address the attitude and behaviour of the people especially in the developing nations so that modern contraceptive methods and messages may be introduced and packaged in a way that is acceptable to the people.

2.2 Methods of contraception

Over the years, both natural and artificial methods have been promoted. Natural methods have been promoted more in developing nations where modern methods have faced resistance due to cultural beliefs and misconceptions. The common natural methods that have been promoted in developing nations include breastfeeding, moon beads, abstinence and coitus interruptus. The modern methods that have been popular include condoms-which are also promoted for prevention of STIs, injections, pills, Intrauterine Device (IUD)-commonly known as the coil, and long-term methods (tubal ligation and vasectomy) (Nakiboneka and Maniple, 2008). Studies done by Kasedde in 2000 show that long-term methods have in many cases been rejected in various African communities. Voluntary family planning has been encouraged because in case it is effective, it has the potential to bring about sustainable change in development in terms of improved quality of life and overall country development (Cueto, 2004; Mertens, 1995).

Modern family planning methods have proved to be more effective in reducing the CPR than natural methods. Countries such as Zambia, Zimbabwe, Namibia, Malawi and other countries in Sub-Saharan Africa have experienced outstanding changes in their fertility rates because they embraced modern family planning methods in the 1990s (Sharan, et al, 2011). However, modern methods have faced rejection in many countries on the basis of religion, cultural norms, effectiveness, and side effects like post partum infertility (Rwirahira, 2011; Qazi et al, 2010)-

Despite the fact that family planning has been present for a long time, the world contraceptive prevalence is still low, and in some countries in Africa, the fertility rates are still rising (UNFPA, 2009). In Uganda, the latest Demographic and health survey documented the following obstacles to family planning: women's level of education with the less educated not as likely to embrace modern contraception as the educated ones, low income, negative cultural and religious perceptions, and limited access in terms of cost, distance, and health promotion and education (UDHS, 2006).

2.3 Population growth and Contraceptive Prevalence Rates (CPR)

The global average population growth rate is 1.2% and this is backed by a CPR of 55%. The developed nations have even lower growth rates and higher contraceptive prevalences. Europe, for example, has a population growth rate of 0.1% due to the low fertility rate (1.52) and a modern CPR of 55%. Asia, with a population growth rate of 1.1% has a corresponding TFR of 2.3 and a modern CPR of 61. Africa on the other hand, which is home to many developing nations, has a higher birth rate of 4.45 due to the low CPR of 23% and consequently, a higher population growth rate of 2.3% (UNFPA, 2010).

Currently, the world wide use of modern contraceptives among married women is 62 percent. In 2005, the use of modern contraceptive methods was 25 percent among women of reproductive age, while 23 percent were not using contraception even when they wished not to become pregnant (UNFPA, 2009). This illustrates the magnitude of the unmet need for family planning. This unmet need and low CPR are attributed to various obstacles like the fact that many women do not use contraception because the are unable to access the services and some are hindered by religious or cultural factors, while others do not believe that they are at risk of getting pregnant. The gravity of this is that more than 60 percent of the women in north Africa and west Asia, about half of them in Latin America, and 35 percent in south and south east Asia and Sub-Saharan Africa cite this reason for rejecting the use of contraception. Other obstacles to effective family planning include lack of information about family planning, concern with regard to the associated or perceived health risks and side effects, opposition from partners or close family members, and contraceptive methods not being readily available (Maki, 2007). It is therefore important to consider the attitudes and practices that hinder the uptake of family planning especially in the developing nations.

Family planning is important in Africa, especially now when nations are striving to meet the Millennium Development Goals, whose success has been impeded by high population growth rates which makes it hard for countries to sustain achieved gains (Newman, 2011; McCaffety, 2007). Africa has the second highest population in the world, and much as Asia is expected to remain the most populous continent in the world in the 21st century, UNFPA estimates that between 2011 and 2100, Africa's population will increase from 1 billion to 3.6 billion which at the time will be three times higher than Asia's current population (UNFPA, 2011). These growth rates are more pronounced in particular regions in Africa, for example, Sub-Saharan Africa.

In 2009, Sub-Saharan Africa had a fertility rate of 5.1, the highest in the world. This is twice as much as that of South Asia (2.8). It is therefore no wonder that even its CPR at 22% was less than half that of South Asia, a region that not so many years ago, was at the same level, and in some cases, worse than Africa in terms of development (Sharan, et al, 2011). This could be partly due to the fact that in Africa, child bearing is linked to gender roles and prestige of communities which sometimes results in incapacitation of women and men's ability to limit the number of births and also because modern methods have been marred by rumours and misconceptions (Kasedde, 2000). The focus of family planning education ought to address the unrealistic perceptions of risk and offer better educational and economic opportunities which can empower women and promote long-term cultural change in favour of family planning.

Contraceptive prevalence is significant in reducing a country's population growth rate. A country like Niger, with a higher birth rate than Uganda (7.01), has a lower CPR (5%), and hence a higher population growth rate (3.9%). UK on the other hand which has a lower birth rate (1.86) has a much higher modern CPR (84%) and therefore a low population growth rate (0.5) (UNFPA,2010: MoFPED, 2009). This shows that there is an undeniable relationship between a country's contraceptive prevalence rate, its total fertility rate, and its population growth rate.

Table 2.1 shows selected health indicators for selected countries to further illustrate the relationship between CRP, TFR and population growth rates.

Table 2.1: Selected population health indicators for selected countries

Region/Country	**TFR**	CPR		**Total popn-**	**Av. Popn**	**Projected**
		Modern	**Any**	**2010 (millions)**	**growth rate(%)**	**popn (2050)**
Europe	**1.52**	**55**	**68**	**732.8**	**0.1**	**691**
1. U.K	1.86	84	84	61.9	0.5	72.4
2. Germany	1.33	66	70	82.1	-0.1	70.5
Latin America	**2.17**	**64**	**71**	**588.6**	**1.1**	**729.2**
1. Cuba	1.51	72	73	11.2	0.0	9.7
2. Mexico	2.12	67	71	110.6	1.0	129.0
Asia	**2.30**	**61**	**67**	**4166.7**	**1.1**	**5231.5**
• China	1.77	86	87	1354.1	0.6	1417.0
• India	2.63	49	56	1214.5	1.4	1613.8
Africa	**4.45**	**23**	**28**	**1033.0**	**2.3**	**1998.5**
South	2.55	58	59	58	1.0	67.4
• South Africa	2.48	60	60	50.5	1.0	56.8
North	2.8	44	49	212.9	1.7	321.1
• Algeria	2.32	52	61	35.4	1.5	49.6
East	5.09	21	26	327.2	2.6	691.0
• Kenya	4.78	39	46	40.9	2.6	85.4
• Uganda	6.16	18	24	33.8	3.3	91.3
• Rwanda	5.25	26	36	10.3	2.7	22.1

Source: UNFPA report, 2010

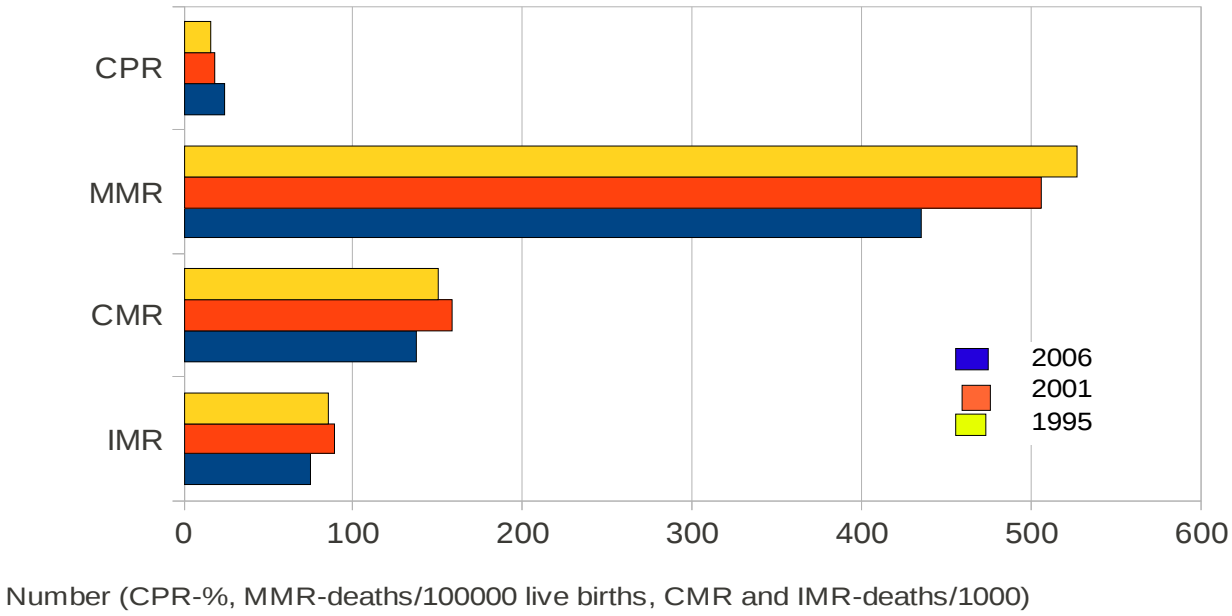
For developing countries in Africa, the effect of low CPR has as well been manifested in the adolescent birth rates. These are highest in Africa, where the average is 103/1000 births. It is important to also note that the maternal and child deaths have also increased in some developing nations. A study by Minnesota International Volunteers (MIVU) in Ugandan districts of Mubende and Sembabule revealed that high

fertility played a significant role in increasing the infant, child, and maternal mortality rates. From table 2.1, it is evident that the rates were even much higher than the national average shown in table 2.2 (USAID, 2008)

Table 2.2: Infant, Child and Maternal mortality indicators in Ugandan districts of Mubende and Ssembabule

Mortality	*Uganda*	*Ssembabule*	*Mubende*
Infant (per 1,000 live births)	76	122	119
Child (per 1,000 live births)	137	—	—
Maternal (per 100,000 live births)	435	500	600

Figure 2.1: Trends in selected health indicators in Uganda 1995-2006



Source: HSSP III

One of the interventions that has been suggested to avert the rate of teenage pregnancies, maternal and child mortality, is to legalise abortion. However, in most developing countries, this is illegal and therefore many of the abortions carried out are done under unsafe conditions (Sedgh et al, 2007). In such countries, the only direct answer seems to be promoting of modern methods of contraception including emergency contraception, such that unwanted pregnancies can be avoided all together before their after effects can be realised. However, with modern methods in Uganda, questions arise as to whether a country that has for so long paid little or no attention to short term, and much less long term modern methods of contraception, can embrace emergency contraception. This is because knowledge about emergency contraception is either limited, or non-existent (Byamugisha, et al, 2006: Tajure and Pharm, 2010).

The other option that has been advocated for is investing in the socio-economic aspects of the youthful population. The youth account for 3 billion of the world population. It is believed that investing in their sexual and reproductive health has prospects for lessening the disease burden, averting maternal and child deaths, improving and sustaining present and future economic gains, controlling fertility rates and population growth, and giving developing nations competitive advantage in achieving the MDGs (Hainsworth and Kade, 2010)

2.4 Relationship between attitude and use of modern contraception

People are driven by individual or societal attitudes that hinder or accelerate their uptake of modern contraception. Other factors that influence the utilization of contraception include religious or cultural values, myths, effectiveness of methods, health promotion, demographic factors like sex, age, marital status, country policies, and client and provider attitudes (Nakiboneka and Maniple, 2008). This takes into account both developed and less developed regions in the world. A study done in Cambodia revealed that partner support greatly influences use of contraception as women who believed that their partners approved of modern FP were three times more likely to use it compared to those who did not (Samandari, et.al, 2010). In 2009, DeRose and Ezeh did research in Uganda and found out that in communities where women played a role in decision making, CPR was 29% more likely. Another study done in Uganda revealed that post-primary education, ethnicity, residence, and the presence of the spouse in the household and discussion of family planning with spouse were strong predictors of knowledge and favourable attitudes towards contraception (Migadde and Agyei, 2008).

CPR is influenced by various factors. These factors may be socio-economic, demographic, cultural, and access factors, all of which have a bearing on people's attitudes toward utilization of modern contraception. A sentinel study done in Ethiopia revealed that CPR was associated with socio-economic factors such as age, marital status, family income, spousal communication and media coverage (Fasil, 2006). In Bangladesh, parity determines women's attitudes toward use of contraception. As the number of living children increases, women prefer non terminal efficient methods like IUD, implants, and the pill and reject condom use which they claim is inefficient (Mannan, 2002). Religion may directly or indirectly influence use of modern contraception as a study in Bangladesh revealed. The non Muslims were more willing to use condoms than sterilization because of the perceived side effects (Mannan, 2002). A study done in Nigeria also revealed that religious beliefs of the respondents, accounting for 38%, were the commonest reason for disapproval of modern FP (Ijadunola et al., 2009). These and other factors have been documented to influence the contraceptive prevalence rate.

2.5 High population growth in slums

High CPR is usually most significant in congested areas designated as slum. Slums have been known to have fewer social and economic power, limited land ownership, poor environmental conditions and isolation from access to health services, and most recently high numbers of young people migrating and staying in urban slums. This is in contrast with their non-slum counterparts as research has shown (Hazarika, 2009). Moreover, there is also insufficient employment to cover the number of people. In 2007, the UN-HABITAT was fearful that if the slum growth rate continues over the next 10 years, the urban situation may go out of hand and may deter countries from meeting the MDGs (MLHUD, 2008). Table 2.3 shows slum growth in selected developing countries.

Table 2.3: Population growth in slums

Country	Slum annual growth rate %	Slum pop (thousands)	Scenario 2020 with no change
Angola	5.28	3,918	10,677
Kenya	5.88	7,605	23,223
Nigeria	4.96	41,595	76,749
South Africa	0.19	8,376	8,677
Uganda	**5.32**	**3,241**	**8,904**
Tanzania	6.16	11,031	35,561
Brazil	0.34	51,676	55,074
El Salvador	1.89	1,386	1,986

Source: UN-Habitat, Urban Observatory, 2007

Worth noting is that most of the people migrating to urban slums are youth in search of better employment opportunities. Other causes of rural urban migration include climate change which has led to disasters and consequent displacement, and loss of property and food sources, and political instabilities (MoFPED, 2009). These youth are potential child bearers and with the fertility rate as high as Uganda's, it requires the country to devise immediate measures to control overall fertility.

2.6 Contribution of the youth to population growth and CPR

According to the UNFPA report of 2011, 43%of the world's population are youth below the age of 25 years and some of the population challenges that countries are facing include high fertility and transitions in the population pyramid such that there are more youth than adults. Uganda's current population

structure is such that over 50% of the population are youth who are unproductive and depending on a few working adults. Moreover, this means that these youth may soon start having children to add to the already elevated population and the consequences will be mortifying. Because of the many unproductive youth, the country has one of the highest dependency ratio in the world (115) and 31% of the population are still living in absolute poverty. Uganda's population structure is expected to remain so for another 15 years (MOFPED, 2011; MOFPED, 2010). This is not completely a disadvantage for the country. If these youth are invested in, they have the potential to turn the country's economic situation around. The investments can be in two forms, economic activities, and family planning services. The Population Secretariat argues that Uganda's problem is not that of a high population, but of the quality of the population when it is evaluated in terms of health, education, skills, employment opportunities, and basic needs.

It is believed that a youthful population can only be advantageous if it has competitive and employable skills, high productivity and purchasing power. This can be achieved when the population is controlled and the adults have fewer dependants. This is because they can be easily provided for in terms of better quantity and quality of health services and they can reverse the poverty trends when they turn into productive adults (Nyakato, 2011). This calls for desperate measures to improve the economic situation of the youth. Fertility reduction has proved to be effective in turning around such situations. Thailand's fertility rate was 6.4 in the 1960, and it was classified as a low income country, however, by 1990, it had transformed into a middle income country. The significance of this is that its fertility at the time had dropped to 2.2 children per woman. Other Asian countries like Malaysia, Singapore, South Korea, Taiwan, and others have also shared the same fate (MoFPED, 2009). Reducing the fertility rate for Uganda through increasing the CPR for modern methods will mean more resources shall be invested in education, health services, skilled labour and other resources that would make the country's youth more productive. Governments also need to equip the youth to recognise opportunities such that they place themselves in a position to qualify for them (UNFPA, 2011).

2.7 Summary of literature review

In Uganda, despite the fact that the married women are knowledgeable about modern contraception, only 18 percent of the married women of 15-49 years are currently using a modern method of contraception, yet the birth rate is one of the highest in the world (UDHS, 2006; MoH, 2010). This may imply that many of these women are driven by their attitudes and beliefs that make them reluctant to take up modern contraception.

According to UNFPA (2009), demographic research has demonstrated that when women and their partners take advantage of client focused family planning services, fertility falls, particularly when combined with education for girls and economic opportunities for women. The key point here is that women and men themselves, not governments or any other institutions, make the decisions on child bearing that contribute to an environmentally sustainable population.

Since family planning has been in Uganda for over 50 years, and health promotion and education have been widely conducted about it, one would assume that a great majority of the population uses modern contraception. However, this is not the case. The observed population explosion may be a result of the low uptake of modern contraception and probably because the attitudes and behaviour of the potential users of modern family planning methods have not been addressed. It is therefore important to identify the factors that influence the use of modern contraception, ascertain the problems, and devise means of re-introducing modern contraception in ways that will be acceptable to the population. This is what may lead to increased use of modern contraception and ultimately a reduced fertility rate in Uganda.

CHAPTER 3

RESEARCH METHODOLOGY

3.0 Introduction

This chapter highlights the procedures that were entailed in the process of data collection. It includes the research design, characteristics of the study population, the data collection methods, instruments, management and analysis plan. It also explains the measurements that were used in interpreting the results obtained from the data that was collected.

3.1 Study design

A cross sectional study was conducted in June 2011, in which both qualitative and quantitative methods were used to assess the attitudes and practices of the people in relation to modern contraceptive use.

Quantitative methods

Trained research assistants administered a standardized, pre-coded and structured questionnaire to obtain information about the respondents' demographic data, use, knowledge, attitude and practices regarding contraception.

Qualitative methods

Focus group discussions were held with the staff of Marie Stopes clinic, community health teams, and groups of men and women in Namuwongo, to identify the attitudes and practices of the people with regard to modern family planning. The men, as with the women, formed separate groups in which they openly presented their views, grievances, and recommendations on modern contraception.

3.2 Study site and study population

The study was done in Namuwongo, an informal community that has settled on a government owned wetland for over 50 years. Namuwongo is situated in Makindye division in Bukasa parish. It is bordered by Lugogo in the North, Kiswa and Bugolobi in the East, Kisugu and Kabalagala in the South, and Kibuli in the West. In the Northeast is Nakawa, and in the Southeast and Northwest are Muyenga and Kololo respectively. These are mainly upper and middle income communities.

The community is divided into 4 zones, that is, A, B, Yoka and Kanyogoga. The residents are mainly migrants from Northern parts of Uganda, and other conflict areas within and outside the country.

Namuwongo is characterised by an ever changing flow of residents, some of whom move from one zone or house to another. The major economic activities include brewing alcohol, hand crafting, brick making, boda-bodas (transporting people for money by motorcycles), farming, and trading in scrap metals.

Namuwongo has a high number of youth as these are the ones who mainly leave their homes, usually rural or conflict areas, to make a living in the urban areas. It is from this youthful community that consenting men and women of ages 15-49 years were selected to participate in the study. The study subjects were selected from three of four zones, that is, B, Yoka, and Kanyogoga.

Inclusion criteria

To be included in the study, the participant had to be a resident of Namuwongo, of sound mind, and lie in the age range of 15-49years (for females), and 15-70 years (for males). The participant had to also be able to speak and understand the languages that are commonly spoken within the community. The help of a translator was sought to ensure that questions are asked and answered as intended.

Exclusion criteria

People who could not speak and understand the languages commonly used within the community, those who were mentally challenged, female residents who did not lie on the stipulated age range, and those were non residents of Namuwongo were excluded.

3.3 Sample size estimation

The community was divided into three strata (stratified sampling method), according to the different zones, that is, Zone B, Yoka, and Kanyogoga. From each of these strata, respondents, both men and women, were selected using simple random sampling.

To obtain the overall sample, the formula (Leslie and Kish formula) was used. (Mugenda, 2002)

Assumption: The country overall contraceptive prevalence rate is representative of that of Namuwongo.

$$N = \frac{z^2pq}{d^2}$$

Where N= the desired sample size

z= the standard normal deviate at the required confidence level (95%), z=1.96

p= proportion of the target population estimated to be using modern contraception in Namuwongo (24%).

q=1-p (the standard deviation of the population)

d= level of statistical significance.

P=50%, z-statistic=1.96, and d=0.05

Therefore, $N = \frac{(1.96)^2 * (0.24) * (1-0.24)}{(0.05)^2}$

$N=280$

A sample of 282 respondents of ages 15-49 participated in the study. A total of 94 respondents were selected from each zone.

3.4 Data collection instruments

The questionnaires were standardized, pre-coded, and structured. These were used to obtain information from the respondents. Part A of the questionnaire dealt with demographic characteristics of respondents, Part B with knowledge and use of contraception, and Part C with attitude and practice. The key informants' guides were designed to include questions about general accessibility and attitude toward modern family planning methods. The group discussion topics included felt needs with regard to modern contraception, perception on the various modern family planning methods, views, grievances, and recommendations by the residents who participated in the group discussions.

3.5 Data collection procedure

Questionnaire administered interviews were used to collect data from the respondents. The data was collected by trained research assistants. The data collection procedure was carried out over a period of ten days. Two focus group discussions were held with the community, one with the women and the other with the men. Three key informants were interviewed, two gentle men and two ladies, all of them local leaders.

3.6 Variables

The independent variables that were considered in the study were knowledge, attitude, and practices regarding the use of modern contraception. The dependent variable was the use, or non use of modern family planning methods.

3.7 Validity and reliability

The questionnaires were pretested for 3 days in Kabalagala, a neighbouring slum to Namuwongo by research assistants that had undergone two days of training. After pretesting,the questionnaires were corrected for errors. The research assistants were hired basing on their knowledge and skills in the field of data collection and health. The questionnaires were standardized, structured, and pre-coded to ensure consistency in the data collected. They were also reviewed on a daily basis in a spirit of teamwork to ensure that they had been completed correctly and that the questions had been answered as intended.

3.8 Data management and analysis

Data integrity

The data was collected with the help of two trained research assistants from the community. The research assistants underwent a two-day training about the data collection tool, and further training during the pre-testing stage in Kabalagala.

Editing and cleaning

The filled in questionnaires were checked for completeness, accuracy and correction of errors on a daily basis by the respective interviewers and then stored.

Data entry

The data was entered using EpiData 3.1. A data base was created in which the questionnaire was designed and a coding sheet, from which the codes given to the different questions in the questionnaire was stored. The data was then entered manually using double entry validity. Codes were assigned to each response to the question with the corresponding number in the coding sheet that was developed.

Analysis

In this study, the data, entered using EpiData 3.1 was exported to a statistic software package Statistical Package for Social Scientists (SPSS 17.0 student version) for analysis and formulation of frequency and cross tabulations. The frequency, percentage as a descriptive statistics was used to describe background characteristics of respondents and establish relationships between variables.

Pearson's Chi square was used to test the significance of the relationships between the independent variable and the dependent variables.

3.9 Ethical Considerations

3.9.1 Approvals

Approval was sought from International Health Sciences University, first from the Institutional Review Board, then from the administration. These approvals was in form of letters which were presented to the Local Council authorities in the three zones in Namuwongo.

A verbal and written consent was obtained from every respondent prior to the interview and a consent form signed concurrently.

3.9.2 Respect for persons

The interviewers introduced themselves to the potential respondents in the language that the respondent were clearly spoken and understood, that is either, English, Luganda, or Acholi. The interviewers then explained the purpose and benefit of the study and give them a chance to decide whether to participate in the study or not.

The names of the respondents were not written anywhere on the questionnaires or on the consent forms. A signature, serial number, or thumbprint was used to identify the respondents.

CHAPTER 4

DATA PRESENTATION AND ANALYSIS

4.1 Respondents' characteristics

These are divided into demographic and socio-economic characteristics. The demographic characteristics include sex, age, religion, marital status, and parity. The socio-economic characteristics include education level, occupation and family planning health education.

4.1.1 Demographic characteristics

A total 282 respondents participated in the study, 94 from each of the three zones. Table 4.1 shows the distribution of demographic characteristics of the respondents. Of all the participants, 193 (68.4%) were female while 89(31.6%) were male. The youth, in the age group 15-24 years constituted the highest percentage of respondents at 51.1%. The mean age was 18 years. The most dominant religion was that of Catholics (36.9%) followed by the Protestants (29.4%). Married/cohabiting respondents constituted a high percentage at 63.8%, followed by 20.2% who were single, 9.9% who were separated 3.2% divorced, and 2.8% widowed. Majority of the respondents had less than 4 children. Only 7 respondents had more than 6 children. The average number of children was 1.5.

Table 4.1: Respondents' demographic characteristics

Characteristic	Frequency	Percentage
Sex: Male	89	31.6
Female	193	68.4
Total	**282**	**100**
Age: 15-24	144	51.1
25-34	86	30.5
35-44	39	13.8
45+	13	4.6
Total	**282**	**100**
Religion: Protestant	83	29.4
Catholic	104	36.9
Muslim	50	17.7
Pentecostal	42	14.9
Others	3	1.1
Total	**282**	**100**
Marital status: Married/cohabiting	180	63.8
Divorced	9	3.2
Single	57	20.2
Widowed	8	2.8
Separated	28	9.9
Total	**282**	**100**
Parity: None	90	31.9
1 - 3	137	71.4
3 – 6	48	25.0
>6	7	3.6
Total	**282**	**100**

4.1.2 Socio-economic characteristics

From table 4.2, at least 40.4% of the respondents had attained primary level education, 39.4% had attained secondary level education, and only 5.7% had tertiary level education. The remaining 14.5% had not attained any form of education. A large percentage of the respondents were not employed (40.8%), 18.4% were casual labourers, 12.1% were into retail business, and 11% were students. Only 5% of the respondents were formally employed. Of all the people interviewed, 90 had received health education about family planning and 132 had not received it.

Table 4.2: Respondents' socio-economic characteristics

Characteristic	Frequency	Percentage
Education level: None	41	14.5
Primary	114	40.4
Secondary	111	39.4
Tertiary	16	5.7
Total	**282**	**100**
Occupation: Student	31	11.0
Security	19	6.7
Bar/Hotel	14	5.0
Formal/Professional	14	5.0
Retail/Business	34	12.1
Transport	3	1.1
Casual	52	18.4
Unemployed	115	40.8
Total	**282**	**100**
Health education: Yes	90	31.9
No	192	68.1
Total	**282**	**100**

4.2 Contraceptive Prevalence

4.2.1: Contraceptive prevalence rate

A total of 112 respondents were using modern contraception at the time of the study.

Table 4.3: Current use of modern contraception

	Frequency	Percentage
Current use : Yes	112	39.7
No	170	60.3
Total	**282**	**100**

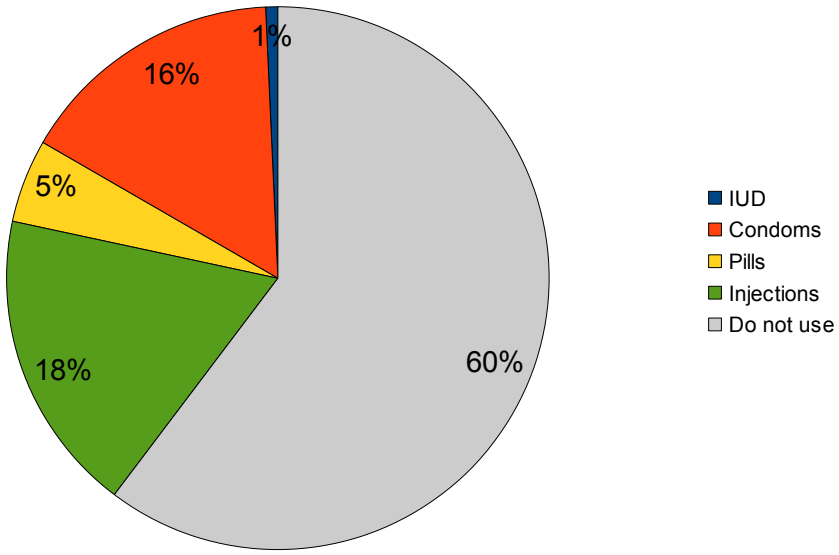
Contraceptive Prevalence rate = 112 / 282 * 100

= **39.7%**

4.2.2: Method of choice

From figure 4.1, the commonly used methods were injections 51 (18.1%), and condoms 45 (16%). Only 5% of the respondents were using pills, and a mere 0.7% was using IUD. The majority of the respondents, 170 (60.3%) were not using any method. There were no people using long term or natural methods.

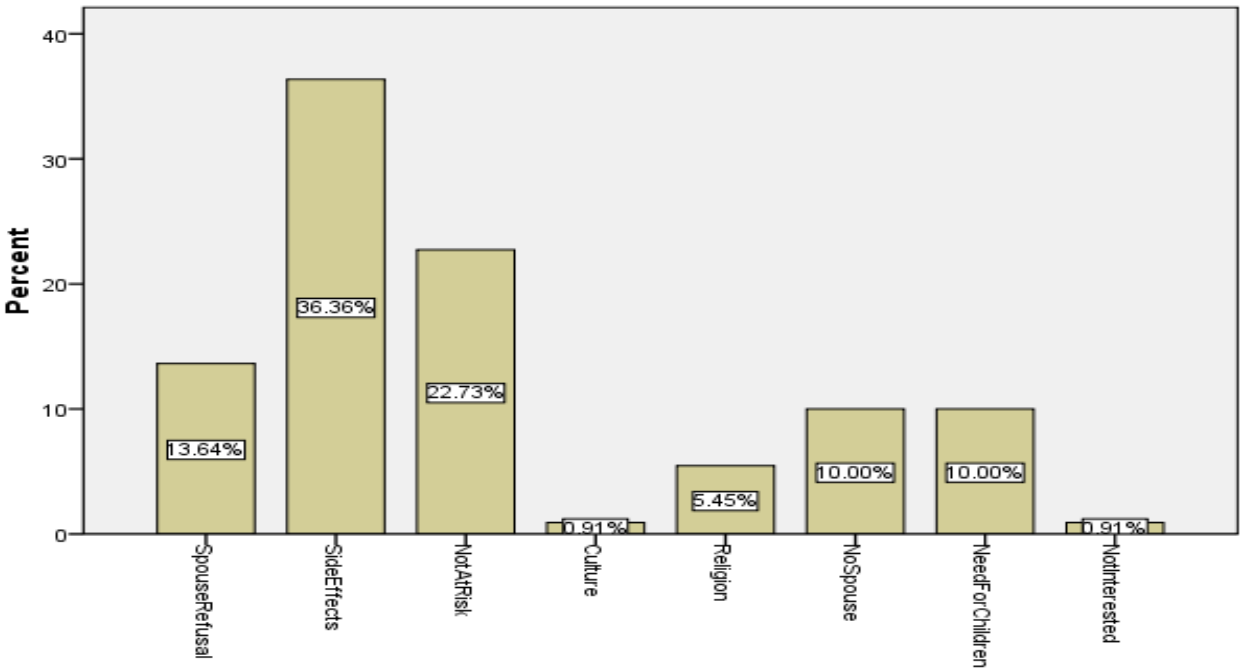
Figure 4.1: Frequency distribution of methods of choice



4.2.3 Reason for not using contraception

From table 4.3, 60.3%of the respondents were not using modern contraception at the time of the study. In figure 4.2, the main reason cited for not using was the belief about side effects of family planning, (36.36%) followed by those who thought that they were not at risk. Spousal refusal constituted 13.64%.

Figure 4.2: Percentage distribution of reasons for not using modern contraception



4.3: Factors related to use of contraception

4.3.1 Demographic factors

Table 4.4: Distribution of demographic factors in relation to use of contraception

Factors		**Current use of family planning**				**Total (Freq)**
		Yes		**No**		
		Freq	**%**	**Freq**	**%**	
Sex:	Male	28	9.9%	61	21.6%	89
	Female	84	29.8%	109	38.7%	193
Total		112	39.7%	170	60.3%	282
Pearson´s X^2= 2.545		df= 1		P= 0.111		
Age:	15-24	52	18.4%	92	32.6%	144
	25-34	40	14.2%	46	16.3%	86
	35-44	15	5.3%	24	8.5%	38
	45+	5	1.8%	8	2.8%	13
Total		112	39.7%	170	60.3%	282
Pearson´s X^2= 1.913		df= 3		P= 0.591		
Religion:	Protestant	33	11.7%	50	17.7%	83
	Catholic	45	16.0%	59	20.9%	104
	Muslim	18	6.4%	32	11.3%	50
	Pentecostal	14	5.0%	28	10.0%	42
	Others	2	0.7%	1	0.4%	3
Total		112	39.7%	170	60.3%	282
Pearson´s X^2= 2.267		df= 4		P= 0.687		
Marital status:	Married/cohabiting	79	28.0%	101	35.8%	180
	Divorced	4	1.4%	5	1.8%	9
	Single	18	6.4%	39	13.8%	57

Widowed	2	0.7%	6	2.1%	8
Separated	9	3.2%	19	6.7%	28
Total	112	39.7%	170	60.3%	282
Pearson´s X^2= 6.762		df= 4	P= 0.149		
Parity: 1 - 3	64	22.7%	73	25.9%	137
3 – 6	19	6.7%	28	10.2%	48
>6	2	0.7%	5	1.8%	7
None	27	9.6%	63	22.3	90
Total	112	39.7%	170	60.3%	282
Pearson´s X^2= 1.493		df= 2	P= 0.474		

From table 4.4 , for all ages, there were more female respondents 84 (29.8%) using modern contraception than the male 28 (9.9%). There were more youth (15-24 years) using modern contraception than any other age group 52 (18.4%). This age group was followed by the 24-34 year old 40 (14.2%), followed by 35-44 year old 15 (5.3%). Only 5 (1.8%) of respondents over 45 years were using a modern method of family planning. Married women and men were more likely to be using modern contraception than their other counterparts 79 (28%), followed by the single respondents 18 (6.4%). The widowed respondents were least likely to be using any method. The Catholics were the majority modern FP users 45 (16%) followed by protestants 33 (11.7%). Muslims constituted 18 (6.4%) of users and Pentecostal 14 (5%). Respondents with less children were more likely to be using contraception.

For the demographic factors, p>0.05, therefore we can conclude that none of the demographic factors was statistically significant in determining contraceptive prevalence.

4.3.2 Socio-economic characteristics

Table 4.5: Relationship between FP use and socio-economic characteristics

Factors	Current use of family planning				Total (Freq)
	Yes		No		
	Freq	%	Freq	%	
Education level: None	17	6.0%	24	8.5%	41
Primary	42	14.9%	72	25.5%	114
Secondary	45	16.0%	66	23.4%	111
Tertiary	8	2.8%	8	2.8%	16
Total	112	39.7%	170	60.3%	282
Pearson´s X^2= 1.176		df= 3	P= 0.759		
Occupation: Student	10	3.5%	21	7.4%	31
Security	7	2.5%	12	4.3%	19
Bar/Hotel	11	3.9%	3	1.1%	14
Formal/Professional	9	3.2%	5	1.8%	14

Retail/Business	15	5.3%	19	6.7%	34
Transport	2	0.7%	1	0.3%	3
Casual	19	6.7%	33	11.7%	52
Unemployed	39	13.8	76	27.0%	115
Total	112	39.7%	170	60.3%	282
Pearson´s X^2= 5.486	df= 7	P= 0.601			

From table 4.5, the unemployed respondents constituted the highest percentage of users at 39 (13.8%) followed by the casual labourers 19 (6.7%). Respondents in retail/business followed 15 (5.3%), then hotel/ bar 11 (3.9%) and students 10 (3.5%) respectively. These were closely followed by the respondents in the formal/professional employment 9 (3.2%), then by the security personnel 7 (2.5%), and lastly by the respondents in transport 2 (0.7%). Respondents who had attained secondary education were the majority modern FP users 45 (16%) followed by primary school education 42 (14.9%). Respondents with no form of education were least likely users at 17 (6%).

4.3.3: Social factors

Table 4.6: Relationship between social factors and use of contraception

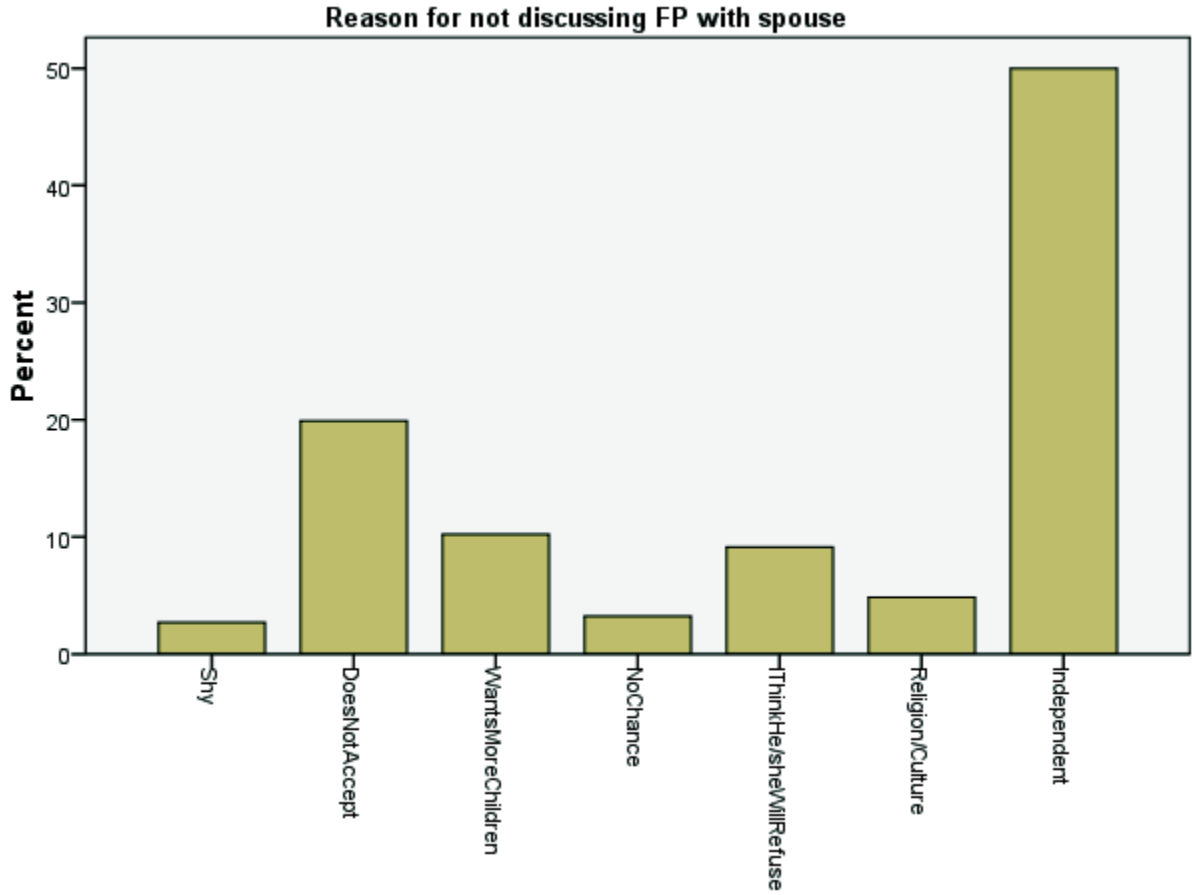
Factors	**Current use of family planning**				**Total %**
	Yes		**No**		
	Freq	**%**	**Freq**	**%**	
Spousal communication: Yes	70	24.8%	80	28.4%	150
No	42	14.9%	90	31.9%	132
Total	**112**	**39.7%**	**170**	**60.3%**	**282**
Pearson's X^2= 12.234,	df= 1,	P=0.000			
Final decision: Self	44	15.6%	65	23.1%	109
Spouse	8	2.8%	26	9.2%	34
Both of us	60	21.3%	79	28%	139
Total	**112**	**39.7%**	**170**	**60.3%**	**282**
Pearson's X^2= 8.533	df= 1	P= 0.036			
Knowledge of beliefs: Yes	7	2.5%	16	5.7%	23
No	105	37.2%	154	29.2%	259
Total	**112**	**39.7%**	**170**	**60.3%**	**282**
Pearson´s X^2= 1.909	df= 1	P= 0.167			

Final decision: From table 4.6, majority of the respondent made family planning decisions as a couple 60 (21.3%), followed by those who made the decision as individuals 44 (15.6%). The rest 8 (2.8%) had their spouses make the final decision.

Knowledge of beliefs: Only 7 (2.5%) of FP users knew of any cultural or religious beliefs related to use of contraception. The beliefs that were pointed out included; Christianity beliefs that discourage hindering of the reproduction process (6%), reduction of sexual prowess (0.4%) and that FP causes miscarriages as a punishment from supernatural beings (0.4%).

Spousal communication: The majority of respondents discussed family planning with their spouses 150 (53.2%) while 132 (46.8%) did not. Those who discussed it with their spouses 70 (24.8%) were more willing to use contraception than those who did not 42 (14.9%). The reasons for not discussing FP with spouses are shown in figure 4.3.

Figure 4.3: Percentage distribution of reason for not discussing contraception with spouses



Spousal communication and final decision making on modern FP use were statistically significant in determining contraceptive use because $p<0.05$.

4.3.4 Access factors

The factors that were considered included source of information, service points, distance and spending.

Source of information:

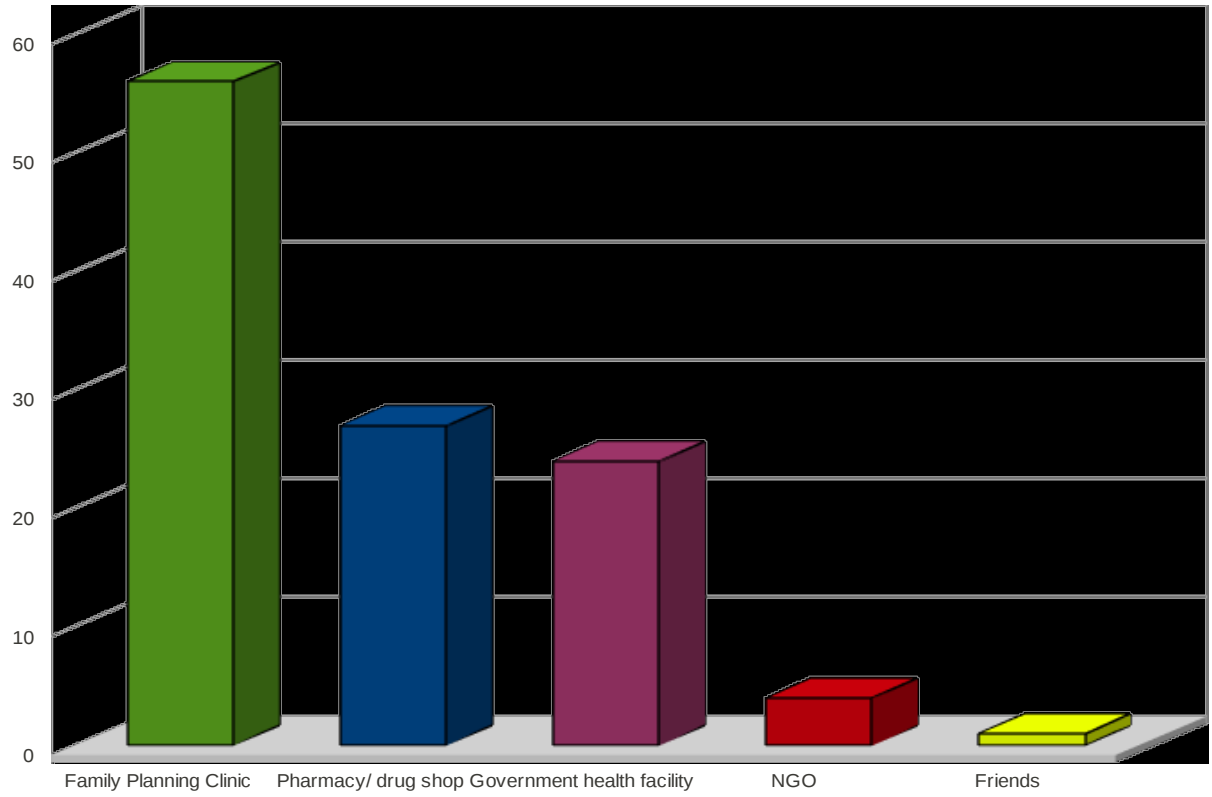
The major source of information for users of FP was from health workers at the health centres at 61 (21.7%). Friends and relatives constituted 47 (16.7%) and 4 (1.4%) relied on media.

Family planning service points:

Family planning clinic were the main service points 60 (21.3%) followed by pharmacies and drug shops 27 (9.6%). Government health facilities had 24 (8.5)respondents using them as service points, NGOs had 4 (1.4%) and 1 (0.4%) from friends.

The government health centres that were mentioned included Kiswa health centre, Naguru health centre and Naguru teenage centre.

Figure 4.4: Frequency distribution of family service points



Distance:

Of all the users, 36 (12.8%) travelled a distance of less than 0.5 km to the family planning service points, 50 (17.7%) travelled a distance that is between 0.5 and 1 km, 21 (7.4%) of the respondents travelled 1 to 5 km, and 5 (1.8%) travelled more than 5km.

Spending

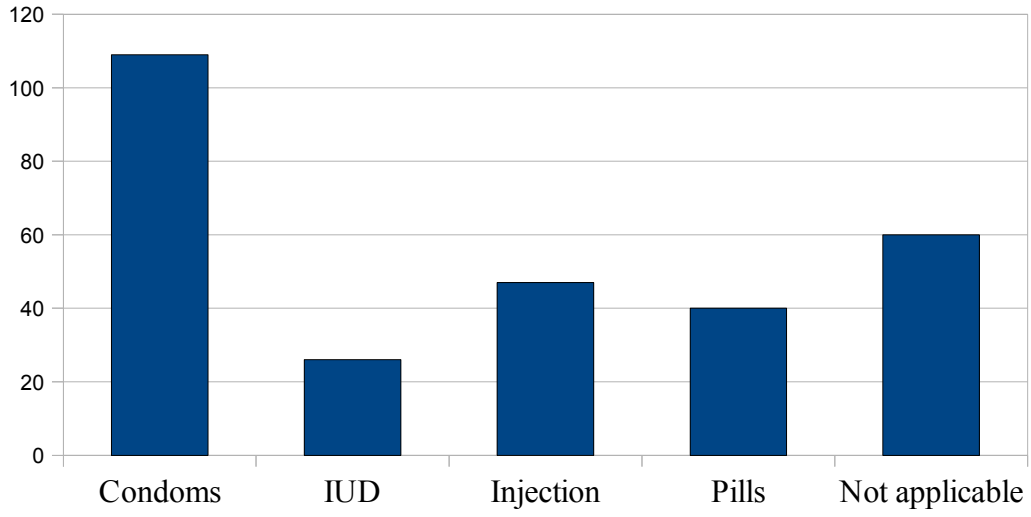
Spending on Family planning at the point of access was measured over a three months period. The majority of the users 80 (28.4%) of the FP users spent 1000-5000 Uganda shillings on family planning, 14 (5%) spent less than 1000 shillings, 8 (2.8%) spent over 5000, and 8 (2.8%) spent no money on procuring the services or products for each visit to the centre. Those that did not spend any money were those obtaining the services from government health facilities.

4.4 Knowledge

4.4.1: Knowledge of methods

Of all the people interviewed, 222 (78.7%) said that they had ever heard of family planning and 60 (21.3%) had never heard of it. From figure 4.5, the commonly known methods were; condoms 109 (38.7%), injections 47 (16.7%), pills 40 (14.2%), and IUD 26 (9.2%). Of those who said that they had never heard of it, 46 (16.3%) admitted to using condoms. This means that these respondents do not know that condoms are a form of family planning.

Figure 4.5: Frequency distribution of knowledge of methods



4.4.2: Relationship between knowledge and use of contraception

From table 4.7, except for respondents with knowledge of pills, those who knew of other methods were more willing to use contraception than their counterparts who did not know of the methods. Since $p<0.05$, we can conclude that knowledge of methods is significantly related to contraceptive use.

Table 4.7: Relationship between knowledge of methods and use of contraception

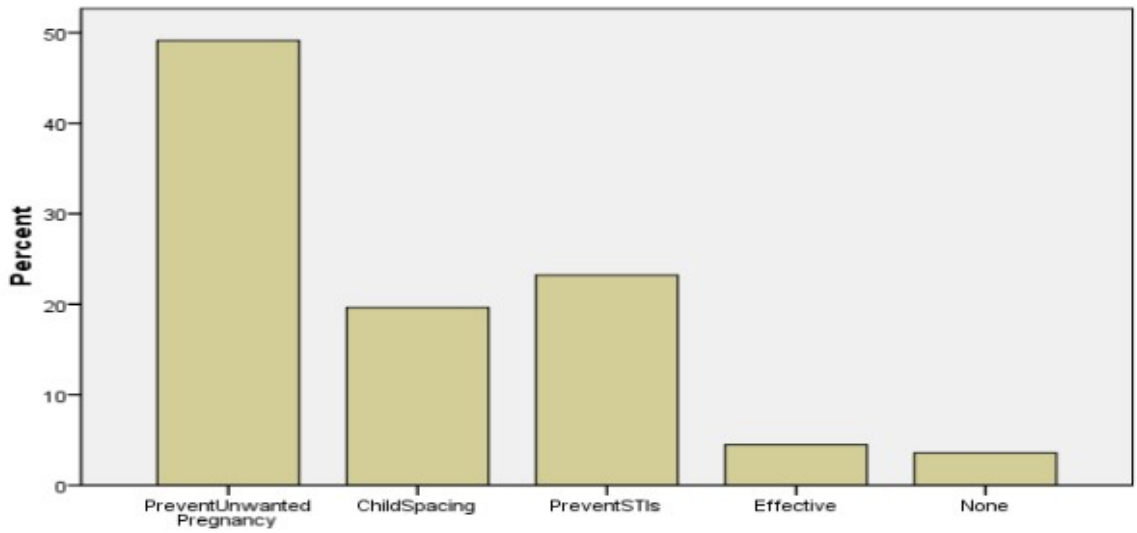
Method	Current use of family planning				Total (Freq)
	Yes		No		
	Freq	%	Freq	%	
IUD	27	9.6%	33	11.7%	60
Condoms	62	22%	81	28.6%	143
Pills	12	4.2%	30	10.6%	42
Injections	11	3.9%	26	9.2%	37
Total	**112**	**39.7%**	**170**	**60.3**	**282**
Pearson´s X^2= 9.301		df= 3	P= 0.026		

4.5: Attitude

4.5.1 Advantages of method of choice

In the figure below, the main advantage of contraception pointed out by the respondents was prevention of unwanted pregnancy 55 (19.5%),followed by prevention of STIs 26 (9.2%). This means that among the respondent that participated in this study, the need for limiting the number of children was higher than the need for spacing them.

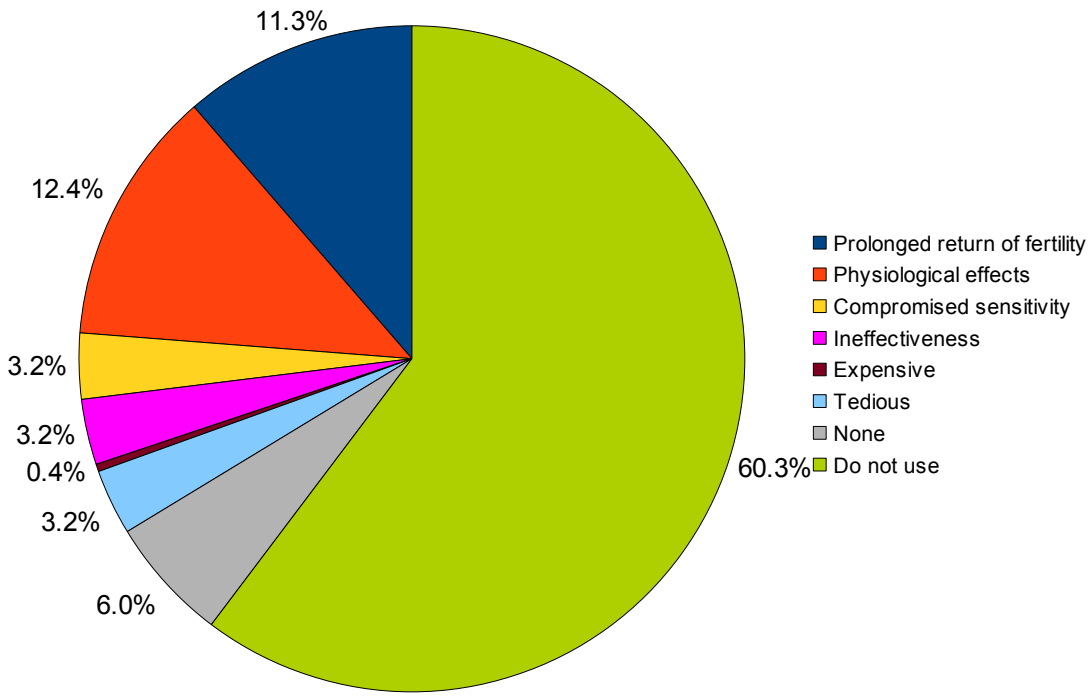
Figure 4.6 Percentage distribution of advantage of method of choice



4.5.2 Disadvantages of method of choice

From figure 4.7, the disadvantages that respondents cited with the methods they were using included; Physiological effects 35 (12.4%), prolonged return of fertility 32 (11.3%), compromised sensitivity (3.2%), ineffectiveness (3.2%), tedious (3.2%) and expensive (0.4%), while 5.7% of the respondents did not find any disadvantage in their method of choice. The remaining 170 (60.3%) were not FP users. In addition to this, 67 (23.6%) respondents said that they had noticed side effects with the methods that they were using and due to this, 38 (13.5%) people said that they planned to stop using contraception in the future.

Figure 4.7: Frequency distribution of disadvantage of family planning method of choice



Majority of the respondents attributed the failure of modern contraception to side effects 147 (52.1%) followed by limited knowledge of contraceptive methods 81 (28.6%), expensive methods 30 (10.7), and

the need for more children 16 (5.7%).

CHAPTER 5

DISCUSSION OF RESULTS

5.1 Population characteristics

In this study, women were more willing to be participants than men. Most of the men lost interest as soon as they realised that the study was about modern contraception. Many of them associated FP with women. This immediately points out the perception of the men and how limited their involvement in family planning is.

Similar to recent reports by the population secretariat, Namuwongo has a high composition of youthful population and these are either students, casual labourers, or unemployed. This presents a constraint in the country´s economic status because this cluster of the population does not contribute economically to the country´s economic prowess. Moreover, the majority of them had only achieved up to primary education (40.4%) and only 5.7% had gone on to acquire tertiary education. This in itself puts the population at a competitive disadvantage.

Since 63.8% of the respondents were married, this, coupled with the fact that the population is mainly youthful and the CPR is considerably low, presents difficulties in planning and providing for the future population. Nonetheless, there is potential in this age group if it is invested in economically. (Commonwealth Secretariat, 2007). This economic boost should be done together with health education and promotion of modern methods.

5.2 Contraceptive prevalence rate (CPR)

This study found the contraceptive prevalence to be 37.9%. This however did not take into account the people who were using condoms but had said they were not using condoms. When these are incorporated, the CPR increases to 46.8%. This meets and surpasses the HSSP III target of 35%. (HSSP III, 2010). This however cannot be representative of the country´s CPR because it is only a portion of the total population and Namuwongo being in the urban area, its residents have considerable access to family planning and other health services, as is the case in many comparative studies in which access for the urban population is more abundant compared to that of the rural population. From this study, the CPR seems promising, however, with 38 people planning to discarding FP because of side effects, the CPR is bound to reduce. This requires for more effort to either maintain, or increase the current CPR.

Similar to the UDHS results of 2006, most of the modern FP users relied on injectables (18.1%), followed by condoms (16%) as a modern method of family planning. Seemingly, utilization of other

methods, especially long-term, or permanent methods is minimal. This study did not reveal anyone using a permanent method and even then, people´s contraceptive choices seem to be limited as they rely on methods that have been widely used by people that they know. A similar study by Bogale, 2011 revealed that injectables were the commonest method, followed by pills, and that permanent methods faced resistance.

5.3 Factors which influence the utilization of modern contraceptive methods

Previous studies of family planning knowledge, attitude and practice have focussed on women. This study, however, took into account both women and men as the influence of men on utilization of modern contraception has proved to be significant in determining women´s use of the methods and ultimately an increase in the overall CPR as a study by Tsedeku revealed in 2006. Much as there were few men as participants, this may be a starting point for the government´s plan to involve men in reproductive health issues.

5.3.1 Demographic and socio-economic factors

The UDHS, 2006 revealed that use of any contraceptive method generally rose with age. This was not the case in this study as there were more youths (15-24) using contraception. This could be because there were more respondents in this age group than any other. Also, married women were more likely to use modern contraception. The average number of children was 1.5 children which showed a considerable reduction in the fertility rate. This however is not sufficient ground to base on a conclusion, and even if this was the case in this study, parity was not statistically significant in determining current use of modern contraception. Education, religion, and occupation were not statistically significant either, which implies that their influence on utilization of modern FP is minimal. This is contrary to previous studies by Ijadunola, 2009 and UDHS, 2006. This could mean that the trend of the factors that influence the utilization of modern contraceptives has shifted from individual characteristics to method specific factors like side effects, effectiveness, cost, period of utilization, and other social factors.

Contrary to popular beliefs that Catholicism negatively influences people's use of contraception, in this study, Catholics constituted 36.9% and 28.8% of total respondents and users of modern contraception respectively. The protestants and moslems followed with 29.4% and 19.6% respectively. This further affirms that the factors influencing the use of contraception may be shifting from demographic factors to method specific and social characteristics.

5.3.2 Access factors

Majority of the respondents relied on information from health workers followed by friends or relatives, then by the media. This was contrary to UDHS study of 2006 where the media was the major source of information but similar to results of a recent study by Qazi et al in Pakistan in 2010 which also revealed that the major source of information was general practitioners and family planning workers. This could be attributed to the fact that over the years, the effort put in health education and promotion of family planning methods has reduced and people have to source it out themselves. Needless to say, this could be one of the contributing factors to the limited choice and utilization of modern contraception.

Most of the respondents relied on family planning clinics-where they are expected to pay- as their FP service points. Surprisingly, government health facilities, where FP services are supposedly free, are not accessed by the majority of FP users. It is important to note that these facilities have been known to have constant drug stock outs, expired drugs, and health workers with poor attitudes toward clients. Also, the distance to the government health facilities accessible to the population was a contributing factor. The closest government health facilities at the time of the study were Kiswa health centre, Naguru health centre and Naguru teenage centre for the youth. This could have contributed to people shunning these for nearer, client friendly FP service points.

5.3.3 Social factors

In this study, spousal communication and final decision making were statistically significant in determining utilization of modern contraception. The percentage of couples discussing modern FP was 150 (53.2%) and 60 (21.3%) of decision making about FP was done by couples, not individuals. A study done by Mustafa et al in 2008 also found out that partner opposition was significant in determining contraceptive use. This confirms the need expressed by Ogunjuyigbe et al, 2009, to involve men in issues of FP. This strengthens couple communication and decision making, which makes FP use sustainable.

5.4 Knowledge , attitude and practice

Knowledge of contraceptive methods among respondents was considerably high at 78.7%. The most popular methods were condoms and injectables. There were gaps in knowledge as 16.3% of respondents who admitted to having no knowledge of FP methods said they were using condoms. This could mean that this proportion of the population uses condoms for prevention of STIs but are not aware that it is a form of contraception. This presents an opportunity for the government to strengthen the promotion of condoms as a method contraception since these are widely known and acceptable. Knowledge of family planning was statistically significant which implies that it plays a major role in influencing people's

decision to take up contraception. Results from this study revealed that only 31.9% of the respondents had ever received health education. Therefore, more effort should be invested in educating people about the methods that are available more so since this was the major recommendation pointed out in order to increase contraceptive uptake.

Side effects (36.36%) were the major hindrance to modern FP use. There is insufficient evidence to back this claim as past studies have not focussed on the role of side effects. This exhibits gaps in the issue of side effects and its effect on CPR, however, they could be attributed to uninformed decision making or even misconceptions regarding modern FP methods. This is heightened by limited health education and health promotion of modern FP. Other non users said that they were not at risk (22.73%) and 13.64% that their spouses had objected. This shows that family planning health education needs to be done for both men and women as couples such that the men will be brought on board. Religion only constituted 5.45% of reasons for none use as cultural beliefs was the most insignificant reason at 0.91% which implies that people´s attitudes toward use of modern contraception are not driven by religious and cultural beliefs.

Some of the users had not received any explanation from health workers about their methods of choice. Instead, when they noticed side effects, they either changed the method without consulting the health worker or stopped using contraception. This de-motivational and it is no wonder that some of them said that they would stop using modern FP because of these side effects.

The commonest method used was condoms and injections. Condoms could have been chosen because they are cheap and easily accessible, while injections could have been chosen because it is relatively cheap and the injection is taken once every three months. This is better for them in terms of frequency of visits to the FP service centres and in cases of disagreement with spouses about use of FP than the pill that has to be taken on a daily basis at the same time. There was no mention of use of long term methods of FP. Evidently, the choices available to the users are limited to about four methods, that is, the pill, IUD, condoms, and injectables.

The 2006 UDHS showed that the need for spacing(25%) was higher than the need for limiting (16%). This seems to be the trend in other developing countries, unlike developed nations . This study however, proved other wise as the need for preventing unwanted pregnancies at 19.5% was much higher than the need for spacing (1.8%). Even the need for prevention of STI surpassed it at (9.2%). These results are promising of a smaller population, if at all people do not shun modern FP because of side effects, and of the transitions in population dynamics and FP trends.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Whether CPR will increase to meet some of the MDG targets remains uncertain for Uganda. Much as there seems to be slight increases in CPR, it is threatened by people's doubts, brought about by side effects of modern contraception. A low CPR has and still cripples the country's economic progress. The country faces an even greater challenge with its high youthful population that is unproductive and high urbanisation rate. If this situation is not reversed, the country is bound to sink deeper into poverty and ill health. The health indicators including Maternal, infant and child mortality rates may become worse, teenage pregnancies will definitely increase, malnutrition will set in and the economy may collapse completely.

In some African countries, some of which were in a worse situation than we are currently in, FP has thrived amidst various constraints, including political and religious limitation. Family planning is possible in Uganda. The major hindrance seems to be limited knowledge about the various methods, including emergency contraception, long term and permanent methods of modern contraception. These have not been promoted as much as they should be, yet modern FP seems to be the one viable solution to Uganda's failing health indicators even to the point of steering the country to meeting many of the MDGs.

The potential in the youthful population should be exploited to the greatest level to achieve economic progress, but while at this, the population should be led to see the benefits of using modern FP by encouraging individual and couple communication in FP decision making and addressing modern FP method specific obstacles to its use. This is sustainable because the benefits can be felt by individuals and when the population is controlled, there unwanted pregnancies are avoided, fewer mothers, infants and children will die, there will be a smaller population to plan and provide for, and the quality of life will generally improve. If the citizens can be made to see this through health promotion and health education on modern contraception, Uganda will soon benefit from investing the available resources in modern family planning methods.

6.2 Recommendations

Health Education and health promotion of modern family planning methods should be increased as there seems to be gaps in knowledge. This should be tailored to meet the needs of the different age groups and should be promoted using routes accessible to those age groups.

This research has revealed that people have limited access to FP services and there are no health workers to aid FP users to make informed decisions. The study also found out that while FP services are free in government health facilities, people still choose to go to private health providers. The government should partner with private Family planning service providers to make FP services more accessible to the general population.

The role of men in family planning issues could no longer be ignored because their spouses look up to them for FP decision making. FP messages should also encourage men to use the FP services available like condoms and vasectomy.

Long term methods of FP should be provided in health centres and encouraged such that modern FP users have a wide range of FP choices available to them. Health workers should as well be trained in administering these methods to clients who may need them.

There should be further studies on the perceived side effects of modern family planning methods. This is because it is unclear as to whether the claim that FP methods have side effects has a basis. In the event that there is no basis, the myth should be dispelled such that people can again gain confidence in the methods.

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