

**FAMILY PLANNING AND MATERNAL HEALTH IN  
WAKISO SUB COUNTY, WAKISO DISTRICT-  
UGANDA**

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A Thesis

Presented to the

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Kampala International University

Kampala, Uganda

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In Partial Fulfilment of the Requirements for the Degree  
of Masters in Project Planning and Management

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September, 2013



## DECLARATION A

"This thesis is my original work and has not been presented for a degree or any other academic award in any university or institution of learning

*N. Liz*  
NABIRTE SUZAN LIZ TABURA  
Name and signature of the candidate

30<sup>th</sup> NOVEMBER 2013  
Date



## **DEDICATION**

I dedicate this project to my husband Geoffrey Steven, and my children Elsie, Elisha and Elizabeth. My studies would not be complete without the support and encouragement of colleagues at work, Eva, Sanyu, Rashida and Kamyra whose assistance towards accomplishing this endeavor is invaluable and I shall forever remain grateful. Although there may be many others who remain unacknowledged in this humble note of gratitude there are none who remain unappreciated. Thank you all.

**APPROVAL SHEET**

This thesis entitled "Family Planning and Maternal Health in Wakiso Sub Souny, Wakiso District" was prepared and submitted by Nabirye Suzan Liz Tabura as a partial fulfilment of the requirement for the award of Master of in Project Planning and Management, has been examined and approved by the panel on oral examination with a grade of ..... Pass.

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Name and Sig. of Chairman

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Name and Sig. of Supervisor

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Name and Sig. of Panelist

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Name and Sig. of Director,

CHDR

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Name and Sig. of Principal, CHDR

## **ACKNOWLEDGEMENT**

I'm deeply grateful to the Almighty God for his Grace and gift of life, to my supervisors, Dr. Abuga Mokono Isaac and Dr. Wilberforce Tindyebwa for their guidance, patience and support. I consider myself very fortunate for being able to work with a very keen, considerate and encouraging person like him. Without his offering to accomplish this research, I would not be able to finish my study at Kampala International University. I'm much obliged to my colleagues Bukenya and Adam, their enlightening suggestions and encouragements made me feel I was not isolated in my research. I owe them many thanks and all my friends that always supported and helped when exchanging new ideas. They made my life at Kampala International University (KIU) a truly memorable experience and their friendships are invaluable to me. I am most grateful to my immediate family and my mother who have always stood by me, encouraged and supported my every choice. As I know, they are the happiest and the most proud when seeing their own receive this award.

## **ABSTRACT**

The study sought to establish the relationship between family planning and maternal health in Wakiso sub-county, Wakiso district. This study was guided by four specific objectives namely; to determine the demographic characteristics of respondent in terms of gender age, marital status and education qualification, ii) to determine the level of family planning, iii) to determine the level of maternal health, iv) to establish whether there is a significant relationship between family planning and maternal health in Wakiso sub-county, Wakiso district. The research employed descriptive correlational design to describe the relationship between the variables. The findings revealed the following: The middle aged respondents 26-35 years are more involved in carrying out family planning methods. The researcher concluded that the level of family planning was generally high in Wakiso sub-county, Wakiso district, and the level of maternal health was found to be satisfactory, hence concluding that hence concluding that maternal health centres do provide maternal health services to women of Wakiso Sub County-Wakiso District efficiently hence leading to satisfaction. Family planning and maternal health are positive and significantly correlated, therefore concluding that increase in family planning levels improves on maternal health services among women in Wakiso Sub County-Wakiso District, and regression analysis which was indicated by adjusted R squared of 42% was established. The researcher recommended that family planning providers should put in action more sensitization techniques like workshops and seminars on family planning education among couples, family planning providers should introduce family planning methods which allow couples to produce children whenever they want.

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## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Background of the study**

Many developing societies are characterised by rapid population growth due to high fertility. Globally, in India men are the dominant decision makers (national family health survey (1992), it's prudent to discover the knowledge, perception, attitudes and contraceptive practices of both men and women who are literate in order to improve their involvement in the reproductive health needs of families. Seventy two couples from a tribal primary health centre (PHC) area in thane district of Maharashtra state, India were surveyed with special emphasis on investigating the reasons for not accepting family planning male methods (Ramesh et al.1996).

The majority of them not only had no concept of family spacing, but had not even taken any initiative to improve their knowledge or acceptance of condom/ vasectomy. Men and women who are aware of contraceptive methods had little knowledge of their correct use due to illiteracy.

#### **1.1.1 Historical perspective**

As early as 1979, a few demographers were proclaiming that rapid population growth was coming to an end (Bogue and Tsui 1979); by 1990, that view was more widespread, despite the persistence of high fertility in most of the world poorest countries, concentrated in Africa. In other words of Stan Bernstein, "the race against population growth was, in effect, declared over before everyone crossed the finish line"(Bernstein 2005). Concurrent with the widespread fertility declines

of the 1970s and 1980s, the Coale-Hoover thesis that rapid population growth had a large negative effect on economic progress came under critical scrutiny from economists.

From the 1970s to the mid-1990s, support for international family planning grew dramatically around the world. In the 1970s and 1980s, government in developing countries in Asia and Latin America began prioritising support for voluntary family planning programs. And by 1996, 115 countries around the world had official policies to support family planning.

One reason offered for why family planning in Asia has been relatively more successful than Africa is that Asia has experienced significant social economic change. In addition, vigorous population campaigns in the region have involved local community leaders and other influential people. The campaigns were aimed at creating the desire to limit family size. Typically, concerted efforts were made to increase the desire for small families and then to provide family planning services as a means of controlling fertility. Similar efforts have gained momentum in Africa but with little results due to illiteracy among women and men.

The history of successful family planning in Bangladesh started with resounding failure in the early 1960s when Bangladesh was an eastern province of Pakistan. The result of the 1947 partition of India, the Pakistani government instituted a heavy handed family planning program that went against local needs and preferences. The coercive approaches used eventually led to a popular backlash, contributing to the 1968 collapse of the government. It was not until 1975, after a deadly famine and growing concerns about the demographic pressure on the country's natural resources and economic prospects that the

now independent Bangladesh embarked on the renewed family planning program. As it did so, leaders recalled the cautionary tale of how attempts to effect the most profound decisions in families and communities led to political conflict. The main challenges facing the program at the start, in 1975, were low levels of knowledge about family planning, a prevailing belief that large families were best (typical of agrarian societies), low levels of women's status, and lack of access to family planning services among the predominantly rural population particularly among women who had limited mobility. Each of these constraints was addressed through the program and through complementary public sector actions

Today, Indonesia is recognized as an international leader in family planning and reproductive health. It has one of the world's most successful programs. In the 1960s, Indonesian women routinely had six children, at least two of whom would die before reaching school age, realizing that preventing rapid population growth was important to both Indonesia's future and to its family's well being.

Forty years ago in the rural areas of Brazil, families not infrequently had between ten and twenty children. In recent years that number had decreased, especially in the large cities. The average number of children in a family has gone from 6.3 in 1960 to 2.8 in 1993. Brazil is a good example of a country where a strong demand for smaller families arose spontaneously from previous declines in child mortality and changes in aspirations and opportunities. Unwittingly, the spread of television and its immensely popular soap operas, featuring small families, might have been crucial in the spread of new ideas favouring family planning.

In 1960, Brazil had a total fertility rate of 6.2 and a high rate of illegal abortion. From 1964 until 1985, the country was governed by military regimes that had no interest in attempting to curb population growth. Only in 1985 was family planning made available within the government health services, but supplies from this source remain erratic. The vacuum was filled in three main ways. First, BEFMAM was created in 1964 as an affiliate of the Planned Parenthood federation by doctors concerned at the high rate of illegal abortions. By 1970, the organisation, with international funding, had agreements with many local municipalities to provide family planning services.

Second, the pharmaceutical industry, realising that the market for contraceptives was growing, started selling oral contraceptives through pharmacies.

Third, public health doctors circumvented a law prohibiting tubal ligation by offering the procedure together with the elective caesarean section, with costs of ligation subsumed by the costs of caesarean section. Supplemented by under-the table payments.

The Indian government, was anxious to hold the galloping population growth, launched the program immediately after the country gained freedom. The programme evoked far greater response in Kerala than elsewhere in the country. Historically, Kerala was fortunate in having enlightened rulers in the states of Cochin and Travancore, which were amalgamated in 1956 to form the state of Kerala. Both ruling families encouraged the development of education and health services, and this has been continued under successive state governments.

Population growth has long been a concern of the government, and India has a lengthy history of explicit population policy. In the 1950s,

the government began in a modest way, one of the earliest national, government sponsored family planning efforts in the developing world. The annual population growth rate in the previous decade (1941 to 1951).

Singapore`s post-war baby boomers were in their productive years in the 1940s and the country experienced exponential rates of population growth. This led to social problems such as food and housing shortages, and raised concerns over the welfare of mothers who underwent multiple pregnancies (some as many as 19 pregnancies) and the unwanted children produced by the families without the means to support them. Up till then, family planning was perceived as a personal family matter rather than a national concern. Pioneers advocating the practise of family planning identified the problem as being the number of children produced in excess of their families` financial means. Hence in early 1949, several concerned volunteers suggested that family planning advice be made available to mothers at infant welfare clinics. With permission from the municipality, a weekly family planning session was introduced at three to five municipal clinics, but it soon became evident that the services should be expanded to address the problem and that a voluntary body akin to the family planning association of Great Britain should spearhead the work.

The first family planning campaign began in October 1960. The three-month campaign aimed raise awareness of the disadvantages of large, unplanned families and the need of family planning advice to sources available at clinics, hospitals and private dispensaries.

Following the Korean war in the early 1950s, south Korean population remained primarily rural and agricultural. Its total fertility rate (TFR) exceeded six children per woman. South Korea began its national family planning campaign to reduce women`s un wanted births through a program of information, basic maternal and child health services, and the provision of family planning supplies and services. The program was seen as essential if the goals of economic growth and modernisation were to be archived.

In Africa the rate of population growth is one of the highest in the world, with an average growth rate 2.80%. This is a consequence of persistent high fertility although the rate of population growth in Nigeria is 3.0% per annum largely because of high fertility. In spite of an increased emphasis on family planning programmes in the regional, there has been little done due to illiteracy.

In Uganda family planning started with the family planning association of 1957 with an aim of helping people to prevent unwanted pregnancies, reducing on their financial expenses due to small size and to enable people to plan for their families.

A woman dies every 90 seconds from complications during pregnancy or childbirth — 86% of them in sub-Saharan Africa or South Asia.<sup>1</sup> According to experts, an estimated one in 26 women in sub-Saharan Africa is at risk of dying during childbirth over her lifetime, compared with one in 7300 in developed regions. Girls are dying as well, since many are forced into marriages and pregnancies when they are as young as 11 years old. Maternal deaths are all the more tragic because they are nearly all preventable.

In 1987, three United Nations (UN) agencies — UNFPA, the World Bank and the World Health Organization — launched the Safe Motherhood Initiative to raise awareness about the numbers of women dying each year from complications of pregnancy and childbirth and to challenge the world to do something. The importance of maternal health was again addressed by the international community when it met in 2000 and agreed on eight Millennium Development Goals (MDGs) aimed at ending extreme poverty worldwide by the year 2015. MDG 5 focused specifically on improving maternal health — setting a target of reducing maternal mortality levels by three-fourths. In 2007, in recognition to the close links between maternal health and other reproductive condition, a second target — ensuring universal access to reproductive-health services — was added to MDG 5.

Recently, some progress on the reduction of maternal mortality worldwide has been reported: a study published in April 2010 in the *Lancet* shows that the number of annual maternal deaths worldwide declined from roughly 525,000 in 1980 to about 343,000 in 2008.

A UN report recently released confirms the maternal mortality decline, providing an estimate of 358,000 maternal deaths in 2008. This represents a 34% decline from the 1980 levels. We take this as a sign that the hard work and investment over the last many years are finally paying off. It also signals that more effort and resources being directed toward this catastrophic problem will help; it is a cause for hope but, more than that, an impetus to invest in women's lives. The troubling news in these two studies is that progress has been unequal: while many countries are showing a downwards trend, in some, maternal deaths actually increased. The United States is one of these countries

showing a striking 96% increase in the maternal mortality ratio between 1990 and 2008.

We need to focus on two fronts — the international and domestic. Indeed, maternal mortality ratios in the United States have nearly doubled between 1999 and 2006 (7.1 deaths per 100,000 births to 13.3 deaths per 100,000 births). The United States now ranks only 50 in maternal mortality out of 171 countries, far below other developed nations and even some developing countries like Vietnam and Albania, according to UNFPA figures. This piece takes a global perspective on maternal mortality, and the next installment in this editorial series will focus on the US context.

The fact is that pregnancy always carries risk of unexpected complications, and 15% of pregnancies *everywhere* are life threatening.<sup>7</sup> Thus, wherever pregnant women live — whether in a Tanzanian village, Silicon Valley or an underserved area of the Bronx — access to skilled, high-quality prenatal care and assistance in childbirth can mean the difference between life and death.

We have known for decades what needs to be done to prevent maternal deaths — relatively simple, safe and affordable approaches exist to successfully prevent or treat most obstetric complications and thus save women's lives. When there is political will, these tools become available to all women. Indeed, there are some mid- and low-income countries that have made the reduction of maternal mortality their priority and have therefore successfully reduced maternal deaths. In Sri Lanka, Cuba and Tunisia, all relatively poor countries, women have a very low risk of dying from pregnancy-related causes. These countries have provided quality maternal health care, ensured access

to safe abortion services and made contraception readily available. In sum, they have invested in women and empowered them to take care of their reproductive lives.

Eradicating preventable maternal deaths worldwide will ultimately require structural changes such as getting women out of poverty, eliminating gender inequalities and building stronger health systems. High maternal mortality is inextricably linked to development and culture-related factors that are not simple to change. While the bigger picture elements improve, there are some concrete measures that need to be immediately put in place in order to address this critical problem.

### **1.1.2 Contextual Perspective**

In Uganda the family planning association was started in 1957 with an aim of helping people to prevent unwanted pregnancies, reducing on their financial expenses due to small size and to enable people to plan for their families.

The total population of Uganda is currently estimated at 28 million persons having grown from 2.5 million in 1911 to 5.0 million in 1948, from 9.5 million in 1969, 12.6 million in 1980 and 24.4 million in 2002 (UNFPA 2008).

According to projections, the population of Uganda (in the low grade scenario<sup>1</sup>) is estimated to increase from 28.6 million in 2007 to 40.6 million in 2017; while (in the high growth scenario), it is estimated to increase from 30.2 million in 2007 to 43.4 million in 2017 (UBOS, 2007). The annual births are projected to increase from 1.4 million in 2007 to 1.9 million in 2017.

The maternal mortality rate among women age 15-49 is 0.93 maternal deaths per 1,000 women years of exposure. By five year age groups ,the maternal mortality rate is highest among 30-34(1.30). In the 2011 UDHS maternal deaths represent 18 percent of all deaths of women age 15-49.The percentage of female deaths that are maternal varies by age and ranges from 10 percent among 45-49 to 23 percent of all deaths among women 20-29.

Maternal mortality is a cause of great concern. The major causes of these deaths have been identified as haemorrhage (both ante and post partum), toxemia (hypertension during pregnancy), anaemia, obstructed labour, puerperal sepsis (infections after delivery) and unsafe abortion.

According to a recent report from the World Health Organization, **maternal deaths in Uganda have been reducing at a rate of 5.1% every year over the last ten years.** The United Nations Millennium Development Goals for 2015 have called for the improvement of maternal health, specifically by reducing the maternal mortality ratio by three quarters and, though maternal mortality rates the world over have nearly halved since 1990, mortality rates are still 15 times higher in developing regions, such as Uganda, than in developed nations.

About 800 women die every day due to complications of pregnancy and child birth. The new WHO report, titled "Countdown to 2015: maternal, newborn, and child survival," was released at the Women Deliver global conference in Malaysia June 2013. Over 5,000 representatives from international development agencies, government offices, NGOs, academic circles and media outlets attended the

conference to identify the best opportunities to improve maternal health and access to reproductive health and rights.

The report says that, while maternal and child mortality has been steadily dropping over the past two decades, some countries, particularly in Sub-Saharan Africa, have had slower progress. "These countries must be prioritized for collective global, regional, and national action," the report said. "Improving newborn survival, including reducing still births, must be a major focus of policies and programs."

The Hunger Project supports maternal health by increasing awareness of and access to pre-natal care. In 2010, over 14,000 women accessed antenatal care services at Hunger Project epicenters in Africa under the care of government-sponsored health specialists. Among these professionals are nurse practitioners like Esther Nawatti who advises and cares for pregnant women at the Wakiso Epicenter in Uganda. "What motivates me to work even harder," she has said, "is that I save the lives of people in the community including children pregnant mothers elderly women and men."

Improving maternal nutrition and addressing the critical need for family planning are just some steps that can be taken to meet the United Nation's goal of reducing maternal deaths by 75% by 2015 and Uganda's 5.1% decline in maternal mortality is an important step on this road to prosperity and a world of nations that are successfully lifting themselves out of poverty.

According to the UNFPA, about 200 million women and girls globally who *want* to use contraceptives do not have access to them.<sup>8</sup> For example, a 2006 survey of women in Uganda found that 41% of

In 1989, a Community Health Based Care (CHBC) was initiated and started for people living with HIV/AIDS in collaboration with both Islamic faith based organisations. Relying on volunteerism as community health workers who would provide family planning services.

However, at a high level family planning Association of Uganda has worked with the Ugandan ministry of health to develop policy and service guidelines and training curricular for post abortion care and for home based care for people living with HIV/AIDS. Currently, Family Planning Association of Uganda IS involved in numerous projects with a particular focus on the availability of reproductive health and family planning services in conflict settings.

There are various methods used by literates which are categorized under the temporary and permanent methods of family planning. Temporary methods of family planning include the oral contraceptives, the condoms, the diaphragm, contraceptive foam, the intrauterine Device (IUD), withdrawal (coitus interrupters), Rhythm method, mucus and breast feeding. Besides, the permanent method such as vasectomy for men and tubal ligation for women is used by those who have various reasons and never want to have any more children. In Uganda today, one may wonder the kind of people who use family planning methods. As one draws near the rural areas you might be surprised to find that a lot of illiterates in our community use those methods but the question is, is there any influence on illiteracy on the use of family planning methods mainly in the rural areas of Wakiso sub county, Wakiso district.

### **1.1.3 Conceptual Perspective**

The independent variable for this study is family planning, in its basic meaning, is defined as the planning of when to have children, and the use of birth control and other techniques to implement such plans. Other techniques commonly used include sexuality education, prevention and management of sexually transmitted infections, pre-conception counseling and management, and infertility management. Family planning is sometimes used as a synonym for the use of birth control, however, it often includes a wide variety of methods, and practices that are not birth control. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy (also known as spacing children), family planning may encompass sterilization, as well as abortion (Stenson et al (1996).

Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality. Preconception care can include education, health promotion, screening and other interventions among women of reproductive age to reduce risk factors that might affect future pregnancies. The goal of prenatal care is to detect any potential complications of pregnancy early, to prevent them if possible, and to direct the woman to appropriate specialist medical services as appropriate. Postnatal care issues include recovery from childbirth, concerns about newborn care, nutrition, breastfeeding, and family planning. In many developing countries, complications of pregnancy and childbirth are the leading causes of death among women of reproductive age. A woman dies from

complications from childbirth approximately every minute.<sup>[2]</sup> According to the World Health Organization, in its World Health Report 2005, poor maternal conditions account for the fourth leading cause of death for women worldwide, after HIV/AIDS, malaria, and tuberculosis. Most maternal deaths and injuries are caused by biological processes, not from disease, which can be prevented and have been largely eradicated in the developed world such as postpartum hemorrhaging, which causes 34% of maternal deaths in the developing world but only 13% of maternal deaths in developed countries (World Health Report 2005).

#### **1.1.4 Theoretical Perspective**

Demographic Transition Theory (DTT) of Davis 1956 described many factors associated with fertility transitions and was long thought to explain fertility decline. Empirical evidence has revealed that this theory explains the variety of conditions surrounding the onset of fertility declines and the variety in place off adoption of family planning behaviour when there appear to be a positive attitude towards limiting family size. Women especially often say that they want to have fewer children but do not actually take any steps to reduce their fertility. The adoption of family planning methods has focused primarily on women`s attitudes about family size information on men`s attitudes about fertility decline is often obtained anecdotally (that is through what women say about men) (Razzaque 1999). The theory still suggests that gender differences in attitudes about optimal family size may be a major impediment in women`s attempts to reduce fertility and men`s attitudes about nativity are necessary for understanding the fertility decline process.

## **1.2 Statement of the problem**

According to the 2002 population and housing census, the population of Wakiso district stood at 907,988 people with a growth rate of 4.1% compared to the 562,209 people and a growth rate of 3.7% in 1991. Wakiso was ranked in the country after Mbarara and Kampala. (UDHS 2000/01). Uganda's Maternal Mortality Ratio (MMR) had remained high for 15 years, with no significant decline more especially in districts with high population levels like Wakiso, Mbarara and Kampala.

The unmet need for family planning is 42% (UDHS 2006). Many women and couples are unable to access effective family planning services. This leads to unwanted pregnancies, with subsequent unsafe abortions. The unmet need for emergency care is over 80% of which Maternal mortality is a cause of great concern. The major causes of these deaths have been identified as haemorrhage (both ante and post partum), toxemia (hypertension during pregnancy), anaemia, obstructed labour, puerperal sepsis (infections after delivery) and unsafe abortion yet most causes of maternal deaths among others are emergencies, HIV which has become a significant indirect cause of maternal and newborn morbidity and mortality in the last fifteen years, unwanted pregnancies, and unsafe abortions, lack of timely access to health care services, ruptured uterus, lack of drugs and intravenous fluids, lack of transfusion and excessive bleeding. This can be overcome by providing family planning services which can enhance proper maternal health, good antenatal care, timely identification and referral of pregnant women with complications of pregnancy and timely provision of emergency obstetric care more especially in Wakiso district.(DHS-2011).

2. What is the level of maternal health in Wakiso sub county, Wakiso district?
3. Is there is a significant relationship between family planning and maternal health in Wakiso sub county, Wakiso district?

## **1.6 Hypothesis**

There is a significant relationship between the level of family Planning and maternal health in Wakiso Sub County, Wakiso district.

## **1.3 Purpose of the study**

The purpose was to identify a relationship between family planning and maternal health in Wakiso sub county, Wakiso district.

Sub County, Wakiso district.

## **1.7 Scope**

### **1.7.1 Geographical scope;**

The study was carried out in Wakiso sub county, Wakiso district which is located 15 km away from Kampala. It lies in the central region of Uganda bordering with Mpigi, luwero and kiboga districts in the north, Mukono in the east and kalangala district in the south and covers a total area of 2,704.55 square kilometres. It is intended to cover several parishes including Buloba, Kalambi, Kiwumu and Bulenga. This was chosen because these areas have large family numbers and also residents claim to use family planning methods.

### **1.7.2 Theoretical scope**

This research study based on Demographic Transition Theory (DTT) of Davis 1956, the theory described many factors associated with fertility transitions and was long thought to explain fertility decline. Empirical

evidence has revealed that this theory explains the variety of conditions surrounding the onset of fertility declines and the variety in place off adoption of family planning behaviour when there appear to be a positive attitude towards limiting family size. Women especially often say that they want to have fewer children but do not actually take any steps to reduce their fertility. The adoption of family planning methods has focused primarily on women`s attitudes about family size information on men`s attitudes about fertility decline is often obtained anecdotally (that is through what women say about men) (Razzaque 1999). The theory still suggests that gender differences in attitudes about optimal family size may be a major impediment in women`s attempts to reduce fertility and men`s attitudes about nativity are necessary for understanding the fertility decline process.

### **1.7.3 Content scope**

In terms of content, this research study concentrated on family planning knowledge, use of modern contraceptives, and maternal health in Wakiso district.

### **1.8 Significance of the study**

The significance of the study will be of help to the following groups of people.

The government, NGO`S, CBO`S will utilize the information to improve on the accessibility of family planning in rural and urban areas of our country Uganda. Community health workers will use it to lay down strategies and improve on their service delivery of family planning services to both rural and urban communities.

Adult educators will utilize the information as a way of creating sensitization and awareness in rural and urban communities about the use of family planning methods.

Traditional leaders will be able to use the information in order to provide voluntary counselling on the use of family planning methods in rural and urban areas.

It will be important for future reference purposes and for further research

### **1.9 Operational definition of terms**

For the purpose of this study the following terms will be operational.

Family planning methods refers to the practice of spacing children and avoiding unwanted pregnancies by using birth control pills, barrier methods, long term methods and natural family planning methods.

Maternal health refers to the health of women during pregnancy, child birth and the postpartum period.

Maternal mortality refers to the death of a woman during pregnancy, child birth or in the 42 days of pregnancy. (Campbell et al.2006)

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

Many developing societies are characterized by rapid population growth due to high fertility, Globally , In India men are the dominant decision makers (National Health Survey(1992), its prude3nt to discover the knowledge , perception, attitudes and contraceptive practices of both men and women who are literate in order to improve their involvement in the reproductive health needs of families.

As early as 1979, a few demographers were proclaiming that rapid population growth was coming to an end (Bogue and Tsui 1979), by 1990, that view was more widespread, despite the persistence of high fertility in most of the world's poorest countries, concentrated in Africa. From the 1970s to the mid -1990s, support for international family planning grew dramatically around the world. In the 1970s and 1980s, governments in developing countries in Asia and Latin America began prioritizing support for voluntary family planning programs and by 1996, 115 countries around the world had official policies to support family planning. However, in Uganda we also have maternal mortality which is one of the leading causes of death in the world.tha United Nations children's fund (UNICEF) refers to maternal mortality as "in scale and severity the most neglected tragedy of our time "(DCAF,

2005). This tragedy inappropriately affects the developing countries, with 99 percent of maternal mortalities occurring in economically underdeveloped nations (Hogan et al. 2010). The most dreadful aspect of the global phenomenon is its avoidable nature. Family planning is one recognized way to mitigate the risks associated with maternal mortality through reducing overall fertility in regions with an “unmet need” for modern family planning programs and lack of access to modern contraceptive commodities, preventive health care procedures, technical expertise and medical solutions exist.

Recent reports highlight decreases in maternal mortality rates since the 1990s; however, this is not a universal reduction (Hogan et al 2010). Particularly in Africa and southern Asia maternal mortality rates remain high (United Nations, 2010).

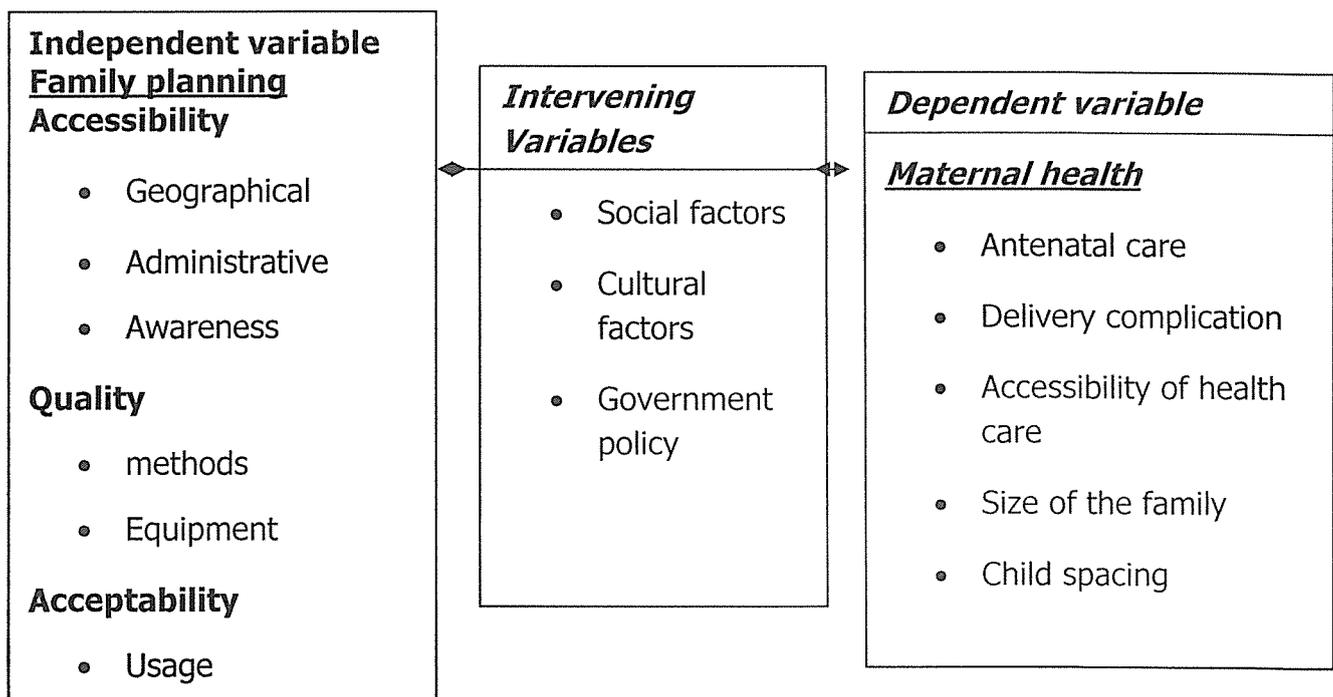
The United Nations development fund for women (UNIFEM) estimates that over half a million women die each year from preventable complications and child birth (UNIFEM, 2008). Specifically in Wakiso district access to appropriately family planning resources could potentially reduce the high incidence of maternal death.

## **2.2 Theoretical review**

Demographic Transition Theory (DTT) of Davis 1956 described many factors associated with fertility transitions and was long thought to explain fertility decline. Empirical evidence has revealed that this theory explains the variety of conditions surrounding the onset of

fertility declines and the variety in place off adoption of family planning behaviour when there appear to be a positive attitude towards limiting family size. Women especially often say that they want to have fewer children but do not actually take any steps to reduce their fertility. The adoption of family planning methods has focused primarily on women`s attitudes about family size information on men`s attitudes about fertility decline is often obtained anecdotally (that is through what women say about men) (Razzaque 1999). The theory still suggests that gender differences in attitudes about optimal family size may be a major impediment in women`s attempts to reduce fertility and men`s attitudes about nativity are necessary for understanding the fertility decline process.

**CONCEPTUAL FRAMEWORK ON FAMILY PLANNING AND MTERNAL HEALTH**



**PRIMARY SOURCE (2013) .**

## **A conceptual framework for the relationship between family planning and maternal health.**

In the conceptual framework depicted above, family planning which is the independent variable is hypothesized to influence maternal health in Wakiso Sub County, Wakiso district. Family planning is defined as use of modern contraceptive methods. The framework postulates that the use of modern contraceptives directly affects maternal health in Wakiso Sub County, Wakiso district. However, this relationship may be modified by maternal mortality for not using family planning methods.

## **Accessibility of family planning methods and maternal mortality**

Literates usually access information on the use of family planning methods in various ways as cited out by different scholars. Stomquist et al (1988), asserts that literates access information on family planning through formal and non formal education which is done by holding work shops and seminars and using teaching materials which are produced in local languages. He states that it clearly that "it is necessary to clarify the goals of family planning first so that it will enable participants to develop self esteem, confidence and the knowledge about family planning and the ability to make their own decisions and to participate more effectively towards the use of family planning in their communities". But also Brown Lalage (1990), who well understood the importance of doing participatory and action research finds it very important to organize workshops in order to train grass root men and women who are illiterate so as to increase the level of accessing information on the use of family planning methods since the participatory research can enable them develop their skills

and critically analyze their existing conditions towards the use of Family planning methods.

However, Stomquist (1993), suggests that for one to have an effect in society, it`s important to undertake campaigns and lobby activities that can increase the chances of illiterates to access family planning and then it also puts the issues of family planning in the minds of the legislators, policy makers and the public at large can be able to access information on family planning methods.

In addition, Lomintz (1977) say that it is possible for illiterates to share experiences and learn from one another. In this matter, understandings and forging solidarity among developed organizations, government and multi-lateral agencies is forged of which sensitivity and bringing together donor agencies will enable to publish information about family planning among the illiterates therefore increasing their level of accessibility to the various methods.

Nowadays, media is playing role in the development of society and mainly in creating awareness in the use of family planning methods. Brown(1990) states that when you consider attitudinal barriers in traditional societies and the role which the mass media plays in reinforcing them, thus helps the illiterates access information on family planning through radios, televisions and at times newspapers which are written in the local languages.

## **Quality of family planning services and maternal health**

All family Planning services should be of the highest quality possible. High-quality contraceptive care involves providing women and men with safe and appropriate methods to meet individuals and couples & needs at every stage of their reproductive lives. Accurate and complete information should be provided, allowing women and men to select freely a method that suits their needs. High quality means that the needs of clients are assessed, an appropriate range of family planning methods is provided, a complete and accurate information about all methods is offered, thus ensuring informed choice, a mix of methods matches the needs of all potential clients, the providers should have the necessary technical skills to offer the methods safely (providers screen women for medical contraindications, assess STD/ I-IIV risks, and can medically manage side effects), the providers should be well trained in a technically accurate and culturally appropriate counselling techniques and use them effectively services are convenient, accessible and acceptable to clients (Subramanian, S. 2000).

## **Acceptability of family planning methods and maternal health**

There are reasons for not using a contraceptive among women as assessed by Govindasamy and Boadi (2000), using data collected in the Ghana Demographic and Health Surveys that were conducted in 1988 and 1998. According to Govindasamy and Boadi (2000), a significant number of women mentioned fertility-related reasons (infrequent sex, menopausal/subfecund, postpartum/breastfeeding, and wanting more children) as principal reasons for nonuse. Method-related reasons, particularly fear of side effects for method use, were also cited as reasons for non use. In Uganda, community mobilization in family planning programs has also been difficult and has been

hindered by opposition to family planning on the part of some religious and community leaders (Okwero et al., 1994). Another report presented a review of literature on male attitudes and behaviors concerning family planning and male initiatives in Africa. The results indicated that men often have positive attitudes toward family planning, but women believe that their husbands disapprove of family planning. The report further noted that spousal communication was positively associated with family planning method use (Toure, 1996). However Ezeh (1993) suggested that spousal influence, rather than being mutual or reciprocal, is an exclusive right of the husband. According to the Demographic and Health Surveys, many married women who want to avoid pregnancy are not using contraception because their husbands object. Nearly one in ten married women with unmet need cited husband's disapproval as the principal reason for nonuse of contraception (Drennan, 1998). Rudranand et al., 1995, indicated that improved access to services of family planning, expanded choice of available methods, and increased knowledge of family planning were important for the acceptance of contraception and efficient maternal health services. However, opposition from husbands and in-laws, the desire for at least two sons, and lack of trust of voluntary health workers from a different caste or religion were obstacles to the acceptance of contraception.

### **Maternal health**

Two of the most powerful drivers of maternal mortality, cited by the Lancet in 2010, include 1. Total fertility rates and 2. Skilled medical attendance during child birth (Hogan et al 2010). Adding it up to a joint report issued in 2009 by guttmacher institute and UNFRA, presents sophisticated research modelling the impact of simultaneously

investing in family planning services and maternal and child health. Take separately, these two areas of investment yield positive results but concurrent investment produces a 70 percent decrease in maternal deaths galling from the current average o 550,000 deaths per year to 160,000 deaths per year (Singh et al 2009)

Research studies further classify distant and intermediate determinants of maternal mortality (Maine, 1991, McCarthy and Maine 1992) a major intermediate determinant factor is access to reproductive health services. Access depends on availability of service, knowledge of service, financial accessibility, quality of care, or physical location (Maine 1991, Partra 2007, McCarthy and Maine 1992). Additional intermediate determinants include: 1. Reproductive behaviour such as age, number of pregnancies per woman, spacing between births and unwantedness of pregnancies 2. Health status such as incidence of disease and age factors and 3. Unknown or unpredictable factors for instance birth complications for women at low risk (Maine 1991, McCarthy and Maine 1992). Distant factors consist of factors related to a woman`s social economic, family household and community status (Maine 1991, McCarthy and Maine 1992).

Wide spread research identifies both direct and indirect medical causes of maternal mortality sometimes referred to as "the long road to death" (McCarthy and Maine 1992). The most common direct causes of maternal deaths are haemorrhage (excessive bleeding), hypertension, infection and obstructed labour. Unsafe abortions are another major cause of maternal death with the Guttmacher institute reporting over 20 million unsafe abortions performed in2008 contributing to high maternal deaths (Singh et al 2009). The indirect causes of maternal deaths include malaria, HIV/AIDS, anaemia, malnutrition and heart

disease. The majority of deaths caused by direct and indirect causes are unavoidable (United Nations 2010).

While it is important to note the shortcomings of an exclusively family planning based approach, research highlights the difficulty of improved health services in many of the worst regions suffering maternal mortality. Judith A. Fortney (1987) asserts good obstetric care preceded modern contraceptives by 20 years developed countries, but developing countries do not have the resources to make a similar transition. Institutionalization of adequate obstetric care is limited in many regions while implementation of family planning programs may be relatively easy even in remote rural areas (Fortney 1987).

Lastly based on the multitude of factors related to maternal mortality and health, this study will further analyze the relationship between family planning methods, maternal health and maternal mortality in Wakiso Uganda where limited research on this topic has been undertaken. By focussing on family planning knowledge and use of modern contraceptives practice, this study hopes to assess the potential influence international family planning programs may have on reducing maternal mortality in developing and conflict ridden regions.

### **Identifying the gap**

The literature review above outlines the relationship between quality of family planning methods and maternal health, it also talked about the acceptability of family planning methods and maternal health but it did not talk about the relationship between family planning methods and maternal health, therefore there is a need to close this gap by the researcher. In a similar way this kind of research has never been done in Wakiso sub county ,Wakiso district so the researcher found it

necessary to carry out research in this area as it was identified as a geographical gap.



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## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 Introduction**

This chapter presents the design, population, sampling strategies, data collection methods, data quality control, procedure and data analysis used in this study.

#### **3.2 Research design**

The researcher used a descriptive cross-sectional survey design. Descriptive research design particularly employing comparative techniques were used to establish significant differences (descriptive comparative) between variables, cause and effect relationships (descriptive correlation) of the independent (level of the people who use family planning methods) and dependent variables (maternal health) in Wakiso Sub County, Wakiso district.

The cross-sectional research design was adopted in this study because it enabled the researcher to collect a lot of data within the shortest time possible (i.e. 400 households in Wakiso sub county, Wakiso district.) The research design was also selected because the researcher intends to generalize from the sample used to the whole population (Amin, 2003) in Wakiso sub county, Wakiso district.

### 3.3 Research Population

The study comprised of 400 households in Wakiso Sub County in Wakiso district, for both men and women because they are both responsible in practicing family planning.

**Table 1: showing the study population and sample size**

Respondents	Population		Sample size
Women	300	$\frac{300}{400} \times 200$	150
Men	100	$\frac{100}{400} \times 200$	50
<b>Total</b>	<b>400</b>		<b>200</b>

### 3.4 Sample Size

The study sample size consisted of 200 respondents. This sample size was arrived at using Slovene's formula for calculating sample sizes, stated as follows

$$n = \frac{N}{1+N(e^2)} \quad n = \frac{400}{1+400(0.05^2)} \quad n = \frac{400}{1+400(0.025)} \quad n = \frac{400}{1+1} \quad n = \frac{400}{2} \quad n = 200$$

### 3.5 Sampling Procedure

The respondents to the study were selected using simple random sampling technique. A list of women and men was obtained from the district headquarters of Wakiso, names were put in rota and randomly selected to participate in the study.

### 3.6 Research Instrument

The questionnaire used in the study had three sections, where by section A was to help the researcher to collect data on the profile characteristics of respondents as mentioned in the first objective of this study.

Section B of the questionnaire involved questions on family planning as the independent variable, and all questions in this questionnaire are closed ended basing on a four point Likert scale ranging from 1= strongly disagree, 2= disagree, 3= agree and 4= strongly agree.

Section C of the questionnaire involved questions on the dependent variable (growth maternal health). All questions in this questionnaire were also closed ended and based on a four point Likert scale ranging from one to four, where 1= strongly disagree, 2= disagree, 3= agree and 4= strongly agree.

### **3.7 Data quality control**

Validity and reliability of research instrument was established as illustrated below:

### **3.8 Validity**

To ensure content validity of the instruments, the researcher requested a panel of 6 experts: 3 professors and 3 senior lecturers to validate the instrument. The experts looked at relevance, semantics and clarity of questions in the instrument in view of the problem, objectives research questions, hypotheses and literature (which was duly provided to them). The experts were requested to rate validity/relevancy of each item/question using the following codes:

VR = very relevant, R = relevant, I = irrelevant, VI = very irrelevant.

After the researcher collected the questionnaires and established a content validity index of 0.7 which was used as basis for reasonable use of the instrument (Amin, 2003).

### **3.7 Reliability**

The test-retest method was used in order to test the reliability of the questionnaire, here the researcher pre-tested the questionnaire on a few people before administering it to the sample size. The researcher gave the questionnaire to a few respondents (10 people) and they answered it, after a period of two weeks, the researcher gave the same questionnaire to the same group (10 people) to answer it again. Responses from the first time (test) were compared to responses of the second test (re-test), since the t-test results indicated a significant difference (Sig-value=0.002), the research instrument was declared reliable.

### **3.8 Data gathering procedures**

#### **Before the Administration of the Questionnaires**

An introduction letter was obtained from the College of higher Degrees and Research for the researcher to solicit approval to conduct the study from respective selected areas.

When approved, the researcher secured a list of the qualified respondents from the area authorities in charge and select through systematic random sampling from this list to arrive at the minimum sample size.

The respondents were explained about the study and were requested to sign the informed consent form. Reproduce more than enough questionnaires for distribution.

### **During the administration of the questionnaires**

The researcher distributed the questionnaires to the respondents and brief them on the questions

The respondents were requested to answer the questionnaires completely.

The researcher emphasized retrieval of the questionnaires within two days from the date of distribution.

### **After the administration of the questionnaires**

On retrieval, all returned questionnaires were checked whether all were answered. The data gathered was collected, edited, coded and summarized into the computer and statistically treated using the Statistical Package for Social Sciences ( SPSS).

### **3.9 Data Analysis**

Frequency tables and percentage distributions were used to determine the profile of the respondents as to age, gender, marital status, and religion. Means and ranks were also used to determine the level of family planning and maternal health and finally a Pearson's Linear Correlation Coefficient was employed to determine a significant relationship between family planning and maternal health in Wakiso sub-county, Wakiso District.

The following numerical values and response modes were used to interpret the means;

<b>Mean range</b>	<b>Response range</b>	<b>Interpretation</b>
3.26 - 4.00	strongly agree	Very high
2.51 - 3.25	Agree	High
1.76 - 2.50	Disagree	Low
1.00 - 1.75	Strongly disagree	Very low

The Pearson's Linear Correlation Coefficient (PLCC) was used to determine the significant relationship between the level of family planning and maternal health in Wakiso district.

### **3.10 Ethical considerations**

To ensure confidentiality of the information provided by the respondents and to ascertain the practice of ethics in this study, the following activities were implemented by the researcher:

The respondents were coded instead of reflecting the names.

Seek permission through a written request to the concerned officials of the study areas.

Request the respondents to sign in the Informed Consent Form, acknowledge the authors quoted in this study and the author of the standardized instrument through citations and referencing.

Present the findings in a generalized manner.

### **3.11 Limitations of the study**

Extraneous variables which were beyond the researchers control such as respondents' honesty, personal biases and uncontrolled setting of the study.

**Attrition:** There was a likelihood of some respondents of not returning back the questionnaires and this was to affect the researcher

in meeting the minimum sample size. To solve this threat, the researcher gave quit more questionnaire exceeding the minimum sample size.

## **CHAPTER FOUR**

### **PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS**

#### **4.0 Introduction**

This chapter shows the demographic characteristics of respondents, the level of family planning, level of maternal health and Pearson correlation between family planning and maternal Health in Wakiso Sub County-Wakiso District. The presentation here is based on data as collected from the field, therefore respondents were asked to provide their gender, age, marital status and education qualification. Their responses were summarized using frequencies and percentages as indicated in table 2;

**Table 2**  
**Profile of Respondents**

<b>Categories</b>	<b>Frequency</b>	<b>Percent</b>
<b>Gender</b>		
male	8	4.0
female	192	96.0
<b>Total</b>	<b>200</b>	<b>100</b>
<b>Age</b>		
below 18 years	39	19.5
19-25 years	72	36.0
26-35 years	76	38.0
36-51 years	13	6.5
<b>Total</b>	<b>200</b>	<b>100</b>
<b>Marital Status</b>		
Married	100	50.0
single	81	40.5
divorced	16	8.0
separated	3	1.5
<b>Total</b>	<b>200</b>	<b>100</b>
<b>Education Qualification</b>		
Certificate	41	20.5
diploma	76	38.0
bachelors	74	37.0
Masters	9	4.5
<b>Total</b>	<b>200</b>	<b>100</b>

Results in Table2 indicated that female respondents 192(96%) were higher than male respondents 8(4%). This implies that the most active group of respondents in this sample were women because are the ones mostly with the responsibilities of practicing family planning in a family.

Regarding age, results in table 2 indicated that respondents in this sample were dominated by those between 26-35 years (38%), these were followed by those between 19-25 years (36%), implying that most of women in this sample were youths.

With respect to marital status, the biggest portion of the respondents 100(50%) were married these were followed by those who are single 81(40.5%), however, there were some divorced over 16(8%).

With respect to academic qualification, majority of the respondents (38%) were diploma holders these were followed by bachelor holders (37%), indicating that respondents are relatively qualified.

### **Level of Family Planning**

The independent variable in this study was the extent of family Planning in Wakiso Sub County-Wakiso District. This variable was operationalised using fourteen questions or items in the questionnaire, with each question Likert scaled between one to four, where 1=strongly disagree, 2=disagree, 3= agree and 4= strongly agree. Respondents were required to show the extent to which they agree or disagree with each item and their responses were analysed using means as summarized in table 3;

**Table 3: Level of Family Planning**

<b>Variable</b>	<b>Mean</b>	<b>Interpretation</b>	<b>Rank</b>
<b>Accessibility</b>			
The family planning service providers are always available in your area	3.43	Very high	1
The family planning centres are extended near to your area	3.10	High	2
You always have enough family planning service providers in your area	2.93	High	3
<b>Average mean</b>	<b>3.15</b>	<b>High</b>	
<b>Quality</b>			
It is always very cheap for you to buy contraceptives	3.02	High	1
Family planning always change the age structure of your fertility	2.81	High	2
Family planning always help parents to produce children whom they are able to look after	2.74	High	3
The type of family planning method you use helps you in spacing of your children	2.67	High	4
Family planning always allow you to produce children whenever you want	2.36	Low	5
Family planning service centres have organized workshops for you.	2.07	Low	6
<b>Average mean</b>	<b>2.61</b>	<b>High</b>	
<b>Acceptability</b>			
You accepted to abstain from sex in fear of getting unwanted pregnancies	3.82	Very high	1
You accepted to carry out withdraw/pulling out technique as your family planning method	3.41	Very high	2
You made your own choice of using contraceptives	3.34	Very high	3
You accepted to carry out long breast feeding as your family planning method	3.31	Very high	4
You always use condoms as your family planning methods	2.93	High	5
<b>Average mean</b>	<b>3.36</b>	<b>Very high</b>	6
<b>Grand mean</b>	<b>3.04</b>	<b>High</b>	

The results in Table 3 revealed that family planning was generally rated high (mean=3.04), implying that generally majority of women do practice family planning methods in Wakiso Sub County-Wakiso District. Still results in table 3 indicate that concerning accessibility of family planning only one item was rated very high and this was; the

family planning service providers are always available in your area (mean=3.43), and the remaining two were rated high and these were; the family planning centres are extended near to your area (mean=3.10); You always have enough family planning service providers in your area (mean=2.93).

With respect to quality of family planning methods, six items were used to measure this construct and results indicate that it was rated high on average and this was indicated by the average mean (mean=2.61), implying good quality of family planning methods provided to the couples in Wakiso Sub County-Wakiso District.

Regarding acceptability, still six items were used to measure this construct and results indicated that it was rated very high on average and this was indicated by the average mean (mean=3.36), still results indicate that the following items on acceptability were rated very high; You accepted to abstain from sex in fear of getting unwanted pregnancies (mean=3.82); You accepted to carry out withdraw/pulling out technique as your family planning method (mean=3.41); You made your own choice of using contraceptives (mean=3.34); You accepted to carry out long breast feeding as your family planning method (mean=3.31) and only one item was rated high; You made your own choice of using contraceptives (mean=2.93), implying that majority of couples in Wakiso Sub County-Wakiso District do have positive attitudes towards family planning methods.

### Level of Maternal Health

The dependent variable in this study was Maternal Health and the researcher wanted to determine its level. Maternal Health was operationalised using ten questions in the questionnaire, each of these questions was based on the four likert scale and respondents were asked to rate the extent to which Maternal Health is good or poor by indicating the extents to which they agree or disagree with each question. Their responses were analysed using SPSS and summarized using means as indicated in table 4;

**Table 4: Level of Maternal Health**

<b>Variable</b>	<b>Mean</b>	<b>Interpretation</b>	<b>Rank</b>
You're always taught by doctors the way you should eat when you're pregnant	3.76	Very satisfactory	1
You can always receive antenatal services from any nearby health center.	3.44	Very satisfactory	2
You always check on HIV status when your pregnant	3.35	Very satisfactory	3
You always get complications when you're pregnant	3.33	Very satisfactory	4
You always receive maternal health services from an international hospital	3.22	Satisfactory	5
You always find it easy to access maternal health services in your area	3.06	Satisfactory	6
You always go for antenatal care every after a month.	3.01	Satisfactory	7
You always attend the antenatal workshops organized by maternal health service providers.	2.91	Satisfactory	8
Maternal health service providers always offer skilled medical attendance during child birth	2.88	Satisfactory	9
You always read news papers and get knowledge concerning antenatal services	2.65	Satisfactory	10
<b>Average mean</b>	<b>3.16</b>	<b>Satisfactory</b>	

The results in Table 4 revealed that level of maternal health was generally rated satisfactory and this was indicated by the average mean of (mean=3.16), implying that women in Wakiso Sub County-Wakiso District are generally satisfied with the maternal health services provided to them. Still results in table 3 indicate that the following items of maternal health were rated very Satisfactory; You're always taught by doctors the way you should eat when you're pregnant (mean=3.76); You can always receive antenatal services from any nearby health center (mean=3.44); You always check on HIV status when you're pregnant (mean=3.35); You always get complications when you're pregnant (mean=3.33). Implying that maternal health centers do provide maternal health services to women of in Wakiso Sub County-Wakiso District efficiently hence leading to satisfaction.

Still results indicate that the following items on maternal health were rated satisfactory; You always receive maternal health services from an international hospital (mean=3.22); You always find it easy to access maternal health services in your area (mean=3.06); You always go for antenatal care every after a month (mean=3.01); You always attend the antenatal workshops organized by maternal health service providers (mean=2.91); Maternal health service providers always offer skilled medical attendance during child birth (mean=2.88); You always read news papers and get knowledge concerning antenatal services (mean=2.65), Implying that maternal health centers do provide maternal health services to women of in Wakiso Sub County-Wakiso District efficiently hence leading to satisfaction.

### **Relationship between family planning and maternal health in Wakiso Sub County-Wakiso District**

The last objective in this study was to establish whether there is a significant relationship between family planning and maternal health in Wakiso Sub County-Wakiso District, for which it was hypothesized that family planning and maternal health are significantly correlated. To test this null hypothesis, the researcher correlated the mean indices on family planning and those on maternal health using the Pearson's Linear correlation Coefficient (PLCC) and results are indicated in table 5 below;

**Table 5: Pearson correlation between Family Planning and Maternal Health in Wakiso Sub County-Wakiso District**

<b>Variables Correlated</b>	<b>r-value</b>	<b>Sig</b>	<b>Interpretation</b>	<b>Decision on Ho</b>
Family planning Vs Maternal Health	.635	.000	Significant Correlation	Rejected

The Pearson's Linear correlation Coefficient (PLCC) results in table 5 indicated a positive significant relationship between family planning and maternal health in Wakiso Sub County-Wakiso District, since the sig. value (0.000) was far less than 0.05, which is the maximum level of significance required to declare a significant relationship in social sciences. Therefore this implies that high levels in the use of family planning techniques improves the level of maternal health services among women in Wakiso Sub County-Wakiso District and low levels in the use of family planning techniques reduces it. Basing on these results the stated null hypothesis was rejected and a conclusion made

that increased levels in the use of family planning techniques among women in Wakiso Sub County-Wakiso District enhances the provision of maternal health services.

**Table 6**

**Regression between Maternal health and Family planning**

<b>Variables regressed</b>	<b>Adjusted r<sup>2</sup></b>	<b>F-value</b>	<b>Sig.</b>	<b>Interpretation</b>	<b>Decision on H<sub>0</sub></b>
Maternal health VS Family planning	0.425	50.039	0.000	Significant effect	Rejected
<b>Coefficients</b>	<b>Beta</b>	<b>t-value</b>	<b>Sig.</b>		
(Constant)		5.580	.000	Significant effect	Rejected
Accessibility	-.099	-.889	-.375	Insignificant effect	Accepted
Quality	.405	4.783	.000	Significant effect	Rejected
Acceptability	.475	4.743	.000	Significant effect	Rejected

Regression analysis results in table 6 above indicated that family planning accounted for 42% in on maternal health indicated by adjusted r squared of 0.425 leading to the conclusion that family planning significantly effects maternal health.

The coefficients table further showed that of all the aspects of family planning, acceptability accounted for the biggest influence on maternal health ( $\beta=0.475, \text{Sig}=0.000$ ).

## **CHAPTER FIVE**

### **DISCUSSION, CONCLUSION AND RECOMMENDATIONS**

This chapter presents a summary of major findings, conclusions and recommendations plus the suggested areas that need further research.

#### **5.1 Findings**

This study intended to find out the relationship between family planning and maternal health in Wakiso Sub County-Wakiso District. It was guided by four specific objectives, that included determining the i) profile of respondents in terms of gender, age, marital status and education qualification ; ii) determining the level of family planning; iii) examining the level of maternal health; iv) the relationship between family planning and maternal health in Wakiso Sub County-Wakiso District.

The study findings indicated that majority of respondents were female (96%) ranging between 26-35 years (38%) and these were single (40.5%) plus being diploma holders (38%).

Data analysis using means showed that the level of family planning was rated high (mean=3.04), accessibility as a construct of family planning was found to be high (mean=3.15), and this implies that couples in Wakiso Sub County-Wakiso District access family planning services at any time, and this is in line with Stomquist et al (1988), who asserts that literates access information on family planning through formal and non formal education which is done by holding workshops and seminars and using teaching materials which are produced in local languages.

The quality of family planning was rated high (mean=2.61) which implies that family planning providers do provide good family planning methods which are favourable to the couples in Wakiso Sub County-

Wakiso District, and therefore this is in line with Subramanian, S. 2000 who suggests that family planning providers should be well trained in a technically accurate and culturally appropriate counselling techniques and use them effectively services are convenient, accessible and acceptable to clients.

The acceptability of family planning methods was rated very high (mean=3.36) which implies that majority of the couples in Wakiso District do support family planning, therefore the researcher disagrees with Okwero et al, 1994 who asserts that in Uganda, community mobilization in family planning programs has also been difficult and has been hindered by opposition to family planning on the part of some religious and community leaders.

The findings also indicated a positive a significant relationship, positive significant correlation between family planning and maternal health in Wakiso Sub County-Wakiso District, this is because the significant value was less than 0.05, which is the maximum level of significance required to declare a relationship significant. Therefore implying that improvement in family planning methods automatically leads to effective maternal health services in Wakiso Sub County-Wakiso District, therefore this is in line with Rudranand et al, 1995 who indicated that improved access to services of family planning, expanded choice of available methods, and increased knowledge of family planning were important for the acceptance of contraception and efficient maternal health services, still the findings show that family planning has a significant effect on maternal health.

## 5.2 Conclusions

From the findings of the study, the researcher concluded that majority of respondents in this sample were female (96%) ranging between 26-35 years (38%) and these were single (40.5%) plus being diploma holders (38%).

The level of family planning in Wakiso Sub County-Wakiso District is generally high, therefore concluding that the most common family planning methods applied by different couples in Wakiso Sub County-Wakiso District include abstaining from sex and withdraw/pulling out technique. Accessibility of family planning was rated very high (mean=3.15) leading to a conclusion that couples do receive family planning services at any time they want, the quality of family planning methods was also rated high on average and this was indicated by the average mean (mean=2.61) hence concluding that the family planning services provided to couples in Wakiso Sub County-Wakiso District are generally of good quality, the acceptability of family planning methods was rated very high on average and this was indicate by the average mean (mean=3.36), leading to a conclusion that family planning services are highly supported in Wakiso Sub County-Wakiso District.

The level of maternal health was generally rated high in Wakiso Sub County-Wakiso District, hence concluding that maternal health centers do provide maternal health services to women in Wakiso Sub County-Wakiso District efficiently hence leading to satisfaction.

Finally family planning and maternal health are positive and significantly correlated, therefore concluding that increase in family planning techniques improves the level of maternal health services among women in Wakiso Sub County-Wakiso District.

Regression analysis results showed that family planning accounted for 42% variation on maternal health indicated by  $r$  of 0.425. The coefficients table further showed that of all the aspects of family planning, acceptability accounted for the highest influence on maternal health  $\beta=0.251, \text{Sig}=0.24$ .

### **5.3 Recommendations**

The researcher recommends that family planning providers should put in action more sensitization techniques like workshops and seminars on family planning education among couples.

The researcher recommends that family planning providers should introduce family planning methods which allow couples to produce children whenever they want.

The Ministry of health should address women's antenatal problems as early as possible in order to improve on maternal health services among women in Wakiso Sub County-Wakiso District.

The Government of Uganda should construct more maternal health centers in the areas of Wakiso Sub County-Wakiso District in order to improve antenatal health services among women.

### **5.4 Areas for further research**

Prospective researchers and students are encouraged to research on the following areas;

1. Family planning and Antenatal care among women in Wakiso Sub County-Wakiso District.
2. Economic factors and Accessibility of health care services among women in Wakiso Sub County-Wakiso District.

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3. Cultural factors and Delivery complications among women in  
Wakiso Sub County-Wakiso District.

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**APPENDICES**  
**APPENDIX I A**  
**TRANSMITTAL LETTER**

**OFFICE OF THE DEPUTY VICE CHANCELLOR (DVC)**  
**COLLEGE OF HIGHER DEGREES AND RESEARCH**

---

Dear Sir/Madam,

**RE: INTRODUCTION LETTER FOR MS. NABIRYE SUSAN LIZ  
TABURA REG. NO. MPP/36737/121/DU, TO CONDUCT  
RESEARCH IN YOUR INSTITUTION**

The above mentioned candidate is a bonafide student of Kampala International University pursuing a Masters degree in Educational Management and Administration

She is currently conducting a field research for her thesis entitled, **"The Effect of Family Planning on Maternal Health in Wakiso Sub-County, Wakiso District."**

Your institution has been identified as a valuable source of information pertaining to her research project. The purpose of this letter then is to request you to avail her with the pertinent information she may need.

Any data shared with her will be used for academic purposes only and shall be kept with utmost confidentiality.

Any assistance rendered to her will be highly appreciated.

Yours truly,

---

Novembrieta R. Sumil, Ph.D.

Deputy Vice Chancellor, SPGSR

## APPENDIX 1B

### TRANSMITTAL LETTER FOR THE RESPONDENTS

---

Dear Sir/ Madam,

Greetings!

I am a Masters. in Project Planning and Management candidate of Kampala International University. Part of the requirements for the award is a thesis. My study is entitled, "**The Effect of Family Planning on Maternal Health in Wakiso Sub-County, Wakiso District.**" Within this context, may I request you to participate in this study by answering the questionnaires. Kindly do not leave any option unanswered. Any data you will provide shall be for academic purposes only and no information of such kind shall be disclosed to others.

Thanking you in advance for your cooperation.

Yours faithfully,

Nabirye Susan Liz Tabura

## APPENDIX II

### CLEARANCE FROM ETHICS COMMITTEE

Date \_\_\_\_\_

#### Candidate's Data

Name : NABIRYE SUSAN LIZTABURA

Reg No. : MPP/36737/121/DU

Course : Masters in Project Planning and Management

Title of Study: ***EFFECT OF Family Planning ON MATERNAL  
HEALTH in Wakiso Sub-County, Wakiso  
District.***

#### Ethical Review Checklist

##### The study reviewed considered the following:

- Physical Safety of Human Subjects
- Psychological Safety
- Emotional Security
- Privacy
- Written Request for Author of Standardized Instrument
- Coding of Questionnaires/Anonymity/Confidentiality
- Permission to Conduct the Study
- Informed Consent
- Citations/Authors Recognized

**Results of Ethical Review**

\_\_\_ Approved

\_\_\_ Conditional (to provide the Ethics Committee with corrections)

\_\_\_ Disapproved/ Resubmit Proposal

**Ethics Committee (Name and Signature)**

Chairperson \_\_\_\_\_

Members \_\_\_\_\_

### **APPENDIX III**

#### **INFORMED CONSENT**

I am giving my consent to be part of the research study of Ms Nabirye Susan Liz Tabura that will focus on Supervision and Teaching Efficiency.

I shall be assured of privacy, anonymity and confidentiality and that I will be given the option to refuse participation and right to withdraw my participation anytime.

I have been informed that the research is voluntary and that the results will be given to me if I ask for it.

Initials: \_\_\_\_\_

Date \_\_\_\_\_

**APPENDIX IV**  
**RESEARCH INSTRUMENT**

**DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS**

**Gender** (a) Male (b) Female

**Age** (a) 18 (b) 18-25 (c) 25-35 (d) 35-51 (e) 51 and above

**Marital status (please tick)**

1. Married (a) single (b) divorced (c) separated (d) widow/  
widower

**Education Qualifications**

1. Not educated at all
2. Certificate
3. Diploma
4. Bachelors
5. Masters
6. Ph.D

## Section B: Section B: Family planning

**Directions:** Please follow the direction and fill in the space provided below with your best option, indicate your best choice by using the rating system below:

Response Mode	Rating	Description
Strongly Agree	(4)	You agree with no doubt at all
Agree	(3)	You agree with some doubt
Disagree	(2)	You disagree with some doubt
Strongly Disagree	(1)	You disagree with no doubt at all

### Accessibility

1 \_\_\_\_\_ You always have enough family planning service providers in your area

2 \_\_\_\_\_ The family planning centres are extended near to your area

3 \_\_\_\_\_ The family planning service providers are always available in your area

### Quality

1 \_\_\_\_\_ It is always very cheap for you to buy contraceptives

2 \_\_\_\_\_ Family planning always help parents to produce children whom they are able to look after

3 \_\_\_\_\_ The type of family planning method you use helps you in spacing of your children

4 \_\_\_\_\_ Family planning always allow you to produce children whenever you want

5 \_\_\_\_\_ Family planning always change the age structure of your fertility

6 \_\_\_\_\_ Family planning service centres have organized workshops for you.

**Acceptability**

1 \_\_\_\_\_ You accepted to abstain from sex in fear of getting un wanted pregnancies

2 \_\_\_\_\_ You accepted to carry out withdraw/pulling out technique as your family planning method

3 \_\_\_\_\_ You made your own choice of using contraceptives

4 \_\_\_\_\_ You accepted to carry out long breast feeding as your family planning method

5 \_\_\_\_\_ You always use condoms as your family planning methods

## Section C: Section B: Maternal Health

**Directions:** Please follow the direction and fill in the space provided below with your best option, indicate your best choice by using the rating system below:

<b>Response Mode</b>	<b>Rating</b>	<b>Description</b>
Strongly Agree	(4)	You agree with no doubt at all
Agree	(3)	You agree with some doubt
Disagree	(2)	You disagree with some doubt
Strongly Disagree	(1)	You disagree with no doubt at all

1 \_\_\_\_\_ You always go for antenatal care every after a month.

2 \_\_\_\_\_ You can always receive antenatal services from any nearby health centre.

3 \_\_\_\_\_ You always read news papers and get knowledge concerning antenatal services

4 \_\_\_\_\_ You're always taught by doctors the way you should eat when you're pregnant

5 \_\_\_\_\_ You always attend the antenatal workshops organized by maternal health service providers.

6 \_\_\_\_\_ You always check on HIV status when your pregnant

7 \_\_\_\_\_ You always find it easy to access maternal health services in your area

8 \_\_\_\_\_ You always get complications when you're pregnant

9 \_\_\_\_\_ You always receive maternal health services from an international hospital

10 \_\_\_\_\_ Maternal health service providers always offer skilled medical attendance during child birth.

**Thank you so much**

## RESEARCHER'S CURRICULUM VITAE

### Personal Information

Name: Nabirye Suzan Liz Tabura  
Nationality: Ugandan  
Marital status: Married  
Address: P.O.BOX 26117 Kampala  
Phone: 0782471972  
Email: liz.suzan0@gmail.com

### Educational Background

<i>Institution</i>	<i>Award</i>	<i>Year</i>
Kampala international university	Masters in Project planning and management	2012/2013
Kyambogo University	Bachelors in adult and community education	2010
Kyambogo University	Diploma in teacher education	2005
Kyambogo University	Certificate grade III teachers certificate	1997

### Working Experience

2010 to date: Principal Rubaga Youth Development Association  
HOD ECD

2007-2010: Head Teacher Hope P/school

- Tutor Buloba PTC
- H.O.ECD
- Social worker Wakiso Health centre

2005 – 2007 - H.O.D Kabojja Junior School

