

Investigation of the Factors Influencing Utilization of Modern
Contraceptives among Women (18-45years) in Mukura
Sub-County, Ngora District

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Akurut Immaculate

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Declaration

I have read the rules of International Health Sciences University on plagiarism and hereby state that this work is my own.

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Throughout the work I have acknowledged all sources used in its compilation.

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Researchers Signature:

Name of Supervisor:

Supervisors Signature:

Date of Submission:

Submitted to:

DEDICATION

I dedicate this dissertation to all my family members; my father and mother Mr. and Mrs. Rose Ouno, my brothers and sisters; Otwao Justin, Asio Martha, Asekenye Joy, Titin Esther, Opio Noah, Odongo Joshua, Okello Emmanuel, Akiriat Catherine, Elwana Ezra and my grandmother Asio Kevin.

It has been a blessing to have you and may God continue richly blessing you.

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God bless you richly.

LIST OF ACRONYMS

HIV	:	Human Immunodeficiency Virus
HSSP	:	Health Sector Strategic Plan
IUCDs	:	Intrauterine contraceptive devices
IUDs	:	Intrauterine devices
LAM	:	Lactational devices
LAPMs	:	Long acting and permanent contraceptive methods
MDGs	:	Millennium Development Goals
MMR	:	Maternal Mortality Ratio
MOH	:	Ministry of Health
UDHS	:	Uganda Demographic and Health Survey
UNFPA	:	United Nations Population Fund Agency
UNICEF	:	United Nations International Children's Fund
USAID	:	United States Agency for International Development

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ABSTRACT

This study aimed at finding out the factors that are influencing the utilization of modern contraceptives among women aged 18-45 in Mukura Sub County, Ngora district.

Mukura Sub County is one of the sub counties in the newly created Ngora district and is generally characterised by poor contraceptive use, high levels of early and teenage pregnancy as well as early marriages driven by the desire for parents to get wealth (cows from the dowry).

This study therefore, sought to look into the different aspects of contraceptive use using an investigation with the specific objectives of: finding out the current modern contraceptive prevalence rate in the area, availability and accessibility of the modern contraceptives, knowledge of the women on the different contraceptives; and determining the motivational and operational factors in the health units that had a role to play in influencing the use of modern contraceptives.

The study employed a cross sectional descriptive study design that was chosen so that the researcher would be able to measure current variable indicators related to contraceptive use. The data collection involved both qualitative and quantitative strategies of administering questionnaires and holding key informant interviews.

The findings of the study indicated a current contraceptive prevalence of 19.2 percent and the knowledge of at least one contraceptive method among women to be as high as 99 percent. Factors like the nature of employment and the highest level of formal education attained were found to have a statistically significant relationship with contraceptive use. Meanwhile, religion and distance to the nearest health facility were found not to have any statistically significant relationship with contraceptive use.

Furthermore, the study established that the fertility rate was highly statistically significant with the non use of modern contraceptives implying that women who were not using contraceptives were more likely to have a greater number of children as compared to those using contraceptives.

The motivational and operational factors believed to be influencing the use of modern contraceptives were cited to be: the need for child spacing as well as having a manageable family size which came up as the major motivators whereas factors like; fears of side effects and health concerns (infertility and excess bleeding) came up as the major demotivating factors. On the other hand, operational factors in the health units included; lack of sufficient infrastructure, human resource, supplies and proper communication avenues for family planning information.

The researcher therefore recommended the greater improvement of the way family planning information is disseminated as well as the need for more refurbished and equitably distributed health facilities and more human resource to be put in place to help better access and availability of family planning services to the women and the communities at large.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

Introduction

Contraceptives are drugs, methods or objects used for preventing a woman from getting pregnant. Contraceptives are grouped into two types: the modern and traditional methods. Modern contraceptives include: female sterilisation, contraceptive pills, intrauterine devices (IUDs), injectables, implants, male condoms, female condoms, lactational amenorrhea (LAM), and emergency (“morning after”) contraception. The traditional contraceptive methods include the rhythm method (periodic), breast feeding and withdrawal.

Reproductive health requires careful attention because it constitutes a sensitive component of public health. It is estimated that each one million dollar shortfall in support for reproductive health supplies means 360,000 unplanned pregnancies, 150,000 additional induced abortions, 11,000 infant deaths and 14,000 deaths of children under five years (UNFPA, 2006). This is a clear indication that contraceptive use plays an important role in reproductive health. In Uganda for instance, 41 percent of women have no access to family planning methods and maternal mortality ratio (MMR) stands at 435 deaths per 100,000 live births, yet less than 10 percent of the national budget is allocated to health (WHO, 2006; MOH, 2005).

Background

According to the National census of Uganda, the population of the country increased five times during the second half of the 20th century, from 5.0 million people in 1948 to 24.3 million in 2002. Significant population growth rate was recorded in one decade, at 3.2 percent per annum between 1991 and 2002. In 2007, Uganda's population was estimated to be 30 million and at the current growth rate, the country's projected population will be 55 million in 2025 and 130 million in 2050. Many factors may play a role in contributing to such an exploding population but keen attention should be paid to the persistently high total fertility rate of 6.9 children per woman in 2001 and 6.7 in 2006 (UDHS, 2006/2007). This can be attributed to the rate of contraceptive use, with the current contraceptive prevalence rate being as low as twenty-four percent and access to and utilization of family planning services remaining low coupled with the continuously high unmet need for family planning of forty-one percent.

Problem Statement

In Uganda, the level of awareness and knowledge of family planning is high in many areas with ninety-seven percent of all women (aged 15-49) having heard of at least one method of family planning (UDHS, 2006/2007: 65). However, the adoption of family planning practices seems to be poor with the country's contraceptive prevalence rate standing at twenty-four percent by 2007. Access to and utilization of family planning services seems to have remained low coupled with the continuously high unmet need for family planning of forty-one percent country wide (UNFPA, 2007).

Ngora district is in the eastern region of Uganda, which is reported to have the second highest total fertility rate (TFR) (7.4) in the country (UNFPA, 2007) as well as high teenage pregnancy and early marriages. Furthermore, the eastern region has a contraceptive prevalence of twenty percent which is lower than the national contraceptive prevalence rate

(UDHS, 2006/2007: 70) and this fuels fertility. Consequently, with such high rates of fertility as opposed to the low levels of contraceptive use among women, much is needed to be done to improve the adoption of family planning practices in Uganda with the prime target being the young mothers and generally women in the reproductive age bracket. This can only be done when the factors influencing the use of modern contraceptives are known and understood.

Justification of the study

On average eighty-five percent of Ugandan women are estimated to be sexually active by the age of 20 (UDHS, 2006/2007: 90) and this is reason enough for the high age specific fertility rate (309 per 1,000 women) at the age of 20-24 which takes first place nationally (UDHS, 2006/2007: 53). In addition, very few women in Uganda in the proportion of eight in ten women aged 15-19 have never given birth as compared to only two in ten women aged 20-24 who have never given birth (UDHS, 2006/2007: 58). This trend of events has greatly contributed to the high TFR of 6.7 in Uganda. This is contrary to the target of the Uganda HSSP II (2005/6-2009/10) which targets to reduce total fertility rate from 6.9 to 5.4 and to increase contraceptive prevalence rate from twenty-four percent to forty percent. Therefore, the findings of this study will help contribute to that cause. This will be useful in that both the local people and the policy makers will be able to identify the pressing issues pertaining to low contraceptive use among young adults and, consequently, find ways to address the existing problems.

The study is hoped to contribute to the provision of specific action plans to local government and the MOH to address the current problem of unmet needs of contraceptive use in Uganda, as well as the high rate of teenage pregnancy associated with other problems like maternal and infant mortality and as a result, addressing such special areas of need will help the country move towards the attainment of the desired contraceptive prevalence target as well as

try and curb the high maternal and infant mortality rates.

General Objective

The main objective of this study was to investigate the factors influencing the utilization of modern contraceptives among the women aged 18 to 45 years in selected villages in Mukura Sub-county, Ngora district.

Specific Objectives

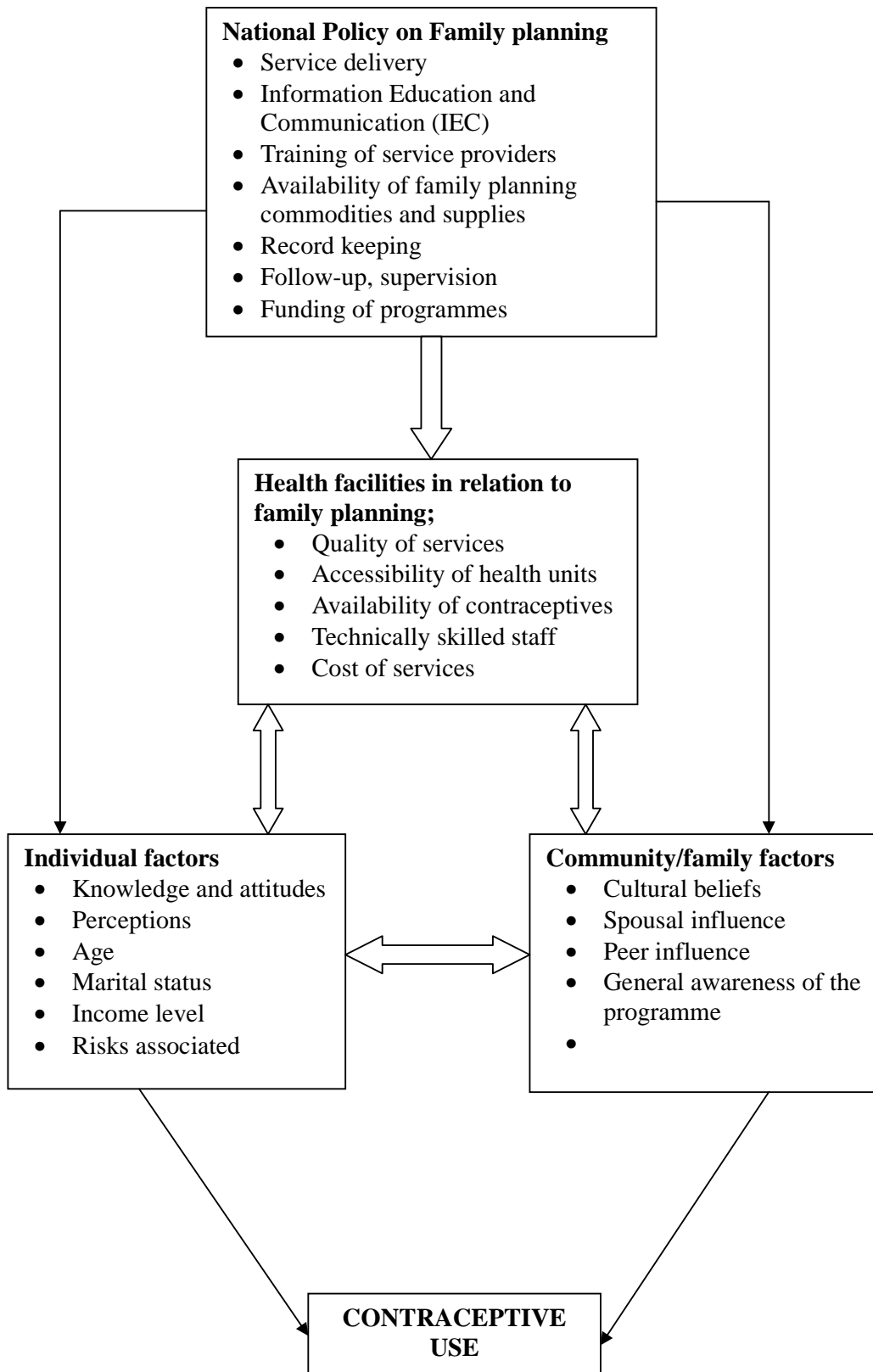
1. To determine the current modern contraceptive prevalence rate among women aged 18-45 years in Mukura Sub-county.
2. To establish the level of availability, and accessibility of modern contraceptives to women aged 18-45 years in Mukura sub-county.
3. To find out the level of knowledge and attitudes of women aged 18-45 years towards the use of modern contraceptives in Mukura Sub-county.
4. To investigate the operational factors in health units that might be influencing the utilization of modern contraceptives among women aged 18-45 years in Mukura Sub-county.
5. To find out the motivational factors that might be influencing the use of modern contraceptives among women aged 18-45 years in Mukura Sub-county.

Research Questions

1. What is the current prevalence rate of the modern contraceptive methods among women aged 18-45 in Mukura Sub-county?
2. What are the available modern contraceptive methods in Mukura Sub-county?
3. How accessible are modern contraceptives to the women in Mukura Sub-county?
4. What are the attitudes of the women towards modern contraceptive methods of family planning?

5. What are the prevailing operational and motivational factors in the health units and community that might be influencing the utilization of modern contraceptive methods among women aged 18-45 in Mukura Sub-county?
6. What is the level of knowledge of modern contraceptives among women aged 18-45 years in Mukura Sub-county?

Conceptual Framework



The issue of contraceptive use has various factors that come into play to bring about the respective contraceptive prevalence rate. These factors are from different levels ranging from national to individual level. The National Policy to begin with has a great role it plays as far as family planning issues are concerned. The strategies and activities consequently carried out at the national level have a big impact on the other levels like health facilities up to the grass roots. The policies made may either increase or decrease uptake of contraceptives. Looking at the aspect of improved service delivery and communication avenues, this would directly have an effect on the individual and community perception of what contraceptive use actually entails. The more sensitization and awareness campaigns carried out, with well packaged information helps better understanding, and the more knowledgeable the communities and individuals will be. This will consequently build up more women willing to use contraceptives. Increased funding of the programme and training of the staff will also ensure that quality services are put into the health centres and consequently rolled out into the communities as a result; services are made available for individual use.

The health facility factors also interplay with individual and community factors to affect the rate of use of modern contraceptives. The community factors like cultural beliefs and practices which encourage large families or take pride in having a certain sex may be detrimental to efforts made towards improving contraceptive prevalence. Spousal influence is the other family issue that may be of great importance. Men have a key role in deciding how many children they should have, so women may have little or no say when they disagree with contraception.

The individual factors like fear of the risks associated with contraceptive use for the perceived side effects has a direct negative effect on the modern contraceptive prevalence rate.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter reviews the literature and is organized in the following order - an overview of the modern contraceptives methods of family planning, factors affecting use of modern contraceptive methods and the trend of contraceptive use.

An Overview of the Modern Contraceptive Methods of Family Planning

According to WHO and USAID (2007), there are two categories of modern contraceptives and these include: hormonal and non hormonal methods. Among these two categories we have the long acting and permanent contraceptive methods (LAPMs). The different methods are further explained as shown below:

Oral contraceptives (Pills):

This contraceptive is in the form of a pill containing low doses of two hormones; estrogen and progestin, which inhibit ovulation and so prevent conception. They work similarly to the natural hormones progesterone and estrogen in a woman's body which work primarily by preventing the release of ova from the ovaries (WHO, 2007). Although combined contraceptives are reported to have side effects including changes in bleeding patterns (such as excessive bleeding and a few days of bleeding, irregular bleeding, infrequent bleeding or no monthly bleeding) headache, dizziness, breast tenderness, weight change, and mood change; these could either improve or worsen, but usually improves and there are several ways of managing these side effects. Therefore, preference of the method is important as they are controlled by the women, can be discontinued any time without a

provider's help and they do not interfere with one's sexual life. These further reduce menstrual cramps, menstrual bleed problems and ovulation pain (WHO & USAID, 2007).

Emergency Contraceptive Pills (ECP):

It is a modern contraceptive method of family planning comprising of the pills that contain progestin only, or progestin and an estrogen together. These are also called "morning after" pills or post coital contraceptives, and work by preventing or delaying the release of ova from the ovaries (ovulation) but do not work if the woman is already pregnant. The ECP can be taken as soon as possible within 5 days after unprotected sex to prevent pregnancy.

Research conducted by WHO (2007) showed that if 100 women, each had sex once during the second or third week of the menstrual cycle without using contraception, 8 would likely become pregnant. If all 100 women used progestin only contraceptive, one would likely become pregnant, and if all 100 women used estrogen and progestin, 2 would likely become pregnant. Such studies show the effectiveness of contraceptive methods in preventing pregnancy and therefore checking population growth, infant mortality, child mortality and maternal mortality.

Progestin – Only Pills (POP's):

These are pills that contain very low doses of progestin like the natural hormone in the woman's body. They do not contain estrogen, and so can be used throughout the breastfeeding period and by women who cannot use the contraceptives with estrogen. Progestin – Only Pills are also called "minipills" and progestin only oral contraceptives. They work primarily by thickening the cervical mucus by disrupting the menstrual cycle, including the release of the ova from the ovaries (ovulation). However, the effectiveness depends on the user and can be discontinued anytime without a provider's help.

Injectable Contraceptives (progestin only injectable):

These are modern methods of contraceptives which are the injectable contraceptives Depot Medroxyprogesterone Acetate (DMPA) and Norethisterone Anentate (NET-EN) that contain a progestin like the natural hormone progesterone in a woman's body. They do not contain estrogen and so can be used throughout breastfeeding and by women who cannot use contraceptives with estrogen. The injections are given intramuscularly and the hormone is then released slowly into the blood stream to prevent the release of ova from the ovaries. Studies by UNICEF (2007) indicate that, the effectiveness of injectable contraceptive methods depends on getting injections regularly; the risk of pregnancy is greatest when a woman misses an injection which works primarily for a month, 3 months and for 6 months. When commonly used, it is reported that there are about 3 pregnancies per 100 women using progesterone – only Injectables over the first year. This means that 97 of every 100 women using Injectables will not become pregnant. When women have injections on time, there will be occurrences of less than 1 pregnancies per 100 women using progesterone only Injectables over the first year (3 per 1,000 women).

Condoms:

This is another scientific modern contraceptive method consisting of both male and female condoms. Male condoms are sheaths or coverings that fit over a man's erect penis. They are also called "rubbers", "raincoats", and "umbrellas" known by different brand names. Most of these are made of a thin latex rubber and work by performing as a barrier that keeps sperm out of the vagina, preventing pregnancy. They also keep infections in semen, on the penis or in the vagina from infecting the other partner. It is important to note that, the effectiveness of this method depends on the user. However, the risk of pregnancy or SDI is greatest when condoms are not used with every act of sex and the method has no side effects. If commonly used, about 15 pregnancies per 100 women whose partners use male

condoms over the first year are likely to occur, and this means that 85 of every 100 women whose partners use condoms will not become pregnant. When used consistently and collectively, condoms prevent eighty percent of HIV transmission that would have occurred without condoms. There are also female condoms that are sheaths, linings that fit loosely inside a woman's vagina, made of thin latex at both ends. They work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy and infections. When used correctly with every act of sex, about 5 pregnancies per 100 women using female condoms may occur over the first year. However, there are misconceptions on female condoms that; it is difficult to use, can get lost into the woman's body, and have holes that HIV can pass through. These misconceptions are wrong and need to be corrected.

Long Acting and/or Permanent Contraceptive methods:

Four contraceptive methods are categorized as long-acting and/or permanent: intrauterine devices (IUDs or IUCDs), implants, female sterilization, and vasectomy. IUDs and implants are long-acting temporary methods; when they are removed, return to fertility is prompt. Copper-containing IUDs, the ones generally available in African Ministries of Health (MOH) family planning programs, are effective for up to 12 years. Implants, depending on the type, last for up to 3-7 years. Female sterilization and vasectomy, on the other hand, are permanent methods.

Long-acting and permanent methods for example female sterilization and vasectomy are by far the most effective (ninety nine percent or greater) methods of modern contraception available, and are very safe and convenient. They are all clinical methods and thus must be provided in health facilities by trained doctors, nurses, and/or midwives. Only one action by a client and provider results in years of protection against unwanted pregnancy. Long-acting and permanent contraception is vital to fulfilling the MOH's mission to help protect and improve its citizens' health and to help achieve national development goals.

Experience globally as well as in Sub-Saharan Africa confirms that without widespread availability and use of long-acting and permanent methods of contraception, a country cannot cost effectively meet its lowered fertility goals. In turn, inability to reduce high fertility contributes directly and substantially to poor health, poverty, low levels of education, and high under- and unemployment - that is, to low national productivity, economic growth, and socio-economic development. These methods are further discussed here below:

Female sterilization:

This is a permanent contraception method for women who want to completely stop childbearing. The two surgical approaches most often used for this method include, minilaparotomy which involves making a small incision in the abdomen when the fallopian tubes are brought to the incision to be cut or blocked; and also laparoscopy which involves inserting along thin tube with a lens into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tube in the abdomen. The method is also called tubal sterilization, tubal ligation, voluntary surgical contraception. The method works because the fallopian tubes are blocked or cut and eggs released from the ovaries cannot move down to the tubes and so they do not meet sperms. The method is one of the most effective but carries a small risk of failure.

Studies have further indicated the occurrences of less than 1 pregnancy out of 100 women over the first year after having the sterilization procedure (5 per 1,000). This means that, 995 of every 1000 women relying on female sterilization will not become pregnant.

A small risk of pregnancy remains beyond the first year of use and the woman reaches menopause. Over 10 years of use; there will be an occurrence of about 2 pregnancies per 100 women (18 to 19 per 1,000 women). However, the effectiveness varies depending on how the tubes are blocked, but pregnancy rates are low with all techniques. There are no side effects associated with the method except cases of complications of surgery; which carries some

risks such as infections or abscess of the wound.

Implants:

These are small flexible nodules or capsules that are placed just under the skin of a woman's upper arm. They provide long term pregnancy protection and are effective for 3-7 years, depending on the type of implant. These work primarily by thickening cervical mucus (this blocks sperm from fertilizing the ovum), disrupt the menstrual cycle, including preventing the release of ova from the ovaries. This is one of the effective and long standing modern contraceptive methods.

It has been reported that there would be an occurrence of less than 1 pregnancy per 1,000 women using implants over the first 1 year (5 per 1,000 women), and this means that 9,995 of every 10,000 women using implant will not become pregnant.

Vasectomy:

This is a permanent contraception method for men who will not want to continue bearing children. Through a puncture or a small incision in the scrotum, the doctor locates each of the 2 tubes that carry sperms to the penis and tube, the tubes are then blocked by cutting and tying them closed or by applying heat or electricity (cutlery). The method is also called male sterilization or male surgical contraception.

Studies show that where men can have their semen examined after vasectomy, there would be an occurrence of less than 1 pregnancy per 100 women over the first year after their partners have had vasectomies (2 per 1,000). This means that 998 of every 1,000 women whose Partners have had vasectomies will not become pregnant. However, the method is not fully effective for the first three months.

Factors affecting the use of modern contraceptive methods of family planning

Among the factors that affect the use of modern contraceptives are: education, occupation and communication among couples concerning contraception. According to a study carried out by Oyedokun (2007) in Osun state in Nigeria, these factors were found to have a significant impact on the use of modern contraceptives. He found out a positive significant impact on educational level of the respondents and that the impact of spousal communication about contraception and approval of a contraceptive method were particularly pronounced when there is spousal communication about contraception and when the couple approves a method of contraception to use. The study also found out that age and education of the husbands have a negative significant impact on current use of modern contraceptives. This means that contraceptive use in young and less educated men is low.

In addition Mona, (2002) mentioned that female education has been seen as a key determinant of contraceptive use in that, better educated women have more knowledge of contraceptive methods or of how to acquire them than are less educated women because of their literacy, greater familiarity with modern institutions, and greater likelihood of rejecting a fatalistic attitude towards life (Singh, 2004).

Another factor affecting the use of modern scientific methods of family planning is the knowledge of different family planning method by age group. The studies in India by Mao (2007) indicate that family planning knowledge is widespread with at least one method of contraception known. The author asserts that among the various methods known is female sterilization which is more popular among the women who reported knowledge of the contraceptive method.

Religious factors also affect the use of modern scientific methods of family planning. The Roman Catholic Church is morally opposed to contraception and sexual acts outside of the context of marital intercourse. Such acts are considered illicit mortal sins, with the belief

that all illicit sexual acts must be open to procreation. The only form of birth control permitted is abstinence. Modern scientific methods of "periodic abstinence" such as Natural Family Planning (NFP) were counted as a form of abstinence by Pope Paul VI in his 1968 encyclical *Humane Vitae*. The following is the condemnation of contraception;

Therefore We base Our words on the first principles of a human and Christian doctrine of marriage when We are obliged once more to declare that the direct interruption of the generative process already begun and, above all, all direct abortion, even for therapeutic reasons, are to be absolutely excluded as lawful means of regulating the number of children. Equally to be condemned, as the magisterium of the Church has affirmed on many occasions, is direct sterilization, whether of the man or of the woman, whether permanent or temporary. Similarly excluded is any action which either before, at the moment of, or after sexual intercourse, is specifically intended to prevent procreation – whether as an end or as a means (Campbell, 1960).

Protestant movements such as Focus on the Family, view contraception use outside of marriage as encouragement to promiscuity (Rainey, 2002).

On the other hand the Qur'an does not make any explicit statements about the morality of contraception, but contains statements encouraging procreation and various interpretations have been set forth. Early Sunni Muslim literature discusses various contraceptive methods, and a study sponsored by the (Sunni) Egyptian government concluded that not only was *azl* (coitus interruptus) acceptable from a moral standpoint, but other sections of people within Islam believe that it is permissible to use condoms so long as this does not cause any harm and so long as both husband and wife consent to their use, because this is similar to '*azl* (coitus interruptus or "withdrawal"). It however argued that it reduces the sensation of pleasure, which is the right of both partners, and reduces the chance of conception, which is also the right of both partners; neither of them is allowed to deprive the other of these rights. Sheik Muhammed, (2006) also added that Allah is the source of strength. However, there are several schools of thought on this, as well as other issues concerning Islamic morality. In Iran, a Shia Islamic country, contraceptive methods are not only taught to married couples, but also encouraged to youngsters through posters and advertisements. In Turkey, despite

many religious controversies, birth control is not a discussion topic and many people support birth control.

Access to health facilities offering family planning services influence the use of modern contraceptive methods of family planning. Katende *et al.*, (2003) found out that the vast majority of women (eighty nine percent) who access family planning services live in a community with at least one government-run source of family planning, while sixty two percent live in a community with at least one private-sector source, and twenty one percent have access to an NGO- operated source. They further affirm that, short distances to the nearest family planning facility enable women to seek family planning services. Their study concluded that Ugandan women with access to family planning facilities use long term (the implant, sterilization) contraceptives with one woman in two accessing the facility.

Behaviour change, communication materials, including signposts with the family planning logo, and posters and flipcharts in the facility also affects the use of modern methods of family planning. Studies indicate that the relatively high proportions of women living in communities where at least two health facilities displayed materials such as posters and flipcharts and family planning logos; seek family planning services because the women are attracted and reminded by these signs (Katende *et al.*, 2003; Abaasi, 2008).

The social/cultural attachment for children influences the use of modern methods of family planning. The distinct socio-economic experiences of Botswana, Kenya, and Zimbabwe have contributed to their substantial increase in contraception. In particular, the sustained improvements in, and resulting low levels of, mortality in these countries are unique within Africa. However, the diverse nature of these socioeconomic linkages in Africa suggests that features of African social structure remain important determinants of the demand for children (Adamchak *et al.*, 2000).

The long-standing forms of African social organization-the high value attached to the perpetuation of the lineage; the importance of children as a means of gaining access to resources, particularly land; the use of kinship networks to share the costs and benefits of children, primarily through child fostering; and the weak nature of conjugal bonds-clearly inhibit contraceptive adoption and fertility decline (Adamchak *et al.*, 2000).

The understanding of the factors that influence contraceptive use is critical to the efforts of programmes to increase prevalence Oyedokun, (2007). Much unmet need for family planning persists, even in settings where knowledge of contraceptive methods is high. Studies suggest that many potential users choose not to use more reliable methods due to misperceptions and concern about health-related risks. For example, a study in Maldives found that knowledge of family planning was universal, but only thirty percent of couples were using a contraceptive method. Several studies, including one from Malaysia, found that non-use of contraceptives was linked to fears about side effects.

Trend of Contraceptive use

The level of contraceptive use is one of the strongest factors affecting the level of fertility. A linear regression of 105 countries comparing fertility levels and contraceptive use levels finds that seventy seven percent of the variation in fertility as explained by variation in contraceptive use. As the data above indicate, the factors that comprise the remaining twenty three percent of the variation in total fertility are also important, as are the measurements used to examine such associations (Zlizar *et al.*, 2007).

Worldwide, sixty two percent or 650 million of the more than one billion married or in-union women of reproductive age are using contraception. In the more developed regions, seventy percent of married women use a method of contraception, while in the less developed regions sixty percent do. In Africa, only twenty five percent are using it, whereas in Asia and Latin America and the Caribbean prevalence of contraceptive use is fairly high – sixty six

percent and sixty nine percent, respectively.

These are some of the key findings shown in the “World Contraceptive Use 2001”, a wall chart issued by the United Nations Population Division as part of its ongoing monitoring of world use of family planning. The chart presents the most recent data available on the current contraceptive practices in 153 countries and areas of women of reproductive age who are in a marital or consensual union. Also included are data on the number of women who are married or in a consensual union, the percentage using contraception and the types of methods used at the country, regional and international levels, recent trends in contraceptive use, and the percentage of those whose need for family planning is unmet. Data were compiled primarily from surveys based on nationally representative samples of women aged 15 to 49, and pertain on average to the year 1997.

Considerable increases in contraceptive use (fifty percent or more users in the subsequent survey) were not always accompanied with considerable declines in the TFR (at least 10 percent decline in the subsequent survey), as in Haiti, Malawi, Senegal, and Tanzania (between the 1991-92 and 1996 surveys).

Increases in contraceptive use were accompanied by increases in total fertility, as in Bangladesh, Colombia (between 1990 and 1995 surveys) Niger, and Turkey. Also, despite increased contraceptive use in Paraguay and Peru, there was no change in fertility. These countries are showing the effect of changes in tempo.

In Ghana and Kazakhstan, there were substantial decreases in the TFR (10 percent or greater), but increases in contraceptive use less than 10 percent. Lastly, in Rwanda fertility fell by 0.4 children per woman but the CPR actually decreased by forty four percent.

Traditional methods are more popular in the developed countries, where they are used by eleven percent of married couples, compared with just 5 percent in the developing countries.

The higher prevalence in developed countries accounts for much of the difference in contraceptive use between developed and developing countries. The most used traditional methods include rhythm (periodic abstinence) and withdrawal. As a whole, these are used by 6 percent of married women in the world.

Contraceptive use has increased substantially over the past decade. In the developing countries, it annually increased by at least 1 percentage point in sixty eight percent of the countries and by at least 2 percentage points in fifteen percent of the countries. In Africa, usage among married women increased from around fifteen percent ten years ago to twenty five percent today; in Asia, from fifty two to sixty six percent; and in Latin America and the Caribbean, from fifty seven to sixty nine percent. Developed countries show little growth in levels of use over the past decade, as a result of their already high contraceptive prevalence.

High levels of unmet need for family planning remain in the developing countries, despite the recent rapid growth in the use of contraception there. An average of twenty four percent of married women in sub-Saharan Africa need family planning (because they do not want any more children or want to delay their next pregnancy by two years or more), but for various reasons, such as not knowing where to get a method or fear of side effects, they are not using any contraception. In Northern Africa, Asia and Latin America and the Caribbean, the need for family planning is lower at around eighteen percent, and in Europe it is below 10 percent on average.

In the more developed regions, when condoms are reported to be the contraceptive method used, it is usually the primary method. In less developed regions, apart from being used less frequently, condoms tend to be used in conjunction with another more effective method. Finally, studies have shown that use of condoms is higher if respondents are asked about contraceptive use with any partner rather than with just the regular partner.

Nine out of ten contraceptive users worldwide rely on modern methods. The most commonly used are female sterilization (twenty percent of married women), intrauterine devices (IUD's) (fifteen percent), and oral pills (8 percent). Modern methods are considered more effective at preventing pregnancy and require access to family planning services or supplies.

Short-acting and reversible methods are more popular in the developed countries, whereas long-acting and highly effective clinical methods are used more in the developing countries. In developed countries, users rely mostly on oral pills (seventeen percent of married women) and condoms (fifteen percent). By contrast, female sterilization and IUD's used by twenty two percent and sixteen percent, respectively, dominate in the developing countries.

Thirty-five percent of currently married women are reported using modern contraceptive methods such as pills, condoms, female sterilization, male sterilization, IUD's, injection, diaphragm/foam/jelly/ cream, temperature or standard days method. In 2001, the level of use of modern methods was thirty one point one percent.

The percentage of women using traditional methods declined by 2 percentage points (from sixteen point four percent in 2001 to thirteen point eight percent in 2002). This can be attributed to the decrease in the percentage of women using calendar/rhythm (from 10.4 percent in 2001 to 7.9 percent in 2002), particularly in Bicol region where only 7.7 percent were reported using the method in 2002 as compared to the previous years fifteen point six percent. As a result, the contraceptive prevalence rate or the proportion of married women using any family planning method in 2002 declined, although insignificantly, to forty eight point eight percent from forty nine point five percent in 2001.

The use of pills, which have been the leading family planning method since the 1995 survey, increased from fourteen point one percent in 2001 to fifteen point three percent this in 2002.

Use of female sterilization rose from 10.5 percent to eleven percent.

Contraceptive use in Uganda

According to the UDHS (2006/2007) the contraceptive prevalence rate as expressed by the percentage of currently married women aged 15-49 who were using any method of family planning was 24 percent. Eighteen percent of married women were using modern methods, while 6 percent used a traditional method. The contraceptive use was higher among sexually active unmarried women (54 percent) than among married women (24 percent) and, in turn, among all women (20 percent).

The most commonly used method among married women was injectables, which were used by 10 percent of women. The next most commonly used methods were pills (3 percent) and rhythm method (3 percent). Female sterilization, withdrawal, and male condoms were each being used by 2 percent of married women. The mix of methods was very different among sexually active unmarried women, for whom male condom was the most commonly used method (27 percent), followed by injectables (13 percent). The contraceptive use was generally found to rise with age.

The most popular methods among the youngest women were injectables and male condoms. Women in their 20s and early 30s tended to use injectables, followed by the pill, while older women were increasingly likely to be sterilized.

CHAPTER THREE

METHODOLOGY

Introduction

This section is presented under: study area, study population, study sample, research design, sample size calculation, sampling procedures, study variables, data collection techniques and procedures, data management and analysis techniques, quality control, limitations of the study and the ethical considerations.

Study Area

The area that was studied was Mukura Sub-county which is one of the Sub-counties in the newly formed district of Ngora. The sub county is made up of eight parishes: Kokodu, Kumel, Akubui, Mukura, Madoc, Okunguro, Kaler, and Morukakise; and a total of sixteen villages: Olilim, Kokodu, Kees, Kumel, Ajeluk, Akubui, Akeit, Mukura, Agogomit, Madoc, Adul, Okunguro, Kamodokima, Kaler, Ariet, and Morukakise.

Study Population

These were women of the reproductive age (18-45 years) in Mukura Sub-county, Ngora District.

Study Sample

The study was focused on women in the reproductive age of 18-45 years that had been residents of the selected area for at least 2 years. The study included the women in this age bracket who had either had or never had any children. The participants were randomly selected from different households with the interest of including one participant from each

household. The study however, excluded women who were very sick during the time of the study, the mentally deranged persons, the deaf and dumb women as well as any who were new arrivals in the area.

Sample Size calculation

The sample size was calculated using KISH's formula as shown below and the regional (Eastern region) contraceptive prevalence of 20% ($p = 0.2$) was taken as the proportion of the population of the sample characteristics.

$$N = \frac{Z^2 Pq}{e^2}$$

Where;

N is the sample size

Z is normal statistic at 95% confidence interval

P is the proportion of the population of sample characteristics

q is 1-P

e is the level of significance (0.05)

$$N = \frac{(1.96)^2 \cdot 0.2 \times 0.8}{(0.05)^2}$$

N = 246 women

Among the 246 women who were taken to be the sample size; 239 (97%) of them were able to fully participate in the answering of the questionnaires and the 7 (3%) declined to participate.

Research Design

The research used a cross sectional descriptive study design. This is the kind of study where the researcher has no control over the variables being studied and it entails the identification of a defined population at a particular point or period of time, measuring a range of variables on an individual basis and under this, both past and current events were recorded.

The study also used both qualitative and quantitative strategies of data collection so as to ensure that different approaches were used to tackle the problem and as a result, valid results were obtained. Probabilistic sampling was applied in different stages in selecting participants for the study.

Sampling Procedures

The study used a multiple stage sampling approach in obtaining its participants whereby the population was divided into primary and secondary sampling units with the parishes and villages being the primary and secondary sampling units respectively. Under each stage, the units that were to be used were selected by the raffle method. Selection of the samples therefore; followed the following procedure: the sub county under study (Mukura Sub county) had eight parishes and sixteen villages; four parishes that is: Kokodu, Akubui, Mukura and Kaler were selected for the study by use of the raffle method and of the eight villages under those parishes, the raffle method was further used to select six villages to participate in the study and these included Kokodu, Ajeluk, Akubui, Akeit, Mukura, and Kaler. The raffle method of selection was carried out through listing of the names of the parishes in eight different pieces of paper which were then folded and a pick was randomly made for the four parishes by selecting four pieces of paper. Selection of the villages followed the same procedure of listing names of the eight villages and randomly picking six

villages (six pieces of paper).

The selection of the households was consequently done systematically by first of all obtaining the lists of the eligible households from the six different villages. This was possible with the help of the Local councillors (LC I) who had great knowledge of the area. The households that participated in the study were then picked by marking numbers of the households from 1 to 3 and taking every second household on the lists through the systematic random approach. This process was repeated until the required number of households was obtained and to minimize bias; this was carried out in a way that equal numbers of households were selected from the six different villages. From the selected villages, subjects were chosen from each household; where two women eligible to be included in the study were present in one given household, a simple random approach was used to pick one participant, however, households that had four or more women in the desired category; two women were randomly selected to participate in the interview.

Study Variables

The study looked at different variables; socio-demographic and health systems factor variables. The socio-demographic variables included age, religion, marital status, the educational background and the employment nature of the participants. The health systems factor variables were: the level of knowledge of women about the different modern contraceptives, availability of the contraceptives, fertility rate (parity), access of the family planning services and the human resource available in health centres. The dependent variable of major interest was the uptake of modern contraceptive methods. Other extraneous variables included cultural beliefs, and peer influence on contraceptive use.

Data Collection Techniques and Procedures

The research study used both qualitative and quantitative data collection strategies using questionnaires and key informant interview guides. Questionnaires and the key informant interview guides were interviewer administered to the respondents who recorded responses.

The questionnaires had been pretested to ensure precision in obtaining the required responses. The pretesting was done on 20 women from Ajeluk village and later refined before final data collection.

The research assistants that participated in the study were 3; 1 man and 2 women who had at least obtained a Uganda Advanced Certificate of Education (UACE) and were also very conversant with the local language (Ateso). The purpose of this was for them to be able to correctly administer the Ateso version of the questionnaires in which most of the women were able to understand and consequently give the desired answers. Prior to data collection, the research assistants underwent training that made them familiar with the ways in which the questions were to be asked, they were also enlightened on the different ways in which they could seek to create a conducive environment for the participant to freely answer the questions and thus give accurate information without any unnecessary fear of impingement of their privacy.

The key informant interview was carried out in one health centre III and that was Ajeluk from where a group of three people participated in contributing answers to the questions in the key informant interview guide. The responses to the different questions were recorded and later on analysed and incorporated into the result and discussion of this dissertation.

The data collection then commenced with obtaining of consent from the different levels to seek permission in carrying out of the research. The respondents were particularly

reached from the respective households from where their written informed consent was sought. Those individuals who expressed willingness to participate went ahead to answer the questions that were asked. The secondary data was basically from health documents like records, and other sources available at the district and the health centres within the area of study.

Data Management and Analysis Techniques

Data processing and analysis started in the field, with checking for completeness, data consistency and accuracy of the questionnaires. This was paramount because, it gave chance for unanswered questions to be re-asked where possible however; in scenarios where many questions were left out after the data collection process and the data were also greatly inconsistent, the questionnaires were excluded from further data processing since they could potentially affect the outcome. The questionnaires that were satisfactorily filled in were then separated from the rest and sorting of qualitative and quantitative data was proceeded.

The study also endeavoured to obtain some information concerning the non respondents and it was looked into and documented whenever appropriate in the result and discussion section.

Data analysis

Quantitative data

The obtained data was coded, entered in a computer and analysed using SPSS-16 and the data entry was restricted to one questionnaire at a time to ensure that information was properly recorded. Double entry was used and the data was cleaned by running frequency tables so as to ensure correctness and accuracy of the results and consequently, descriptive data was first analysed. The frequency distribution of the variables was done to describe the data and cross tabulation was also carried out to look for associations between the different

independent variables and the dependent variable. The strength of the association between variables was done using the chi square tests and results were put in 2x2 tables. The data that was obtained from the health facilities and the district was also incorporated into the study results whenever appropriate.

Qualitative data

Qualitative data was recorded and summarized according to the various themes and were consequently quoted in the results and discussion section. Analytic cross tabulation was done whenever it was mandatory so as to explore the relationships between the dependent and independent variables. The use of graphs, tables was then used to adequately bring out the relationship between the dependent variable and the independent variables.

Quality control

This included ensuring that questions in the tools had relevance and value to the research objectives. This was therefore done through: training of the research assistants who were made to understand the criteria in which the questions were to be asked and the particular ways they would adequately deal with the participants; pretesting of the questionnaires was also done to ensure that the questions were in the right chronological order as well as being accurately formulated to collect the desired information and this was done through translation of the questionnaires from English to Ateso.

Limitations of the study

The study presented some limitations despite the remarkable efforts put forth to minimize them. Generally given the practice of poor record keeping among the majority of the sectors, health inclusive, the data required was not easily accessible at the different levels especially the secondary data that was to be obtained from the district and health unit's records.

However, it can be noted that despite the shortfalls, the information obtained may be generalized to many other places in Teso and Uganda as a whole.

Ethical Consideration

To conform to the acceptable standards of social and professional behaviour of research, the study was only implemented after the approval of the International Health Sciences University (IHSU) research and ethics committee. Permission from the District Health Office (DHO) was obtained for the study to be conducted in the district. In addition, participation in this study was entirely on a voluntary basis and the interviews were only conducted after obtaining written consent from each participant following a clear explanation of the purpose, procedure and any potential benefits as well as any inconveniences of the study to the participant.

For the male interviewer, where and when necessary, the respondent was free to choose the most convenient environment for the interview to be carried out so as to minimize any infringement on privacy.

Above all, all the data obtained is anonymous and is being handled with maximum confidentiality and only used for the purpose it was intended for.

CHAPTER FOUR

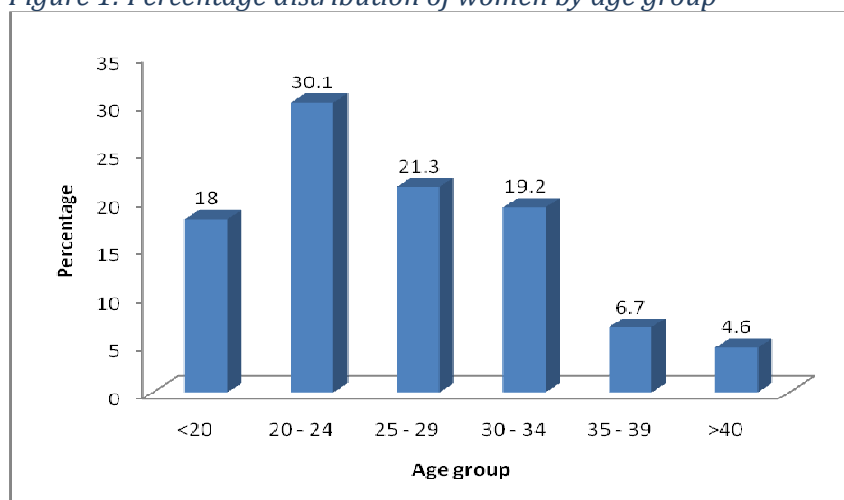
RESULTS

Introduction

This chapter focuses on presentation of results collected from the field. It is arranged as follows: socio-demographic information, the current use and knowledge of modern contraceptives, availability and accessibility of the modern contraceptives, the different associations of other variables on contraceptive use, future use of contraceptive use, the health facilities in the area, and contact of women with family planning providers.

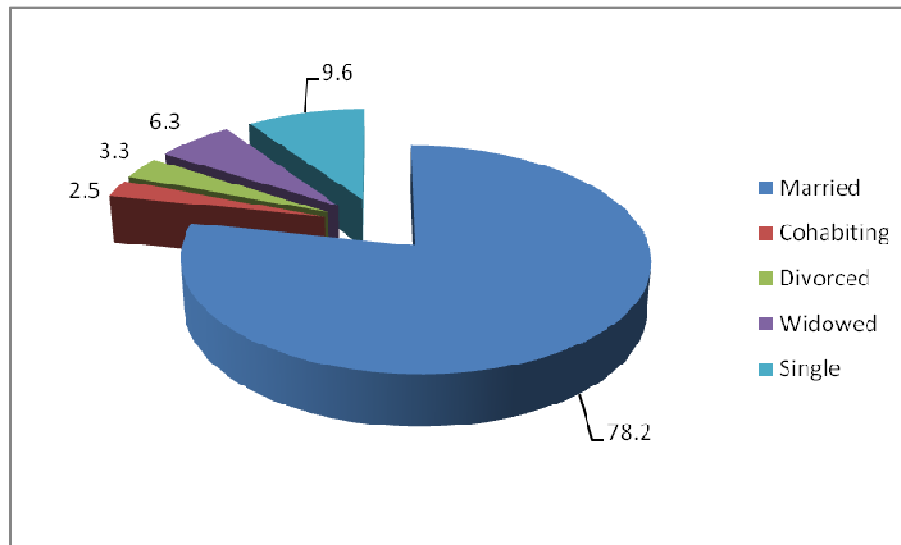
Socio-demographic information

Figure 1: Percentage distribution of women by age group



The range of the respondents was 18-45 years. Women aged 20-24 constituted the highest percentage (30.1 percent), followed by 25-29 age groups with 21.3 percent of the women, then women aged 30-34 and women less than 20 years with 19.2 and 18 percent respectively. The age groups which had the least percentage of women were: women more than 40 years with 4.6 percent and 35-39 years with 6.7 percent.

Figure 2: Percentage distribution of women by their marital status



Majority of the women were married (78.2 percent), the single women constituted 9.6 percent, while 6.3 and 3.3 percent of the women were widowed and divorced respectively. Meanwhile, 2.5 percent of the women were found to be staying together before official marriage (cohabiting).

Table 1: Socio-demographic characteristics of respondents

Variables	Level	Frequency	Percentage
Highest education attained	Primary	139	58.2
	O'level	43	18.0
	A'level	8	3.3
	Tertiary	23	9.6
	University	11	4.6
	None	15	6.3
	Total	239	100.0
Religion	Catholic	123	51.5
	Church of Uganda	54	22.6
	Muslim	7	2.9
	Pentecostal	47	19.7
	Adventist	0	0.0
	Others	8	3.3
	Total	239	100.0
Employment	Peasant farmer	144	60.3
	Business woman	16	6.7
	Civil servant	23	9.6
	Others	13	5.4
	Total employed	196	82.0
	Not employed	43	18.0
	Total	239	100.0

Table 1 above shows the socio-demographic information of the respondents, and according to the information obtained, 58.2 percent of the women had attained primary education, 18.0 percent had attained O'level education while 3.3 percent had attained A'level education. On the other hand, 9.6 percent had attained tertiary education, and only 4.6 percent

had University education giving a total of 93.7 percent of the women with formal education.

Among the various religious denominations noted in Mukura Sub County, catholic had the majority of the women with 51.5 percent, and the denomination with the least percentage of women was Muslims with only 2.9 percent of the women. Meanwhile, there were no Adventist women identified in the area of study.

Among the respondents, it was found that 82 percent of them were employed while only 18 percent were cited not to be employed. Peasant farmers constituted the highest percentage of the employed with 60.3 percent, followed by civil servants with 9.6 percent, and business women with 6.7 percent. The women who had other forms of employment constituted 5.4 percent.

Current use and knowledge of modern contraceptives

Table 2: Contraceptive prevalence rate by age group

Age	Frequency	Number using modern contraceptives	Percentage
<20	43.0	8	18.6
20 - 24	72.0	14	19.4
25 - 29	51.0	10	19.6
30 - 34	46.0	9	19.6
35 - 39	16.0	3	18.8
>40	11.0	2	18.2
All women aged 18-45	239.0	46	19.2

Table 2 above shows that the contraceptive prevalence among women aged 18-45 was 19.2 percent. The highest contraceptive use was among the age groups of 25-29 and 30-34

with 19.6 percent, followed by 20-24 with 19.4 percent; then women ages 35-39 and less than 20 with 18.8 and 18.6 percent respectively. The women above 40 years were the least with 18.2 percent.

Table 3: Knowledge and Current use of modern contraceptives by method used

Modern contraceptive method	Knowledge of modern contraceptives		Use of modern contraceptives	
	Number of women	Percentage	Number of women currently using modern contraceptives	Percentage
Male condoms	229	95.8	*4	8.7
Emergency contraceptive pills	209	87.4	2	4.3
Combined oral contraceptives	224	93.7	11	23.9
Implants	171	71.5	4	8.7
Female sterilization	150	62.8	1	2.2
Vasectomy	52	21.8	*0	0.0
Injectables	199	83.3	23	50.0
IUDs	79	33.1	1	2.2
Female condom	102	42.7	0	0.0
Number of women with knowledge of at least one contraceptive method	236	98.7		

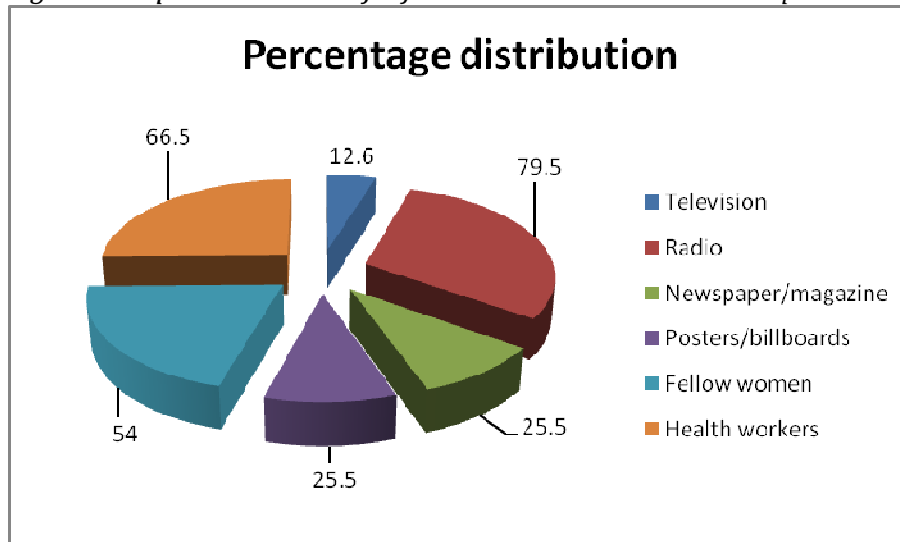
* Used by spouses

The most commonly used method among the women aged 18-45 was injectables used by 50 percent of the women and the least used was IUDs and female sterilization with 2.2 percent. Meanwhile 8.7 percent of the revealed that their spouses were currently using male condoms and none were found to have used vasectomy as a family planning method. On the other hand, none of the women revealed to have been using the female condom.

Among women aged 18-45, 98.7 percent of them had heard or seen at least one modern contraceptive method. The most popularly known methods were male condoms by 95.8 percent, combined oral contraceptives by 93.7 percent, emergency contraceptive pills by 87.4 percent, and injectables by 83.3 percent. Implants by 71.5 percent and female sterilization by 62.8 percent followed in popularity with more than half of the women knowing at least one of them. The other methods were below average with vasectomy being the least known by 21.7 percent.

Source of information

Figure 3: Reported Sources of information on modern contraceptives



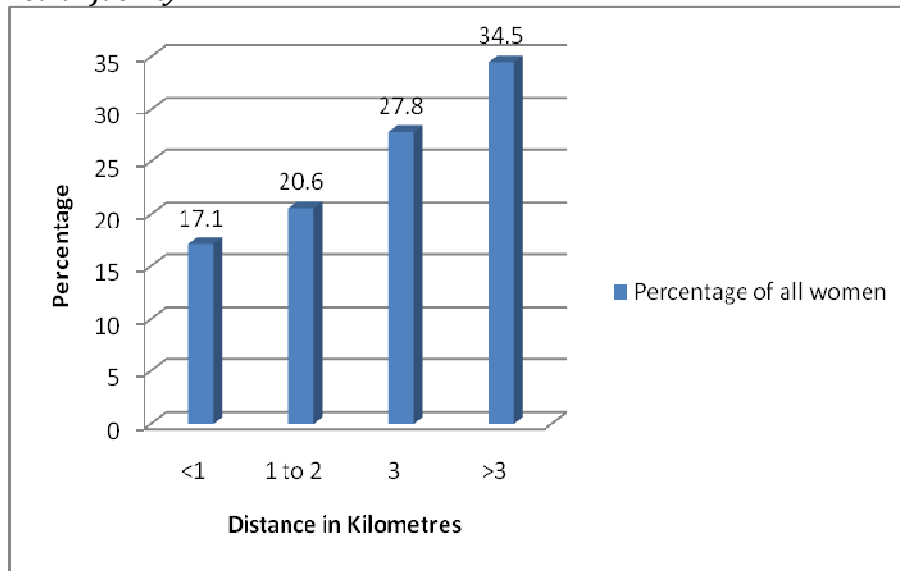
The information in Figure 3 shows that majority of the women had heard about a modern contraceptive method over the radio, cited by 79.5 percent of the women. The second source of information was health workers with 66.5 percent of the women getting information

from them. Fifty four percent (54%) of the women said that they had heard the messages from their fellow women while 25.5 percent of the women got to know a method through newspapers/magazines and posters/billboards. The least number of women cited to have seen a method on the television were 12.6 percent.

Availability and accessibility of modern contraceptives

Accessibility of modern contraceptives

Figure 4: Percentage distribution of the women by distance in kilometers to the nearest health facility.



The study found out that majority of the women were staying more than 3 kilometers from the nearest health facility as shown by 34.5 percent and the women who were staying 3 kilometers from the health facility followed with 27.8 percent. The women who were staying closest to the health units (less than 1 kilometer) were 17.1 percent while those residing 1 to 2 kilometers were 20.6 percent.

Availability of modern contraceptives

Table 4: Availability and use of modern contraceptives

Availability of the different modern contraceptives in the health centres		
Modern contraceptive	Number of women/spouses currently using a specific type of contraceptive	Percentage
Male condoms	*3	6.5
Emergency contraceptive pills	9	19.6
Combined oral contraceptives	14	30.4
Implants	1	2.2
Female sterilization	1	2.2
Injectables	17	37.0
IUDs	1	2.2
Female condom	0	0.0
Total	46	100.0

* used by spouses

Among the modern contraceptives in use, injectables were the most available method with 37 percent of the women currently using the method in the health centers whenever they needed. The second were Combined Oral Contraceptives with 30.4 percent, then emergency contraceptive pills with 19.6 percent. 2.2 percent of the women admitted to having used implants, female sterilization, and IUDs as modern contraceptive methods whereas none of the women found female condoms when they needed them.

Meanwhile 6.5 percent of the women revealed that their spouses found the male condoms whenever they needed them and none revealed to have got any vasectomy services when they needed them.

Associations of other variables with contraceptive use

Association of religion and contraceptive use

Table 5: Association between religion and contraceptive use

Religious denomination	Modern contraceptive use		Total
	Using modern contraceptives	Not using modern contraceptives	
Christians	45	187	232
Muslims	1	6	7
Total	46	193	239
Chi-square with Yates correction: $X^2 = 0.114$ with 1 df and the two-tailed P value = 0.7354.			

Association between the religious denomination and the use of modern contraceptives was considered to be not statistically significant. Implying that religious moral restrictions or tolerance in the different Christian denominations and amongst Muslims do not have a marked influence on contraceptive use among the women in Mukura Sub County.

Association of employment and contraceptive use

Table 6: Association between the nature of employment and contraceptive use

Nature of employment	Modern contraceptive use		Total
	Use modern contraceptives	Not using modern contraceptives	
Peasants	16	128	144
Others	30	65	95
Total	46	193	239
Chi-square with Yates correction: $X^2 = 14.139$ with 1 df and the two-tailed P value = 0.0002.			

The association between the nature of employment and use of modern contraceptives was statistically significant. This implies that the nature of employment has a significant influence on the use or non use of contraceptives with women with other forms of employment being more likely to use modern contraceptive methods as compared to the peasants.

Association of education background and contraceptive use

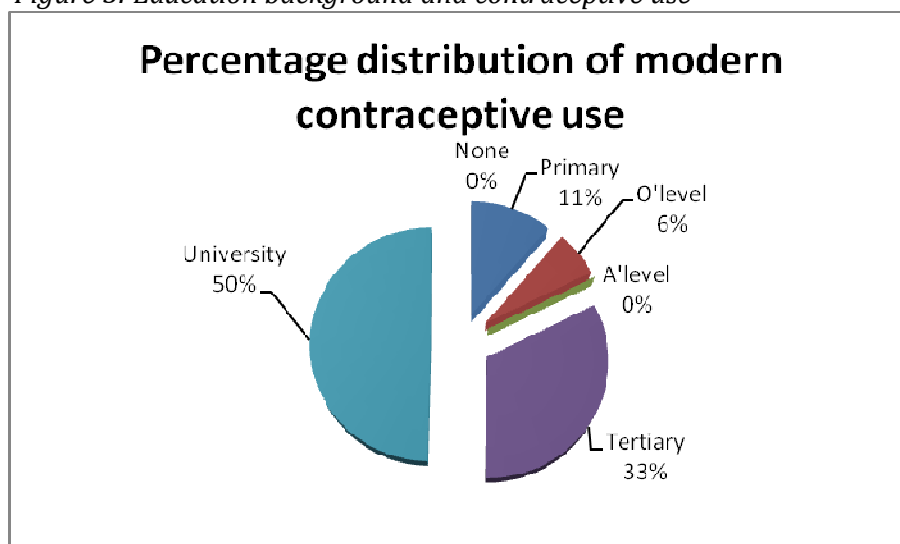
Table 7: Association between education level with contraceptive use

Highest level of education attained	Modern contraceptive use		Total
	Using modern contraceptive	Not using modern contraceptives	
≥Primary	46	168	214
No education	0	25	25
Total	46	193	239

$X^2 = 5.343$ with 1 df and the two-tailed P value = 0.0208.

The association between the highest level of education attained and the use of modern contraceptives was statistically significant implying that the highest level of education attained by the women has a great influence on the use or non use of contraceptives with educated women being more likely to use modern methods of family planning compared to the women who have no education.

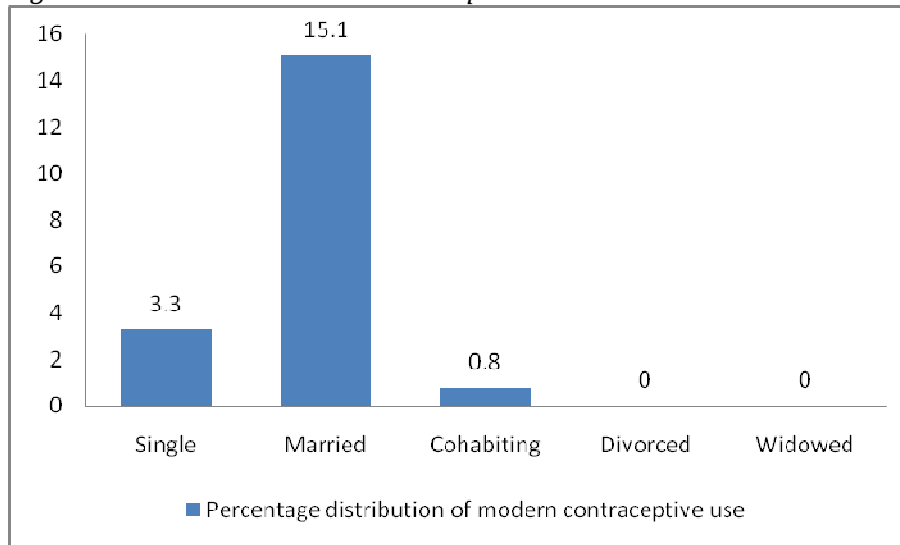
Figure 5: Education background and contraceptive use



There was generally an increase in contraceptive use with educational attainment with 50 percent of the women with university education using modern contraceptive methods, followed by 33 percent of the women with tertiary education, then 11 percent with primary education and 6 percent with secondary education. Women who had not attained any formal education were found not be currently using modern contraceptive methods.

Association of marital status and contraceptive use

Figure 6: Marital status and contraceptive use



The contraceptive use was highest among married women with 15.1 percent using a given modern contraceptive method, followed by 3.3 percent of single women and then cohabiting women with 0.8 percent. None of the divorced and widowed women were found to be currently using any modern method of family planning.

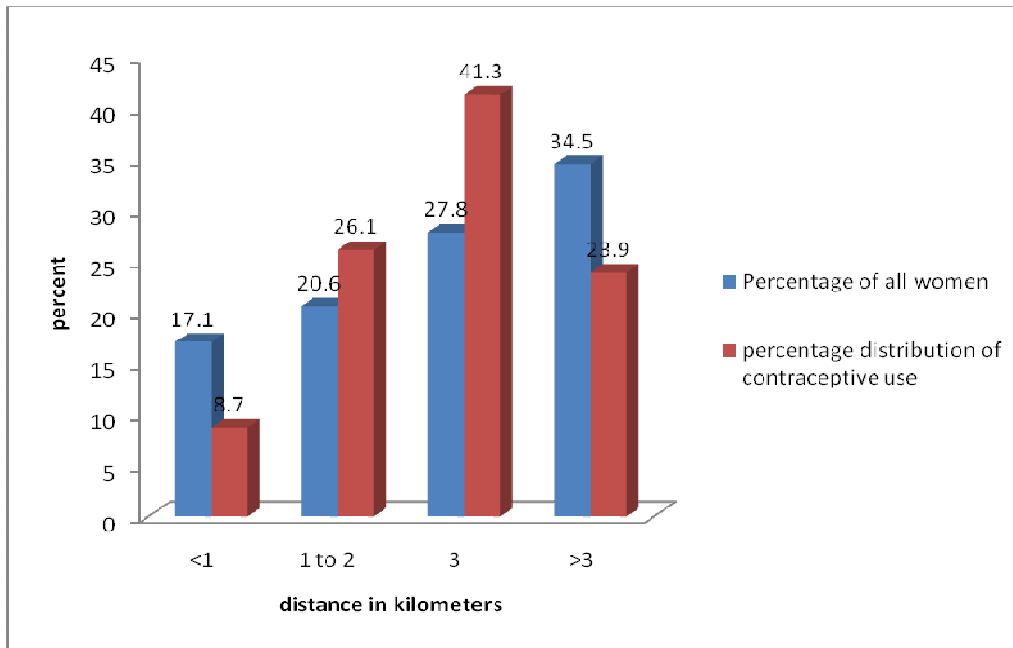
Association of distance to the nearest health facility offering family planning services and contraceptive use

Table 8: Association between distance to the nearest family planning unit and contraceptive use

Distance to the nearest family planning unit	Modern contraceptive use		Total
	Using modern contraceptive	Not using modern contraceptives	
≤2 km	16	68	84
>2 km	30	125	155
Total	46	193	239
X ² = 0.003 with 1 df and the two-tailed P value = 0.9541.			

The relationship between the distance to the nearest family planning unit and use of modern contraceptives was not statistically significant meaning that the distance to the nearest health facility did not have an influence on the use of modern contraceptives among women in Mukura Sub County.

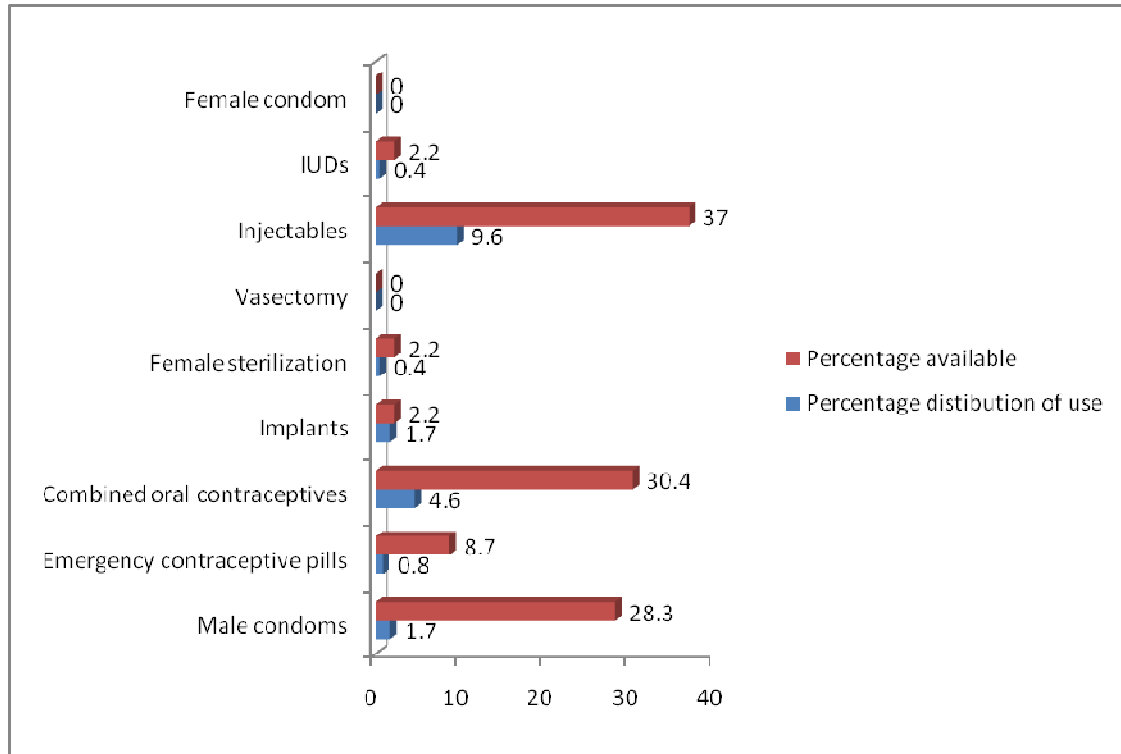
Figure 7: Percentage distribution of all women and modern contraceptive use by distance to the nearest health unit in kilometres.



The above figure shows the distribution of contraceptive use among women by the distance in kilometres to the nearest health facility offering family planning services. It shows that the higher percentage of women (41.3%) currently using modern contraceptives were staying 3 kilometres from the nearest health unit and the least percentage (8.7%) contraceptive prevalence was cited among women staying less than 1 kilometre from the health facilities.

Association of availability and use of modern contraceptives

Figure 8: Percentage distribution of modern contraceptive use and availability by method



The figure above shows that the modern contraceptives that were more available in the health facilities had a higher prevalence compared to those which were revealed not to be available. It can be noted that injectables that were the most available (37%) turned out to be the most used method among the women as cited by 9.6 percent prevalence. On the contrary, female condoms which were not available were henceforth never used by any of the women.

Fertility rate (number of children) and contraceptive use

Table 9: Association between number of children with use of modern contraceptives

Number of children	Modern contraceptive use		Total
	Using modern contraceptive	Not using modern contraceptives	
≤3	24	53	77
>3	22	140	162
Total	46	193	239
X ² = 9.288 with 1 df and the two-tailed P value = 0.0023.			

The association between the number of children and the use of modern contraceptives was statistically significant implying that the number of children the women have is highly associated with their use or non use of modern contraceptives with women who are not using any modern contraceptive methods being more likely to have a bigger number of children as compared to those using modern contraceptive methods of family planning.

Future use of contraceptives

Table 10: Percentage of women intending or not intending to use modern contraceptives

Method	Percentage intending to use	Percentage not intending to use	Total
Any method	63.2	36.8	100
Emergency contraceptive pills	9.8	90.2	100
Combined oral contraceptives	27.5	72.5	100
Implants	15.5	84.5	100
Female sterilization	0.5	99.5	100
Injectables	42.0	58.0	100
IUDs	1.6	98.4	100
Female condom	2.6	97.4	100

Among the respondents who were currently not using any modern contraceptive method, 63.2 percent of them had the intention of using a method in the future. Injectables were the most likely method to be used, citing 42 percent of the women, followed by Combined Oral Contraceptives with 27.5 percent, and implants with 15.5 percent of the women intending to use. Meanwhile, female sterilization was the least preferred method with only 0.5 percent of the women citing intention for future use.

Reasons for future intention or no intention of use of modern contraceptives methods

Table 11: Reasons for not wishing to use modern contraceptives in future

Reasons for not wishing to use modern contraceptive methods in future		
Reason	Number of women	Percentage distribution
Health concerns e.g. side effects	109	56.5
Religious issues	3	1.4
Lack of knowledge	17	9.0
High costs	3	1.6
Inconvenient to use	7	3.6
Culture: need for many children or a particular sex	2	1.2
Infertility	43	22.1
Distance to health facility	4	2.1
Total	188	97.4
Reason not known	5	2.6
Total	193	100.0

The major issues raised by the women as to be contributing to their reluctance to or not to use modern contraceptives were first of all: health concerns like fear of side effects which was cited by 56.5 percent of the women, and infertility with 22.1 percent. 9 percent of the women cited lack of knowledge, 3.6 percent inconvenience of use, 2.1 percent long distance to health facilities, 1.4 percent religious prohibition, 1.6 percent high costs; and the least was cultural limitations with 1.2 percent.

Table 12: Reasons for using or wanting to use modern contraceptives

Reasons for wanting/using modern contraceptive methods		
Reasons	Number of women	Percentage distribution
Child spacing	21	46.0
Manageable family	18	38.3
Health benefits	2	5.1
Knowledge of method	1	3.0
Availability of method	3	7.6
Total	46	100.0

Many of the women pointed out need for child spacing as the most motivating factor towards use of modern contraceptives as shown by 46 percent, followed by need to have a manageable family which was cited by 38.3 percent of the women.

On the other hand, only 3 percent and 7.6 percent of the women age 18-45 cited knowledge and availability of contraceptive methods respectively as some of the motivating factors.

Data from health facilities

The information obtained from the key informant interview revealed that there were basically two Health center IIIs run by government in Mukura Sub County and those were Ajeluk and Oget. These health facilities served the people in various ways; provision of family planning services inclusive as well as being referral units from where individuals would be advised to visit other hospitals like Ngora hospital in case of any conditions that were complicated for the available resources and health workers in the health centre.

The nurses who participated in the interview pointed out certain key issues pertaining to the running of the health units and these included: lack of sufficient infrastructure to fully cater for the health needs of the community, lack of human resource both in numbers and in training for specialized areas of health for instance persons trained to carry out surgical activities like female sterilization, insufficient and inconsistent supply of contraceptives and medicines in general, and limited and poorly distributed number of health facilities in the area to equitably offer health services to the communities.

Contact of women with family planning providers

Table 13: Contact of women with family planning providers

Age	Number of women who visited a health facility and were told about modern contraceptives	Percentage	Number of women who were visited by a family planning provider and were told about modern contraceptives	Percentage
<20	19	8.0	5	2.0
20 - 24	15	6.3	5	2.1
25 - 29	34	14.1	9	3.8
30 - 34	45	18.7	13	5.4
35 - 39	76	32.0	12	4.9
>40	32	13.3	9	3.6
Total	221	92.4	52	21.8
Women 18-45 not talked to about modern contraceptives	18	7.6	187	78.2
Total number of women not talked to by a family planning provider in the field or in the health facility = 205 (85.8%)				

Out of 239 correspondents, 205 (85.8%) were neither visited by a field provider who told them about modern methods nor told about modern contraceptives when they had visited a health facility. Majority of the respondents (78.2%) stated that they had not been visited by a family planning provider who had discussed modern methods with them while 7.6 percent of the women revealed that they were not told about any modern method when they visited a health facility within the last 12 months.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter discusses results of the study findings using the following themes: the socio-demographic factors; the current modern contraceptive use; knowledge of modern contraceptives; accessibility and availability of modern contraceptives; fertility rate (number of children) and modern contraceptive use; and the motivational and operational factors influencing use of modern contraceptives.

The socio-demographic factors

The findings of the study showed that the percentage of women who participated in the study increased with age from 18 percent of the women less than 20 years to reach a peak of 30.1 for women aged 20-24. This was followed by a consequent decline in the percentage of the women at ages 25-39 and the women more than 40 years constituted the least percentage. The age group of 18-24 is ideally when an individual is in a higher institute of higher education or any tertiary institution, however the findings of this study show that majority of these women were already out of school and most of them were already married. This shows the low level of education attained by majority of the women and this negatively affects the use of modern contraceptives because these women may not be empowered economically to afford modern contraceptives. In addition, they may not be able to have a strong position in decision making as far as use of modern contraceptives is concerned.

The study also showed that the highest percentage (78.2%) of the participants was married followed by the single and widowed women. The cohabiting women were the least

with 2.5 percent. The percentage of the married women was remarkably high because of the common practice of early marriage within the communities, in addition school drop outs for the girls was high from where many of them resorted to marriage.

Considering the education background; 93.7 percent of the women had attained formal education while 6.3 percent were found not to have attained any formal education. Among the women with formal education, 58.2 percent of the women had attained primary education while women who had attained secondary education (O and A levels) were 21.3 percent. On the other hand 9.6 and 4.6 percent of the women had attained tertiary and university education. These findings show that majority of the women had not advanced to higher levels of education and may therefore be unable to have a substantial understanding of modern contraceptive use as well as not being in position to get stable employment that would consequently empower them economically to afford the different modern contraceptives. This accordingly leads to poor contraceptive use.

The study established that majority of the women were catholic as shown by 51.5 percent, followed by women from Church of Uganda who constituted 22.6 percent. The percentage of Pentecostal women was 19.7 percent and that of the Muslims was 2.9 percent. There was only one other denomination that was identified as the Christ's Disciple church (CDC) and it constituted 3.3 percent of the women. However, it was established that there were no Adventist women in the area that took part in this study. This could explain the low contraceptive prevalence since majority of the women were catholic; which religious denomination has strict morals against contraceptive use.

Among the women aged 18-45 who took part in the study, it was cited that 82 percent of them were employed in one way or the other, meanwhile 18 percent of the women were revealed not to be employed. The peasant farmers constituted the greatest percentage of the employed women with 60.3 percent. The kind of farming done by many of the women was

basically subsistence in nature with little income generation restricted to the harvest seasons. Otherwise, the produce was greatly purposed for consumption. The farming was done in crops like ground nuts, millet, sorghum, cassava, and sweet potatoes.

The women found to be civil servants were 9.6 percent and majority of them were primary teachers in the schools within the sub county. Some were secondary teachers, and nurses at different levels. The business women dealt in small businesses like trading in produce and selling of local brew (ajon and ewaragi).

This findings show that the kind of employment of the majority of the women was unstable and did not bring any much returns interms of income and this may have acted as an impediment to their access and use of modern contraceptives and thus could have contributed to the low contraceptive use.

The current modern contraceptive prevalence rate among women

The findings of this study showed that 19.2 percent of the women aged 18-45 were currently using a modern contraceptive method of family planning. This contraceptive prevalence was lower as compared to the national and regional contraceptive prevalence rates of 24 and 20 percent respectively (UDHS, 2006/07). This shows that Mukura Sub County is still lagging behind as far as adoption of modern contraceptives is concerned.

The study also revealed that the most commonly used modern contraceptives were injectables, combined oral contraceptives, implants and male condoms, with at least over 8 percent of the women currently using one of them. Meanwhile, female sterilization, emergency contraceptive pills and IUDs were the least used methods. These findings are contrary to the World contraceptive chart report of 2001 that showed that the use of long-acting and highly effective methods like sterilization, IUDs and pills were the main methods used by people in developing countries, of which, Uganda is one.

The use of the different modern contraceptives was considered to be predetermined by their

availability and the knowledge of the women about the given modern contraceptive method. This can be seen by the positive correlation between the percentage availability and use of the different modern contraceptive methods among the women aged 18-45 years in Mukura Sub County.

Knowledge of modern contraceptive methods

The knowledge of modern contraceptive methods among study subjects was at 98.7 percent. Male condoms, combined oral contraceptives, emergency contraceptive pills and injectables were cited to be the most known modern contraceptive methods with over 80 percent of the women having heard or seen one of the methods.

These findings are in disagreement with those of Mao (2007) who reported female sterilization as the most popular method among women.

The source of the family planning information was revealed to be mostly over the radio as shown by 79.5 percent of the women who revealed to have heard contraceptive messages over the radio. Health workers were rated as the second highest source of modern contraceptive information as cited by 66.5 percent of the women. Meanwhile 54 percent of the women revealed that they had obtained the information from their fellow women. Posters/billboards; news papers/magazines were cited by 25.5 percent of the women as another source of information and the television was the least source of family planning information as shown by 12.6 percent of the women. These different sources of family planning information are paramount because they accelerate the level at which women are able to adequately know the different contraceptive methods.

This is in agreement with Katende *et al* (2003) who stated that behavior change, communication materials, including signposts with the family planning logo, and posters and flip charts in the facility affected the use of contraceptives. This was shown by the relatively high proportions of the women living in communities where at least two health facilities

displaying materials like flip charts and family planning logos seeking family planning services because they were attracted and reminded by those signs (Abaasi, 2008).

The researcher therefore noted that the level of knowledge of the different contraceptives does not match the current rate of modern contraceptive prevalence. This is shown by a high rate of knowledge of contraceptives which was established to be almost 99 percent as opposed to the prevalence rate that stood at 19.2 percent. This shows that the majority of the women may be aware of the methods but not in a deeper way that can motivate them to adopt their consequent use.

This study thus identifies the need to focus on repackaging the family planning information and disseminating it, using the most appropriate avenues that are more available to many of the women so that they can be able to have a better understanding of modern contraceptives and family planning in general.

Accessibility and availability of the modern contraceptives

The distance of the health facilities to many of the households was relatively long with majority of the women (62.3%) staying 3 or more kilometers from the nearest health facility as opposed to the smaller percentage that was found to be staying relatively nearer to the health facilities as cited by 37.7 percent of the women. This can be attributed to the fact that there were only two government health centre IIIs in the Sub County and these were the major facilities serving the communities.

On the other hand, availability of modern contraceptives in the health facilities had a positive correlation with modern contraceptive use. This was shown by the higher contraceptive prevalence among methods that were readily available. This shows that women were merely compelled to use a given method by virtue of its presence. However the use of modern contraceptive methods could as well influence the availability of modern contraceptives. This is because health facilities may put more focus on providing the modern

contraceptives according to demand thus making the most used methods more available. This could be because majority of the people in Uganda live with the uncertainty of their children's survival and therefore this makes them skeptical to adopt the use permanent contraceptive methods like vasectomy and female sterilization.

Association of other variables with Contraceptive use

Religion and contraceptive use

The religious affiliations of the women and their contraceptive use were found not to have any statistically significant relationship ($X^2=0.114$; $p=0.7354$). These findings show that religion as a factor was not able to influence the women's uptake of contraceptives and thus other factors may have had a significant influence.

The strict religious morals of the Christians especially the Catholics that generally regard scientific methods of family planning as actions intended to prevent procreation as well as acts taken to be against the human and Christian doctrine of marriage (Campbell, 1960). More so, such actions were regarded to be encouragers of promiscuity (Rainey, 2002). This study therefore found such barriers not to have any significant effect on the use of modern contraceptives. Although such barriers may have an influence on contraceptive use to some extent, it is not satisfactory to consider them as the major limitations to women's use of modern contraceptives in any way.

Education and contraceptive use

The findings found out that there was a statistically significant relationship between the highest level of education attained by the women and their use of modern contraceptives ($X^2=5.343$; $p=0.0208$). The higher the level of education attained by the women, the more likely they were to use modern contraceptive method of family planning.

Naturally better educated women are more knowledgeable of the different contraceptive methods or know how to acquire them (Mona, 2002) compared to less educated

women because of their literacy, greater familiarity with modern institutions, and greater likelihood of rejecting a fatalistic life (Singh, 2004). They were more likely to be employed and were economically empowered to overcome the distance factor to the health facilities as well as the cost factor of the modern contraceptives.

Employment and contraceptive use

The nature of employment was found to have a statistically significant relationship with the use of modern contraceptives ($X^2=14.139$; $p=0.0002$). This shows that, first of all, employed women would have a better likelihood to use contraceptives, as compared to unemployed women, later on considering the differences in the nature of employment.

The general view shows a higher contraceptive prevalence rate among women whose employment has a relatively stable flow of income and they can therefore afford the modern contraceptives as when needed. This is contrary to the peasant farmers who are barely subsistence farmers with a not-so-defined flow of income.

Accessibility of the health facilities and use of modern contraceptives

In testing the relationship between distance to the nearest family planning unit and contraceptive use, it was found that there was no statistical significance between the two ($X^2=0.003$; $p=0.9541$). This shows that distance to the nearest health unit is not a key factor affecting use of modern contraceptives.

These findings contradicted those of Katende *et al*, (2003) who found that short distances to family planning facilities enabled women to seek family planning services.

The findings of this study show that relatively small differences in the access of a health facility may not necessarily have any significant influence on the use of modern contraceptives as opposed to when the distances are much varied.

Fertility rate (number of children per woman) and modern contraceptive use

This study found out that there was a high significant relationship between contraceptive use and the number of children each woman had ($X^2=9.288$; $p=0.0023$). This implies that women who are not using any contraception are more likely to have larger family sizes in terms of the number of children that they have.

These findings are in disagreement with Population Reference Bureau (2006) that found out that considerable increase in contraceptive use were not always accompanied by decline in fertility rates but instead led to increases in fertility in some countries. However, the findings of Zlidar *et al* (2007) that the level of contraceptive use was one of the strongest factors affecting the level of fertility are in agreement with findings in this study.

Motivational and operational factors influencing use of modern contraceptives

A number of factors that influence use of contraceptives were identified and these were either operational or motivational in nature and these are as follows:

Operational factors

Inadequate human resource to cater for the health needs of the communities. The health workers who were available were very limited in numbers and competencies given the population numbers in the community, they were to serve. Specially trained workers who were to perform critical tasks like surgery were lacking and instead nurses or nursing aids were the ones on duty. This deficit led to lack of modern contraceptive services like female sterilization, vasectomy, IUDs and implants that particularly need the services of well trained personnel like doctors. This observation was also noted by WHO & USAID (2007) when

they emphasized that modern contraceptive methods like IUDs, implants, female sterilization and vasectomy were majorly clinical methods that needed to be provided in the health facilities by trained doctors, nurses and/or midwives.

Another operational factor that was noted was insufficient or inconsistent supply of the contraceptives in the health facilities. This is a vital issue given the fact that the use of the majority of the modern contraceptives puts emphasis on consistency, this therefore poses a health risk on the women using and also discourages those who would otherwise wish to take up the use of modern contraceptives. These findings are concurrent with those of UNICEF (2007) that indicated that the effectiveness of the many of the modern contraceptives, particularly injectables, was dependent on getting injections regularly.

The number of health facilities that offer family planning services was limited in number as well as not being well distributed within the communities. This was aggravated by the fact that many of the private health units present in the area were concentrated in the trading centers only which limited access to the services. This means that most of the women will not be able to easily get the family planning services that they require and as a result low contraceptive use is perpetuated.

In addition, the health workers cited lack of proper avenues for proper and adequate dissemination of family planning information like up-to-date posters. In most cases, women do not get the chance to obtain the information they need about the contraceptives and this consequently limits their ability to develop the enthusiasm to use any of the methods. This was further shown by the high percentage of women (78 percent) who had not been visited by any health worker in the field who had talked to them about family planning. Moreover many of the women have been stereo typed to think negatively about modern contraceptives, therefore; lack of sufficient sensitization and increase of awareness on the different methods and their use greatly compromises their level of uptake and success.

Motivational factors

This looked at the different biological, cognitive, and social factors that acted as incentives for individuals to use of modern contraceptives and these factors were as follows:

The need for a manageable family which was expressed as a major factor by 38 percent of the women as well as need to space their children as cited by 46 percent of the women. Many of the women actually knew the advantage of spacing of children and having of a relatively small family and are consequently willing to act on it by using family planning. However, a dilemma arises when they are not convinced on the right method to adopt and this compromises the use of contraceptives.

On the other hand, there were a number of factors that were demotivators to the use of modern contraceptives for instance; health concerns like the fear of side effects as well as excessive weight gain, over bleeding and infertility. This concurs with the study carried in Osun state of Nigeria (Oyedokun, 2007) that revealed that many potential users of contraceptives choose not to use more reliable methods due to misperceptions and concern about the health related risks.

This implies that women are not sufficiently made aware of the implications of the use of specific modern contraceptive methods as regards to the consistency and the consequent side effects if any. In view of that, many women get to experience the side effects they were ignorant of and perceive them as a failure of the method instead of finding ways to circumvent them.

The other factor was the cultural beliefs of the communities and this was expressed through the need for a particular sex of the child, an issue that normally arose among the men and the special attachment to large numbers of children in the culture of the Iteso. This can be considered as a great stumbling block to family planning efforts since men have a big role to play if any success is to be achieved in contraceptive use. This is because men are taken as

the major decision makers culturally and in most cases their decisions are final.

This observation is in line with that of Adamchak *et al* (2000), who reported that the long-standing forms of African social organization were the high value attached to the perpetuation of the lineage; the importance of children as a means of gaining access to resources, particularly land. He further added that the use of kinship networks to share costs and benefits of children primarily through child fostering and the weak conjugal bonds clearly inhibit contraceptive adoption and fertility decline.

Other factors cited by a number of women that influence the use of modern contraceptives included religious restrictions as revealed by 1.4 percent of the women; lack of sufficient knowledge of the modern contraceptives as well as their use was another factor revealed by 9 percent of the women, the high costs of the contraceptives cited by 1.6 percent of the women, inconveniences in using them as expressed by 3.6 percent of the women and finally distance to the nearest health facility which was mentioned by 2.1 percent of the women.

The findings of this study generally point out a need for a paradigm shift in terms of the methods currently used to carry out family planning activities like the dissemination of the information as well as the provision of the services. People have long founded negative perceptions towards family planning which need to be addressed in an appropriate manner. Government therefore needs to put more emphasis on IEC and provision of better services both in quantity and quality.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

Conclusions

The current modern contraceptive prevalence rate in Mukura Sub County was found to be 19.2 percent in the reproductive age group of 18-45. This is much lower than the national level of 24 percent. The findings of this study attribute the low contraceptive prevalence to factors like: the generally low level of education attained by many women as well as the nature of employment among the women.

The knowledge of the women for the different modern contraceptives was found to be generally high, meanwhile religious affiliations and the distance to the nearest family planning unit were found not to have any statistical significance with contraceptive use.

The access of women to health facilities was found to be relatively poor with majority of the women staying 3 or more kilometers from the nearest health facility.

The major factors that are undermining the use of modern contraceptives were found to be; fear of the side effects, infertility, and health concerns and these have played a great role in restraining many women from the use of modern contraceptives.

On the other hand, the operational factors that were found to be greatly influencing the use of modern contraceptives were; the inadequate infrastructure, human resource, IEC and supplies. Meanwhile, the motivating factors were mainly; the desire of many women to have manageable numbers of children with a good child spacing.

Recommendations

The researcher recommends that despite the lack of a significant relationship between distance to the nearest family planning unit and contraceptive use, improvement of access and availability of modern contraceptives is paramount in terms of equitable distribution of infrastructure, family planning services and the human resource for even better use of contraceptives to be realized.

There is a substantial need for proper dissemination of information concerning modern contraceptives through the right channels of communication, and repackaging of the messages in a way that will not only increase awareness but rather create a deeper understanding of modern contraceptives, with particular emphasis on the use, advantages and disadvantages of each of the methods so that women can be in a better position to choose whatever method that suits them. This is because; the findings show a high level of knowledge of contraceptives while on the other hand, the contraceptive use was very low.

Since factors like education play a role in contraceptive use, girl child education should be emphasized and encouraged through facilitation in whatever ways possible.

APPENDICES

CONSENT FORM

Appendix I

Informed Consent Form

I am Akurut Immaculate, a student of a Master of Science of Public Health (MPH) at International Health Sciences University (IHSU). I am currently conducting a research that is seeking to *investigate the factors influencing the utilization of modern contraceptives among women aged 18 to 45 years in Mukura Sub County, Ngora district* for partial fulfilment of the award of a Masters degree. It's with pleasure that I notify you to be an eligible participant in answering the questionnaire herein. I therefore seek your permission to answer the questions here below and I guarantee that the information you give will be treated with utmost confidentiality and anonymity. I add by mentioning that you reserve the right to agree or disagree to the above cause and in this view therefore, you may choose to withdraw from the study whenever you feel the need to do so. Furthermore, you have the right to choose to answer or not to answer a given question. If you agree to this then you can sign below to confirm your acceptance.

I hereby agree to participate in the interview

Signature of respondent

For any questions pertaining to the interview, you are advised to contact Akurut Immaculate on Tel: 0783624556.

Appendix II

Questionnaire for the Women Respondents

PART 1: Demographic Data

Instruction: Please Tick (✓) or fill in the spaces below as appropriately as possible.

1. How old are you now?

- 1) Age in completed years
- 2) Don't know

2. Marital status

- 1) Single
- 2) Married/stable relationship
- 3) Cohabiting
- 4) Divorced
- 5) Widowed

3. What is the highest level of education you attained if any?

- 1) None
- 2) Primary
- 3) Secondary (O ' level)
- 4) Advanced (A" level)
- 5) Tertiary
- 6) University

4. What is your religion (religious denomination)?

1) catholic

2) Church of Uganda

3) Muslim

4) Pentecostal

5) Adventist

6) Others (specify)

5. Are you currently employed/self employed?

1) Yes

2) No

6. If yes, what is your form of employment?

1) Peasant farmer

2) Businesswoman

3) Civil servant

4) Others (specify)

PART II: REPRODUCTION AND CONTRACEPTION: Knowledge, attitudes and

Use of modern contraceptives

7. Have you ever been pregnant?

1) Yes

2) No

8. How old were you when you first became pregnant?.....years

9. How many children have you had so?

Total number (alive and deceased)

10. In your opinion, how many children would you have wished to have?

Total number of children

11. Have you ever heard about or seen any modern contraceptive methods of family planning?

- 1) Yes
- 2) No

12. If yes, what was the source of the information?

- 1) Television
- 2) Radio
- 3) Newspaper or magazine
- 4) Posters/billboards
- 5) Fellow women
- 6) Health workers
- 7) Others (Specify)?

13. What are some of the modern contraceptive methods you know of?

- 1) Condoms (male)
- 2) Emergency Contraceptive Pills (ECPs)
- 3) Combined Oral Contraceptives (COCs)
- 4) Implants
- 5) Female sterilization
- 6) Vasectomy (male sterilization)
- 7) Injectables
- 8) Intra-uterine Devices (IUDs)
- 9) Female condom

14. Are you currently using any modern contraceptive method?

- 1) Yes
- 2) No

15. If yes, mention the method that you are currently using?

- 1) Condoms (male)
- 2) Emergency Contraceptive Pills (ECPs)
- 3) Combined Oral Contraceptives (COCs)
- 4) Implants
- 5) Female sterilization
- 6) Vasectomy (male sterilization)
- 7) Injectables
- 8) Intra-uterine Devices (IUDs)
- 9) Female condom

16. If no, do you intend to use any of the modern contraceptives in the future?

- 1) Yes
- 2) No

17. If yes, mention the methods you will most likely prefer to use?

- 1) Condoms (male)
- 2) Emergency Contraceptive Pills (ECPs)
- 3) Combined Oral Contraceptives (COCs)
- 4) Implants
- 5) Female sterilization
- 6) Vasectomy (male sterilization)
- 7) Injectables
- 8) Intra-uterine Devices (IUDs)
- 9) Female condom

18. Do you have access to the modern contraceptives in your area?

1) Yes

2) No

19. If yes, where do you get them from?

1) Government Hospital

2) Government health centre

3) Family planning clinic

4) Community based distributor

5) Pharmacy/drug shop

6) Private clinic

20. Do you always find the modern contraceptives in the health units or any other place you get them from when you need them?

1) Yes

2) No

21. If yes, which modern contraceptives are available in your health centres or area of access?

1) Condoms (male)

2) Emergency Contraceptive Pills (ECPs)

3) Combined Oral Contraceptives (COCs)

4) Implants

5) Female sterilization

6) Vasectomy (male sterilization)

7) Injectables

8) Intra-uterine Devices (IUDs)

9) Female condom

22. Are you always given advice on the use or side effects of the different modern contraceptive(s)?

1) Yes

2) No

23. Which medical person gave the modern contraceptives or any information pertaining to them (contraceptives)?

1) Doctor

2) Nurse

3) Nursing aids

4) Clinical officer

Others (specify)

24. What is the distance to the nearest family planning facility from your residence?

1) Less than 1 Kilometres

2) 1 to 2 Kilometres

3) 3 Kilometres

4) More than 3 Kilometres

25. During your visits to the health facility in the last 12 months, did any of the health workers discuss with you issues concerning use of the modern contraceptive methods of family planning?

1. Yes

2. No

26. In the last 12 months, were you visited by a health worker who talked to you about the modern contraceptive methods of family planning?

1) Yes

2) No

27. In your opinion, do you think it is good to use modern contraceptives as method of family planning?

1) Yes

2) No

28. If yes, what do you think are the negative influences on the use of modern contraceptives among women?

29. What do you think are the positive influences on the use of modern contraceptives among women?

Appendix III

Questionnaire in Ateso

ATIAKETAIT NASODIT: Nu ikamunitos etunganane

Nutupitono: Elipit okweta (✓) arai ileleb apakio/abaagan kwa ibusakinitor.

1. Ikon ikaru idi kwapekwana luwapolou?

1) Ikaru kaileleba

2) Mam eong ajeni

2. Ejautene loedukone

1) Mam adukokina

2) Adukokina ido ejok aiboi

3) Iboei nepepe komam idukokina

4) Apuserut (Abu lokowaika kotwana)

3. Anyoin aswoman na okuju akere iduminit ijo?

1) Mam asiomit

2) Opuraimare

3) Osinia (nasodit toni naiwongonet)

4) Osinia naikeyara (naikayet toni naikanyet ape)

5) Okolej (Atutuoro aswam)

6) Ounibasiti

4. Anibo edini kon (Atiaketait naedini kon)?

1) Atuliki

2) Ekanisa lo Ouganda

3) Asiriamut

4) Eyuunan

5) Luelipak namukaga

6) Ice (Arai eja kolim).....

5. Iswamai ijo apugan aria bo aswam kon alope?

1) Eebo

2) Mam

6. Aria eebo, inyoin bo akon aswam?

1) Akorion

2) Acurusit/Asubusit

3) Aswaman apugan

4) Ace kere (kolim kaitebeikite).....

ATIAKETAIT NAIYAREIT: AUR KA EITIKITIKE LO AUR: Aijen, epone loipupio ijo aria awomisio kon nepepe ka eitosomae ka iboro luakwana luitikitikete aur.

7. Ipotunitor ijo sek?

1) Eebo

2) Mam

8. Irai bo ijo naikaru idi naipotunio ijo nasodit? Ikaru.....

9. Idi bo idwe ijaasi kajo kopukwana?

Idwekon kere (Lu ejarete ka lu aria apotu kotwakata da).....

10. Kotoma owomitene kon, idi bo idwe ti iwomit ijo tiejok ajaut kede?

Idwe kere.....

11. Ipupunitor ijo arai iwaynunitor ijo edio epone kere loitikitikere aur?

1) Eebo

2) Mam

12. Aria eebo, Aibo ipupokini ijo aria aibo kiwanyuna ijo?

- 1) Etelevision
- 2) Oradio
- 3) Apupeta arai omagasin
- 4) Apaaden
- 5) Neja angor nuce
- 6) Eswamak lu edakis
- 7) Ice kere (Kolim kaitebeikit)?.....

13. Anibo iponesio luakwana luitikitikere aur lujeni ijo?

- 1) Amopiran nuayelo nuikiliok
- 2) Ikeei luatipet luitikokinete aur
- 3) Ikeei luimorikikitai luilikio aitikokinia aur
- 4) Ikeei luitolomio awate nuangor
- 5) Aidingio na angor
- 6) Aidongio naikiliok
- 7) Ikeei luicumanakinio angor aitikokinia aur
- 8) Amopiran luirupio awate nuangor
- 9) Amopiran nuayelo nuangor

14. Itosomai ijo kopekwana iboro luakwana luitikokinete aur?

- 1) Eebo
- 2) Mam

15. Arai erai eebo, kolim epone edio loakwana loitikitikio ijo aur?

- 1) Amopiran nuayelo nuikiliok
- 2) Ikeei luatipet luitikokinete aur
- 3) Ikeei luimorikikitai luilikio aitikokinia aur

4) Ikeei luitolomio awate nuangor

5) Aidingio na angor

6) Aidongio naikiliok

7) Ikeei luicumanakinio angor aitikokinia aur

8) Amopiran luirupio awate nuangor

9) Amopiran nuayelo nuangor

16. Arai mam, iwomit ijo ibuni ijo da aitosoma edio pone kere loakwana loitikitikere aur?

1) Eebo

2) Mam

17. Arai eebo, kolim epone idio kere loakwana lo ibuni ijo akatokin aitosoma aitikitikio aur?

1) Amopiran nuayelo nuikiliok

2) Ikeei luatipet luitikokinete aur

3) Ikeei luimorikikitai luilikio aitikokinia aur

4) Ikeei luitolomio awate nuangor

5) Aidingio na angor

6) Aidongio naikiliok

7) Ikeei luicumanakinio angor aitikokinia aur

8) Amopiran luirupio awate nuangor

9) Amopiran nuayelo nuangor

18. Ipedoritosi yesi aitosoma iponesio luakwana luitikitikere aur kobukusi?

1) Eebo

2) Mam

19. Arai eebo, aibo idumakinete yesi kesi?

1) Adekis na apugan

2) Odwaliro

- 3) Okilinic loitikitikere aur
- 4) Neja luakorak ikee kocaaloi
- 5) Ne egwelanarere ikeei
- 6) Okilinic loegwelenere ikeei

20. Ijo ipedorit duc adumunun iboro luakwana luitikitikere aur kadekesia nuocaloi arai nenidio kere neikotor ijo?

- 1) Eebo
- 2) Mam

21. Arai eebo, anibo iboro luakwana luitikitikere aur, ejaasi adekesia kus nu Ocaloi arai ace aiboisio nuidumununiata yesi?

- 1) Amopiran nuayelo nuikiliok
- 2) Ikeei luatipet luitikokinete aur
- 3) Ikeei luimorikikitai luilikio aitikokinia aur
- 4) Ikeei luitolomio awate nuangor
- 5) Aidingio na angor
- 6) Aidongio naikiliok
- 7) Ikeei luicumanakinio angor aitikokinia aur
- 8) Amopiran luirupio awate nuangor
- 9) Amopiran nuayelo nuangor

22. Idumununei ijo aicoreta kopone loebeitor aitosoma arai ace atiokisio nu eyangaunete iboro luakwana luitikitikere aur?

- 1) Eebo
- 2) Mam

23. Ingai bo emuron abu koinak ijo iboro luakwana luitikitikere aur arai aicoreta
nuitikitikere aur?

1) Edokita

2) Anaasit

3) Amokoliait

4) Emuron loadekis

5) Ice kere (kolim kaitebeikite).....

24. Anyoun orekon amairon bo adi kitoni aiboisit naitikitikere aur?

1) Mam edoli adiope amairo

2) Ageun amairo adiofet toni amairon aarei

3) Amairon awuni

4) Adepari amairon auni

25. Neipejokitor ijo adio aiboisit naitikitikere aur kotoma olapio itomon kaarei luatuboros,
abu idio kopiiriotin lu adekis, kitemitemoto kajo idio epone kere loakwana lo itikitikere
aur?

1) Eebo

2) Mam

26. Kotoma olapio itomon kaarei luatuboros, ipejokitor ijo edio muron lokaila einer
nuikamunitos iponesio luakwana luitikitikere aur?

1) Eebo

2) Mam

27. Kawomisio kon ilopet, iwomit ijo ebe ejok aitosoma iponesio luakwana luitikitikere aur?

1) Eebo

2) Mam

28. Arai eebo, anibo atiokisio iwomit ijo ebe eja kotoma aitosomao naka iponesio luakwana
luitikitikere aur?

.....

29. Anibo ajokisio nuka aitosoma iponesio luakwana luitikitikere aur?

.....

Appendix IV

Interview Guide for the Key Informants (Health Workers)

Instruction: You are requested to answer the questions here below as appropriately and precisely as possible.

1. Are there any available outlets of family planning programmes in the area mainly targeting use of modern contraceptives?
2. If yes, describe how services are given, and the level of utilization by clients?
3. How would you express the availability of modern contraceptives in this health centre and area at large?
4. How accessible are the modern contraceptive services in this area?
5. How would you comment on the quality of family planning services specifically the modern contraceptive methods?
6. What are the modern contraceptive methods available in your area?
7. What are the factors that you suggest to be affecting the utilization of modern contraceptives in your area?
8. What is your comment on the level knowledge of the women on modern contraceptives?

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