DECLARATION

I Atugonza Immaculate hereby declare that the work presented in this research report is my own work and has never been presented either wholly or in part for any academic award both in this university and any other institution of higher learning.

SIGNATURE: ……..

RESEARCHER'S NAME: ATUGONZA IMMACULATE

DATE: …….....

APPROVAL

This is to certify that this report was done under my supervision and I append my signature as an approval for its submission.

Signature: ……. Date: ……

MR. TASHOBYA DANIEL KAMUGISHA

SUPERVISOR

DEDICATION

I dedicate this project to my mother Katusabe Annet (Mrs.), my uncle Mr. Katomi Silver and all my friends for their cooperation and encouragement during this research process. May God bless you all

ACKNOWLEDGEMENT:

I give Glory to the Almighty God for the great work He has done in my life to see me through to this level.

I appreciate all who contributed in one way or another to make this research process a success; especially Mr. Tashobya Daniel Kamugisha - my supervisor,

I also acknowledge Kampala International University through its administration as one of the greatest contributors, most especially the School of the Allied Health Sciences.

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LIST OF ACRONYMS

FP: Family Planning

WHO: World Health Organization

IUDs: Intrauterine Devices

NFP: Natural Family Planning

PHC: Primary Health Care

FPAU: Family Planning Association of Uganda

USA: United States of America

MDG: Millennium Development Goals

IAEG: Inter-Agency and Expert Group

FAMs: Fertility Awareness-Based Methods

IUD: Intrauterine device

MOH: Ministry of Health

HIV: Human Immunodeficiency Virus

AIDS: Acquired Immunodeficiency Syndrome

NGOs: Non-Governmental Organizations

Fig.: Figure

DEFINITION OF OPERATIONAL TERMS:

Contraception: Is the prevention of the fusion of gametes during or after sexual activity

Abstinence: Refraining from vaginal, anal, or oral intercourse

Female sterilization: A surgical intervention that mechanically blocks the fallopian tube to prevent the sperm and egg from uniting

Vasectomy: A surgical procedure that prevents pregnancy by blocking the Passage of sperm into the ejaculated seminal fluid

ABSTRACT

The purpose of the research study was intended to assess the Utilization of family planning services among married couples of aged 18 and 59 years in Rukunyu Health Center IV with three objectives which included among others to find out the knowledge about Family Planning services among married couples of age 18 and 59 years in Rukunyu Health Center IV to establish the of utilization level of Family Planning services among married couples of aged 18 and 59 years in Rukunyu Health Center IV and to find out the factors associated with low utilization of the family planning services a mong married couples of aged 18 and 59 years in Rukunyu Health Center IV Kahunge Sub-County Kibale county Kamwenge District

The study involved a cross-sectional design where qualitative research methods gave immediate knowledge and information on the subjects under study. Data sources from this

Study was entirely obtained from the questionnaires. The data collected was analyzed using Microsoft excel, and the result presented in a number of ways including Tables, Figures, Pie charts, Bar and Line graphs and histograms. The guidance of a statistician will be sought during the process.

Generally, this research project In this study the researcher found that a lot is still needed as far as utilisation of family planning services in both the gender, but more in the male counterparts who still have a very big gap which needs to be timely addressed as long as FP still seem to be a way to basing on the current population growth rate as well as the challenges associated to high population growth and the socio-economic aspects attached to it. The end of the journey therefore does not seem yet near according to the findings above.

CHAPTER ONE

1.0 INTRODUCTION

This chapter addresses the Background of the study, Problem Statement, Objective of the Study, Main Objective, Specific objectives and questions, Significance of the Study, and Justification of the study:

1.1. BACKGROUND:

Family planning is a means of helping individuals or couples to decide for themselves when to start having children, how many children to have and how to space them and when to stop producing children. High fertility rates are strongly associated with inadequate spacing between births, which in turn is associated with high maternal and infant mortality rates. Family planning prevents unwanted pregnancies, induced abortions and reduces family size. FP was introduced concerning the welfare of the society as a whole than the wellbeing of an individual, a man or a woman. (Wood 1997)

Internationally, efforts such as the FP-2020 initiative have focused renewed attention on family planning and necessitated standardized indicators of unmet need for family planning by which to measure progress. This study examines current levels and trends in unmet need among women between 15 and 24 years of age, both married and unmarried. It explores factors associated with unmet need: place of residence, wealth, educational attainment, and parity. Casterline and Siding 2000

This describes the levels and trends in the components of unmet need: age at marriage, fertility preferences, and use of contraception. The following are among the study's key findings:- Unmet need for family planning among young married women is highest in the West and Central Africa region (averaging 29.3%), followed by the East and Southern Africa region (25.5%); the region with the lowest level of unmet need is the Middle East and North Africa (10.8%). Among individual countries, unmet need is highest in Ghana (45.7%) and Haiti (44.8%) and lowest in Egypt (8.8%) and Indonesia (8.0%). Only slightly more than half (57.7%) of the total demand for

family planning (unmet need plus current use of contraception) is satisfied in this population, on average. Casterline and Sinding 2000

Total demand among young married women is highest in Latin America and the Caribbean (79.9%) and lowest in West and Central Africa (44.9%). Unmet need has declined among young married women in the majority of countries (51 of 61 countries). West and Central Africa is an exception; unmet need has increased in six countries in this region. Unmet need among young unmarried women is highest, around 40 percent, in the two African regions (41.7% in West and Central Africa; 39.8% in East and Southern Africa) Africa. Among individual countries, it is highest in Senegal (69.5%) and lowest in Ukraine (7.3%). (Casterline and Sinding 2000)

Regionally, over a period of time there has been considerable progress in enabling women and men make informed choices about the number and timing of pregnancies. Contraceptive use worldwide has gone up from around 10% of couples in the 1960s to Over 50% today. Accessibility to good quality FP information and services is now available in both developed and developing countries. However available data on maternal morbidity and mortality, women‘s reproductive health, population growth and unmet needs signal a lot to be desired. (World Population Reports, 1994)

The unmet need for contraception remains too high. This inequity is fuelled by both a growing population, and a shortage of family planning services. In Africa, 23.2% of women of reproductive age have an unmet need for modern contraception. In Asia, and Latin America and the Caribbean – regions with relatively high contraceptive prevalence – the levels of unmet need are 10.9 % and 10.4%, respectively (World Contraceptive Reports 2013, UNDESA)

Studies on the unmet need has received renewed attention as an advocacy and monitoring tool for family planning programs, becoming a key indicator (Indicator 5.6) for the Millennium Development Goals (MDG) (Inter-Agency and Expert Group on MDG Indicators (IAEG) 2008). It is an important measure for assessing progress toward the Family Planning 2020 goal to extend family planning services to an additional 120 million women and girls by 2020 (Carr et al. 2012; Horton and Peterson 2012).

Both Nationally and locally, Family Planning programs previously focused attention primarily on women, because of the need to free women from excessive child-bearing, and to reduce maternal and infant mortality rates through the use of modern methods of contraception. Most of the family-planning services were offered within maternal and child health package, most research and information campaigns focused on women. This focus on women has reinforced the belief that family planning is largely a woman's business, with the man playing a very peripheral role. Therefore, male involvement should be understood in a broader sense than only female contraception, and should therefore refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family-planning practices. (Tuloro T, Deressa 2017)

In Uganda, more than 70% of the population lives in villages. Many rural women will try to visit antenatal health services but due to poor facilities and a lack of equipment and materials in hospitals, they end up dying during pregnancy or labor. Information itself is not available to rural women and the majority gives birth on floors since hospital beds are either not available or not enough. This is a key motivating factor to lead to research on Family Planning utilization among the population.

Birth Control Patch , Birth Control Pills , Birth Control Shot (Depo-Provera) , Birth Control Sponge (Today Sponge) , Birth Control Vaginal Ring (NuvaRing) , Breastfeeding as Birth Control , Cervical Cap (Fem Cap) Condom , Diaphragm , Female Condom , Fertility Awareness-Based Methods (FAMs) , IUD , Morning-After Pill (Emergency Contraception) , Outercourse , Spermicide , Sterilization for Women (Tubal Sterilization) , Vasectomy , Withdrawal (Pull Out Method). http://www.plannedparenthood.org//learn/birth-control/-23/02/2017-19:32)

1.2. PROBLEM STATEMENT:

Large families and short birth intervals are closely associated with poverty and poor health. The children are prematurely weaned and deprived of the required antibodies, nutrients and love from the mother and they are likely to suffer from malnutrition with its attendant poor mental and physical development. Frequent birth usually lead to lack of material resources, overcrowding, housing are poor, hygiene and sanitation for the children similarly, frequent pregnancies lead to

maternal depletion, anaemia and other health problems. So the mother, the unborn child, and living children are all negatively affected by frequent births. Uganda like many developing countries has a high fertility rate of 6.9 children per woman compared to fertility rate of 1.5 in developed countries**.** (Velicer et al, 2000).

The unmet need for contraception survey estimated that 225 million women in developing countries would like to delay or stop childbearing but are not using any method of contraception. Reasons for this include Limited choice of methods; limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people; fear or experience of side-effects; cultural or religious opposition; poor quality of available services; users and providers' bias and Gender-based barriers.

Information itself is not available to rural women and the majority gives birth on floors since hospital beds are either not available or not enough. This is a key motivating factor that led me to currying out a research on Family Planning utilization among the population.

1.3. PURPOSE OF THE STUDY:

To assess the Utilization of family planning services among married couples of aged 18 and 59 years in Rukunyu Health Center IV Kahunge Sub County Kibale County Kamwenge District

1.4. SPECIFIC OBJECTIVES:

1. To find out the knowledge about Family Planning services among married couples of age 18 and 59 years in Rukunyu Health Center IV Kahunge Sub-County Kibale county Kamwenge District.

2. To establish the of utilization level of Family Planning services among married couples of aged 18 and 59 years in Rukunyu Health Center IV Kahunge Sub-County Kibale county Kamwenge District

3. To find out the factors associated with low utilization of the family planning services a mong married couples of aged 18 and 59 years in Rukunyu Health Center IV Kahunge Sub-County Kibale county Kamwenge District

1.5. RESEARCH QUESTIONS:

1. What is the general knowledge of the study population about Family Planning services among married couples of aged 18 and 59 years in Rukunyu Health Center IV Kahunge Sub County Kibale County Kamwenge District?

2. What is the level of utilization of Family Planning services among married couples of aged 18 and 59 years in Rukunyu Health Center IV Kahunge Sub County Kibale County Kamwenge District?

3. What factors are associated with the utilization of Family Planning services among married couples of aged 18 and 59 years in Rukunyu Health Center IV Kahunge Sub County Kibale County Kamwenge District?

1.6. SIGNIFICANCE OF THE STUDY:

If adopted, the findings of the study may be useful to the policy makers especially the ministry of health (MOH), Economic planning and national development, Finance, Local government development partners engaged in family planning programmes to formulate practical policy guidelines that would encourage females of reproductive age and their male partners to improve on their knowledge and usage of the available methods of contraception and advantages of family planning.

To the student researcher for partial fulfilment for the award of Diploma in Clinical Medicine and Community health, as well as building research skills in the researcher. Furthermore in the academic field it may help those in training in institution(s) of higher learning.

1.7.0 SCOPE OF THE STUDY

1.7.1 Content Scope:

The study was based on establishing the assessment of the utilisation of family planning services among the married males and females aged between 18 and 59 years in Kahunge Sub county Kibale county Kamwenge district. It located 3km off Kamwenge – Fortpotal Road.

1.7.2 Geographical Scope:

The study was conducted in Rukunyu health centre which is found in Kahunge Subcount Kibale county Kamwenge district. It located 3km off Kamwenge –Fortpotal Road.

1.73. Time Scope:

This study took a period between Apirl – July 2017.

1.8. JUSTIFICATION OF THE STUDY:

People have used birth control methods for thousands of years. Today, we have many safe and effective birth control methods available to us. All of us who need birth control want to find the method that is best for us. If you're trying to choose, learning about each method may help you make your decision. Although the majority of respondents reported knowing of a contraceptive methods (76%), only 28% were currently using one, and fewer than half (47%) reported ever having used one. A smaller proportion of men (42%) than women (50%) had ever used contraceptives, and women were more likely than men to have ever used a traditional method or a modern method. (It is not possible to say whether the women used these methods with their spouses, since the study was not couple-based.). Respondents were generally supportive of family planning, although overall women were more likely than men to agree with the positive attitudinal statements. International Family Planning Perspectives Volume 25, Number 2, June 1999, 25(2):86-91

Following a study carried out in Nigeria which is one of the most populous countries in Africa, with more than 88 million people; it also has a high annual rate of population growth (3.5%) and

a total fertility rate of 6.0 lifetime births per woman. Additionally, the country has relatively high levels of infant mortality (104 infant deaths per 1,000 live births) and maternal mortality (800 maternal deaths per 100,000 live births). In response to these and other serious demographic and health issues, the Nigerian government put into effect a national population policy in 1989 that called for a reduction in the birthrate through voluntary fertility regulation methods compatible with the nation's economic and social goals**.** International Family Planning Perspectives, 1999, 25(2):86-91

CHAPTER TWO:

2.0. LITERATURE REVIEW

2.1. BACKGROUND

Globally, family planning (FP) is promoted as a mechanism to address the reproductive health needs of men and women as well as the critical challenge of rapid population increase**.** The world population passed the six billion mark in 1999 and over three billion people survive on three dollars or less per day**.** Reproductive rights rest on the respect of the basic right of all couples and individuals to choose freely and responsively the timing of conception of their children and to access the information and means to space them**.** The Alma Alta declaration on primary health care (PHC) cited family planning as one of the key strategies to achieve a better quality of the life for all people**.** In 2002, the Uganda Population and housing census showed that, Uganda had 24.4 million people, with an average growth rate of 3.4 % per annum, much higher than the sub-Saharan African average rate of 2.1%**.** By 2015,the Uganda government is committed to reducing the population living in absolute poverty to 10%, infant mortality rate to 4/1000 live births, child mortality rate to 60 per 1000 live birth and maternal mortality rate to 131 per 100,000 live births. It also focuses on decreasing the high fertility rates from 6.9 %to 5.4% mainly by increasing the contraceptive prevalence rate to 40% and the couple's years of protection to 494,980 by the year 2009. It's proposed to increase the range of family planning services by emphasizing an increase in the availability of logistics and accessibility of the services**.** The latter proposal and promotion on the contraceptives go against the teaching of the Roman Catholic Church, which teaches that children are a blessing to married couples basing on the biblical statement of God 'be faithful and multiply' (Genesis, 1:28).

Many proponents of artificial birth control have always accused the Roman Catholic Church of the insensitivity to the socio-economic challenges due to the family size and population, however, after its second Vatican council (Vatican I); the Roman Catholic Church officially reaffirmed its knowledge of the genuine need for birth control and child spacing. It acknowledged the presence of pregnancy related risks to the mothers and child health. It also acknowledged the economic difficulties associated with large unplanned family(ies) and the

limited resources especially in developing countries**.** However it differs from other proponents of FP over the means by which to achieve the goal of birth control. (The World Population report 1999)

In 2014 the United Nations estimated there is an 80% likelihood that the world's population will be between 9.6 billion and 12.3 billion by 2100. Most of the world's expected population increase will be in Africa and southern Asia. Africa's population is expected to rise from the current one billion to three or four billion by 2100, and Asia could add another billion in the same period. Because the median age of Africans is so low (For example Uganda = 15 years old), birth credits would have to limit fertility to one child per two women to reach the levels of developed countries immediately. For countries with a wide base in their population pyramid it will take a generation for the people who are of child bearing age to have their families. An example of demographic momentum is China, which added perhaps 400,000 more people after its one-child policy was enacted. Arthur has suggested that the focus should be on the developed countries and that some combination of birth credits and additional compensation supplied by the developed countries could rapidly lead to zero population growth while also quickly raising the standard of living in developing countries. (http://www.en.wikipedia.org)

Family planning services are offered mainly as part of maternal and child health package and this arrangement does not favor male participation. Furthermore, to date male methods are limited to only withdrawal, condoms and vasectomy rendering very little choice for them (Kamal et al, 2003).

In Uganda, the establishment of Family Planning Association of Uganda was to promote family planning, particularly modern methods of contraception. With the introduction of primary health care activities, Family Planning Association has extended its activities to rural areas where the majority of the population is found. Large-scale survey as well as small studies done in Uganda as well as other countries indicate that men’s family planning and other reproductive health knowledge, attitude and practices are more clearly understood now than before. (Velicer et al, 2000).

2.2. Knowledge/Awareness about Family Planning

Regardless of socio-economic status, respondents have a high knowledge of, and a positive attitude towards, family planning. About half of the respondents were practicing some modern methods. However, negative attitudes persist towards young people or unmarried women using contraception. In addition, whether women practice family planning depends on many factors, and the most common factors are avoiding unwanted pregnancy or spacing out the number of children, the side effects of the methods, and the women's standard of living. If women want to have more children, or were unable to tolerate the side effects of the method itself, family planning would not be practiced. Side effects were the biggest concern for both current users and non-users. Rumors about possible side effects deterred some women from using modern contraception, especially the pill and injectable contraceptive, and most users of these methods reported some experience of side effects. In addition, family planning experts should prioritize further research and development into minimizing the side effects of contraception. (Domrei "Family Planning Survey: Contraception among Married Women of Reproductive Age in Cambodia 2005 Phnom Penh.)

Rural women need knowledge on how to both support pregnant women and mobilize more pregnant women to access antenatal services rather than visiting traditional birth attendants, but they cannot do this without volunteers such as village health teams who mobilize women at community level to access services. Every minute a woman dies giving birth, and seven new babies die. A mother's risk of dying from pregnancy related complication is about 250 times greater in a developing country than in un developed country. In developing countries, pregnancy and childbirth and their consequences are still the leading causes of death, disease and disability among women of reproductive age, and newborn deaths are 40% of all child deaths in developing countries. "The issue of contraceptives may expose teenagers to HIV/AIDS infection. In 2010, about 1,527 girls carried out pregnancy tests and 775 of them tested [HIV] positive. A reasonable number of these pregnancies were unwanted. Parent teachers are shy to talk about sex with children and this has left many children with no option but to experiment the action themselves, said Sanyu Caroline communication's officer at Joy for Children Uganda. She added: "The rising population in Uganda is a great worry to the government. A lot of attention must be shifted to family planning use; people should be encouraged to give birth to children

they can best take care of. So teenagers should be encouraged by their parents to focus much on what they want their future to be like. Planned Parenthood Federation of America Inc. 2014

The reason that has also contributed to low utilization of family planning is because of method failure as stated by Kelly (2001) he showed that certain group of women seems to experience contraceptive failure especially those aged between 15 and 19 years of age, were less likely to use birth control methods consistently. Failure rate is high among the cohabiting and unmarried women especially those who are below poverty income level and among black and Hispanic women.

2.3. Benefits

Family planning has many potential benefits. It reduces poverty, maternal and child mortality; empowers women by lightening the burden of excessive childbearing and it reduces environmental degradation by stabilizing the population of the planet [1, 2]. Unintended pregnancy related to unmet need is a worldwide problem that affects women and their families and societies at large. About 40 % of all births that occurred globally in 2012 were unwanted posing hardships for families and jeopardizing the health of millions of women and children [3]. Serving all women in developing countries who currently have an unmet need for modern methods would prevent an additional 54 million unintended pregnancies, including 21 million unplanned births, 26 million abortions (of which 16 million would be unsafe) and seven million miscarriages; this would Partner support to family planning is very important. This study revealed that women whose partner had non-supportive attitude about contraceptives use were more likely to have unmet need for family planning compared to women whose partners had supportive attitude. This study also showed that women who were not counseled about contraceptives were more likely to have unmet need for FP compared to those women who were counseled. This finding was in line with a study conducted in Mekele city, Tigray. This similarity might be due to use of similar strategies and guide lines to inform the society about FP. In sub-Saharan Africa, 25 % of women of reproductive age who are married or in union have an unmet need for family planning. Genet et al. (Reproductive Health (2015) 12:42 Page 5 of 5)

FP has a number of benefits including delay or stop childbearing, Some family planning methods, such as condoms, help prevent the transmission of HIV and other sexually transmitted infections reduce the need for abortion, especially unsafe abortion, prevents deaths of mothers and child, reinforces people's rights to determine the number and spacing of their children. (WHO update of May 2015).

Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continues to be low in sub-Saharan Africa. Globally, use of modern contraception has risen slightly, from 54% in 1990 to 57.4% in 2014. Regionally, the proportion of women aged 15–49 reporting use of a modern contraceptive method has risen minimally or plateaued between 2008 and 2014. In Africa it went from 23.6% to 27.6%, in Asia it has risen slightly from 60.9% to 61.6%, and in Latin America and the Caribbean it rose slightly from 66.7% to 67.0%. Use of contraception by men makes up a relatively small subset of the above prevalence rates. The modern contraceptive methods for men are limited to male condoms and sterilization (vasectomy).Planned Parenthood Federation of America Inc. 2014

The human population has been growing continuously since the end of the Black Death, around the year 1350, although the most significant increase has been in the last 50 years, mainly due to medical advancements and increases in agricultural productivity. The rate of population growth has been declining since the 1980s. The United Nations has expressed concern on continued excessive population growth in sub-Saharan Africa. Recent research has demonstrated that those concerns are well grounded. As of November 20, 2015 the world's human population is estimated to be 7.284 billion by the United States Census Bureau, and over 7 billion by the United Nations. Most contemporary estimates for the carrying capacity of the Earth under existing conditions are between 4 billion and 16 billion. Depending on which estimate is used, human overpopulation may or may not have already occurred. Nevertheless, the rapid recent increase in human population is causing some concern. The population is expected to reach between 8 and 10.5 billion between the year 2040 and 2050. In May 2011, the United Nations increased the medium variant projections to 9.3 billion for 2050 and 10.1 billion for 2100.During 2005–2050, nine countries are expected to account for half of the world's projected population increase: India, Pakistan, Nigeria, Democratic Republic of the Congo, Bangladesh, Uganda,

United States, Ethiopia, and China, listed according to the size of their contribution to population growth. China would be higher still in this list were it not for its policy. http, 15:01

It is also beneficial as it improves stability and happiness of married couple as they will be able to share the resources available in the family. Unintended pregnancies have significant consequences and occur most frequently in adolescents, low-income groups and women from minority groups. Improving contraceptive compliance among high-risk adolescents is a key to reducing the rates of unintended pregnancy in this group of the population (Dona, 1997).

The 1994 Cairo international conference on population argued that FP programmes must be part of wide approach to population growth regulation and health development. FP increases women's control over their bodies, gender equality and enhances their health levels**.** During the conference it was also emphasized that rapid population growth, especially in sub-Saharan African countries, cannot keep pace with the available resources. If unchecked, it would result into greater malnutrition, lack of housing, unemployment, shortage of social services, environmental degradation and street children**.** Therefore, helping them to reduce unintended pregnancies would slow population growth and reduce on natural resources. Some societies and individuals believe that a large population promotes agricultural, military and political power, as a result, strategies for limiting population growth as a means to acquire good standard of living are counteracted by the combination of strategies that society, religion, culture and poor people adopt in pursuing their livelihood or survival of their values. However if the views above were true, Ethiopia and Bangladesh, with population of over 100million, would not be in deep poverty**.** In Uganda, successive participatory poverty assessment process reports identified large families as a cause of poverty**;** In fact high fertility rate wipes out developmental achievements. And without action taken, by 2013/14 the number of Ugandans living in poverty is estimated to increase to 10.3 million.

Family planning has made males to participate in birth control methods as they enhance good decision making on the family planning methods available. The Community is not left behind as it benefits when the population size is low. This help in improvement of quality life of people in terms of food, education and job opportunity and this reduce the risk of malnutrition, illiteracy and crime due to sufficient funds and resources to use. On other hand contraceptives for example

combined oral pills help prevent anemia, incidence of pelvic inflammatory disease, it also decreases menstrual cramps and pain and several types of cancer (Cynthia, 2005).

2.4. Family planning methods.

WHO defines NFP methods as those used for planning and preventing pregnancies through observing naturally occurring signs and symptoms of the fertile and infertile phases of a woman's menstrual cycle, and Artificial family planning(AFP) methods as those which prevent, conception by application of any mechanical, chemical, surgical and pharmaceutical method**.** NFP methods include Abstinence, the cervical mucus (Billing's method), the basal body temperature (BBT) methods, the symptom-Thermal (multiple indicators) method, the rhythm (calendar) method.

2.5. Factors affecting Utilization of FP Methods

According to WHO (1996) FP Utilization may be influenced by the likely rate of effectiveness, least side effect, ability to take a pill every day or insert a cap before every sexual act, availability and cost of the method. A study in Southern Sub-Saharan Africa (SSSA) found that both government and Non-government agencies educated the population about various modern FP methods and free contraceptives were offered in almost every institution. However, Catholic institutions only counselled about Natural FP methods Rotenberg and back, 2004.

There is a problem of inadequate staffing in health units and this has contributed to low utilization of family planning and also lack of training. Unless more personnel are hired staffs have more to do and clients have to wait longer. So family planning providers should be highly trained and there should be periodic update. Most of the people believe those contraceptives are for women alone as some are not able to persuade their partners to use condom. Most people do not use condom as a means of prevention of pregnancy. Between 10% and 15% of women who rely on condom become pregnant on the first year of use mainly because they do not use condoms consistently and correctly. Kelly (2001)

In Uganda UDHS data of 2000 -2001 showed that 3-5% of marrie couples did not use AFP because of religious reason. Low use of modern contraceptive due to strong adherence to the

catholic faith was also reported in some parts of Uganda. Another factor with an effect on the use of family planning is the client's knowledge of reproductive physiology. The UDHS 2000-2001 showed that 96.4% of the respondents had good knowledge about modern methods whereas 66.1% knew at least one method of FP.

Katherine (1997) stated that, basing on natural survey of female adolescent in US and Canada, contraceptive use has been relatively low. In US, approximately 1/3 use contraceptive and in Canada is ½ although most of the people are aware of contraceptive use, few put it in practice. Although there was much level of contraceptive awareness, it did not do much with similar level of practice, e.g. the 1996 Tanzania demographic and health survey TDHS, explain that more than 80% of women and men knew at least more than one method of family planning, only 16% of all women are currently using the method, while 12% are using modern methods. 22% of male in Tanzania are using contraception, 14% using modern methods and 8% using traditional methods.

Though majority of the people worldwide do not make use of contraceptive, there is a danger of rapid population growth rate as stated by (Kim 2004) who indicates that, while fertility is falling in many regions, world population will increase from 6.4 billion today to 8.9 billion by 2050; the 50 poorest countries will triple in size to 1.7 billion people.

Religious beliefs have contributed to low utilization of family planning as Katherine (1997)stated that, in 1996, the state of California enacted legislation that require employer to include contraceptive as part of employees health insurance. An exemption was included for religious employers such as Roman Catholic, institution that oppose contraception as moral evil from national register. There is still a high population growth rate and fertility rate is still high for a woman as shown from UDHS (2003) which stated that, Uganda has an average population growth rate of 2.9%. The high fertility and declining mortality level brings about high growth rate. It also showed that the current total fertility rate of 6.9 children per woman is nearly one of the highest in the whole world. It also showed that in Uganda, percentage of currently married people who are using any method of contraception is 23%.

Garry (2001) stated that the WHO estimate that 25% of all pregnancies worldwide are unwanted and that 50 million of them are terminated by abortion every year. Also among developed countries rate of unwanted pregnancies vary widely, in US the proportion of pregnancy that are unplanned is 50%, Canada is 39% and Netherlands 6% respectively. Although adults in all the three countries are relatively well informed about the contraceptive, America seems more skeptical about the effectiveness of birth control methods and more likely to bring the incident of unwanted pregnancy of societal problems. Even when the birth control technique are available, people do not make use of them, data from various study indicate that among sexually active individuals, some do not use contraception with any regularity.

Majority of the people still have negative attitude towards family planning and this has contributed to low utilization of family planning. Kosh (2007) has shown that women attitude towards sexuality can affect decision making about contraception. Those who have more positive attitude about sex tend to use more effective method of birth control and to do so with greater consistence than women with negative attitude.

Cultural and religious beliefs to some extent have contributed to low utilization of family planning methods. Some of the world's major religious groups are opposed to efforts that encourage the use of birth control or abortion especially roman Catholics and Muslim groups in making any sexual related decision that we must examine the ethical and religious value (Amooti,2007).

2.6. Contraceptive Coverage

The study done by many people show that there is still low utilization of contraceptives due to various reasons. Wood (1997) stated that 5% of the couple use modern method in sub-Saharan countries. Kenya, Botswana and Zimbabwe were rated as 27%, 33% and 43% respectively for those who use contraceptive. Early marriage pattern and lack of acceptance of contraceptives are affected by underlying economic social and cultural forces which lead to high fertility. Contraceptive use is low although people know most of the contraceptives as indicated by FPAU

(2001) which state that, the level of knowledge about contraceptive among adolescence and its use is low with less than 25% of sexually active adolescence using them

It is important that family planning is widely available and easily accessible through midwives and other trained health workers to anyone who is sexually active, including adolescents. Midwives are trained to provide (where authorized) locally available and culturally acceptable contraceptive methods. Other trained health workers, for example community health workers, also provide counseling and some family planning methods, for example pills and condoms. For methods such as sterilization, women and men need to be referred to a clinician.

2.6.0 Accessibility of Family Planning services

There is also lack of accessibility to most of contraceptive as stated by (Kosh 2004) who showed that many individuals do not have access to family planning methods however there is a minimal increase in the use of contraceptives from 1993 to 1998 from 33% to 39% for all methods. There is also regional variation the highest being central province with 55% rift valley with 34% and the lowest 20% in the coast province. Therefore the increase in the population growth rate is due to lack of utilization of family planning.

Lack of male participation in family planning has contributed to high population as stated by Mark (2008) who explained that overpopulation of the world would not be brought under control until men share fully in the family planning responsibility. It is clear that decision making about that type of birth control to be used and the responsibility for using it can be shared by a man and a woman. Caroline et al (1993) states that, men are underserved audience. Over the past decade however, increasing recognition of man influence on reproductive decision and family planning practices has given rise to new communication projects promoting male involvement in family planning. The Zimbabwe national family planning council successfully implemented a male motivational campaign with technical assistance from John Hopkins population services, the national family planning that began in Zimbabwe in 1998 was successful as contraceptive prevalence rate reached 36% which was the highest in sub-Saharan Africa. Family size however remained large with an average woman bearing 5.5 children and with more than 4/5 of all contraceptive users relying on single short term method, the pill. The program was directed

towards only overlooking men even though survey showed exerted a greater influence on family size and family planning decision.

2.6.0 Male Participation in Family Planning

Men's participation is crucial to the success of family planning programs and women's empowerment and associated with better outcomes in reproductive health such as contraceptive acceptance and continuation, and safer sexual behaviors. Limited choice and access to methods, attitudes of men towards family planning, perceived fear of side-effects, poor quality of available services, cultural or religious oppositions and gender-based barriers are some of the reasons for low utilization of family planning. Hence, this study assessed the level of male involvement in family planning services utilization and its associated factors in Debremarkos town, Northwest Ethiopia. (http://www.biomedcentral.com/1472-698X/14/33 December 2014, 19:43)

Only 44 (8.4%) respondents were using or directly participating in the use of family planning services mainly male condoms. The reasons mentioned for the low participation were the desire to have more children, wife or partner refusal, fear of side effects, religious prohibition, lack of awareness about contraceptives and the thinking that it is the only issue for women. Opinion about family planning services, men approval and current use of family planning methods were associated with male involvement in the services utilization. Kassa et al (2014); licensee BioMed Central Ltd

CHAPTER THREE

3.1.0. RESEARCH METHODOLOGY

3.1.1. INTRODUCTION:

This area addressed the research methodology which was employed in the project. Key areas include the study area, study population, Sampling technique, Inclusion criteria, Exclusion criteria, data collection tools, data analysis and presentation and ethical considerations

3.2.0 RESEARCH DESIGN

The study involved a cross-sectional design where qualitative research methods were employed. The design offered information about a population at a given point in time. It tended to give immediate knowledge and information on the subjects under study. Data sources from this study were entirely obtained from the questionnaires.

3.3.0 AREA OF THE STUDY

The study was carried out in Rukunyu health centre which is found in Kahunge Subcount Kibale county Kamwenge district. It located 3km off Kamwenge –Fortpotal Road.

3.4.0 STUDY POPULATION

The study population included both the married males and females aged between 18 and 59years.

Place	**No. of patients**	**Males population**	**Female population**
Rukunyu Health Center IV	611	288	323

3.5.0 SAMPLE SIZE DETERMINATION

Fisher et al formula was used to determine sample size;

Whereby:

$N= Z^2pq/d^2$, where

N is the derived size of the population.

Z is the standard deviation at 95% of the degree of confidence which is 1.96

p is the proportion of the target group is estimated to be 31%

q is 1-p= 1-0.31= 0.69

d is the measure of anticipated error as a proportion of standard deviation about 0.05

z =95% = 1.96, **p**= 31% (0.31) **q**=1-0.31=0.69 **d**=0.05

n= $(1.96)^2$x 0.31 x 0.69 / $(0.05)^2$ =328 Therefore, n (sample size) =328

Therefore due to financial constraints and limited time a sample size of 200 will be used

3.5.0. INCLUSION CRITERIA

The study involved all married males and females adults aged between 18 and 59 years. The members to be interviewed shall only be those who have willingly and fully consented for their participation in the study.

3.5.1. EXCLUSION CRITERIA

This excluded all the subjects of the community outside the study group, whether by age or status. Also the study group population was willing to participate in the study was excluded.

3.6 SAMPLING METHODS

Simple random sampling method was used. Participants who consented for their participation in the study were selected randomly until the required sample size is attained

3.7. DATA COLLECTION TOOL

The data was collected using questionnaires which contained the participants' number, and both open and closed ended questions derived from the objectives of the study, these questions were relevant to the study. Other tools included pens, files and/or clip board.

3.8. DATA COLLECTION PROCEDURE

The participants were asked to sit comfortably where they were able to answer the questions from the questionnaire. The principle researcher was the one to collect the data and an aid incase need arises. The main tool which was used in interviewing the participants was the questionnaire.

3.9. PRE-TESTING:

In order to ensure quality control and detection of possible sources of error in the research, the researcher carried out a half-day pre-testing data collection in the study area. This was greatly help in anticipation and creation of an avenue for possible precautions against the preventable errors.

3.10. DATA ANALYSIS

The data collected was analyzed using Microsoft excel, and the result presented in a number of ways including Tables, Figures, Pie charts, Bar and Line graphs and histograms. The guidance of a statistician will be sought during the process.

3.11.0 DATA QUALITY CONTROL

Questionnaires were distributed equally among the legible respondents regardless of their religion, ethnicity, tribe, or educational levels, backed by the pretested questionnaire. Any aides needed during data collection were trained on how to collect data and approaching the participants. Participants were chosen randomly to reduce biasness in terms of the kind of information that was required.

3.12.0 STUDY LIMITATION

Since the research was carried out alongside my other studies, these were the limitations.

- Limited time.
- Language barrier was a problem because the study area is metropolitan.
- Limited finances.

3.13.0 ETHICAL CONSIDERATIONS

An introductory letter was acquired from the Dean of the Faculty of Allied health to allow the researcher to carry out data collection. Proper community entry process was followed by passing through the community leaders. The purpose of the research was explained to the participants to gain maximum co-operation. For confidentiality purposes, the participant's names were not to be included in the questionnaire, except only specific numbers that were assigned to each participant; Also any information obtained from the participants was not be shared to anyone without the consent from them. The participants are to be fully informed about the exercise to be carried out by the researcher and the importance of the study. One had to willingly accept without having any external persuasion or pressure and then consent in signing. Privacy was ensured during the interview so that the participants were free to discuss any concern issues with the researcher. The participants had total liberty to refuse participating from the exercise without penalty and can withdraw at any during data collection.

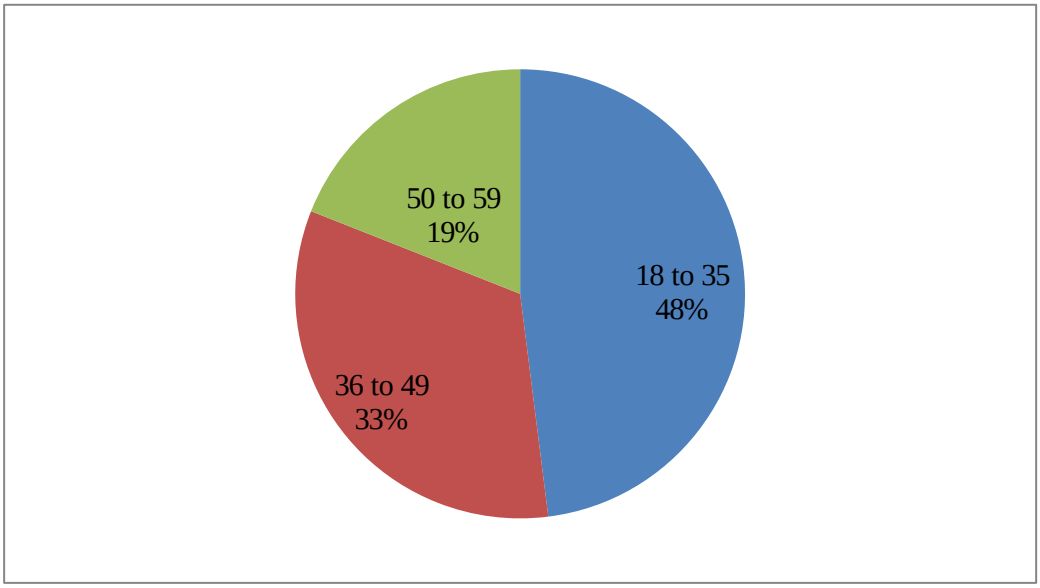
CHAPTER FOUR

4.0 STUDY FINDINGS

4.1. PART ONE (1): SOCIO-DEMOGRAPHIC INFORMATION

4.1.1 Respondents by age.

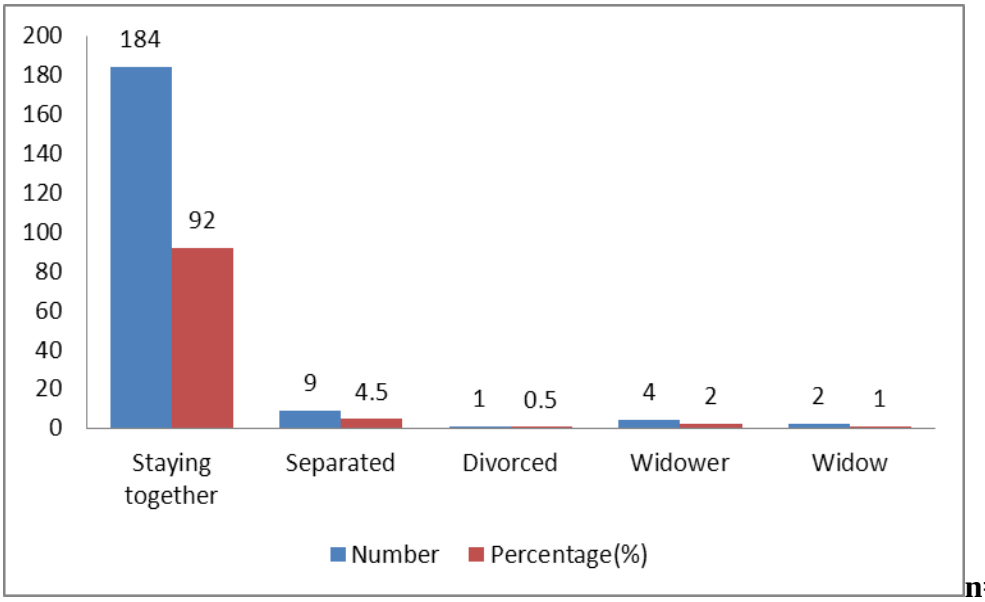
Figure 1: Respondents by age (years)



n=200

4.1.2. Marital status

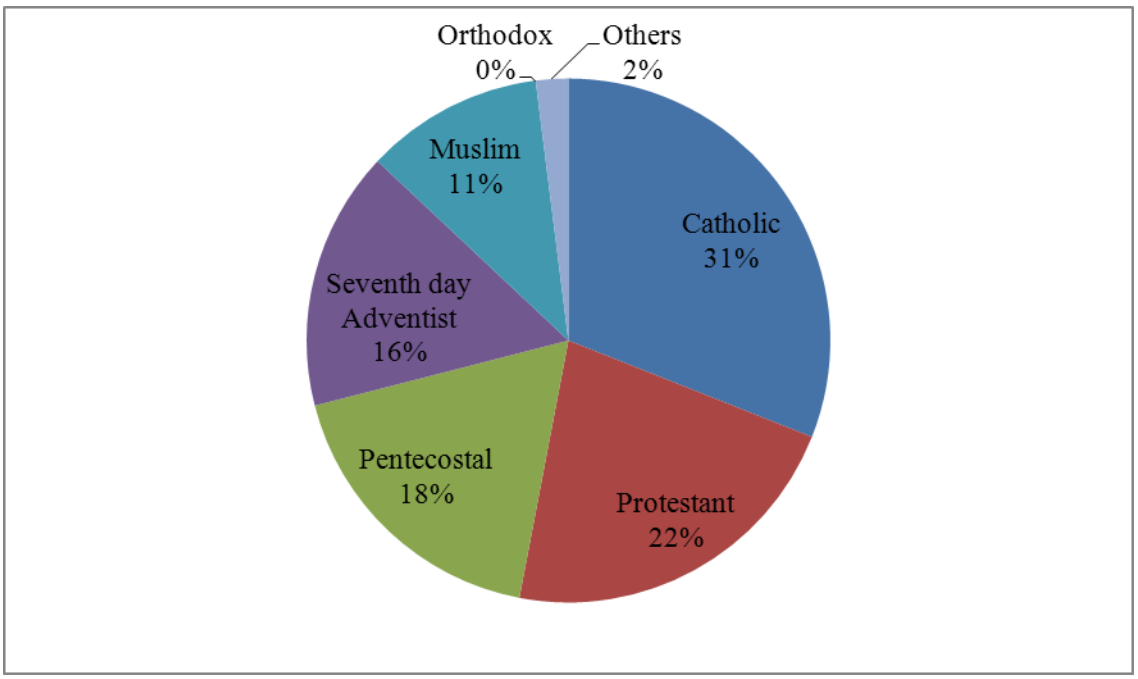
Figure 2: Marital status



n=200

4.1.3. Respondents by Religion

Figure 3: Respondents by Religion



n=200

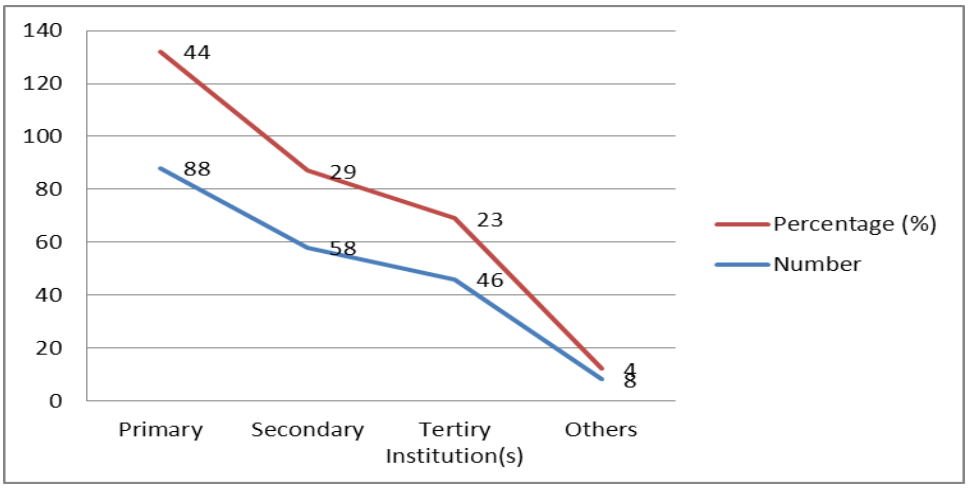
4.1.4. Occupation of respondents

Figure 4: Occupation of respondents

Occupation	Number	Percentage(%)
Health worker	18	9
Teacher	26	13
Students	10	5
Businessmen/women	42	21
Self employed	28	14
Large scale farmer	6	3
Peasant	48	24
Engineer	4	2
Others	18	9
Total	**200**	**100**

4.1.5. Educational levels attained by respondents

Figure 5: Educational levels attained by respondents



n=200

1.2.0 PART TWO (2). GENERAL KNOWLEDGE OF THE RESPODENT ABOUT FAMILY PLANNING SERVICES

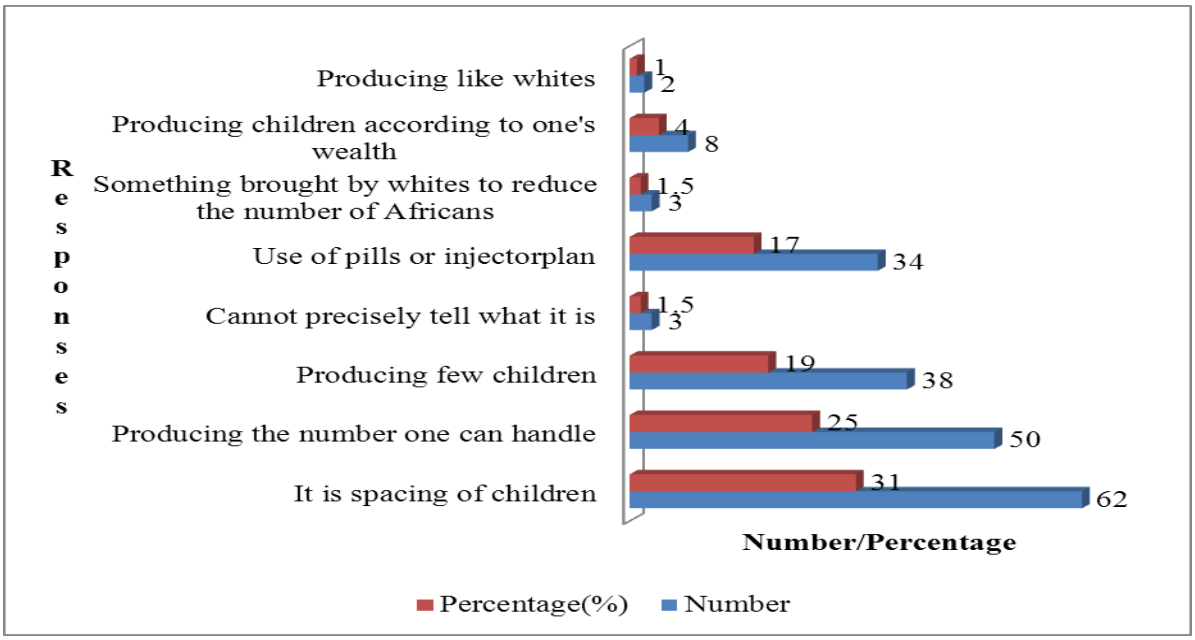
4.2.1. Awareness about Family Planning Services

Table 1; Awareness about Family Planning Services

Category	Number	Percentage(%)
Aware	199	99.5
Not aware	1	0.5
Total	**200**	**100**

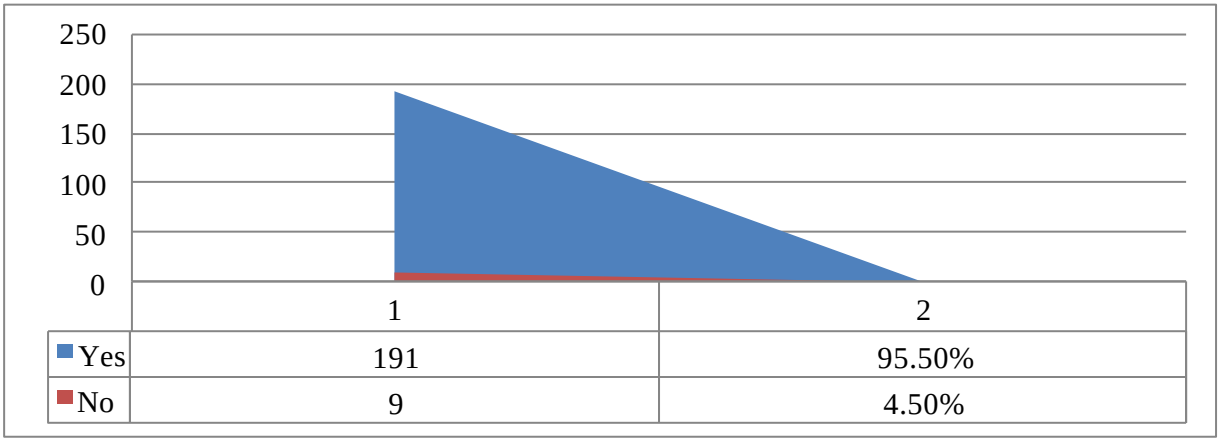
4.2.2. Respondents' understanding of what Family Planning is

Figure 6: Respondents' understanding of what Family Planning is



n=200

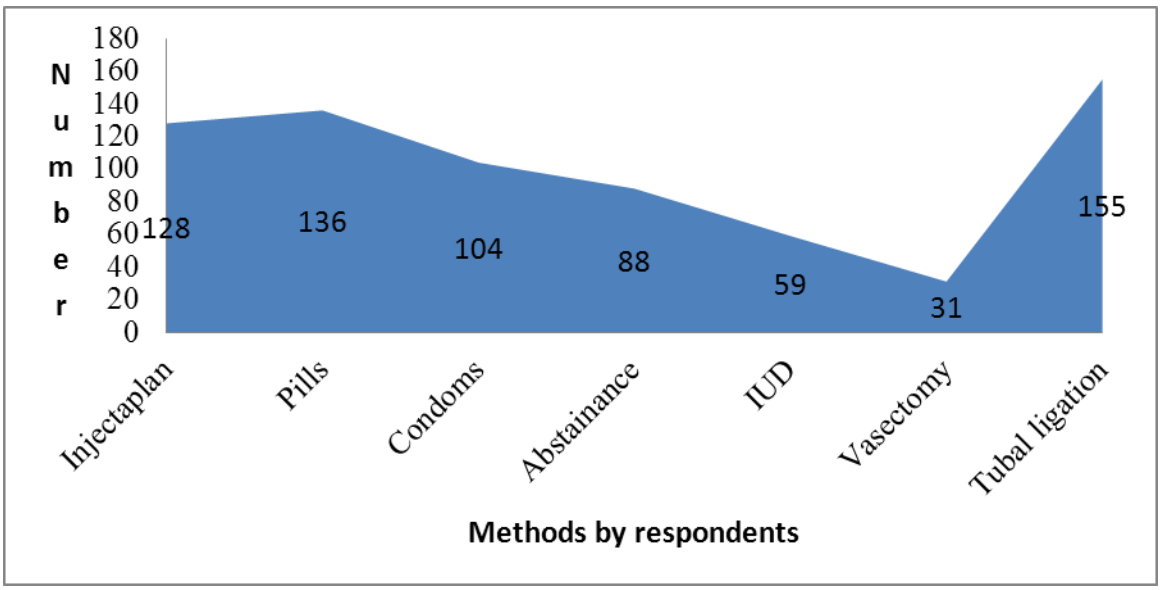
Figure 7: Knowledge about Family Planning method(s)



n=200

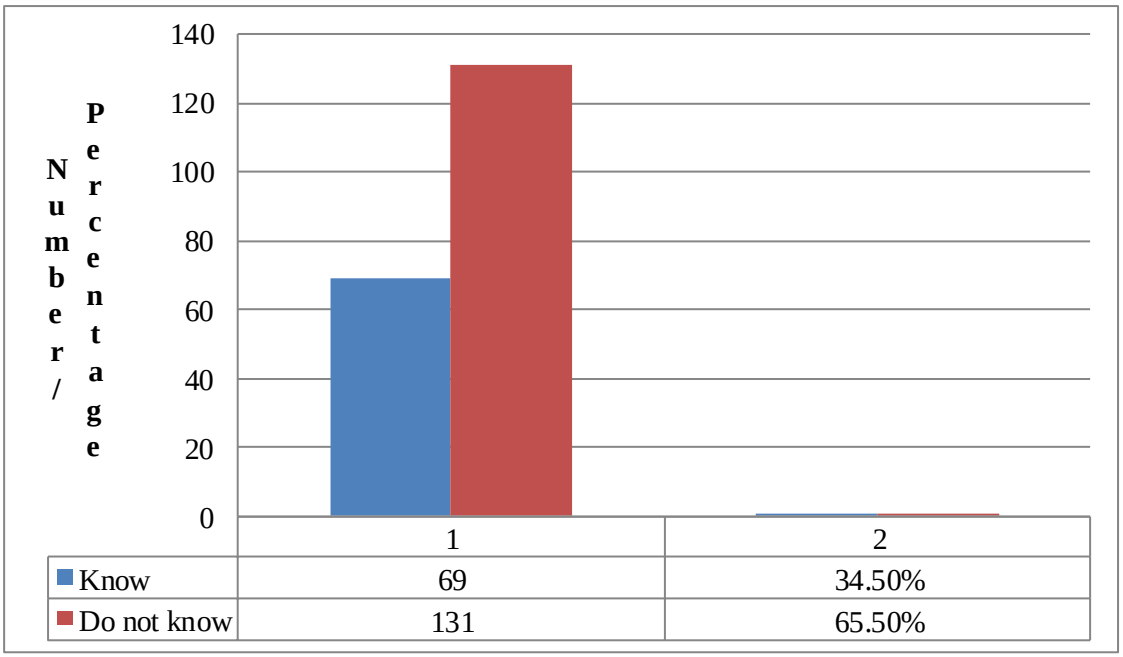
4.2.3. Method(s) of Family Planning as listed by the respondents

Figure 8: Method(s) of Family Planning as listed by the respondents



4.2.4. Knowledge about any other services offered at Family Planning service centres

Figure 9: Knowledge about any other services offered at Family Planning service centres



n=200

4.2.5. The other services offered at Family Planning service centers n=200

Figure 10: The other services offered at Family Planning service centers n=200

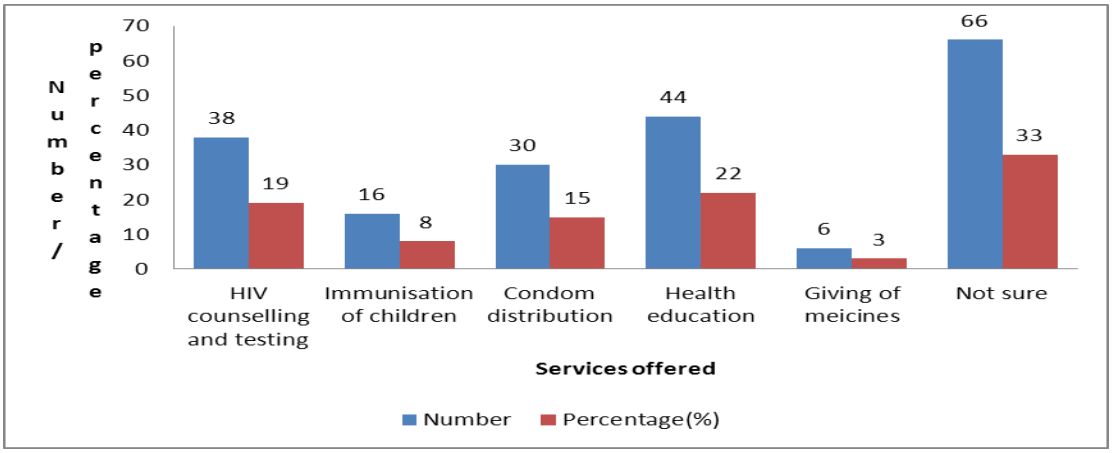


Table 2: Knowledge about the benefits attached to Family Planning

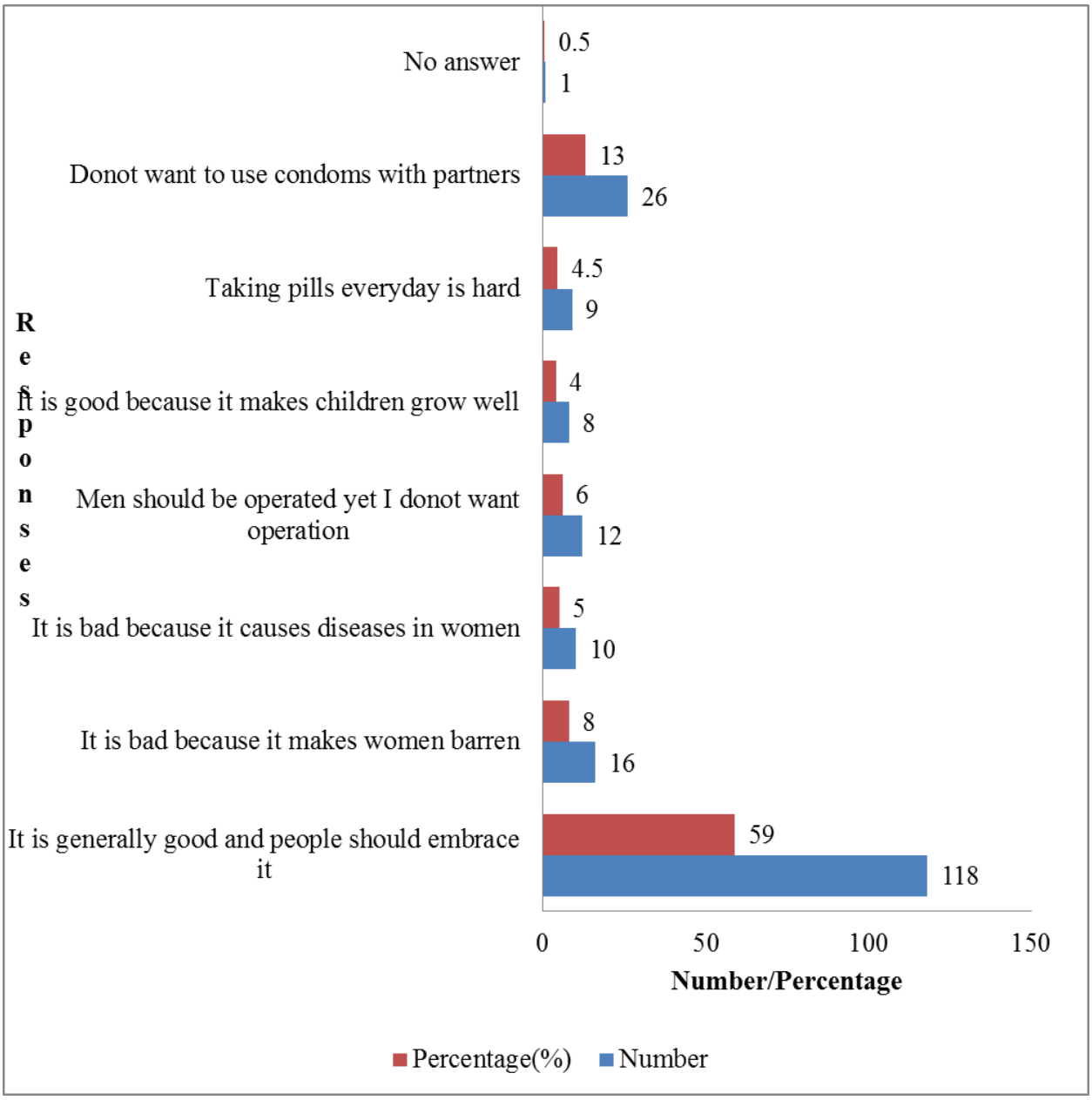
Category	Number	Percentage(%)
Know	188	94
Do not know	12	6
Total	**200**	**100**

Table 3: The benefits attached to Family Planning as reported

Benefits	Number	Percentage (%)
Makes children grow ell	36	20
Makes paying of school fees easy	12	7
Keeps women healthy	34	19
Makes the family eat well	18	10
Prevents some diseases	11	6
Has no benefit	3	2
Makes planning for the family easy	42	23
Keeps children healthy	24	13
Total	**180**	**100**

4.3.0. PART THREE (3): GENERAL ATTITUDE ABOUT FAMILY PLANNING SERVICES

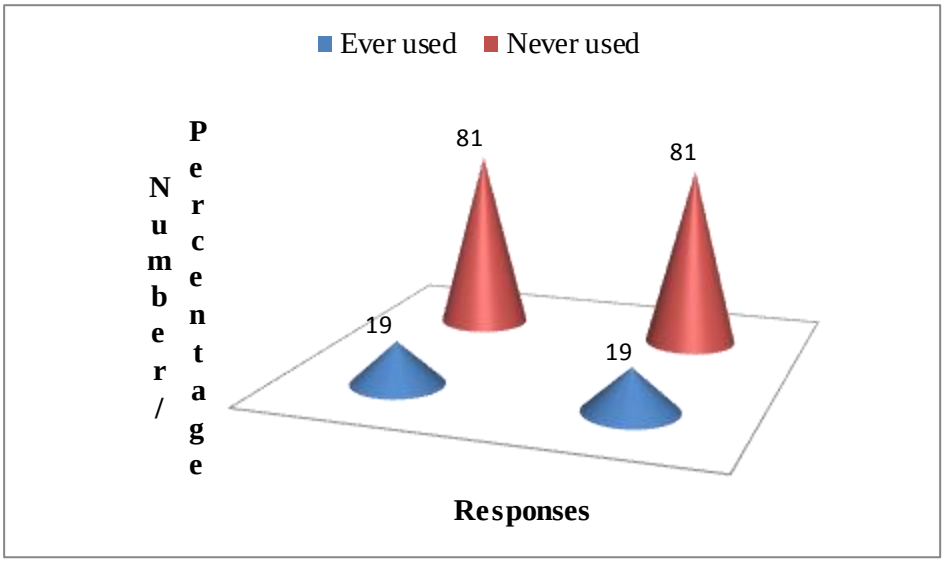
Figure 11: General attitudes of the respondents about Family Planning n=200



4.4.0 PART FOUR (4): UTILISATION OF FAMILY PLANNING SERVICES

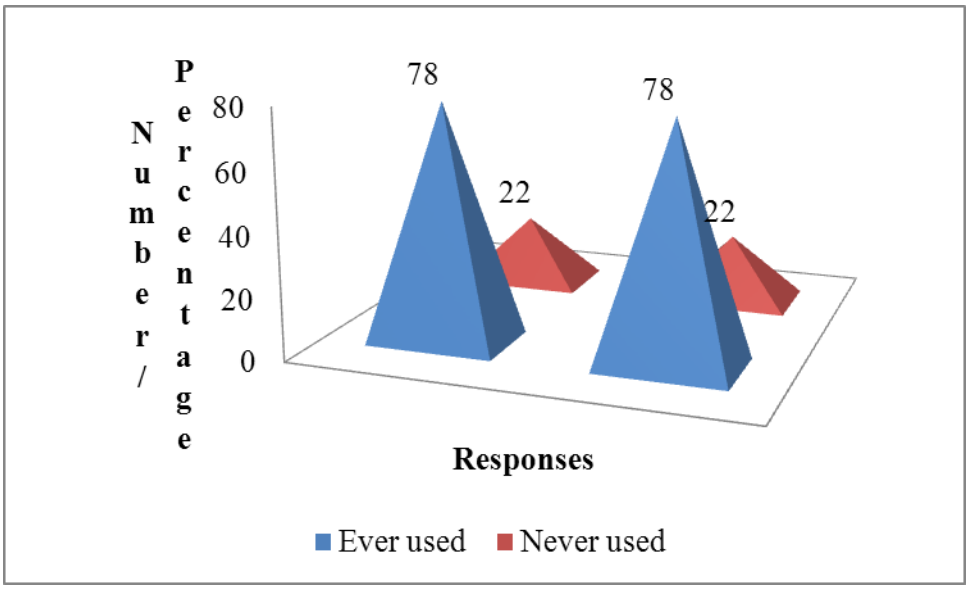
4.4.1: Utilization of family planning method(s)

Figure 12: Utilization of family planning method(s) in males



n=100

Figure 13: Females

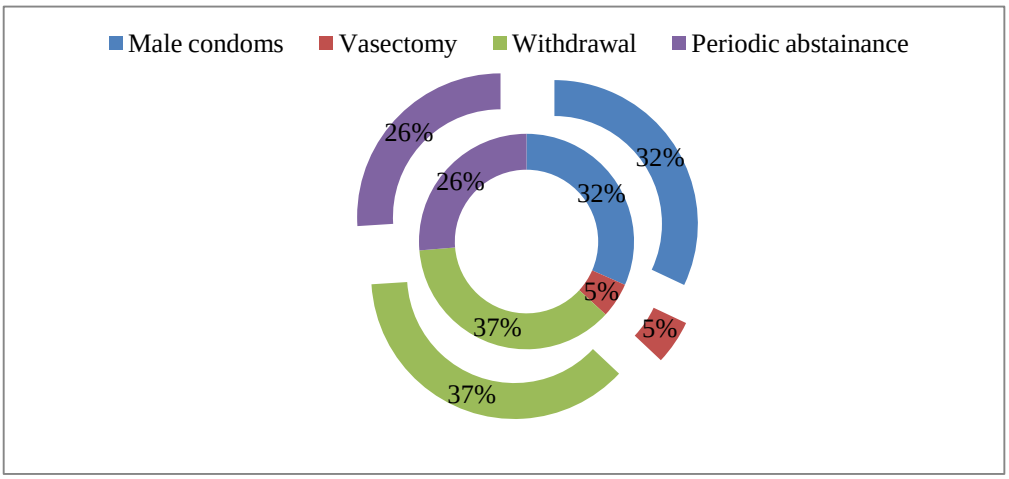


n=100

Figure 2.1 When the methods were n=97

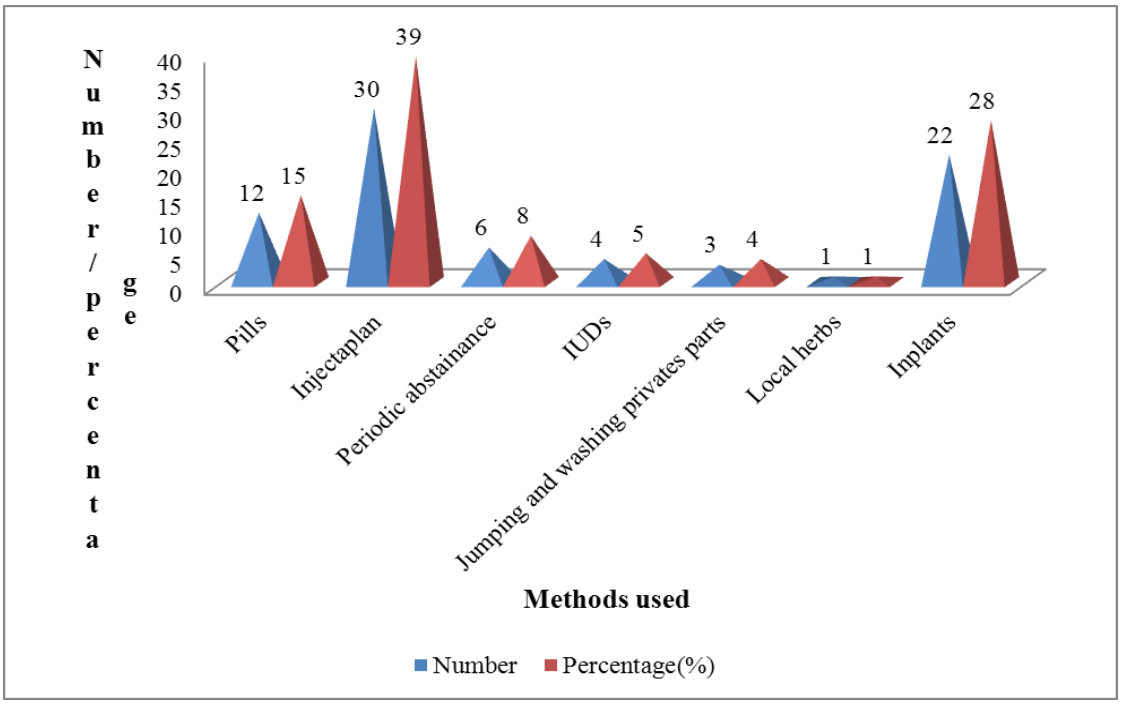
4.4.2. The method(s) used by the respondent

Figure 14: The method(s) used by the respondent (MALES)



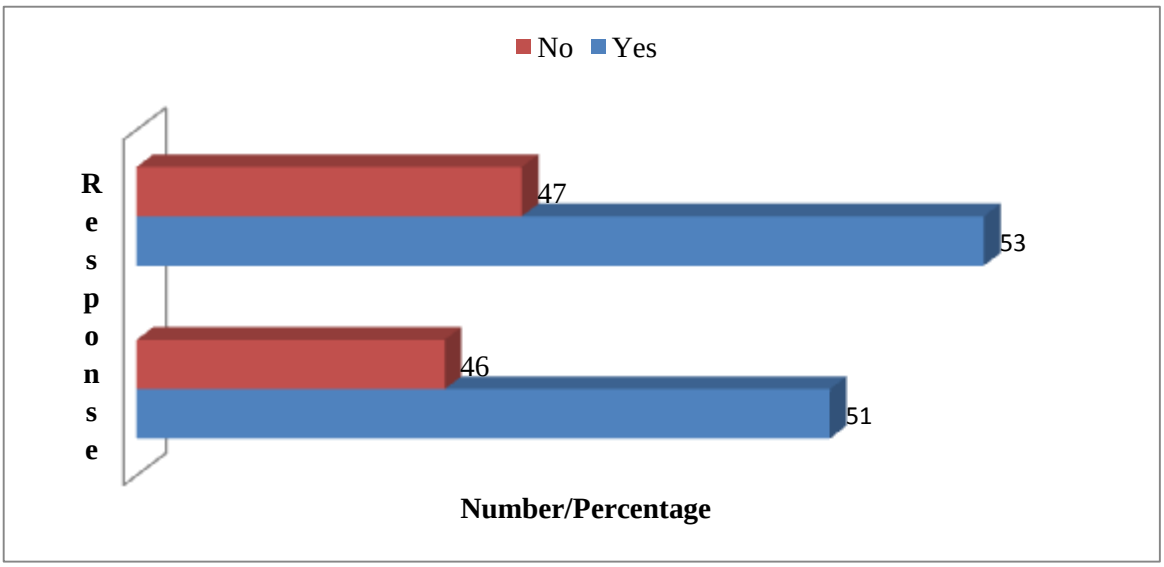
n=19

Figure 15: The method(s) used by the respondent (FEMALES)



n=78

Figure 16: Whether still using the same methods



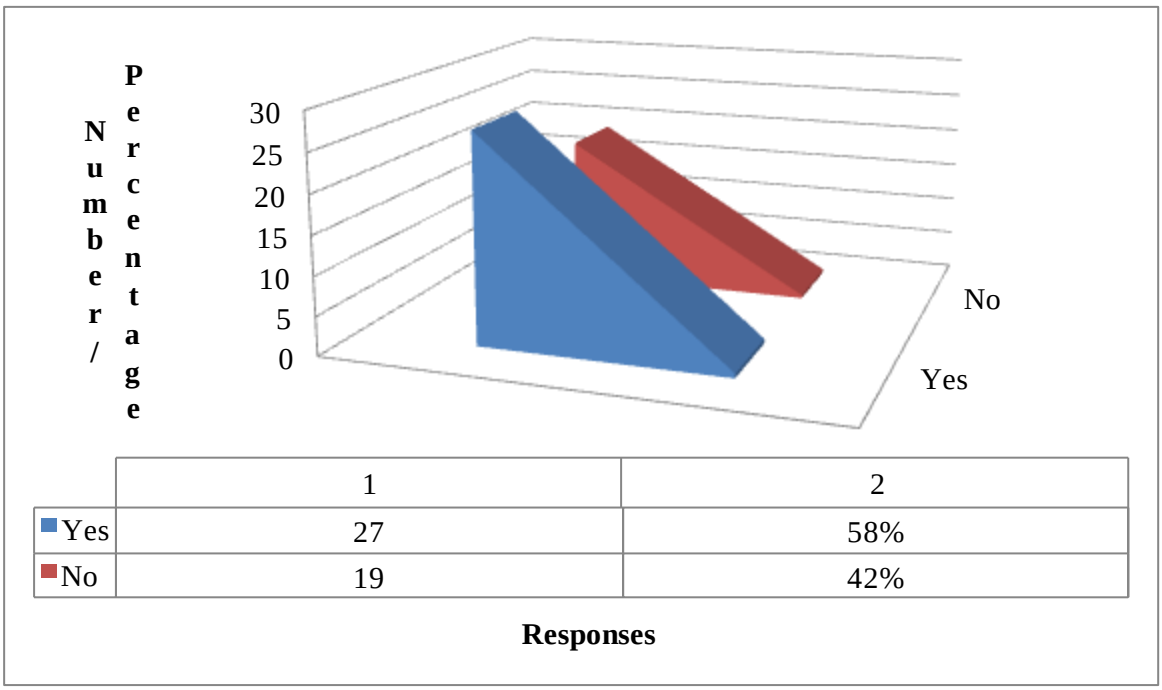
n=97

4.4.3 Reasons for stopping the use of the Family Planning methods

Table 4: Reasons for stopping the use of the Family Planning methods

Reasons	Number	Percentage(%)
Due to side effects	17	38
Wanted to produce	13	28
Due to sickness	2	4
Because of spouse' pressure	5	10
Because of pregnancy	2	4
Due to the bad smell of condoms	4	9
No reason	1	3
Fear of becoming barren	2	4
Total	**46**	**100**

Figure 17: Possibility of resuming use of the methods

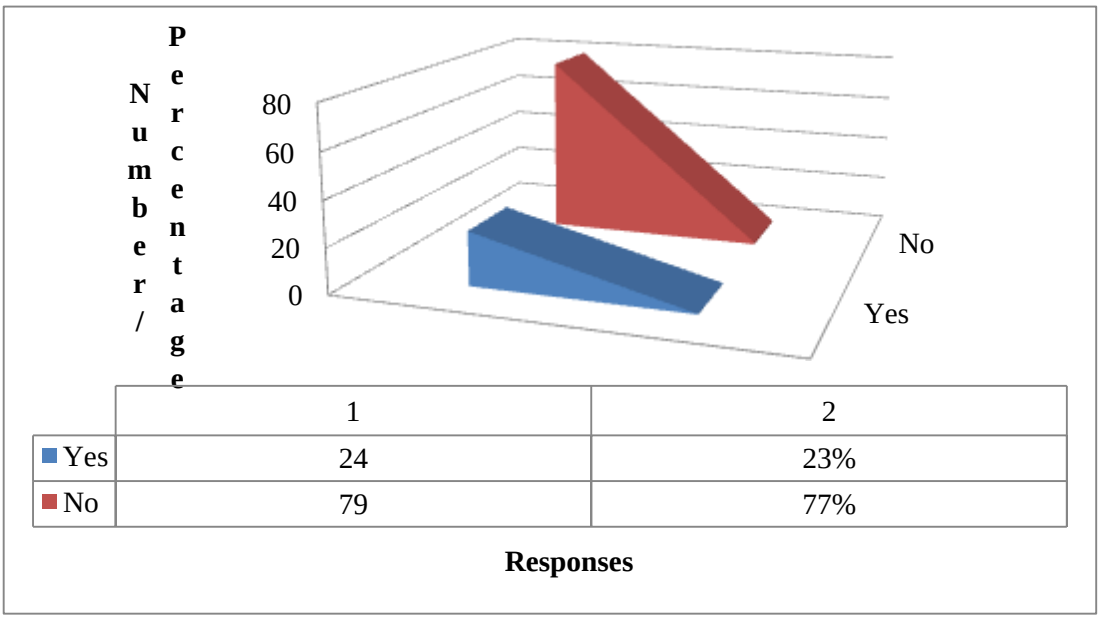


n=46

Table 5: Reason(s) for not using Family Planning services at all

Reasons	Number	Percentage(%)
They make people barren	19	17.5
They weaken people physically	3	3.9
My culture is against it	4	3.9
Family planning causes diseases	9	8.7
That it has bad side effects	16	15.5
Due to my religion	11	10.7
God created man to fill the earth	5	4.9
There is no need	6	5.8
Can make one grow fat	2	1.9
It is expensive	14	13.6
Can cause cancer	14	13.6
Total	**103**	**100**

Figure 18: Possibility of using Family Planning services in future by those who never ever used it



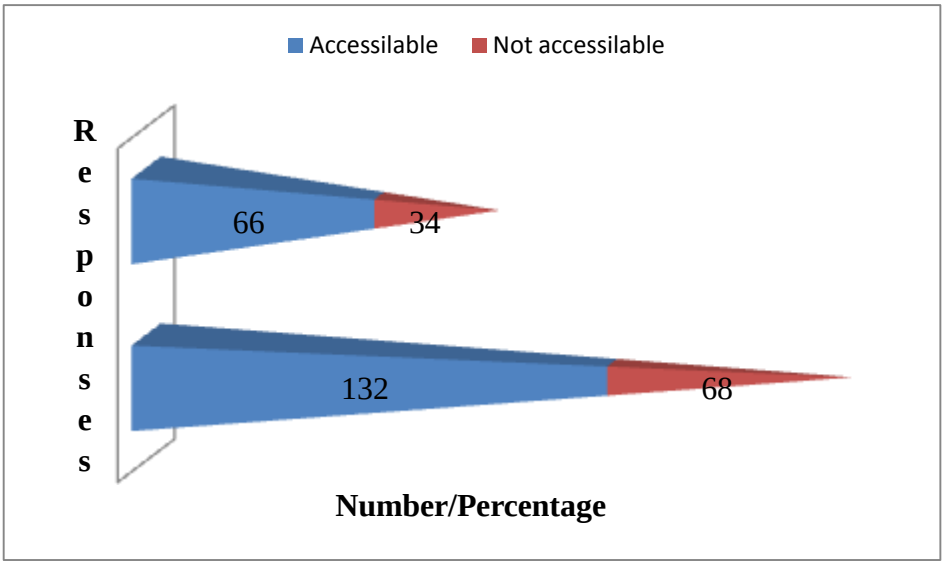
n=103

5.0 PART FIVE (5): OTHER AREAS 0F CONCERN

Table 6: Availability of the Family Services

Response		Number	Percentage(%)
Available	184	92	
Not available	16	8	
Total	**200**	**100**	

Figure 19: Accessibility of the Family Planning services

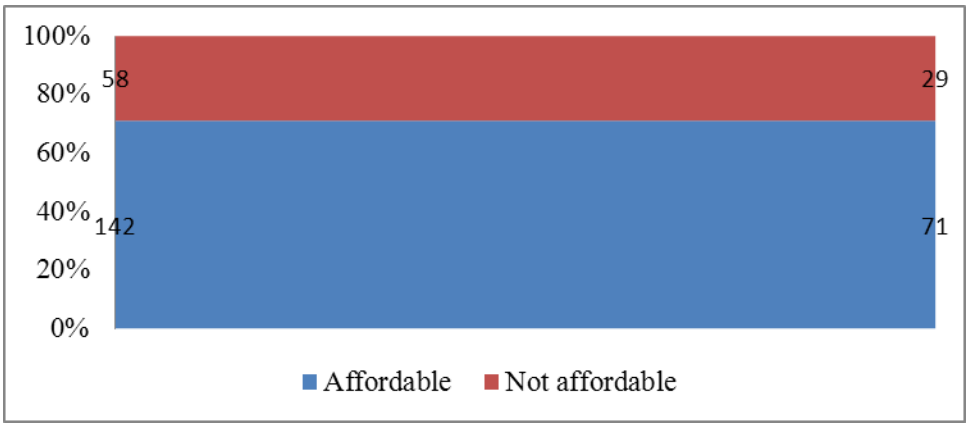


n=200

Table 7: Reasons for no accessibility

Reasons	Number	Percentage(%)
The service centres are far	50	74
Free services are only provided by Government centres	2	3
No time to go for the services	4	6.5
Too long waiting lines at the service centres	3	4
Family Planning items are out of stock	4	5.5
No answer	5	7
Total	**68**	**100**

Figure 20: Affordability of the services



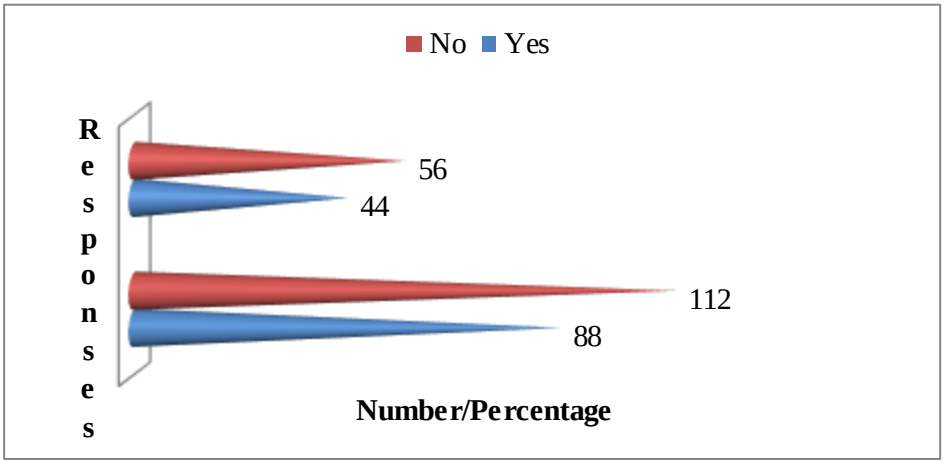
n=58

Table 8: Reasons for no affordability

Reasons	Number	Percentage(%)
Services are expensive	24	41
No information	4	7
No transport to go for the services	9	16
No money to waste on it	1	2
Do not know the price	10	17
Not interested in knowing	5	9
Not sure	5	8
Total	**58**	**100**

Influence of Religion, Culture and Other external forces.

Figure 21: Religion influence

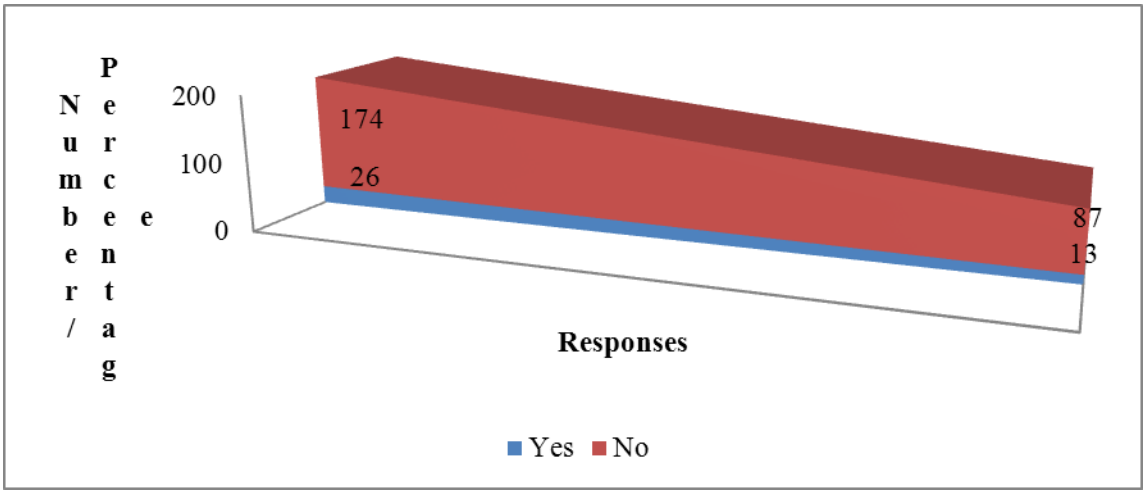


n=200

Table 9: Religious influence

The influence	Number	Percentage (%)
My religion does not allow it	27	31
They think you are a prostitute	13	15
That the bible does not talk about it	16	18
They think you want to change the religion	9	10
Just do not want it	23	26
Total	**88**	**100**

Figure 22: Cultural influence

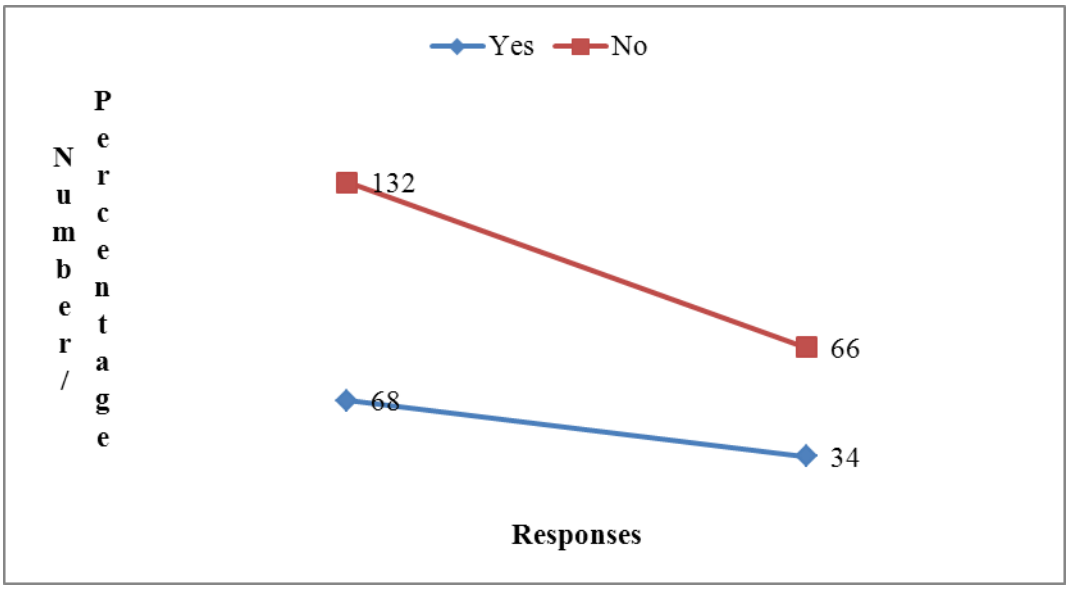


n=200

Table 10: The Cultural influence

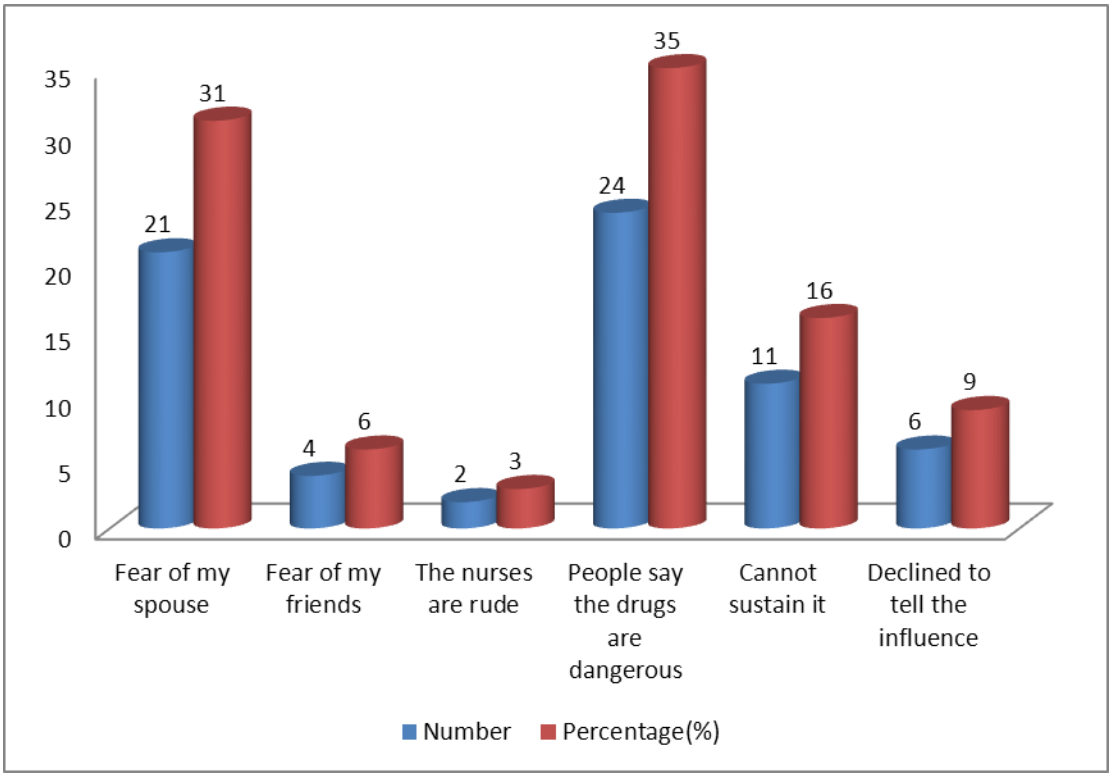
Response	Number	Percentage(%)
The culture does not allow it	4	15
My culture does not talk about it	5	19
Only natural method is allowed	7	27
My culture does wants people to multiply	8	31
Do not know the reason	2	8
Total	**26**	**100**

Figure 23: Other external influences



n=200

Figure 24: The other external forces



n=68

CHAPTER FIVE

5.0. DISCUSSION OF THE FINDINGS

All the findings discussed below were obtained after obtaining full consent from each respondent. As above these findings were presented in a number of ways for easy interpretation of the result. Therefore, the discussions below will be directly based on the data presented above.

Socio-demographically, as seen in Fig.1.0, 1.1, 1.2, 1.3 and Table 1.0, it was found that almost half of the respondents (48%) were aged between 18 and 35 years of age, followed closely by those aged between 36 and 50 years, and only a relatively smaller group of 19% were aged between 59 and 59 years of age. It was also discovered that almost all thee respondents (92%) were staying together in their relationship with their spouses, except a small minority of (4.5%) who were separated, 2% were widowers, 1% widowed and 0.5% divorced. Furthermore, it was found that majority of the study population (31%) were Catholic, followed closely by 22% who were Protestants, 18% Pentecostal, 16% Seventh Day Adventist and 11% Muslim; Only a very small percentage 2% belong to the group of Others which they declined to spell out clearly; No Orthodox was registered during the study. By occupation, a high majority of 24% were discovered to be Peasants, a relatively similar population of 21% were Businessmen/women, a fair number of 14% and 13% were Self-employed and teachers respectively; 9% each were Health workers and Others respectively, whereas only 5% were students, 3% large scale farmers and 0nly 2% were Engineers. It also came to attention that almost a half of the respondents only stopped at Primary level of education, 29% secondary, 23% Tertiary institutions and only a very small percentage of 4% belonged to the category of others-actually they said they never went to school. Generally, the revealed a vast category of population encountered.

As far as the general knowledge of the respondents about Family Planning was concerned, the study discovered that almost all the respondents 199(99.5% were fully aware about Family Planning services, with only an isolated case of 1(0.5%) who said he was not aware about the services; interestingly, even the one who said he had no ideas about Family Planning services went ahead answering most of the questions on the questionnaire. In regard to the understanding of what FP actually is, most of the study population members-62(31%) said it is the spacing of

children; a near percentage to the above of 25% said FP is Producing the number of children one can handle; 19% responded that it is just Producing few children; 17% said it is the use of Pills and Injectaplan; much smaller percentages of 4%, 1.5% and 1% said FP is producing children according to one's wealth, Something brought by the Whites to reduce the number of Africans, and producing like Whites respectively. 3(1.5%) of the respondents said they could not precisely tell what FP actually is. These findings are clearly depicted in Figure 1.4 and Table 1.1.

Consequently, in regard to the various methods of FP as per Fig. 1.6 and 1.7, a vast majority of 191(95.5%) agreed that they knew at least a method of FP; however, a very small population of only 9(4.5%) made a mention that they did not know of any method of FP. Of those who said they knew the methods of FP, majority of the respondents talked of Tubal ligation which most of them referred to as tying of the tube of the women, followed closely by those who made mention of Pills and Injectaplan; then by a relatively smaller number who talked of Condoms; much lesser numbers mentioned Abstinence, IUDs-which some termed 'Coil' and Vasectomy.

When asked about the respondents' knowledge about the other services as observed in Fig.1.7 and 1.8, it revealed a very big knowledge gap as concerns these services; a commanding high majority of 131(65.5%) said they did not know of any other services offered at the FP service centres; only a small percentage of 34.5% said they ideally knew of the other services offered at these service centres. When asked about what these services are, most of the respondents 33% said they hear or think there are other benefits but they could not exactly tell what they are; a fairly good population of 22% and 19% mentioned Health education and HIV counseling and testing respectively; 15% talked of Condom distribution, 8% immunization of children, and 3% said there is distribution of medicine. This seemed a big challenge because if there are a number of services offered which if known about by the majority could actually help improve health service deliveries.

Concerning the benefits attached to FP services in Table 1.3, it was discovered that almost all the respondents 188(94 %) knew about the benefits attached to these services; only a very low population of just 12% reported no knowledge of FP benefits. Those who had ideas about the benefits brought out the following benefits as indicated in the Table 1.4, near similar percentages of 23%, 20% and 19% said that it makes planning for the families easy, makes children grow

well and keeps women healthy respectively; this was followed by a moderate population of 13% who attributed FP to keeping children healthy; 10% said that it makes the family members eat well; 7% said it makes paying of school fees easy, 6% said that it prevents diseases; 2% of the population strictly said that FP has no benefits, actually some of them said that it is just sweet talking people by the government so the people can go for these services.

On the general attitude of the study population about FP services as clearly seen in Fig. 1.9, it was found that the population had a lot of conceptions and misconceptions about FP services which actually seem key in addressing the acceptability as well as maintenance and improvement in the these services. These respondents gave the following answers; more than a half of the study group-118(59%) said FP is generally good and encouraged people to for it; Smaller groups of 13%, 8%, 6%, 5% each and 4.5%,and 4% said that they do not want to use condoms with their partners, it is bad because it makes women barren, most men do not want to be operated yet they believed this is the only method for men, it is bad because it causes diseases in women, taking pills everyday is very hard and that it is good because it makes children grow well respectively; only a much smaller percentage of said they had no answer. These answers are too diverse and therefore leave a lot to be desired as far as FP services are concerned.

As far as the utilisation of FP services is concerned in Fig. 2.0-2.3, it came out clearly that only a very small population of the male category (19%) had ever utilized FP services; a very big percentage of 81% said they had never used these services. However for the female counterparts, it was discovered that almost the exact opposite to the above male utilisation was encountered, where up to 78% of the female population said they had ever utilized the FP services compared with only 22% who said they have never ever utilized these services. When asked when these methods were utilized, it was discovered that most of the respondents (52%) used these methods when they were already old and married, and a closer percentage of 47% said they used these services when they were already old, but not yet married. The dominant methods used by males included withdrawal (37%), Male condoms (32%), periodic abstinence at 26% and only a very minimum population of 5% reported having used Vasectomy. Meanwhile for the female counterparts, it was found that most of them (39%) had ever used Injectaplan, 28 % had used Implants, 15%, 8%, 5% and 4% had used Pills, Periodic abstinence, IUDs and Jumping and washing of private parts respectively. A very small percentage of only 1% reported having used

Local herbs. When asked whether still using these methods, only 53% of the respondents said they were still using the methods, a reasonably large percentage of 47% were no longer using these methods; a few said they had changed to other methods, but majority said they were not now using any method. From this it can easily be seen that the rate of drop down of the use of the FP services seemed too high and there seemed to be a need to ascertain the cause of the failed attempts.

In Table 1.5, as seen above, it was discovered that the members stopped the use of the respective methods due a vast number of reasons as reported by the respondents which included Side effects (38%), Need to produce (28%), Due to spouse' pressure (10%), Due to bad smell of condoms (9%), Due to sickness (4%), Due to pregnancy (4%), Fear of becoming barren (4%) and 3% of the respondents said they had no reason of stopping the use of the services-that they just wanted to do so. And as concerns the possibility of resumption of the use of the stopped services in Fig 2.4, it was reported by only 58% of these respondents that they are likely to resume the use; a very significant percentage of 42% said they were not going to resume the use of these methods in their lives.

For those who never at all utilized FP services, Table 1.6 clearly brings out the reasons why they did not do so, ranging from Fear of becoming barren (17.5%), Fear of side effects (15.5%), That it is expensive(13.6%), That it can cause cancer (13.6%), Religious influence (10.7%), Fear of it causing diseases (8.7%), That there is no need (5.8%), That God created man to fill the earth (4.9%); 3.9% each said FP weaken people physically and that the culture does not allow for its use respectively; a very small percent of 1.9% said FP makes people become fat. In Fig. 2.5, despite these many reasons given, the respondents were still asked whether they had a possibility of ever utilizing these services in future and only 23% said they may, but a very large population of 77% said they will not utilize these services even in future. When one peruses though the limiting points above to the utilisation of FP services, it can be discovered that there is need for adequate information to such a population since this may greatly improve the understanding of the masses about the FP services.

Moreover, majority of the respondents (92%) as seen in Table 1.7 accepted that FP services are readily available to them, and only a very small population of 8% said the services are not

available. And on the accessibility of the services as stipulated in Fig.2.6, most of the respondents (66%) said the services are accessible and good number of up to 34% said the services were not accessible, and said this was majorly due to the service centres being far(74%) and very small percentages said it was due to no time to go for the services (6.5%), FP items being out of stock (5.5%), too long waiting lines at the service centres (4%),free services are only provided by government facilities and up to 7% of the respondents declined to give an answer to this question. On affordability of the services as in Fig. 2.7, it was discovered that most respondents (71%) said the services were affordable, where most of them knew that most of these services were provided freely, and only 29% said the services were not affordable, whereby most of these individuals (%) attributed this to the services being expensive (41%), did not know the price (17%) and no transport to go for the services (16%). Minority of the members attributed this to not being interested, no information, and no money to waste for the services. These are well spelt in Tables 1.8 and 1.9.

On the possible other external influences to the use of the FP services, 112(56%) said their religions and no influence on FP services utilisation and 88(44%) said their religions had influences these services; 174(87%) said their culture had no influence on their participation and only 26(13%) said this had influences; 132(66%) dissociated any other external factors affecting their participation in FP service utilisation and only 68(34%) attributed their religion to having influence on their participation. The religious influences included, that their religion do not allow it (31%), that they think you are a prostitute (15%), that the bible does not talk about it (18%), that they think you want to change the religion (26%, and that they Just do not want it (10%). The cultural influences included: The culture does not allow it (15%), that the culture does not talk about it (19%), Only natural method is allowed (27%), Do not know the reason (8%), and that the culture does wants people to multiply (31%). The other external forces included: Fear of my spouse (31%), Fear of my friends (6%), The nurses are rude (3%), People say the drugs are dangerous (35%), Cannot sustain it (16%) and Declined to tell the influence (9%). From the above it can be discovered that the religion, culture and other external all had influence on the participation of though small but significant number of the respondents as seen in Fig. 2.9-3.2 and Tables 2.0 -2.1.

5.2. CONCLUSION

Generally, this research project was a very important milestone in my academic world as well as an empowering tool for my work outside there which cannot be denied due to the rigorous moment the researcher went through up to the end, and this made me learn a lot about even what one would think could be obvious; a thank you to my supervisor. In this study the researcher found that a lot still needs to be desired as far as utilisation of family planning services in both the gender, but more so in the male counterparts who still have a very big gap which needs to be timely addressed as long as FP still seem to be a way to basing on the current population growth rate as well as the challenges associated to high population growth and the socio-economic aspects attached to it. The end of the journey therefore does not seem yet near according to the findings above.

5.3. RECOMMENDATION

- ✓ This opportunity to carry out a research project was a true blessing to me because I truly learnt a lot, and for that matter I encourage the institution to make this continue for all my up-coming predecessors in this beautiful medical training, as well as the other academic fields.
- ✓ The researcher recommend that adequate information through sensitization should be given to the population to bridge up the obvious knowledge gap encountered during the study period.
- ✓ The institution through its faculties should encourage the learners to start their research projects early enough and give them adequate time so that they may well understand the research/researching concepts.
- ✓ The male counterparts should be thoroughly educated about FP services and be encouraged to fully participate rather than seeing it as a business for only women.
- ✓ The researcher recommend the good initiative taken up by the this institution to give each of us a chance to engage in this learning; bravo to you our University
- ✓ The cooperation of the local leaders as well as the respondents is highly recommended and encouraged for the future researchers.

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APPENDICES

Appendix I: QUESTIONAIRE

Consent Part

Introduction

Am Atugonza Immaculate, a student of Kampala University International carrying out a research on assessment of the utilization of family planning services among married males and females aged between 18 and 59 years in Rukunyu Health Center IV Kahunge Subcounty Kibale County Kamwenge district, I request you as my respondent to honestly and faith fully fill in the information that is factual as demanded by the questions and be used for the academic purposes only. It is typically academic as a partial fulfillment for the award of diploma in Clinical medicine and Community health. Your participation in answering this questionnaire is completely voluntary, yet very important for my career. The information obtained from you shall be confidential. Any question(s) will be allowed at any time of the interview. You will not receive any direct benefit from me for your participation; however, the information given may be used by policy makers to improve on the services; and the services of the new health worker you are ushering in.

If you agree to the above, I therefore request you to sign here:

Signature: …… Date ……. Your serial number will be ….....

PART ONE (1): SOCIO-DEMOGRAPHIC INFORMATION answer as appropriate by circling.

1. Age of respondent (Years)

i) 18 to 35 ii) 36 to 49 iii) 50 to 59

2. Marital status of respondent i) Staying together ii) Separated iii) Widower iv) Divorced v) Widow

3. Religion of the respondents

i) Catholic ii) Protestant iii) Seventh Day Adventist

iv) Pentecostal v) Orthodox (v) others (specify)……

4. Occupation of the respondents

i) Health worker ii) Teacher iii) Businessman iv) Self-employed v) Farmer

vi) Peasant farmer vii) Engineer viii) others (specify)……...

5. Educational levels of the respondents i) Primary school ii) Secondary school

iii) Tertiary Institution(s) iv) Others (specify)……

PART TWO (2). GENERAL KNOWLEDGE OF THE RESPONDENTS ABOUT FAMILYPLANNING SERVICES

1. Are you aware about Family Planning?

i) Yes ii) No

If yes, then what is it? …….....

……

Do you know of any method(s) of Family Planning? (i) Yes ii) No

If yes, can you kindly list for me the methods you know? …….

……

……..

2. Do you know of any other services offered at Family Planning service centers

i) Yes ii) No

If yes then can you kindly tell me of the services you know ……..

……....

3. Do you know of any benefit attached to Family Planning?

i. Yes ii) No

If yes then can you kindly list for me the benefits you know of?

……

……

PART THREE (3): GENERAL ATTITUDE

What do you generally think about Family Planning services? **.....**

…….....

......……

PART FOUR (4). UTILISATION OF FAMILY PLANNING SERVICES

1. Have you ever used any Family Planning method?

i) Yes ii) No

If yes, then can you please answer the following questions?

a. When did you do so? i) When I was old but not yet married
   ii) When I was already married
b. Which method did you use? …….
   ……
c. Are you still using the same method?
   (i) Yes (ii) No

If you are not using the same method then which method are you using now?

…….....

What was the reason for stopping the use of the Family Planning? …….

……

If you stopped using the services then are you willing to resume again in the future?

(i) Yes (ii) No (iii) Not sure

If you have never used any form of Family Planning then can you please give me the reasons for not using any? ……..

……

Do you think you may use any Family Planning Services in the future?

(i) Yes (ii) No

PART FIVE (5). OTHER AREAS OF CONCERN

1. Availability of Family Planning Services

   Are the Family Planning Services available to you?

   i) Yes ii) No iii) I do not know

If no, then why? ……

……

2. Accessibility of the Family Planning Services

   Are these services accessible to you?

   i) Yes ii) No

If no, then why? …….

3. Affordability of the services

   Are these services affordable to you?

   i) Yes ii) No iii) I do not know the price

If no, then why do you think you cannot afford the services? …….

……

4. Influence of religion, Culture and other external forces

   a. Do you think your religion has an effect on your decision to use the Services?

   i) Yes ii) No

b. If yes, then can you please tell me the influence? …….

……

c. What about your culture? i) Yes ii) No

If yes, then what is the influence?

…….. …

d. Do you think there is/are any other external force(s) that barrier you from using the Family Planning Services?

i. Yes ii) No

If yes, can you tell me more about the force(s) ……

……..……

Thank You Very Much

Appendix II: TIME FRAME FOR RESAERCH PROCESS

SERIAL NO.	PERIOD	ACTIVITY
01	APRIL - MAY	WRITING OF THE RESEARCH PROPOSAL
02	JUNE-JULY	DATA COLLECTION
03	JUNE -JULY	DATA ANALYSIS
04	JULY	SUBMISSION OF THE RESEARCH REPORT

Appendix III.RESEARCH BUDGET

NUMBER	ITEM	ITEM BREAK DOWN	UNITS	UNIT COST	TOTAL COST (SHS)
01.	Proposal writing	-Typing -Printing	Consolidated	Consolidated	50,000
02.	Data collection	-Questionnaires -Transport -Research assistants' allowance	-200 copies -Consolidated -02	-400 Consolidated - 50,000	80,000 20,000 100,000
03.	Data analysis	Technical assistance, Typing and Printing	Consolidated	Consolidated	100,000
04.	**Total:**				**394,000**=

Appendix IV: MAP OF KAMWENGE DISTRICT