

**FACTORS INFLUENCING UTILIZATION OF LONG ACTING CONTRACEPTIVE
METHODS AMONG WOMEN ATTENDING MCH CLINIC AT JINJA
REGIONAL REFERRAL HOSPITAL**

BY

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BMS/0115/151/DF

**A RESEARCH REPORT SUBMITTED TO THE FACULTY OF CLINICAL
MEDICINE AND DENTISTRY IN PARTIAL FULFILMENT OF
REQUIREMENTS FOR THE AWARD OF BACHELOR
OF MEDICINE AND SURGERY OF
KAMPALA INTERNATIONAL
UNIVERSITY**

NOVEMBER, 2018

DECLARATION

I declare that this research is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted before for any other degree at any other institution.

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APPROVAL

This is to certify that this student did his research titled '*Factors influencing utilization of long acting contraceptive methods among women attending MCH clinic at Jinja regional referral hospital*' under my supervision.

.....

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ACKNOWLEDGEMENT

I thank the Almighty God for granting me the strength and good health during the period of this study and courage to complete the study.

I would like to acknowledge my parents and everyone that supported me during this study in terms of funds, prayers and advice.

I acknowledge my supervisor DR. NAMALA ANGELLA for her support and guidance throughout the duration of the research.

I acknowledge my friends, colleagues and respondents who offered me great support and encouragement to make sure that i finished this research project on time.

DEDICATION

I dedicate this research to my Dad, **DR. Ahmed Abdulkareem**, my Mothers, **Hajia Maryam Ahmed** and **Hajia Madinah Ahmed**, my Siblings, (**Khalid, Salamatu, Khadijah, Zeenat, Zainab**, and **Khalidah**).

Also to the lecturers who taught me in **Iginedion University Okada, Kaduna State University**, and **Kampala International University**.

Also to everyone that has helped me in one way or another through medical school.

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LIST OF ABBREVIATIONS

IUCD	Intrauterine Contraceptive Device
JRRH	Jinja Regional Referral Hospital
LACM	Long acting contraceptive methods
MMR	Maternal Mortality Ratio
RRH	Regional Referral Hospital
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
WHO	World Health Organization
MCH	Maternal and Child Health

ABSTRACT

Background: Unintended pregnancy remains an alarming global public health concern with its subsequent socioeconomic impact on individuals, families, and the society. Over time the use of long acting contraceptive methods (LACMs) has not kept pace with that of short-acting methods such as oral contraceptives (pills) and injectable and reasons for their low uptake are not well known. Thus, the purpose of this study was to identify the level of utilization of LACM among women attending MCH clinic at Jinja regional referral hospital (JRRH) and factors that may influence the utilization of such contraceptive methods.

Methods: A descriptive cross-sectional study design was used. A pretested questionnaire was used to collect data from 52 respondents. Collected data was entered into IBM SPSS 25.0 for data analysis. Chi square test was done to determine factors associated with use of LACM. Results were presented in tables and charts.

Results: The mean age of the respondents was 27.6 ± 4.8 (SD) years. Prevalence of LACM was 26.9%. Factors associated with use of LACMs were; mother's age ≥ 30 years and current number of children ≥ 4 . i.e ($X^2=11.47$; $p=0.001$) and ($X^2=37.66$; $P<0.001$) respectively.

Conclusion and recommendations: The prevalence of LACM use among women attending MCH clinic at JRRH was low(26.9%) as compared to short acting contraceptive methods(73.1%). Significant factors associated with use of LACM were woman's age ≥ 30 years and parity ≥ 4 . This study recommends that, health workers in MCH and stakeholders should come up with ways to increase utilization of long acting contraceptive methods by women of less than thirty years old and parity of equal or less than three. Also, more research should be done to ascertain the reason why the prevalence is low.

CHAPTER ONE: INTRODUCTION

1.0 Introduction

Family planning allows people to attain their desired number of children and determine the spacing of pregnancies. It is achieved through use of modern contraceptive methods and the treatment of infertility (World Health Organization [WHO], 2017). Modern contraceptives methods are divided into three: - Long acting reversible contraceptive methods (IUCD & Implants); permanent contraceptive methods (tubal ligation & vasectomy) and short term contraceptives methods (Oral pill, inject-able, male& female condoms, foam tablet &cervical cap (WHO, 2016). Because of their long lasting protection and reversibility, the reversible long term contraceptive is an effective contraceptive method appropriate for women wishing to limit child bearing, as well as to space births, thus potentially playing an enormous role in reducing maternal mortality (Hubacher, Spector, Monteith, Chen, & Hart, 2017).

Globally, 214 million women of reproductive age in developing countries who want to avoid pregnancy are not using a modern contraceptive method (Guttmacher Institute, 2017). This unmet need for contraception is too high and variation in different regions is observed (WHO, 2017). This inequity is fueled by both a growing population, and a shortage of family planning services. In Africa, 24.2% 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 for family planning are 10.2 % and 10.7%, respectively (United Nation, Department of Economic and Social Affairs, 2015).

Unintended pregnancy remains an alarming global public health problem with its subsequent socioeconomic impact on individuals, families, and the society (Mazza et al., 2017). Though there is a considerable variation in the prevalence of unintended pregnancy across regions, the global burden is very high (44% in 2014) (Bearak, Popinchalk, Alkema, & Sedgh, 2018) and responsible for 27% of maternal deaths (Mayondi et al., 2016). Different cross-sectional studies around the globe noted that there has been a high prevalence of unintended pregnancy for example, 69% in Malawi (Haddad et al., 2015), 27% in Canada (Oulman, Kim, Yunis, & Tamim, 2015) and 44% in Botswana (Mayondi et al., 2016) highlighting the need for effective contraceptive utilization

(Mayondi et al., 2016). The 2016 Uganda Demographic and Health Survey (UDHS) report showed that there was 28% and 32% of unmet need for family planning among married and unmarried sexually active women respectively (UBOS, 2016). Evidence suggests that women who have more than 4 children are at increased risk of maternal mortality (Hounton et al., 2015). By reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion (Mermelstein & Plax, 2016).

The Uganda ministry of health and private ~~partners~~partner's campaigns for the use of long acting contraceptive method, however, the contraceptive method mix is dominated by short term methods like pills and Injectables (Asiimwe, Ndugga, & Mushomi, 2014). There are no studies that have examined the factors contributing to long acting contraception methods utilization on the study area. The present study was intended to contribute to bridging information gap about and subsequently the coverage of long acting contraceptive method utilization in the local setting.

1.1 Problem statement

Family planning is essential in the effort to reduce the fertility rate and the consequential maternal mortality and morbidity as well as contributing to improvement in infant welfare (WHO, 2016). Notably, Uganda's maternal mortality ratio (MMR) stands at 336 per 100,000 live births which is among the highest in the world (UBOS, 2016). According to population projections, the Ugandan population is projected to explode to 130 million by 2050 from the already high 44.27 million people (Population Reference Bureau, 2018). This will further strain the reproductive health services and increase the unmet need for contraception.

Over time the use of LACMs has not kept pace with that of short-acting methods such as oral contraceptives (pills) and injectable. Data from demographic and health survey show that the proportion of women currently using LACMs is significantly lower than the proportion using short-acting methods (UBOS, 2016). The later are unreliable with both high failure and discontinuation rates (Tibaijuka et al., 2017).

However, the reasons responsible for this low uptake of long-acting contraceptive methods remain undefined. Hence the study.

1.2 Objectives of the study

1.2.1 General objective

This study was to identify the level of utilization of long acting contraceptive methods among women attending MCH clinic at Jinja regional referral hospital and related factors.

1.2.2 Specific objective

1. To describe the proportion of women utilizing LACMs among women attending MCH clinic at Jinja regional referral hospital.
2. To identify the factors associated with the utilization of LACMs among women attending MCH clinic at Jinja regional referral hospital.

1.3 Research questions

1. What is the proportion of women utilizing LACMs among women attending MCH clinic at Jinja regional referral hospital?
2. What are the factors associated with the utilization of LACMs among women attending MCH clinic at Jinja regional referral hospital?

1.4 Justification of the study

The uptake of LACM is very low not only in Jinja but also in the entire country with short-acting reversible methods like Depo-Provera and oral pills being the most preferred modern contraceptives. Repeated health facility attendance of clients on short term FP methods poses a challenge to the already strained health care providers as well as increasing the risk of contraceptive failure.

Uganda's unmet need for FP services is still high estimated at around 24% in 2015, moreover, the annual population growth rate is 3.2% and the country has one of the highest total fertility rates (6.2 children per woman) in the world (UBOS, 2016). This need could be met adequately by LACMs which are effective for users over time.

In a previous study in Uganda, only 3.2% of respondents were using either an intrauterine device or a hormonal implant (UBOS and ICF, 2011). Although this could be due to lack of access to the methods (Jacobstein & Stanley, 2013), some studies suggest that women in resource-limited settings may simply prefer short-acting methods over LAC methods (Tibaijuka et al., 2017). The factors driving such preference have not been clarified. A better understanding of such factors

could facilitate the design of future interventions to increase the uptake of LAC methods in Jinja district and the country at large.

1.5: Study scope

1.5.1: Geographical scope

The study took place in JRRH, Jinja district, Eastern Uganda.

1.5.2: Content scope

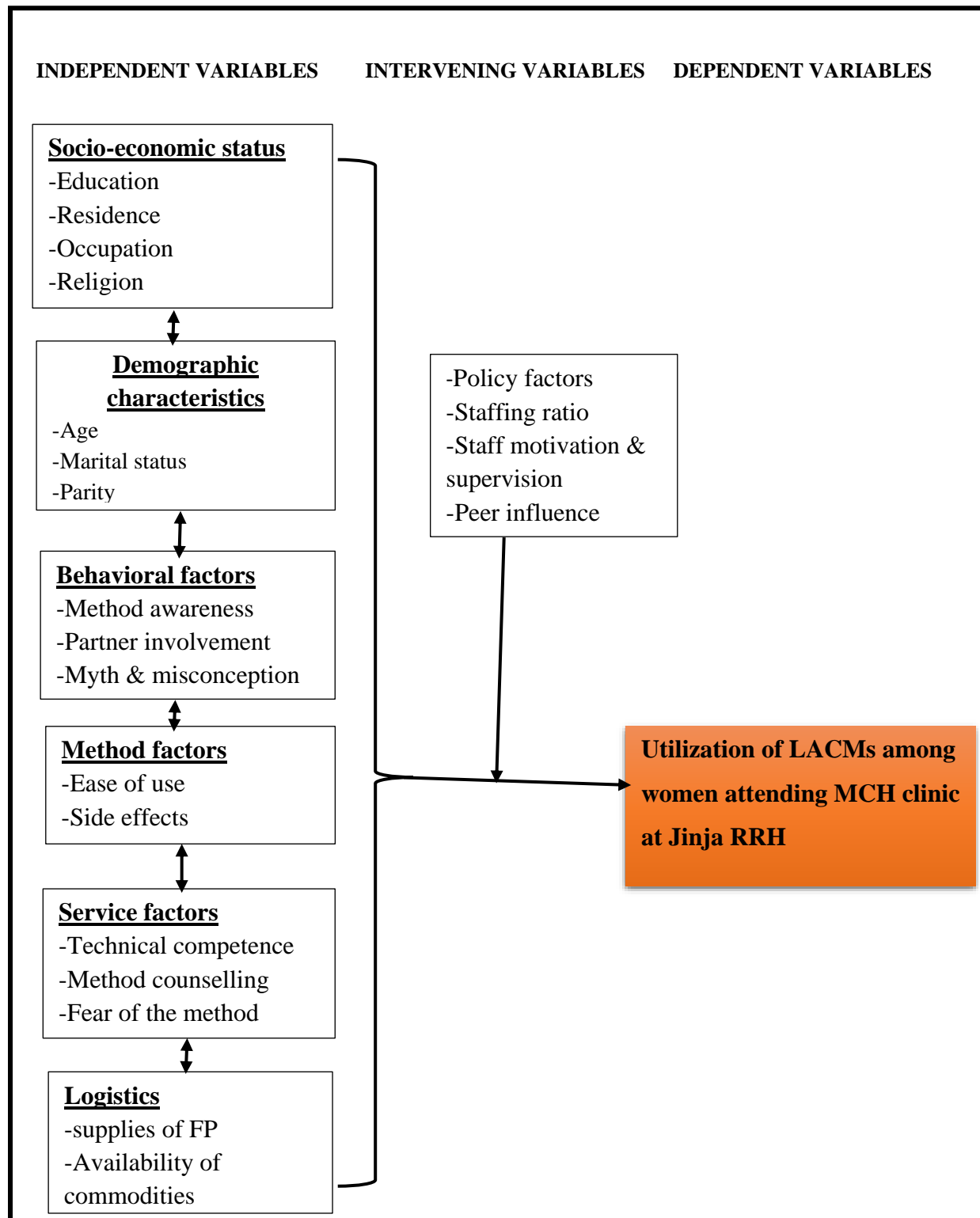
The study determined factors influencing utilization of long acting contraceptive methods among women attending MCH clinic at Jinja regional referral hospital.

1.5.3: Time scope

The study took place in November 2018.

1.6 Conceptual framework of factors influencing use of LACMs

Figure 1: Conceptual frame work for the utilization of long acting contraception methods



Source: designed by the researcher, 2018

CHAPTER TWO: LITERATURE REVIEW

2.1 Overview

Even though Contraceptive use has increased worldwide over the last decade, more than 350 million couples worldwide have limited or no access to effective and affordable family planning services, especially to long acting contraceptive methods (Ajong et al., 2016). Yet, Africa like many other regions of the developing world continues to have a high unmet need for family planning (WHO, 2016). Among those who are using contraception, most are using short-acting methods, such as oral contraceptives and inject-able (Genet, Abeje, & Ejigu, 2015). Like other sub-Saharan countries, Uganda has low long acting Contraceptive method prevalence rate (3.2%) with highly dependent on short-term family planning methods and high unmet need (28%) (UBOS, 2016).

2.2 Factors influencing use of Long Acting Contraceptive Use

A number of factors could contribute to the lack of availability and access to long acting contraceptive methods. Evidences from other countries and within Uganda showed that many factors could act as barriers to choose long acting contraceptive methods (Damnjanovic, Jednak, & Mijatovic, 2015).

A cross sectional hospital based survey conducted to assess factors associated with utilization of long acting and permanent contraceptive methods among married women in Mbarara district showed that, the majority of the married women were not using long acting reversible contraceptive methods (Tibaijuka et al., 2017). The same study shows that, mothers who had high knowledge were 8 times more likely to use long acting contraceptive methods as compared with those who had low knowledge, mothers who had two or more pregnancies were 3 times more likely to use long acting contraceptive methods as compared with those who had one pregnancy & more than half (53.6%) of married women had negative attitude towards practicing of LARCMs.

The study conducted In 2011, in Northern Ethiopia revealed that women who attained primary and secondary plus level of education have about 2 times more likely to use contraception than women who have no formal education (Alemayehu et al., 2015).

Religion has been reported to influence contraception use. For instance, a study in Nigeria among Hausa and Muslim community reported a very low contraceptive use (Blackstone & Iwelunmor,

2017). In Jordan, nearly 40% of Muslim men do not believe in practicing contraception and more than half believe that family size should be left up to God (Ahmed, Li, Liu, & Tsui, 2012). . In countries that are predominantly Catholic (for example Brazil), the Catholic church is at the forefront of influencing government policies particularly in the area of limiting FP services available and discouraging fertility limiting behaviors (Jalang et al., 2017). Nevertheless, the influence of religion has stiffened the transmission of adequate and accessible information via radios and televisions as well as in schools (Ajong et al., 2016).

With regards to residence, Costa et al., (2016) noted that contraceptive prevalence is higher among women in the urban areas. This evidence is supported by studies in Uganda (Sileo, Wanyenze, Lule, & Kiene, 2015) and elsewhere (Eliason et al., 2014). This is because FP clinics are in most cases located in urban areas; this affects accessibility of the services among the rural women. In affirming to the variation in FP use by rural-urban residence, the 2016 UDHS noted that the use of FP is more than twice as high in urban areas when compared to the rural (UDHS, 2017). It is therefore not a surprise that contraceptive use is lower in the northern region of Uganda which is predominantly rural when compared to the central region which is mainly urban. Likewise, a higher contraceptive use among educated women would not be surprising (Asiimwe et al., 2014). This is because educated women are more likely to be located in the urban areas than in the rural. In a study regarding contextual influences on modern contraceptive use among women in six Sub-Saharan African countries, Emina et al., (2014), noted that secondary or higher educational attainment was more likely to be associated with use of modern contraceptives.

Attitude and side effects have been reported to contribute to method choice of contraception. A study conducted in Mekelle town Ethiopia showed that, 26.8% of women agreed that implant can result in irregular bleeding and cause severe pain during insertion and removal while 19.6% agreed that IUCD prevents them from doing normal activities and 34.4% agreed that undergoing an operation for female sterilization was dangerous (Bogale, Wondafrash, Tilahun, & Girma, 2011).

A study in Tanzania (Keogh et al., 2015) reported that 43.1% of the respondents were not using long acting contraception methods because they could not get them in the nearby health facility unless they walk a long distance, in some instances up to 18 kilometers. Another 12.6% reported

absence of all contraceptives or the ones they preferred in facilities. About 4.8% mentioned lower level service providers' incompetence.

A study among East African countries about contraception utilization found that more than 82% of women who were using contraception had discussed family planning with someone, but only 48.3% had discussed contraception with their partners (Bakibinga et al., 2016) indicating an importance of having information about the service.

Pertaining to marital status, the argument is that married people highly depend on their spouses for approval of modern contraceptive use. In the contrary, the non-married women do not usually seek approval from any one in matters concerning contraceptive use. Thus, husband's non-approval was cited as the major reason for non-use of modern contraceptive among the married women (Keogh et al., 2015). Thus, the low utilization of modern contraceptive services among married women in many developing countries would not be surprising. On the same note, women in male headed households are regarded to have reduced chances of using modern contraceptive use when compared to their counterparts in female headed households (Cleland et al., 2014).

CHAPTER THREE: METHODOLOGY

3.1 Study design

A cross-sectional study design was used.

3.2 Study area

The study was conducted in MCH clinic in Jinja Regional Referral Hospital.

3.3 Study population

The study involved women attending MCH clinic.

3.3.1. Inclusion criteria

- women who are 18-49 years old
- Willing to participate

3.3.2. Exclusion criteria

- Not willing to participate in the survey
- Below 18 years and above 49 years

3.4. Sample size determination

The sample size was determined by using Kish's formula (Rutterford, Copas, & Eldridge, 2015) which states that,

$$N = \frac{Z^2(p(1-p))}{\epsilon^2}$$

Where;

N = the required sample size

p= Proportion of women using LAPMs (3.5%) as per UBOS, (2016).

ϵ = margin of error on p (set at 5%)

z= standard normal deviate corresponding to 95% confidence level (=1.96)

$$N = \frac{1.96^2(0.035(1-0.035))}{0.05^2} = 52$$

3.5 Sampling technique

The study used consecutive sampling where each woman that comes and agrees to participate was enrolled.

3.6. Data collection methods

This study used a questionnaire to collect data from the respondents.

3.7. Data Processing and analysis

Collected data was entered and analyzed using IBM SPSS version 25.0 Categorical variables were presented in a table of frequencies for descriptive statistics. A Chi-square test was computed to test the factors influencing utilization of LACMs. The point for statistical implication was p-values of ≤ 0.05 .

3.8 Quality control

The questionnaire for data collection was pre-tested to ensure that questions are clear and allow gathering of information needed for the study. The questions that showed ambiguity during pre-testing were revisited and modified as required.

3.9. Ethical considerations

Ethical approval was sought from Kampala international university western campus Faculty of clinical medicine and dentistry in form of introduction letter after approval of the proposal. A written and verbal consent was sought from the respondents before they participated in the study.

3.10 Study Limitations

Reported nature of the data collection approach could have been affected by desirability bias hence distorting the results.

CHAPTER FOUR

RESULTS

4.1 Demographic characteristics of respondents

The mean age of the respondents was 27.6 ± 4.8 (SD) years. More than half (65.4%) were aged ≤ 29 years, 57.7% were house wives and only 19.2% had tertiary education. Table 1.

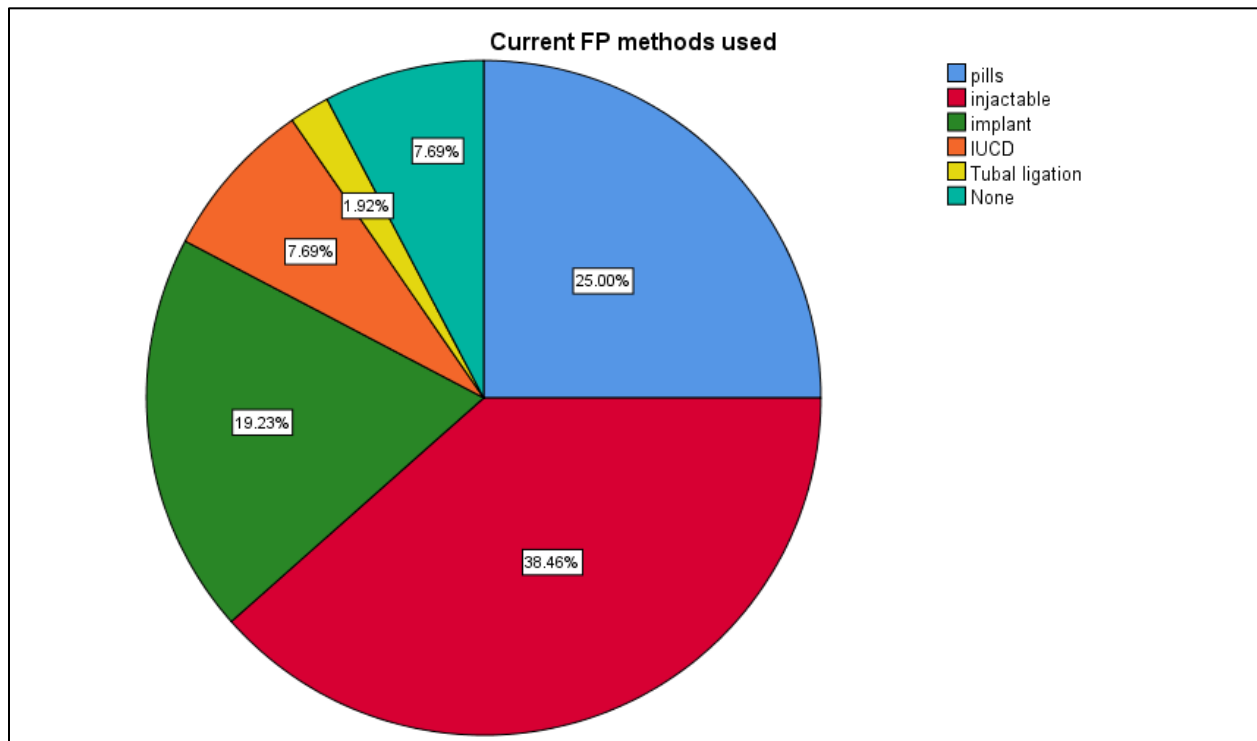
Table 1: Demographic characteristics of respondents

	Variables	Frequency	Percent
Age group	≤ 29	34	65.4
	≥ 30	18	34.6
	Total	52	100.0
Occupation	House wife	30	57.7
	Business	11	21.2
	Employed	11	21.2
	Total	52	100.0
Religion	Catholic	20	38.5
	Protestant	10	19.2
	Muslim	7	13.5
	Pentecostal	15	28.8
	Total	52	100.0
Education level	Non	10	19.2
	Primary	20	38.5
	Secondary	12	23.1
	Tertiary	10	19.2
	Total	52	100.0
Parity	≤ 3	39	75.0
	≥ 4	13	25.0
	Total	52	100.0

4.2 Current contraceptive methods used

Almost half of the respondents (38.5%) were using injectable FP methods followed by 25% who were using pills. 7.7% were not using any method and only 1.9% had done tubal ligation. Figure 2.

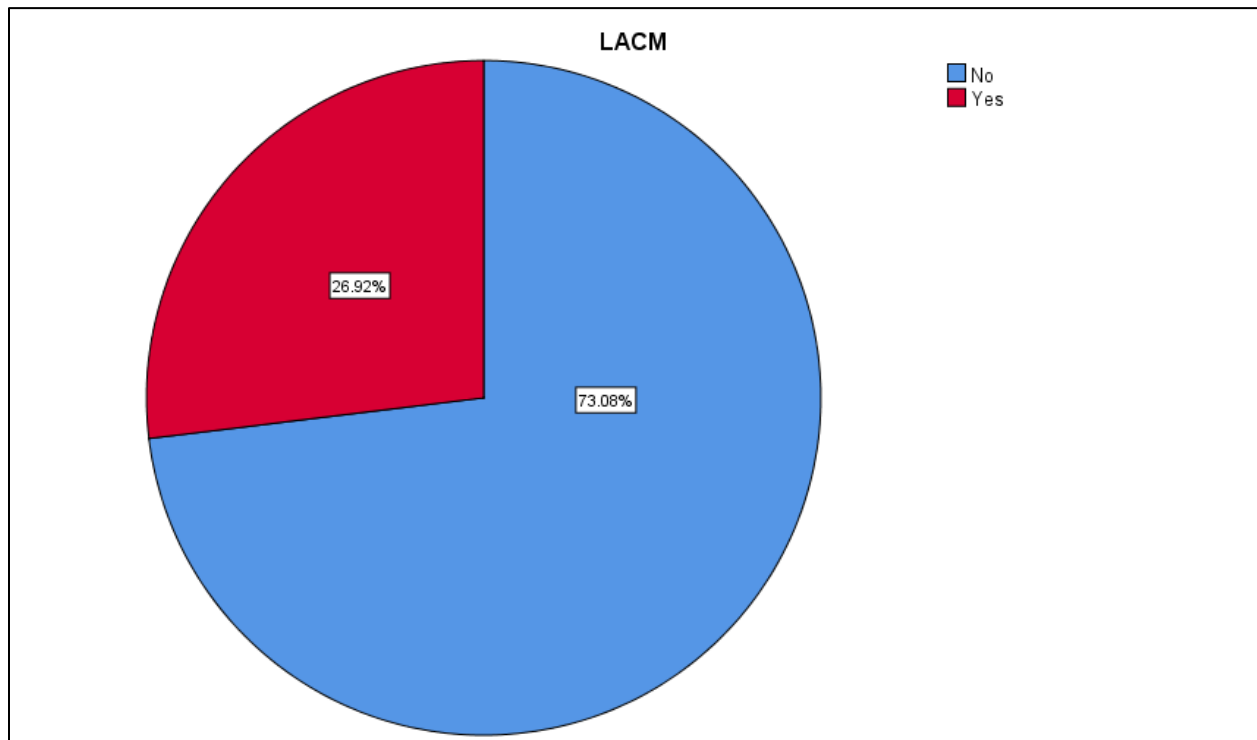
Figure 2: Current contraceptive methods used



4.3 Prevalence of long acting contraceptive methods (LACM)

Results show that less than half of the respondents (26.9%) were using LACM compared to majority (73.1%) who were using short acting methods. Figure 2.

Figure 3: Prevalence of long acting contraceptive methods (LACM)



4.4 Factors influencing utilization of long acting contraceptive methods

4.4.1 Relationship between demographic characteristics and use of LACM

Only age was found significant ($X^2=11.47$; $p=0.001$) among the demographic variables. Table 2.

Table 2: Relationship between demographic characteristics and use of LACM

Variables		LACM		Total	Chi square (X^2)	P value
		No	Yes			
Age group	<29	30	4	34		
		88.2%	11.8%	100.0%	11.47	0.001
	>30	8	10	18		
		44.4%	55.6%	100.0%		
Occupation	House wife	23	7	30		
		76.7%	23.3%	100.0%		
	Business	8	3	11	0.69	0.706
		72.7%	27.3%	100.0%		
	Employed	7	4	11		
		63.6%	36.4%	100.0%		
Religion	Catholic	14	6	20		
		70.0%	30.0%	100.0%		
	Protestant	8	2	10		
		80.0%	20.0%	100.0%	0.35	0.950
	Muslim	5	2	7		
		71.4%	28.6%	100.0%		
	Pentecostal	11	4	15		
		73.3%	26.7%	100.0%		
Education level	Non	7	3	10		
		70.0%	30.0%	100.0%		
	Primary	15	5	20		
		75.0%	25.0%	100.0%		
	Secondary	9	3	12	0.16	0.984
		75.0%	25.0%	100.0%		
	Tertiary	7	3	10		
		70.0%	30.0%	100.0%		

4.4.2 Relationship of LACM use and current number of children

The results show that current number of children the woman have is statistically significant ($X^2=37.66$; $P<0.001$).

Table 3: Relationship of LACM use and current number of children

Variables		LACM		Total	Chi square	P value
		No	Yes		(X ²)	
Current number of children	≤3	37	2	39		
		94.9%	5.1%	100.0%		
	≥4	1	12	13	37.66	<0.001
		7.7%	92.3%	100.0%		
Total		38	14	52		
		73.1%	26.9%	100.0%		

4.4.3 Relationship of LACM use and discussion of FP with partner

Discussion with partner about FP was not found to be statistically significant ($X^2=0.01$; $p=0.977$).

Table 4: Relationship of LACM use and discussion of FP with partner

Variable		LACM		Total	Chi square	P value
		No	Yes		(X ²)	
Discussion with partner about FP	No	8	3	11		
		72.7%	27.3%	100.0%		
	Yes	30	11	41	0.01	0.977
		73.2%	26.8%	100.0%		
Total		38	14	52		
		73.1%	26.9%	100.0%		

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Discussion

5.1.1 Prevalence of LACM use among women attending MCH clinic at JRRH

In this study, the prevalence of long acting contraceptive use was 26.9%. The prevalence of contraceptive use among women in this study is comparable to that of the general women population in Uganda (26.9% versus 30%) (UDHS, 2017). The contraceptive prevalence in this study is also consistent with earlier studies reporting contraceptive use of 22.3% in Uganda (Sileo et al., 2015) and a prevalence of 29% in a Kenyan hospital (Jalang'O et al., 2017). The similarity could be attributed to similar social economic characteristics of the participants.

5.1.2 Factors influencing use of LACM

The variables which were found significant were; mother's age ($X^2=11.47$; $p=0.001$) and current number of children ($X^2=37.66$; $P<0.001$).

Age and number of children has been reported by other studies to influence use of contraception in Ethiopia (Alemayehu et al., 2015), Cameron (Ajong et al., 2016), Uganda (Asiimwe et al., 2014) and Rwanda (Bakibinga et al., 2016).

In this study, it is noted that age specific LACM prevalence rate increase with age of women. Majority of women who were using LACM were ≥ 30 years (71.4%) compared to those ≤ 29 years old. This may be attributed to many reasons; firstly, age is associated with experience in child birth which may come with access to health education about contraception. Secondly, old age may be associated with increasing needs from large family which puts economic pressure thus need to limit or control child birth.

Like with this study, there is consensus from other studies (Blackstone & Iwelunmor, 2017; Hounton et al., 2015; Guttmacher Institute, 2017) that LACM use is more likely among women with higher number of children. This study found that a large percentage (92.3%) of women who had ≥ 4 children were using LACM compared to only 5.1% of those that had ≤ 3 children. Also, many women reject contraception because bearing and raising children is the path to respect and dignity (Ajong et al., 2016). As aforementioned, a high number of children comes with a cost, not

only for feeding but also healthcare and education. The driving force towards use of LACM in older women and those with large number of children could be due to the desire for limiting the number of children in the face of an advancing age. The reproductive health implication of these findings suggests a targeted intervention such as health education and patient-specific counselling to create awareness on the benefits of LACM.

Unlike other studies which showed that the factors that determine LACM use among women included higher education (Hounton et al., 2015), employment status (Hubacher et al., 2017), and discussion of family planning with a partner (Keogh et al., 2015), this study found these factors not significant.

5.2 Conclusion

The prevalence of LACM use among women attending MCH clinic at JRRH was low(26.9%) as compared to short acting contraceptive methods(73.1%), and is significantly associated with age above thirty(30) and parity equal to or greater than 4

5.3 Recommendation

This study recommends that, health workers in MCH and stakeholders should come up with strategies to encourage women under thirty years old and those with parity of less than or equal to three about the benefits of using long acting contraceptive methods and encourage the use so as to increase the prevalence.

Also, more research is needed to ascertain the reason for low utilization of long acting contraceptive method among women of age less than thirty and parity less or equal to three.

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APPENDICES

Appendix i: Consent form

IHereby give consent to the researcher to collect any information from me concerning **factors influencing utilization of long acting contraceptive methods among women attending MCH clinic at Jinja regional referral hospital**. I agree also to fill the questionnaire presented to me. I hereby declare that the basis of my consent is the comprehensive explanation of the researcher. I understand the information is purely for research purposes only and it will be kept confidential.

By signing this consent form, I authorize my participation in the study.

Signed

Date

Appendix ii: Questionnaire

STUDY TITLE: Factors influencing utilization of long acting contraceptive methods among women attending MCH clinic at Jinja regional referral hospital.

PART. I. Socio -Demographic Conditions

Number	Questions	Possible responses	Skip to
1	How old are you?	1. years	
2	Current occupation	1. House wife 2. Business 3. Employed	
3	Religion	1 Catholic 2 Protestant 3 Muslim 4 Others(specify)	
4	Educational status of the women	1. Non 2. primary 3. secondary 4. tertiary	

PART. II. Reproductive History

Number	Questions	Possible responses	Skip to
5	How many live children do you have?	Enter NO... 1	
6	How many children would you like to have in your life?	1. Enter NO..... 2. Not yet decided	

PART.III. Family planning information

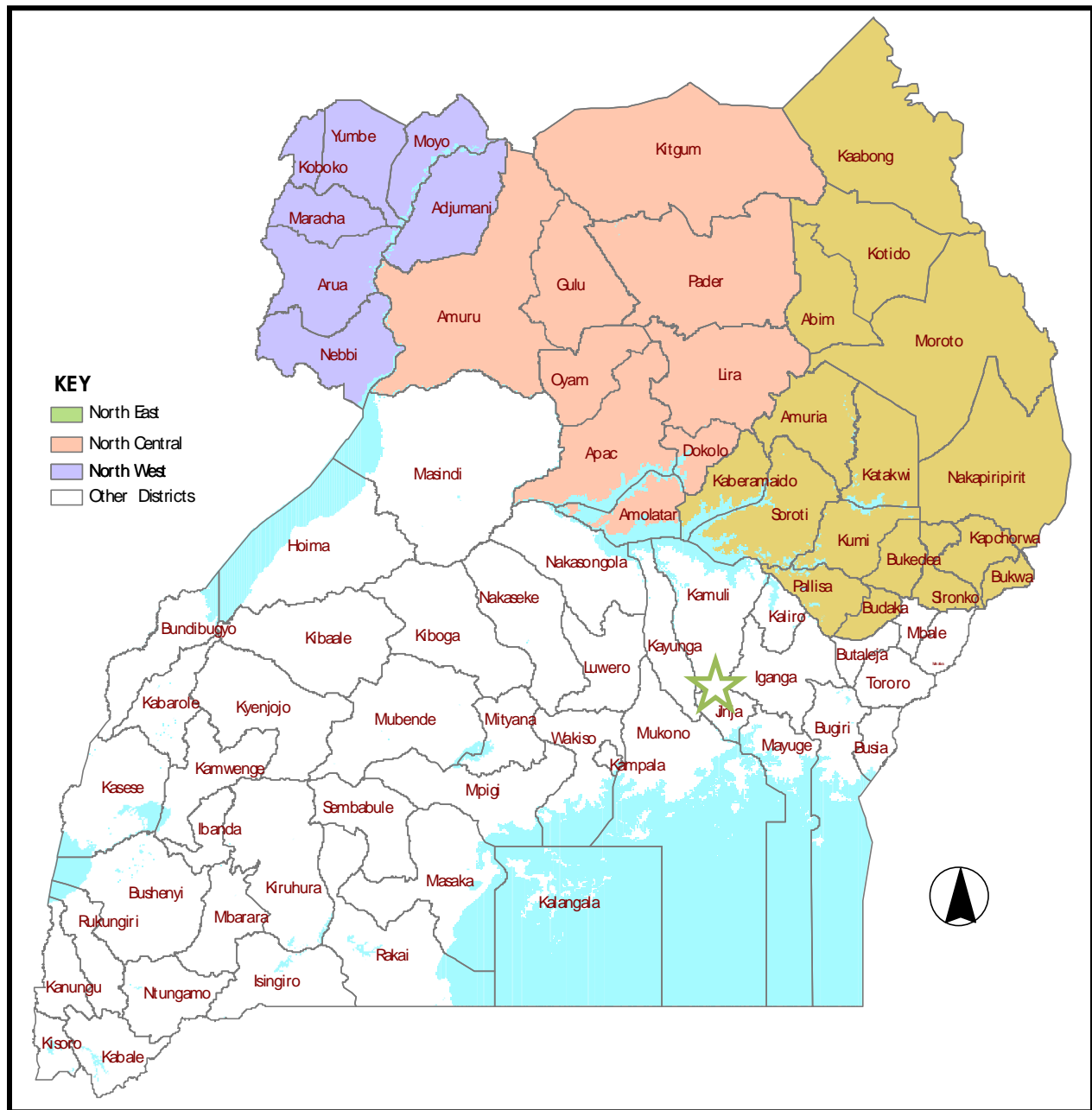
Number	Questions	Possible responses	Skip to
7	Do you have Television in your home	1. YES 2. NO	
8	What type/s of modern contraceptive methods do you know? (more than one response is possible)	1. Pills 2. Injectable 3. Implant 4. IUD 5. Female sterilization 6. Condom 7. Others(specify) -----	
9	From whom do you get information on family planning for the first time?	1. From neighbors 2. From Health workers 3. From VHTs 4. From my husband 5. Others(specify) -----	
10	What sources of family planning do you know?	1. Government HF's 2. Private hospital 3. Pharmacy 4. NGO Health facility 5 . Others(specify) -----	
11	Which methods have you ever used? (tick all mentioned)	1. Pills 2. Inject able 3. Implant 4. IUCD 5. Female	

		sterilization 6. condom 7. Others(specify)	
12	Which method are you using now?	1. Pills 2. Inject able 3. Implant 4. IUCD 5. Condom 6. Others(specify)	
13	Who chooses the method you are using for you?	1. By my self 2. The provider 3. My husband 4. My neighbors 5. my family 6. Others(specify)	
14	Do you discuss about family planning with your husband?	1. Yes 2. No.	

PART Four Attitude, Awareness, Religion and cultural conditions			
15	Contraceptive use may cause infertility in women	1. Agree 2. Disagree 3. Neutral 4. Other (specify)	
16	A woman to use contraceptives, men only decides	1. Agree 2. Disagree 3. Neutral 4. Others	
17	No matter if you have too many children	1. Agree 2. Disagree 3. Neutral 4. Others	
18	Implants are removed from the place of insertion	1. Agree 2. Disagree 3. Neutral 4. Others	

THANK YOU VERY MUCH FOR YOUR TIME AND COOPERATION

Appendix iii: Map of Uganda showing location of Jinja district



KEY



Location of Jinja district