ASSESSMENT OF FACTORS HINDERING FAMILY PLANNING SERVICE UTILISATION AMONG WOMEN OF REPRODUCTIVE AGE IN MUBENDE TOWN COUNCIL

BY

MAGALA JOSEPH

BMS/0073/71/DU

MBChB (KIU-WC)

A DISSERTATION SUBMITTED IN TO THE SCHOOL OF CLINICAL MEDICINE AND DENTISTRY IN PARTIAL FULFILLMENT FOR THE AWARD OF BACHELORS DEGREE OF MEDICINE AND SURGERY OF KAMPALA INTERNATIONAL UNIVERSITY

MARCH 2013

DECLARATION

I hereby declare that, to the best of my knowledge, this dissertation is my original work and has never been submitted to this University or any other institution of higher learning for an academic award or publication.

I hereby submit it for the award of Bachelorof Medicine and Bachelor of Surgery.

AUTHOR:

……………………………. Date………………………………

MAGALA JOSEPH

This dissertation has been submitted for examination with the approval of the following supervisor

……………………. ….. Date………………………………….

DR. CHRIS OYOO.

Kampala International University, Obstetrician and Gynecologist

DEDICATION

This report is dedicated to my parents: My mother Mrs.NakibuuseKeviinaBusuulwa, my father Mr. Busuulwa Vincent, all my biological brothers(Kugonza, Mugamba) and sisters(Nakayiwa, Nakamatte, Sande, Nansereko and BirungiOlivia) and finally to my beloved one Mbabazi Bridget.

ACKNOWLEDGEMENT

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS AND ABBREVIATIONS

FP-   Family Planning

MOH- Ministry of Health

USAID-United States Agency for International Development

UDHS-Uganda Demographic and Health Survey

MOFPED-Ministry of Finance Planning and Economic Development

HH- House Hold

UBOS- Uganda Bureau of Statistics

UHMG- Uganda Health Marketing Group.

IUCD- Intrauterine Contraceptive Device

MTC –Mubende Town Council

WORA- Women of Reproductive age

OPERATIONAL DEFINITIONS

- ❖ **Not applicable**-   Respondents who were not fit for the proceeding questions of the questionnaire.
- ❖ **Owoobosobozi Bisaka**- He is the leader of his own religious denomination based in Kagadi-Muhooro Kibaale district

ABSTRACT

In Uganda about 755,000 women get unintended pregnancies each year, many of which end up in abortion and about 6,000 women die as a result of pregnancy related complications. A significant proportion of these deaths occur because women are not able to have healthy planned pregnancies and according to the Uganda Demographic and Health Survey, 41% of married women wish to space their pregnancies or want to stop child bearing altogether but are not using family planning methods because of the unmet need for family planning which include; fear of side effects, lack of knowledge and lack of access to family planning supplies.
The purpose of the study was to establish the factors hindering family planning utilization in Mubende town council.

It was found that women were highly aware of family planning and its benefits and many had ever used family planning methods (87.50%), but the dropout rate was high (21.30%) especially among married women (31.50%) due to lack of sustained information and counseling about FP , difficulties in accessing FP services, associated side effects (63.1%),negative attitude towardssome contraceptive methods(11.20%), scarcity of FP supplies(28.80%) and few working hours at the available health centers(open late and close early).

One of the nurses at a health units at MTC reported that the health unit hardly gets adequate supply of contraceptive methods visa vie the demand population and always experienced stock outs of the methods. Also there are two healthcentre II's that covers a population of 45,056 people in MTC which are insufficient to meet the demand and to offer family planning methods that require highly skilled expertise. Also long distance to the health units affect accessibility (12.5%) and financial constraints (13.80%) because family planning services in private clinics have to be paid for.

Many women use family planning in secrecy, thus inject plan which offers protection for a long duration (3months) was the commonly preferred because pills are hard to hide from spouses who are not supportive(42.5%). Among those using family planning only 23.50% had supportive husbands.

Therefore, despite the high knowledge about family planning and its initial utilization among women of reproductive age in MTC, there is a high dropout especially among married women, there is inadequate supplies of family planning in the few lower level health units that are

understaffed, open few hours and cannot offer family planning services which require specialized expertise.

In conclusion, there is need of continuous counseling about family planning, need improve awareness and participation of men in family planning services, government should

Improve on family planning delivery through staffing the health units ensuring that there are no stock outs.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Factors hindering family planning service utilization are those negatively affecting the appropriate use of contraceptive methods. They could be socio-cultural, economical, political, or in terms of resources among others.

In Africa, a large proportion of teenagers and even young adolescents are having children because there has been very low use of contraceptives among sexually active adolescents despite widespread knowledge(*Sapire,1988; Speiser et al 2001*).

This in part, may reflect both lack of interest in contraception among those who wish to bear children as well as socio-cultural barrier that attach stigma to the use of contraception by young women, and thus prevent them from having access to contraceptive methods (*Speizer et al 2001)* reported that only a small minority of adolescent women could identify their fertile period. The lack of understanding of the fertile period is a reflection of general deficit in basic knowledge about human reproduction and that such knowledge is necessary for the sexually active young people many of whom may have access to contraceptives.

According to projections, the population of Uganda (in low growth scenario) is estimated to increase from 28.6million in 2007 to 40.6 million in 2017; while (in high growth scenario); its estimated to increase from 30.2million in 2007 to 43.4million in 2017(*UBOS, 2007*).The annual population growth rate is projected to increase from an estimated 3.3% per annum in 2007 to 3.5% in 2011. At a growth rate of 4.5% per annum, the northern region experienced the fastest rate of population growth, the Eastern, Western and Central regions followed at 3.6%, 2.9%, and 2.8% respectively (*MOFPED, 2004*)

Every year Uganda loses about 6,000 women as a result of pregnancy related complications. A significant proportion of these deaths occur because women are not able to have healthy planned pregnancies. In Uganda, according to the Uganda Demographic and Health Survey, 41% of married women wish to space their pregnancies or want to stop child bearing altogether but are not using family planning methods.

Women may have unmet need for family planning because of various reasons including fear of side effects, lack of knowledge and lack of access to family planning supplies.

Many women bear children before they are ready to and have more than they can care for. About 755,000 women get unintended pregnancies each year, many of which end up in abortion. Every year about 297,000 women have unsafe abortions and 85,000 suffer from complications. Uganda has a high teenage pregnancy rate with about 25% of adolescents already mothers or pregnant with their first child.

Uganda has a total fertility rate of about 6.7 Children per woman and a population growth rate of 3.2%. If current trends continue, Uganda's population will reach 130 million by 2050. (*William Kituuka, March 2011*).

This could be explained by sustained unmet need for family planning in Uganda. The rising population in Uganda is a great worry to the government, a lot of attention must be shifted to family planning use. The government has tried to generate more incomes to run its programs but because of the uncontrolled population which is a threat to the few resources available, burden comes back to the government.

African women seem to have doubts on the best methods and choice of family planning. There are a range of methods, for women and men, but the range of methods for women are more and so many options may be confusing the majority of young, poor illiterate women.

Poor and marginalized women, particularly women living in rural areas, face significant challenges accessing family planning services. Young women face unique barriers as they can be inhibited from seeking family planning services by stigma and negative staff attitudes. The issue of contraceptives may expose teenagers to HIV/AIDS infection. In 2010, about 1527 girls carried out pregnancy test and 775 of them tested HIV positive and yet a reasonable number of these pregnancies were unwanted (*William Kituuka, 2011*).

Research also showed that one third of all maternal deaths could be prevented through family planning. Studies show that addressing the unmet need in Uganda could be expected to prevent 16,877 maternal deaths and about 1 million child deaths by 2015.
Investing in contraceptive commodities and services to fill all unmet need would result in

savings of US$ 112million (194 billion shillings) over what would be spent on costs associated with unplanned pregnancies and births. For every dollar spent, more than three dollars would be saved, thus contributing to national development and attainment of Millennium Development Goal 4 & 5 of reducing child mortality and improving maternal health.

1.2 PROBLEM STATEMENT

More than 200 million women worldwide currently seek to delay or avoid pregnancy, but lack safe and effective means to family planning. In some countries, the unmet need for family planning outruns the actual use, and the United Nations estimates that by 2050, contraceptive demand will grow by 40 per cent as record numbers of young people enter their reproductive ages.(*Werner Haug,2009*).

Despite decades of research and field experience with successful family planning programmes, global attention to this health intervention has dramatically declined in the past 15 years. This has led to less government support and funding for family planning programmes, risking couples' ability to space their births to their families' benefit. .(*Werner Haug,2009*)

With an annual growth rate of 3.4 percent, Uganda has one of the world's fastest growing populations, and experts say the country's public services are unable to cope.(*Charles Akena,2012*).

 Uganda's fertility and population growth rates are among the highest in the World, with four out of ten women of reproductive age having an unmet need for family planning. On average, rural Ugandan women have six children each. The unmet need for family planning remains highest among women in the north and in rural areas throughout the country.(*Francis KagoloandVioletNabatanzi,2012*)
The unfriendly environment at the service delivery points is weak. The policy environment is supportive, but service delivery needs to be strengthened through training, monitoring of policy and service delivery*,(Robina Biteyi,2012*)

Although the government plans to reduce the 'unmet need' for family planning from 40 percent to 10 percent by 2022; women are still considered to have an unmet need for contraception use even when they would wish to space their children's births or limit childbearing.

(*CharlesAkena,2012*)

According to the 2011 Demographic and Health Survey, almost all adults in Uganda can name one method of family planning but married women of reproductive age use any form of contraception (*Charles Akena, 2012*).

This is because many women of reproductive age are failing to get clear education about the effective use of family planning methods. Many women don't have easy and direct access to family planning services despite the government's effort to install the services at almost all hospitals. There are no enough qualified health care providers and practitioners committed to delivering family planning services in hospitals and the community at large (*William Kituuka,2011*).

1.3 STUDY OBJECTIVES

1.3.1 General objective.

To establish negative factors affecting family planning services utilization among women of reproductive age in Mubende town council.

1.3.2 Specific objectives

- ❖ To determine current utilization of family planning services among women of reproductive age in mubende town council.
- ❖ To identify FP methods frequently utilized by women of reproductive age in mubende town council.
- ❖ To find out where women of reproductive age in mubende town council access the family planning services.

1.4. RESEARCH SCOPE:

Geographical:

Mubende town council is found in Mubende district which is in Central Uganda, Mubende town council is made up of about 33 local council I (L.C I) and it's boarded by Madudu, Kitenga, Bageza and Kiyuni Sub counties. it has 2 health centres at the level of Health Centre II.

Content:

Longdistance**s** to the health facility, low level of education, poor health seeking behaviorsare among the factors affecting utilization of family planning services in mubende town council.

Time:

The study was conducted from December 2012 to March 2013.

1.5. CONCEPTUAL FRAMEWORK.

Accessibility of respondents' to services:

- Geographical access
- Distance
- waiting time
- Transportation and cost

Attitudes and beliefs of respondents:

-Rumors.

-Religion and cultural reasons.

-Lack of knowledge and awareness.

-partner influence

Utilization of family planning services.

Socioeconomic status of respondents:

-Employment status.

Demographic characteristics of the respondents:

- Age

- Educational level

- Religion

- Marital status

1.6 JUSTIFICATION OF THE STUDY

Giving people access to voluntary family planning saves lives and can help break the cycle of poverty, slow population growth and ease the pressure on the environment. It is a cost-effective development investment.(*Werner Haug,2009*)

The Uganda Demographic Health Survey (UDHS, 2011) report showed that only 26% of women of reproductive age were using modern contraception, yet over half of all pregnancies are unintended.

 1.8 million Women of reproductive age want to stop having children or to space their births (Jon Cooper,2012).

The country'Ss health services, already overburdened, are struggling to meet the demands of a rapidly growing population. The average Ugandan woman will have six children in her lifetime, while an estimated 16 women die in childbirth every day (MOH Uganda, 2012).

The need for contraception is particularly high among teenagers - one in four girls will give birth before the age of 19(*RobinaBiteyi, 2012*).

Contraception services must be increased to teenagers. It's only at 11 percent, (*Anne AlanSizomu, 2012*). Service providers should be increased across the country and recruit more personnel to offer these valuable services to women and teenage girls to especially aim at those who want and are unable to access.(*Anne Alan Sizomu, 2012*)

The high unmet need for family planning services represented by high rates of un-intended pregnancies and sexually transmitted infections as well as the ineffective and non use of contraception among sexually active teens and young adults suggests that some of those in greatest need of services are not accessing family planning clinics or programs (*Guttmacher Institute, 2006*). In particular a continued challenge among family planning programs in getting the highest risk populations to come to clinics, as well as ensuring that those who have come in the past continue to receive services and use methods correctly and consistently.

If all women in need of supplies were able to access them this would reduce unwanted pregnancies and prevent 84 to 85% of unsafe abortions (*William Kituuka, 2011*). Increasing allocations to family planning would reduce expenditure on social services because the resultant

low population would decrease the demands on government for clean water, food, education, healthcare and employment.(*William Kituuka,2011*)

1.7 SIGNIFICANCE OF THE STUDY

This study will be carried to identify the factors affecting family planning service utilization in women of reproductive age in Mubende town council. The information will therefore be important to determine and design future programs of educating and enriching the population with the knowledge about family planning and its utilization. The results obtained from this study will be disseminated to the Ministry of Health, District Health Officers, District Health Team, and the local residents of Mubende town council.

CHAPTER TWO

2.0 LITERATURE REVIEW

DEFINITION

Family planning (FP) is a voluntary and informed decision by an individual or couple on the number of children to have and when to have them, by use of modern or natural FP methods *(MOH, 2005).* It can also be simply referred to as having children by choice and not by chance. Modern FP methods commonly available include oral contraceptives, Depot Medroxy-Progesterone Acetate (DMPA) injections, Implants, condoms, diaphragms, Intra Uterine Devices (IUD) and voluntary sterilization (vasectomy and tubal ligation). The traditional methods include Lactational Amenorrhea Method (LAM) and Fertility Awareness Based methods (FAB).(*MOH,2005*)

Family planning is the practice of spacing children that are born using both natural (traditional) and modern (artificial) birth control methods. Birth spacing promotes the health of the mother, children and the father (*MOH Uganda, 2006*). Reproductive health is the right of men and women to be informed and have access to safe, effective affordable and acceptable method of FP of their choice. FP offers individuals and couples the ability to anticipate and attain the desired number of children through spacing and timing of their births (*MOH Uganda, 2006*).

It should be recognized that all couples and individuals have the basic right to decide freely and responsibly the number of children and their spacing. However, they should also have access to information and education in order to make an informed choice and the means to do so'.

The high prevalence of unintended pregnancies and sexually transmitted diseases among sexually active teens and young adults indicate the extent of unmet need for family planning services as well the ineffective utilization of contraception. It may as well suggest that some of those in greatest need of services are not accessing family planning clinics or programs. In particular, there is a continued challenge of identifying the highest risk populations to come to

clinics, as well as ensuring that those who have come in the past continue to receive services and use methods correctly and consistently (*Guttmacher Institute, 2006*).

In Uganda political leaders have a tendency to encourage high population rate and are therefore opposed to any strategy that would constrain population growth. However, the number of political leaders who believe in high fertility and the impact of their perceptions on family planning are not clearly known. There is need to educate political leaders on the impact of population growth and the integration of family planning services in all health and education activities and to support programs aimed at sensitizing people on the benefits of small families (*Nuwagaba et al 2009*).

In 2006 the *UDHS* highlighted the uptake levels for FP methods in Uganda. All women who had ever heard of a method of family planning were asked whether they had ever used that method while Men were asked about ever use of male methods, i.e., male sterilization, male condom, rhythm method, and withdrawal. The results showed that just over half (52 percent) of currently married women have ever used a contraceptive method, 42 percent had used a modern method, and 21 percent traditional method. The methods most commonly ever used by married women were injectables (27 percent), male condoms (16 %), pills (14 percent), and rhythm (13 percent) but other methods did not exceed 10%. Use of any method was highest among sexually active unmarried women, 75 % of whom had used a method at some time. Sexually active unmarried women were much more likely (55 %) to have used male condoms than either all women (18 percent) or currently married women (16 percent). It was also found that the proportion of married women who have ever used any method had increased over time especially with the use of injectables (doubled between 2000-01 and 2006). The use of male condoms by currently married women increased by 50 percent during the same period *(UDHS, 2006)*.

The contraceptive prevalence rate (CPR) is defined as the percentage of currently married women aged 15-49 who are using any method of family planning. According to the (*UDHS, 2006*) this is only 24%. Eighteen percent of married women are using modern methods, while 6 percent use a traditional method. Current contraceptive use is higher among sexually active unmarried women (54 percent) than among married women (24 percent) and in turn, among all women (20 percent).

By far the most commonly used method among married women is injectables, which are used by 10% of women. The next most commonly used methods are pills (3%) and rhythm method (3%). Female sterilization, withdrawal, and male condoms are each being used by 2 percent of married women. The mix of methods is very different among sexually active unmarried women, for whom male condom is by far the most commonly used method (27%), followed by injectables (13 %). Use of any contraceptive method generally rises with age, from 11% among married women age 15-19, to a peak of 29% at age 40-44, and then declines to 23% among women age 45-49. The most popular methods among the youngest women are injectables and male condoms. Women in their 20s and early 30s tend to use injectables, followed by the pill, while older women are increasingly likely to be sterilized (*UDHS,2006*) .

Family planning remains limited by cultural factors, illiteracy and distance from government health units (*MFPED, 2004*). Male involvement in utilizing FP services is generally low; accompanied by negative attitude towards allowing their partners to access such services. One of the reasons given for this is that men often see children as a source of wealth (*UPPAP, 2002*). However, people with many children are unable to save and find it prohibitive to provide adequate nutrition and health care for every member of the HH. High fertility has particularly a negative impact of maternal health, thus influencing a mother's ability to adequately care for her children during both ante- and post-natal phases (*MFPED, 2004*).

The Uganda MOH summarized the key factors affecting family planning as follows: Women, their partners, and other family members often have misconceptions about the safety and efficacy of modern methods, shortage of skilled staff to provide FP, FP is rarely at the top of community's list of priority issues given economic realities and education levels. Also, those who decide to use family planning often find services difficult to access, health centres are few and far between, and health professionals are over stretched and often unable to focus adequate effort on family planning, the logistical systems are under developed leading to frequent contraceptive shortage, and the private sector often has no incentive to invest in the provision of contraceptives (MOH 2004).

 The study by *Mugisha et al 2007*, established that, service providers responses reflected lack of knowledge of the latest medical eligibility criteria and practice recommendations. This lack of training and skills limited methods they could offer. According to the report, many family

planning clinics had not stocked implants and intrauterine devices because they lacked trained providers who could insert them. Hence some providers were known to put conditions such as – a client must be menstruating before starting a contraceptive method. As noted by respondent in this study, this practice could result in unintended pregnancies and such providers could also administer a FP method to a pregnant woman.

Uganda is one of the countries with the highest population growth rate in the world, at a rate of 3.4% per annum. This immediately points to the need to take action to reduce the population growth of Uganda. In terms of designing the overall message, there is need to highlight the population growth rate in comparison to Uganda's neighbors. The messages need to be targeted to the regions with the highest growth rates, such as Northern Uganda. In recognition that the population is young, the messages should reach out to this category since these will also contribute to further population growth unless they are brought on board with FP messages right from their youthful years. One suggestion was to incorporate FP into the educational curriculum, right from primary school (*Mugisha et al 2007).*

 Uganda is one of the countries with the highest fertility in Africa and at global level. Lowering of fertility should hence be a key communication message and various messages should be crafted to target different population categories. The campaign should prioritize women in the poorest households with a fertility of 8.0. These groups should be made aware of the advantages of lower fertility of their counterparts in the wealthier households at 4.9. The campaign should also target rural rather than urban areas and households dependent on agriculture since these also experience higher fertility (*Mugisha et al 2007).*

In Sub Saharan Africa the median age of first birth is at 18.5 and teenage pregnancies are very common at a rate of 25% of all pregnancies. Thus, the primary audience is to keep the girl child longer in school other than focusing on parenthood. The new FP campaign can also pick on the differences between the actual and wanted fertility rate and unwanted or unintended pregnancy (*Mugisha et al 2007).*

Sexually active unmarried women, who are mostly adolescents or women in their 20s and who are particularly affected by an unplanned pregnancy, have a great need for better education on sexual and reproductive health and prevention of unplanned pregnancy as well as improved

access to contraceptive services and supplies. Without comprehensive steps to improve the current situation, many Ugandan women will continue to risk their health and lives to end unwanted pregnancies by unsafe abortion. The quality and accessibility of family planning services in Uganda, including post abortion services and contraceptive counseling, must be substantially improved by the public sector (at the national, district and local levels), assisted by the private sector and nongovernmental organizations if current levels of unintended pregnancy and unsafe abortion are to be reduced(Ahmed FH et al 2005)   .

Quality sexuality education, family planning and reproductive health services, and access to quality contraceptive commodities in combination with less restrictive abortion laws are urgently needed to reduce unintended pregnancy, unsafe abortion, and associated maternal mortality and morbidity among youth (Bayer , Nicole et al 2011).

Misconceptions and myths about possible side effects of modern methods, particularly the pill and IUD, are obstacles to their use, suggesting the need to improve education about family planning methods in Uganda. Lack of support by a spouse or partner also contributes to low levels of contraceptive use among Ugandan women. In qualitative studies, many women report that their partners are not supportive of contraception. Evidence also suggests that couples rarely discuss family planning. Focus group discussions with Ugandan men and women reveal that men believe that responsibility for family planning lies with women, while women say that their husbands prevent them from using contraception (Ahmed FH et al 2005) .

However, recent studies have shown that uptake of family planning services is increasing, albeit slowly (*Charles Akena,2012*).
More women are accepting modern family planning methods and there is now a shift from short-term to long-term family planning methods. Women are moving from pills and injectables to implants and IUDs [intrauterine devices]. (*Betty Kyaddondo,2012*).

Over the years, family planning efforts in Uganda have focused primarily on women yet women's use of family planning methods often depends on their partner's approval and support. thus, family planning methods programs must involve men and encourage them to support women in use of modern contraception— for example, by setting up services that are male-friendly and that encourage men to accompany their partners((Ahmed FH et al 2005) .

Men should therefore be brought on board to support their women in this effort of family planning. The women are secretly going for these services because their men don't support contraceptives (*Kyaddondo,2012*).

Family planning products are readily available in the country, with protector condoms reaching 77% of its Good Life clinics and injectaplan reaching 60%.(*Emily Katarikawe,2012*).

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

The chapter describes an overview of the study methodology; it shows how the study was conceptualized and executed, the study design, sample size determination, study population and data collection tools that were used. It also explains the sampling methods, pre-testing data, ethical consideration analysis and problems that may be encountered during the data collection process.

3.2: Study area

This study was carried out in Mubende town council found in Mubende district which is in Central Uganda. Mubende District is bordered by Kyankwanzi District to the north, Kiboga District to the north east and Mityana District to the east. Gomba District and Sembabule District lie to the south, Kyegegwa District to the southwest and Kibaale District to the northwest of Mubende District. Mubende, the district headquarters, is located approximately 172 kilometers (107 mi), by road, west of Kampala, the capital of Uganda, and the largest city in that country. The coordinates of Mubende District are: 00 36N, 31 24E.The total area of Mubende is 4645 square kilometers with a reproductive population (15-49 years) of 87,298(20.0%) according to 2002, Housing and population census. The total population of Mubende town council alone was 24,418 according to the 2002 census. Mubende town council is made up of about 33 local council I (L.C I) and it's boarded by Madudu, Kitenga, Bageza and Kiyuni Sub counties.

3.3: Study design

It was a descriptive cross sectional study that involved use of questionnaires to collect data from females of reproductive age living in Mubende town council Mubende district.

3.4: Study population

The study population included females of reproductive age whose views were required for research.

3.5: Sample size determination

Sample size for that matter was calculated using Kish and Lesley formula.

$$N = \frac{(Z)^2 \times p \times q}{(d)^2}$$

N=desired sample size for population greater 10,000.

$\mathbf{Z}^2$=standard normal deviation usually set at 1.96 or 2 which corresponds to 95% to confidence level.

p=proportion in the population estimated to have particular characteristics

p=11.8% or 0.118

q=(1-p) = (1-0.118) =0.882

d=Degree of accuracy (0.05).

$$N = \frac{(1.96)^2 \times 0.118 \times 0.882}{(0.05)^2}$$

$$N = \frac{0.3998}{0.0025}$$

N=159.9 approximately 160 women/females

3.6: Sampling method

Simple random sampling method was used in which I moved to randomly selected homesteads/residential places and working premises where only females of reproductive age participants were interviewed using questionnaires and interpretation was made for those who did not understand the English language.

3.7: Data collection tools

Questionnaires, pens, big size envelopes

3.8: Data collection method

A interviewers' schedule was used for participants who could not read and write and a self administered questionnaire with different alternatives and spaces were to be filled according to the respondent's views/ideas. The questionnaire was interpreted to the local language for those who could not understand English. Four research assistants were trained to help in data collection.

3.9: Inclusion criteria

- o All women of reproductive age in Mubende town council who consented and assented to participate in the study.

3.10: Exclusion criteria

- o Mentally ill patients
- o Those who will not have consented and assented.
- o Very old patients above 50 years.

3.11: Data analysis and Presentation

Data was analyzed using micro soft excel and SPSS, summarized into percentages and presented in form of pie charts, tables,   percentages and graphs.

3.12: Ethical considerations.

An introductory letter was sought from the Dean of Clinical medicine and dentistry to the leaders of Mubende town council and local councils(L.C I) where the research was carried out. Privacy was provided by interviewing each participant independently and was assured of confidentiality. Informed was given to those above 18 years and those below assented.

CHAPTER FOUR.

4.1 PRESENTATION OF RESULTS

TABLE 1: SOCIO-DEMOGRAPHICS OF THE RESPONDENTS

AGE	FREQUENCY	PERCENTAGE
16-25	55	34.4
26-35	71	44.4
36-45	34	21.2
Total	160	100.0
RELIGION		
Catholic	96	60.0
Protestant	44	27.5
Muslim	15	9.4
Others(OwoobusoboziBisaka)	5	3.1
Total	160	100.0
OCCUPATION		
Civil Servant	2	1.2
Business person	46	28.8
Peasant	30	18.8
Others(house wives, maids, shop attendants)	82	51.2
Total	160	100.0
MARITAL STATUS		
Single	32	20.0
Married	118	73.8
Divorced/Separated	10	6.2
Total	160	100.0
HIGHEST LEVEL OF EDUCATION		
None	20	12.5
Primary	92	57.5
Secondary	38	23.8
Tertiary	10	6.2
Total	160	100.0

Most of the participants were between the age of 26-35(44.40%) followed by those between 16-25 (34.40%) and then 36-45(21.20%)

Most of the respondents were of the Catholic denomination (60.00%) followed by Protestants (27.50%), Moslems (9.40%) and then others (3.10%) like the traditional religion of Owoobusobozi Bisaka. Most of the respondents were House wives(51.20%),then Business ladies (28.80%), Peasants (18.80%) and lastly the civil servants (1.20%).

Most of the participants were married/cohabiting (73.80%) followed by those living a single (20.00%) life and then those who had separated/divorced (6.20%)

Most of the respondents had attained primary (57.50%) as their highest level of education followed by those of secondary(23.80%), then those who were not educated at all (12.50%) and tertiary level (6.20%) .

FIGURE1: SHOWING RESPONDENTS WHO HAVE EVER USED FP.
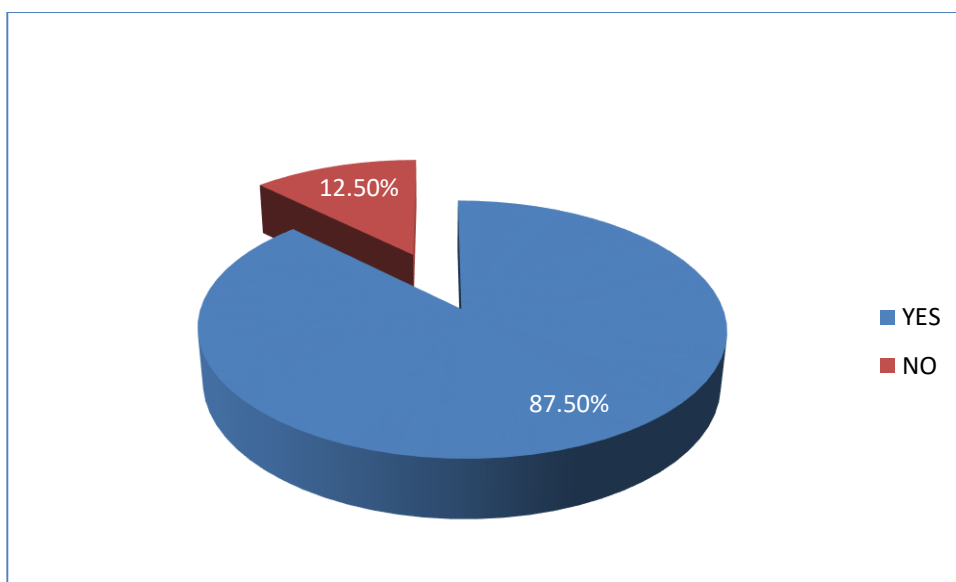
The figure shows that among the interviewed respondents only 87.5% had ever used family planning and 12.5% had never used any form of family planning

TABLE 2: SHOWS CURRENT FP UTILIZATION AMONG WOMEN OF REPRODUCTIVE AGE MTC

RESPONSE	FREQUENCY	PERCENTAGE
YES	106	66.2
NO	34	21.2
Total	140	87.5
Not applicable	20	12.5
TOTAL	160	100.0

The table shows that among the respondents who had ever used family planning services(87.5%), Only 66.2% of them were currently using family planning methods while 21.2% had stopped using family planning methods.

FIGURE 2: SHOWING CURRENT FAMILY PLANNING METHODS USED AMONG WOMEN OF REPRODUCTIVE AGE IN MTC
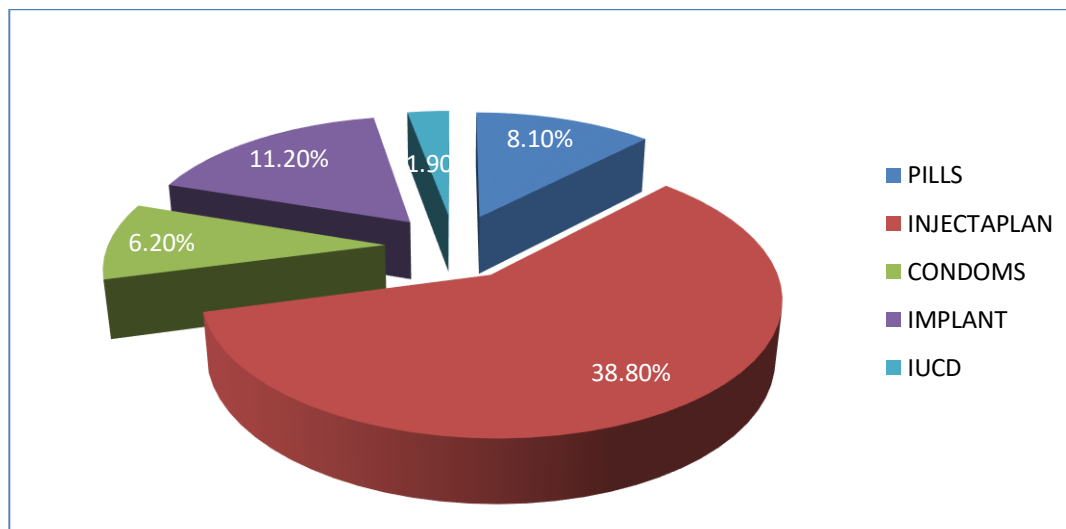
Currently, among the types of FP methods used by respondents/participants; Injectaplan(depo-provera) was the most used (38.8%). Other than Injectaplan, other modern FP methods (Condoms,pills, implants,IUCD) were used by 27.4% of the respondents currently utilizing FP services. 12.50% were not applicable to this question.

FIGURE 3: SHOWING RESPONDENTS WHO HAD PROBLEMS WITH ANY OF THE FP METHODS.
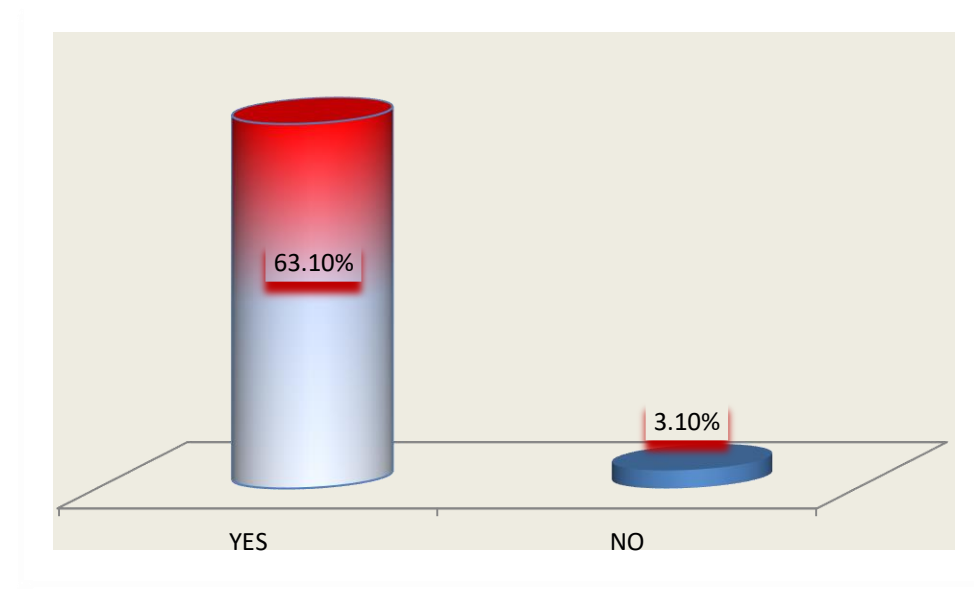
Of the 106 (66.2%) respondents who were currently utilizing FP, only 3.1% of these respondents had not had any problem or complaint associated with any of the FP methods. However, the largest percentage (63.1%) reported to have had several problems as it shall be discussed.

TABLE 3: SHOWING FP METHODS ASSOCIATED WITH PROBLEMS

	Frequency	Percent
PILLS	48	30.0
INJECTAPLAN	52	32.5
CONDOMS	2	1.2
IMPLANT	4	2.5
Total	106	66.2
Not applicable	54	33.8
TOTAL	160	100.0

Of all the methods that were currently being utilized, Injectaplan(32.5%) was the most associated with complications followed by Pills(Pilplan)-(30.0%) then Implants and condoms with 3.7% and no problem reported among those who used IUCDs.

TABLE 4:   A CROSS TABULATION OF AGE AND CURRENT FP UTILISATION

AGE GROUP	RESPONSE		
	YES	NO	Total
16-25	55	0	55
	100.0%	.0%	100.0%
26-35	50	21	71
	70.4%	29.6%	100.0%
36-45	1	13	14
	7.1%	92.9%	100.0%
Total	106	34	140
	75.7%	24.3%	100.0%

As reflected in the table above, 100% of the respondents in the age group 16-25 were currently using one of the family planning methods. 70.4% of the respondents in age group 26-35 were on family planning while 29.6% of this age group were not using any FP method . In the age group of 36-45, 7.10% of the respondents were currently using family planning while the largest percentage of this group(92.2%) had stopped. Therefore, being within the age groups 16-25 and 26-35 had a significant statistical association with FP than being in the age group of 36-45.

TABLE 5: A CROSS TABULATION OF RELIGION AND CURRENT FP UTILISATION AMONG WOMEN OF REPRODUCTIVE IN MTC

	RESPONSE		
RELIGION	YES	NO	Total
CATHOLIC	95	1	96
	99.0%	1.0%	100.0%
PROTESTANT	8	33	41
	19.5%	80.5%	100.0%
MUSLIM	3	0	3
	100.0%	.0%	100.0%
Total	106	34	140
	75.7%	24.3%	100.0%

The table above shows the comparison of family planning utilization and the respondents' religion. Catholics (99.0%) were the most users of family planning methods compared to other religions like Protestants among which only 19.5% were using family planning.

TABLE 6: A CROSS TABULATION OF OCCUPATION AND CURRENT FAMILY PLANNING UTILISATION AMONG WOMEN OF REPRODUCTIVE AGE IN MTC

	RESPONSE		
OCCUPATION	YES	NO	Total
CIVIL SERVANT	2	0	2
	100.0%	.0%	100.0%
BUSSINES PERSON	46	0	46
	100.0%	.0%	100.0%
PEASANT	30	0	30
	100.0%	.0%	100.0%
HOUSE WIVES	28	34	62
	45.2%	54.8%	100.0%
Total	106	34	140
	75.7%	24.3%	100.0%

From the table above, civil servants, business persons and peasants who had previously used family planning, were currently using it (100% for each group) while the house wives 45.2% were still using and 54.8% had stopped using family planning.

TABLE 7: A CROSS TABULATION OF MARITAL STATUS AND CURRENT FP UTILISATION AMONG WOMEN OF REPRODUCTIVE AGE IN MTC

| MARITAL STATUS	RESPONSE		
	YES	NO	Total
SINGLE	32	0	32
	100.0%	.0%	100.0%
MARRIED	74	34	108
	68.5%	31.5%	100.0%
TOTAL	106	34	140
	75.7%	24.3%	100.0%

The table shows that of the 108 married respondents, only 68.5% were currently using FP while 31.5% had stopped. On the other hand all the single women (100.0%) however few, they were still using FP methods.

TABLE 8: A CROSS TABULATION OF HIGHEST LEVEL OF EDUCATION ATTAINED AND CURRENT FAMILY PLANNING UTILISATION IN MTC

HIGHEST LEVEL OF EDUCATION ATTAINED	RESPONSE		
	YES	NO	Total
NONE	14	6	20
	70.0%	30.0%	100.0%
PRIMARY	92	0	92
	100.0%	.0%	100.0%
SECONDAR Y	0	28	28
	.0%	100.0%	100.0%
Total	106	34	140
	75.7%	24.3%	100.0%

Of the respondents (106), 75.7% were still utilizing FP while 24.3% had stopped **.**The highest current family planning users were those in primary(100.0%) followed by those who had not attained any education level (70.0%) , Education level therefore was less likely to be associated with FP use ,as reflected in the table above with a large percentage of the current family planning users being not educated and others having attained their highest level of education in primary.

FIGURE 4: SHOWING THE SOURCES OF FP METHODS
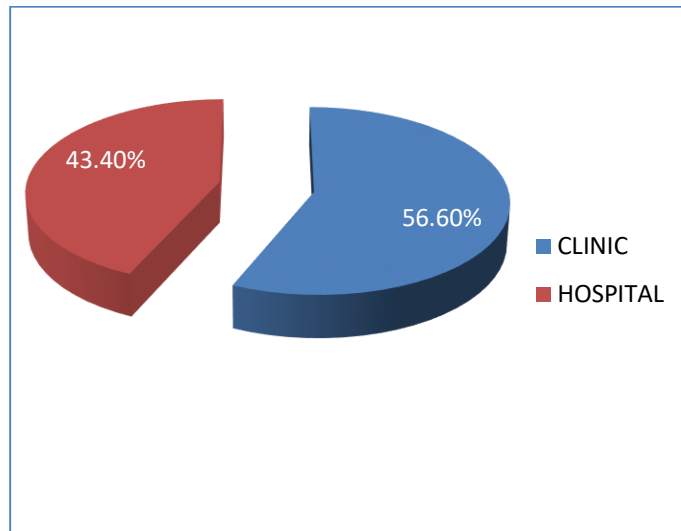
The figure above shows that the Clinics(56.6%) were the most providers of the family planning services followed by Hospital(43.4%) among the interviewed respondents .

TABLE 9: SHOWING RESPONDENTS WHO GOT REGULAR INFORMATION ABOUT FP SERVICES

	FREQUENCY	PERCENT
YES	52	32.5
NO	54	33.8
Total	106	66.2
Not applicable	54	33.8
TOTAL	160	100.0

The table above shows that among the respondents who got family planning services only 32.50% had received regular information about family planning and 33.80% had never received any information. This information could have been in form of family planning counseling.

FIGURE 5: SHOWING RESPONDENTS WHOSE PARTNERS SUPPORTED FP UTILISATION.
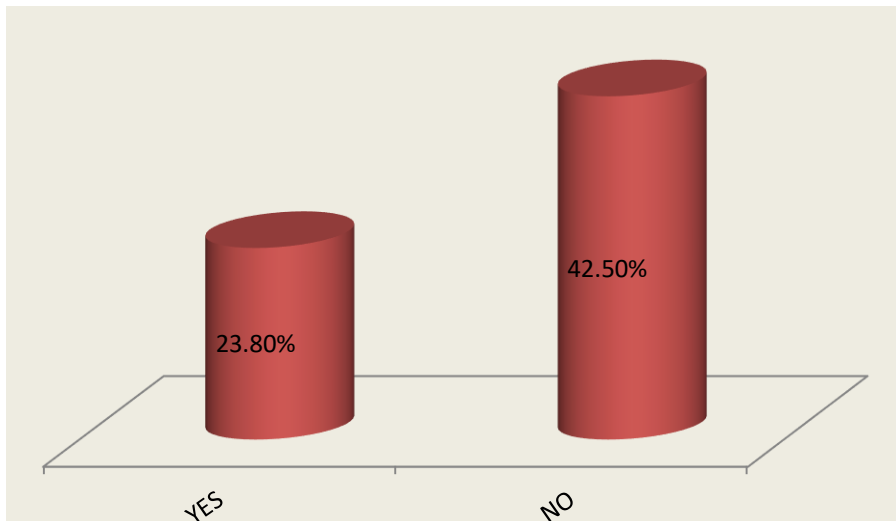
The figure above shows that among the respondents using family planning services 23.80% had their partners support family planning utilization while 42.50% of them had partners who did not family planning use.

TABLE 10: SHOWING RESPONDENTS WITH FP ASSOCIATED DIFFICULTIES.

|	FREQUENCY	PERCENT
YES	82	51.2
NO	24	15.0
Total	106	66.2
Not applicable	54	33.8
Total	160	100.0

The table above shows that 51.20% of the respondents using family planning had difficulties in accessing the family planning services while 15.00% had no problem/ difficulties.

TABLE 11: SHOWING DIFFICULTIES/ PROBLEMS IN ACCESSING FP SERVICES AMONG CURRENT FP USERS

PARAMETER	Frequency	Percent
FINANCIAL CONSTRAINTS	22	13.8
DISTANCE TO THE HEALTH FACILITY	20	12.5
SCARCITY OF SUPPLIES	46	28.8
OTHERS	18	11.2
Total	106	66.2
Not applicable	54	33.8
Total	**160**	**100.0**

Most of the current FP users were faced with Scarcity of supplies (28.8%), followed by Financial constraints(13.8%) and Distance to health facility(12.5%),then Others(11.2%) like Un supportive partners.

FIGURE 6: SHOWING THE SOURCES OF INFORMATION ABOUT FP
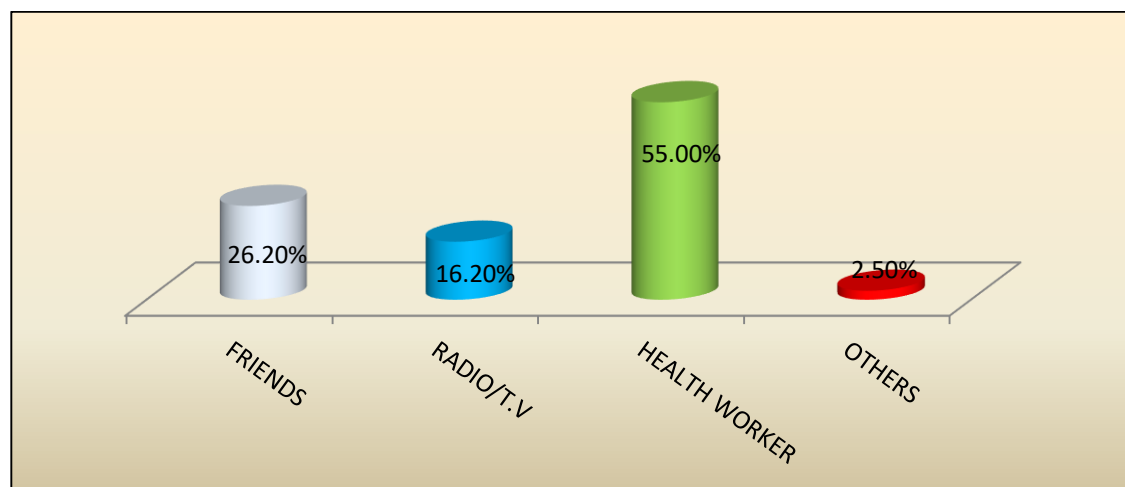
The figure above shows the most source of information about family planning among the interviewed respondents as health workers(55.0%) and Friends(26.2%) followed by Media like Radio/TV (16.2%) and Other sources(2.5%)

CHAPTER FIVE:

5.1 DISCUSSION

Use of any contraceptive method generally rises with age, from 11% among married women aged 15-19, to a peak of 29% at age 40-44, and then declines to 23% among women age 45-49(*UDHS, 2006*). The age group of respondents was between 16 to 45 years with most of them being in the age group of 26-35(44.40%) followed by 16-25(34.40%), then 36-45(21.20%), possibly because they are the most sexually active age groups and also most women get married or start cohabiting in these age groups thus have increased or high demand for family planning utilization.

The respondents were of different religious denominations with Catholics having the highest representation(60.00%),followed by Protestants(27.50%),Muslims(9.40%),then Others (Born again Christians and traditional religions(OwoobusoboziBisaka) (3.10%). Although different religions have a different perspective about family planning and Contraceptive use, when women are faced with family related problems and the possible outcomes of having un intended pregnancies, then the need to use family planning may seem to cut across all the denominations.

As indicated in the *UDHS 2006,* although women in Uganda are not using family planning, many are aware of it . 52.0% of the married women had ever used a contraceptive method, 42 .0% used a modern method, and 21 percent traditional method (*UDHS, 2006*).   This is currently true as respondents in MTC were aware of family planning with most of them (87.50%) having ever used one of the contraceptive methods and only 12.50% had not used any. The large percentage of awareness about family planning is possibly due increased availability of information sources especially radios, television and news paper were health workers get opportunity to educate the public about health programs including family planning. 55.00% of respondents had known about family planning from health workers, 16.20% from media .Also Friends (26.20%) are highly involved in sharing information about family planning.

Despite the high awareness of family planning and its primary use (87.50%), there is a high dropout. Only 66.20% of all those that had ever used FP were currently using while 21.30% had stopped . The reasons why women stopped using FP methods include; lack of sustained information and counseling about FP (33.80%), difficulties in accessing FP services, associated

side effects (63.10%) with at least one of the family planning methods. Women reported to have had problems mostly with injectables specifically inject plan (32.50%), pills (30.0%) then implants and condoms (3.70%).

The continued challenge among family planning programs is getting the highest risk populations to come to clinics, as well as ensuring that those who have come in the past continue to receive services and use methods correctly and consistently(*Guttmacher Institute,2006*). According to the (*UDHS, 2006*) in Uganda, the contraceptive prevalence rate (CPR) which refers to the percentage of currently married women aged 15-49 that are using any method of family planning, is only 24%.18% are using modern methods, while 6% use traditional method. Current contraceptive use was higher among sexually active unmarried women (54 %) than among married women (24 %) and in turn, among all women (20 percent). Similar findings were noted among the respondents in which all the unmarried/single women(100.00%) were currently using FP as compared to married women (68.50%) who were still currently using contraception. Thus, the drop out is higher among married women (31.50%) than the unmarried.

The commonest family planning methods used are, injectables (38.80%), implants (11.20%), pills (8.10%), male condoms (6.20%) and then others like IUCD (1.90%). Many women use family planning in secrecy, thus inject plan which offers protection for a long duration (3months) is preferred because pills are hard to hide from spouses who are not supportive(42.5%). The low level of condom use is possibly because some women were married, or because its interference with sexual intercourse and poor adherence to its use.

 MFPED 2004 indicated factors limiting family planning which included; cultural factors, illiteracy and distance from government health units.   Also *MOH Uganda (2004) found that* Women, their partners, and other family members often have misconceptions about the safety and efficacy of modern methods. Shortage of skilled staff to provide FP, FP is rarely at the top of community's list of priority issues given economic realities and education levels, those who decide to use family planning often find services difficult to access, health centres are few and far between, and health professionals are over stretched and often unable to focus adequate effort on family planning, Logistical systems are under developed, leading to frequent contraceptive shortage and the private sector often has no incentive to invest in the provision of contraceptives.

It was also found that scarcity of FP supplies(28.80%) contributed to the less utilization of family planning in MTC.

One of the nurses at a health units at MTC reported that the health unit hardly gets adequate supply of contraceptive methods visa vie the demand population and always experienced stock outs of the methods. In her words she said, "A woman secretly comes from far to pick a contraceptive to use for a longer time without her husband's notice, but can only be given monthly supply of Microgynon because you have to save for another one". Also, MTC has only two healthcentre II with only 4 enrolled nurses and takes care of a population of 45,056 peaple . Thus, limited family planning services can be offered due to under qualification.

The other difficulties faced in accessing FP services were financial constraints (13.80%), distance to the health units (12.50%) as some of the respondents reported to be coming far away from the town council health centers and so could go on for some time without accessing any form of FP method hence inconsistence in the use. There were other factors (11.20%) like mistrust of some contraceptive methods, few working hours of the available health centres (open late and close early)

The key factors affecting family planning according to the *MOH, Uganda 2004,* were that Women, their partners, and other family members often have misconceptions about the safety and efficacy of modern methods. Shortage of skilled staff to provide FP, FP is rarely at the top of community's list of priority issues given economic realities and education levels, those who decide to use family planning often find services difficult to access, health centres are few and far between, and health professionals are over stretched and often unable to focus adequate effort on family planning, Logistical systems are under developed, leading to frequent contraceptive shortage and the private sector often has no incentive to invest in the provision of contraceptives.

Male involvement in utilizing FP services is generally low; accompanied by negative attitude towards allowing their partners to access such services (*UPPAP, 2002*). According to Ahmed FH et al 2005, family planning efforts in Uganda have focused primarily on women yet women's use of family planning methods often depends on their partner's approval and support. Thus, family planning methods programs must involve men and encourage them to support women in use of modern contraception.Similarly according to Kyaddondo 2012, Men should be brought on board

to support their women in this effort of family planning. The women are secretly going for these services because their men don't support contraceptives. Many of the women in MTC had un supportive partners (42.5%) as far as FP utilization was concerned while 23.50% had their partners supporting them.

5.2 LIMITATIONS OF THE STUDY

- Time was not enough given the work load in class.
- Some respondents were not cooperative
- Limited finance. My sponsor was not supportive when urgent funds were needed.
- Moving long distances to reach some areas of residence

6.0 CONCLUSIONS AND RECOMMENDATIONS

This chapter presents conclusions and recommendations which are based on the findings of the study.

6.1 CONCLUSIONS

Majority of women of reproductive age in mubende town council were aware of FP and reported use of some method of FP.

There was a drastic fall out of most women as denoted by the decrease in the levels of those who had ever used and those currently using.

Persistent or Current Contraceptive use was more with the sexually active age groups especially among the single/unmarried women than the married.

Injectables (injectplan) were the most frequently used FP method followed by implants, pills and male condoms. Current use of modern contraceptive options other than injectables and implants was at 16.20%.

Knowledge about FP methods and approval of one's spouse were significant predictors of FP use. Other factors that were more likely to be associated with FP use were constant information and counseling, and access to FP methods.

Most clients were getting family planning services from clinics (56.60%) and from hospital (43.40%)

6.2 RECOMMEDATIONS

- ❖ There is need of more health centre's to provide health services and family planning services.
- ❖ There is also need for recruitment of more expertise (enrolled mid wives) in the field of family planning at the available health units to prevent understaffing.
- ❖ Need to improve on the family planning stock to avoid stock outs or shortages of contraceptives.
- ❖ More efforts in sensitizing the community of MTC about FP, and counsel about the associated problems especially among the married couples to reduce on the high rate of drop outs.

REFERENCES:

1.Mugisha, J.F., Reynolds, H., 2008. Provider perspectives on barriers to FP – A Qualitative study. FSRH J FamPlannReprod Health Care 2008: 34(1)

http://docserver.ingentaconnect.com/deliver/connect/ffp/14711893/v34n1/s11.pdf

2. The Ministry of Health (2006), The National Guidelines and service standards for sexual and reproductive health rights, Reproductive Health Division, Dept. of Community Health, MOH, Kampala

3. The Ministry of Health (July 2004), A strategy to Improve Reproductive Health in Uganda (2005 –2010), Reproductive Health Division, Dept. of Community Health, MOH, Kampala

4. Ministry of Finance, Planning and Economic Development, 2004, Discussion Paper 9, Population Growth and Poverty Eradication, Population Secreteriat, MFPED, Kampala.

5. Ministry of Finance, Planning and Economic Development, (2004 December), Poverty Eradication Action Plan, 2004/5 – 2007/8, Kampala

6. Ministry of Finance, Planning and Economic Development. (2006). State of Uganda's Population Report, 2006. Linking Population, Energy and Environment: A Critical Path to Poverty Eradication and Sustainable Development. Population Secretariat, UNFPA

7 .Ministry of Finance, Planning and Economic Development, 2008, National Population Policy for social transformation and sustainable development, MOFPED, Kampala

8. Williamkituuka. Com (March,19 2011)

9 .Reproductive health Uganda (RHU)   rhe@rhu.or.ug/fpau@fpau.org.ug.

10. Werner Haugh,Director of the technical division of UNFPA.International conference of Family Planning-Research and best practices.(12th November,2009)

11. FarazNaqvifpconferencemedia@gmail.com

Tel: +256 784 742 518 (active from Friday 13 November)

12. HuguesKonekone@unfpa.org

13. Charles Akena, Anne Alan Sizomu, RobinaBiteyi(National Coordinator of the Uganda Chapter of the White Ribbon Alliance for safe Motherhood),Betty Kyaddondo(Family health department in Uganda's Population Secretariat;Ministry of Finance and Economic development).Family Planning Pledges on the ground Action,12th October,2012.

14. Emily Katarikawe (UHMG Executive Director),New Vision December,15th 2012.

15. Ahmed FH et al., Reducing unintended pregnancy and unsafe abortion in Uganda, Guttmacher research institute 2005

APPENDIX1: WORK PLAN

ACTIVITY	TIME ALLOCATION
Data collection	Four weeks
Data analysis	Five weeks
Report writing	Three weeks
TOTAL TIME	Twelve weeks

APPENDIX 2 : BUDGET

ITEM	COST
Stationary	50,000/=
Typing	30,000/=
Internet services	50,000/=
Printing	100,000/=
Binding	30,000/=
Transport	20,000/=
Research Assistants	100,000
Miscellaneous expenses	100,000/=
TOTAL	480,000/=

MAP OF MUBENDE DISTRICT

MAP OF MUBENDE TOWN COUNCIL

EXISTING INFRASTRUCTURE

MAP OF UGANDA
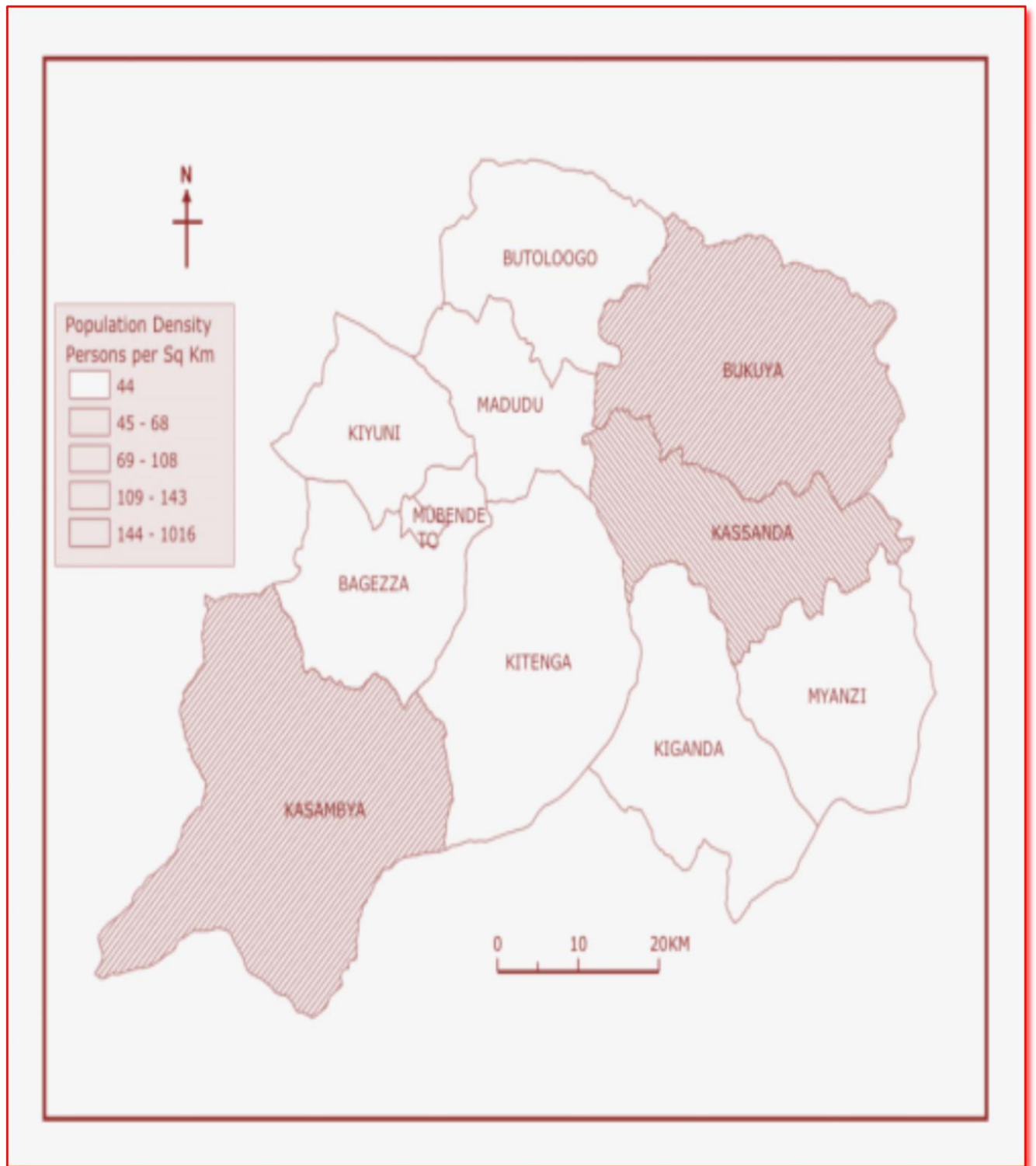
APPENDIX 3: QUESTIONNAIRE

A QUESTIONNAIRE TO DETERMINE THE FACTORS HINDERING FAMILY PLANNING SERVICE UTILISATION AMONG WOMEN OF REPRODUCTIVE AGE IN MUBENDE TOWN COUNCIL

I 'am MAGALA JOSEPH a student of Kampala International University, Uganda, carrying out a research on factors hindering family planning service utilization among women of reproductive age in Mubende town council.

 Your cooperation in answering these questions will be highly appreciated. All information obtained will be treated with confidentiality.

Signature …………………………………

Instructions

You are kindly requested to answer the following questions whose answers are solely required for research purposes. You are free to answer yes or no to the questions as they apply to you. There are no restrictions whatsoever about specific answers to be given. Confidentiality will be observed

Tick as appropriate

Age (years)   [✓]

16-25   [   ]   26-35 [   ]   36-45 [   ]

2. Religion

Catholic   [   ]   Protestant [   ]   Islam   [   ]

Traditional religion [   ]   others (Specify)…………………………

3. Occupation

Civil servant   [   ]   Businessperson [   ]   Peasant [   ]   Others (Specify) …………………

Marital status

Single [   ]   Married [   ]

Separated/ Divorced [   ]   Widow (   )

Highest Level of formal education of attained

None   [   ]   Primary [   ]   Secondary [   ]   Tertiary [   ]

Have you ever heard about family planning before?

       Yes [   ]   No [   ]

 7.   If yes, from Where?

        Friend [   ]   Radio/T.V [   ]   Health workers [   ]

 8. What does family planning do?

    Prevent unwanted pregnancy [   ]   stop conception completely [   ]

     I don't know [   ]   Others(specify)…………………

  9. Have you ever used family planning?

Yes [ ]   No [ ]

If NO go to 20

10. Are you currently using any family planning method?

Yes [   ]   No [   ]

If NO go to 19

11. If yes, which method?

Pills [   ]   Injectaplan [   ]   Condoms [   ]

   Implant [   ]   IUCD[   ]

   Others (specify)………….

12.Have you had problems with any of these methods?

Yes [   ]   No[   ]

13. If yes, which metohod?

Pills [   ]   Injectaplan [   ]   Condoms [   ]

   Implant [   ]   IUCD[   ]

Others (specify)………….

14. Where do you get family planning services from?

Clinic [ ]   Traditional healers [ ]   Hospital   [ ]

Others (specify)……………………………………………

15. Do you have any difficulty (ies) in accessing family planning services?

Yes [   ]   No [   ]

16. If *yes*, which one(s)?

Financial constraints   [   ]   distance to the health facility [   ]

Scarcity of supplies at the health units   [   ]   others (specify) …………

17. Does your partner support use of family planning?

Yes   [ ]   No [ ]

18. Do you always get regular information about family planning methods?

Yes [   ]   No [   ]

19. If you used family planning and stopped, why?

Wanted to have children [ ]   No easy access to the services [ ] Cost of the services[ ]
Associated side effects of contraceptives [   ]

20. If you have never used family planning, Why?

I want to have children [   ]   My religion does not allow [ ]

Personal/Cultural beliefs   [   ]   Unsupportive/Un willing partner [ ]
Others(specify)……………

THANK YOU VERY MUCH FOR YOUR COOPERATION