Kampala International University-Western Campus

Faculty of Clinical Medicine and Dentistry

Determination of Family Planning utilization among women of reproductive age, Bududa District, Uganda

A PROJECT SUBMITTED TO THE DEPARTMENT OF MEDICINE IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF BACHELOR OF MEDICINE AND SURGERY

By

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August, 2013

DECLARATION

I the undersigned, declare that this work is achieved through my personal reading under the informed guidance of my supervisor and has been submitted to you by her approval. To the best of knowledge it has never been submitted to any other college or university by anybody else for academic credit. All information from other sources has been duly acknowledged.

SIGN…… DATE……

WAMAKOTO LEO (RESEARCHER)

BMS/0223/81/DU

This project has been submitted with my approval as the university supervisor

SIGN …….. DATE……..

DR. SAIMA

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DEDICATION

I dedicate this work to my dear wife Agnes, beloved daughters Christiana and Isabella, my son Bellarmine, my Daddy Mr. Makonzo Peter, my missed Late Mum Florence Mary Nabutere (R.I.P), my brothers Joseph, Cosmas and Godfrey, Sisters Annet (R.I.P), Rose and Gertrude; My Nephews and Nieces, friends Peter, Paul, Isaa, Dauda, Alan and Dan.

You all mean a lot to me and thank you for being a special blessing to me.

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Finally I extend my appreciation to my classmates, friends and whoever has helped me along my exodus in education especially the motivation and support of my roommates.

May God bless you.

ABSTRACT

The study investigated into determinations of family planning utilization among women of reproductive age between 15 – 49year in Bududa district in Eastern Uganda. Five objectives and six research questions were used to guide the study.

The researcher carried out a retrospective descriptive study. Review or study of the available records was used in the collection of the data for the period between April 2011–May 2013.The study was aimed at documenting information on family planning utilization in Bududa district.It involved the use of district health and population records.

Data was analyzed, discussed, conclusions drawn and recommendation reachedby using descriptive statistics that included frequencies and percentages.The results were presented in statistical tables, short texts, pie charts and bar graphs.

A total of 34,880 women on contraceptives were noted out of 64,620 women in child-bearing age, which gave Bududa a considerable family planning uptake of 53.9% against national utilization of 24% and21% for rural domain.

The research however, paradoxically revealed that despite the commanding lead of 53.9%,family planning uptake in Bududa district,it had an annual population growth rate of 3.8% which is higher than the national growth rate at3.4% (Daily Monitor 12th July 2013),the rate of abortions is still high 373 (5%) coming 3rd among the top 5 causes of morbidity among inpatient women of child bearing age.The rate of obstetric surgical procedures were top most among major surgical procedures with caesarian section leading with 191(52.5%) and evacuations coming 4th with 09 (2.5%) among the top 5 surgical procedures conducted in the 2 years of the study, there were as well still undefined forms of contraception represented by 06 (0.025%).

The study revealed that the barrier(condoms)method was the most preferred form of contraception at 16,659 (70.7%) new users and 6,234 (53%) revisits, it was also evident that injectable form of contraception was the 2nd highly utilized at 5,101 (21%) new users and 32% revisits. Oral contraceptives were 3rd in the utilized, Oral Lo-Femenal1,178 (5%) new users and 92 (8%) revisits, Oral Microgynon with 586 (2.5%) new users and 537 (4.8%) revisits, Oral Ovrette 35 (0.14%) new users and 20 (0.2%) revisits, other undefined methods were represented by 06 (0.025%).

The study also revealed that family planning services in Bududa are directed at modern forms of family planning with no natural family planning services in the entire district. The research revealed the enormous performance of the CORPs who dispensed 43,392 (97.4%) of condoms against 42,300 (73.2%) dispensed at health units. However, methods which needed more technical skills like injectables 7,207 (12.5%) dispensed at health units compared to low 331 (0.74%) dispensed by the CORPs.Other methods like IUCDs, Oral and others were not dispensed.

It was evident that in Bududa most family planning surgical procedures were conducted on females with a prevalence of 52 (81.25%) of female sterilization (Tubaligation) against (0%)

of male sterilization(vasectomy) in the 2 years of the study. There were more implant removals 05 (7.8%) as opposed toimplant revisits 03 (4.7%).

In conclusion the data analyzed reveal a high level of utilization compared to the national statistics of contraceptive prevalence rate. However the findings still revealed:

- High annual population growth rates.
- High rates of abortions.
- High rates of obstetric surgical procedures.
- High population per sq. Km.
- Existence of undefined forms of family planning.
- Female biased forms of contraception.
- Total lack of natural family planning in Bududa district implies that there is still unmet demand for family planning services in Bududa and therefore a need to strengthen the existing efforts.
- Poor effectiveness of the use of family planning due to high levels of illiteracy

In that regard, the following recommendations were made**;**

- Community based strategies should be promoted rather than vertical approach in order to increase awareness, acceptability, availability, self-reliance and sustenance.
- Family planning service providers should adapt an integrated and comprehensive approach that accommodates Natural Family Planning rather than the sole promotion of Artificial forms of Family Planning that may medically be contraindicated, or cause high level side effects to some users or avoided on cultural, religious and moral beliefs.
- There is need to improve on family planning records so that information at hand can stand a test of proof in case data is contested by other national studies conducted in the same field that may have varying findings.
- There should be increased training of CORPs, VHC and CHWs from the current 250 to improve on service delivery.
- There is need to develop family planning approaches that target men since in African societies they are the determinants of family size.
- There is need to form women forums which can advocate for rights of women against influence of negative cultures and other social factors like inferiority and subordination to spouses.
- There is need for family planning service providers to orient their efforts to the needs and preferences of the users rather than focusing only on contraceptive methods of programme provider’s choice.

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Acronym/Abbreviations

NFP	:	Natural Family Planning
AFP	:	Artificial Family Planning
TFR	:	Total fertility rate
FP	:	Family planning
UDDHS	:	Uganda demographic data and health survey
WHO	:	World Health Organization
UNFPA	:	Uganda National family planning association
NSFGO	:	National study of family growth
NCDS	:	National contraceptive distribution study
IUCD	:	Intra-Uterine contraceptive Device
CORPs	:	Community Own Resource Persons
CHWs	:	Community Health Workers
CBA	:	Child Bearing Age
HFA	:	Health for All
VHW	:	Voluntary Health Worker
MCH	:	Mother Child Health
MOH	:	Ministry Of Health
NGO	:	Non-Governmental Organization
CPR	:	Contraceptive Prevalence Rate
UDHS	:	Uganda Demography and Health Survey

UBOS	:	Uganda Bureau of Standards
LAM	:	Lactation amenorrhea method
UNPF	:	United Nations population fund
BBTM	:	Basal body temperature
CMM	:	Cervical mucus method
POP	:	Progesterone only pill
COC	:	Combined oral contraceptives

CHAPTER ONE

INTRODUCTION

1.1Background of the problem

This chapter serves as a forward into the researcher's study. It places the problem into its context by breaking it into specific areas presented in various subheadings.

Family planning is the means by which the basic human group (family) is organized in accordance with its social, economic and psychological resources in order to achieve optimum health for all its family members. It therefore means having as many children as can be afforded to guarantee the family self-sufficiency when children are born.

This concept has been there throughout ages in differing cultures and societies starting as far back as B.C 1500in Egypt.

However, there has been a myriad of studies on contraceptives use with the aim of educating women and men on how to prevent unwanted pregnancies. On the contrary, there has been less recognition of importance of fertility management on peoples' development and independence, the many relationships that nourishes and supports them and for which they are responsible for the world they build and maintain around them and their families.

Family planning programmes tend to be more concerned with the welfare of society as a whole than with the welfare of an individual woman or man. Though china's one child policy is an extreme example, even industrialized countries have invested interest in eliminating the financial burden of unwanted children preventing induced abortions and reducing family size.

Women and men manage their fertility within a variety of contexts.These are their personal needs, goals and values, their interpersonal relationships, social norms and culture within which they live.

In consideration on contraceptive the methods available to women and men include normal methods like pills (COC and POP) DMPA and no Plant. Barrier method like condoms, diaphragm, spermcides and IUCDs Surgical methods like Tubaligation, Vasectomy which are permanent methods.

Natural family planning methods like LAM, CCM, BBTM, STM, Calendar method and coitus interruptus.

Some females also use traditional methods that is, use of herbs however, all these methods have varying physiological mechanisms, effectiveness, failure rates, side effects and contraindication. It is in this context that they provide women and men the means limited though they may be thought to manage their fertility as best as they can.

This research is founded on the perspective that contraceptive use is an issue of primary concern for both women and men. The research focused on the complexity of men and women's experience with contraceptives and how they affect their lives as a whole. Family planning services can play a fundamental role in trying to reduce total fertility rates in the world especially the 3rd World countries which can be evidenced in changes in people's

income, increased number of children going to school and overall improved standards of living of an ordinary person.

However, in Uganda like in most African countries, family planning is almost exclusively for women with still minimal participation of men yet in African setting men are the key determinants of family size.

Fertility management is an essential component of peoples' wellbeing. The use of a contraceptive method that is uncomfortable can affect a woman's life not only through the possibility of irregular use and unwanted pregnancies, but through decreasing the quality of life throughout the child bearing years.

The beginning of family planning activities in Uganda was marked by the incident visit of Edith Gates the executive director of pathfinder fund USA to Uganda in 1957.Therefore FPAU was the sole provider of FP till 1984 when the government saw the need for expansion. The Family planning policy was formulated and training of it was integrated into nursing and midwifery curriculums and in maternal health services.Todate services are available in major hospitals, health centers, dispensaries, private clinics, NGOs such as Mariestopes.

In this generally poverty stricken population, the struggle for survival tends to worsen with limited utilization of family planning services.This research was written from a specific perspective to address women and men who chose to use family planning services.

In Uganda like most Sub-Saharan African countries, reliable data shows very miserable health indicators including maternal mortality rate of 56 per 1000 live births, infant mortality rate of 88 per 1000 total births and under five mortality rates of 155 per 1000 total births (Uganda population and reproductive health 2007). Uganda is a home to nearly 30 million people; it has the third highest growth rate in the world at 3.37% per anum.

Its fertility rates are also among the highest in the world with an average rate of 6.7 children born by a Ugandan woman in her life time and data indicates that fertility rates are even higher in rural areas (7.1%) and among women who are poor and have little or no education.

The link between high fertility rates and limited social and economic growth is well established.Although more than 500 million married couples in the developing world are satisfied family planning users, another 200 million seek to delay or avoid to have child-birth are not using contraception.

The international conference on family planning and best practices held on (15^{th}- 18^{th} Nov 2009) in Kampala-Uganda, established that persistent unmet need for family planning can undermine achievement of all millennium development goals and compromise global efforts towards human development.

On October 30^{th} Nov 2009 Uganda marked safe motherhood day under the theme "Health timing and spacing of pregnancies "According to Uganda's demographic data and health survey 2006,Uganda's mortality rate stands at 435 per 100.000 live births, most of which

resulted from frequent un intended pregnancies, low contraception has been highlighted as one of the factors contributing to high mortality rates, unsafe abortions which arise from unintended pregnancies also contribute to maternal, neonatal deaths, high rates of population growth are largely a result of frequent child bearing or high fertility which is coupled with low family planning uptake in the country.

Family planning is one of the pillars of safe motherhood but unmet need for contraception rose from about 35% in 2001 to 41% in 2009.

Worse still the frequency of kwashiorkor and other nutritional deficiencies is high in families where births are many and closely spaced. “Maternal depression syndrome” is also a common problem in such families.

It sounds tragic but in WHO (1994) report, it was revealed that some 120million women are not practicing family planning despite their wish to avoid pregnancy. This applied mainly to Africa where needs of less than 1/3 of potential users are being met.

And the most revealing reality of the world’s inability to provide safe, accessible, acceptable and affordable family planning services is the fact that worldwide between 50 and 60 million pregnancies are terminated annually. Some 20million of these abortions are induced under unsafe conditions and at least 7000 women die every year as a result (WHO report 1994).

Another sad fact revealed by the UNDFA (1997) report is that the rate of unwanted pregnancies is still alarming. Of the average 175million pregnancies annually, 75 million are unintended, indicating that there is a lot of work to be done as far as family planning is concerned to improve the situation. The same report revealed that 50million unintended pregnancies are terminated annually; most of these are unsafe, very expensive and illegal. About 95% of these unsafe abortions occur in developing countries, causing death of more than 200 women daily.

The world fertility survey by (Sathar and Chidambaran, 1984) showed that use of family planning methods varied widely from 69% in south East Asia to 11% in Africa. The same survey further revealed that approximately 300million couples in reproductive age did not want more children but where not using any form of family planning method, these indicated a significant unmet need for family planning. The world population has become an acute emergency. This population expands by 30 individuals per second and is expected to double by 2050.

Paradoxically, the rate of growth of social services does not correspond with this high population explosion especially in the developing world. This has resulted into population related problems including environmental degradation, increased prevalence of communicable diseases and sanitation related diseases (UNFPA, 1997).

Uganda is no exception from these crises, unregulated population growth is of great concern, fertility and birth rates are still very high. There is an acute imbalance between resources and beneficiaries.

AUSPICE an NGO in Uganda recently noted that 45% of Ugandans are living below the poverty line and Bududa is not an exception. Small scale peasantry is the basic economic activity and life fundamentals like food, medication and education are difficult to afford. According to Mohammed and Rolf (1990), over the last 4 decades, there has been concern about rapid population growth and its negative impact on the quality of life. The result of this has been the establishment of institutions, policies and programmes to enable people regulate their fertility. In spite of such developments, population growth continues at unprecedented levels. Family planning is the most widely recognized method for checking population explosion and improving family health.

Sai(1986)states that, if family planning methods were more put in practice, up to 42% of maternal death could be averted in the developing countries. However, family planning methods not widely accepted and particularly in rural areas. The high fertility rate of 3.8% among women in Bududa, a district that is already densely populated with limited resources has serious implications which impede the improvement of family welfare and socio-economic progress in general, this is among the causes poor health situation in the district. Notwithstanding all efforts over the years, health indicators remain miserable. There are still many unwanted pregnancies and in particular teenage pregnancies are alarming and this can be qualified by unprecedented numbers of abortions. This therefore poses a fundamental challenge; there is still under utilization of family planning methods in Bududa and rural areas in Uganda in general.

The study also examined the role of man in reproductive health and hopes to discover the shortcomings in family planning programme implementation which may limit the choice or use of available contraceptive methods. It was against this background that the researcher investigated into why Family Planning utilization among women of reproductive age have not done much in decreasing fertility among women in Bududa district.

1.2 Statement of the problem

There is evidence that there is a sharp increase in the number of children who are born in the third world countries and yet poor family health remains a fundamental problem due to the fact that most people are either illiterate or semi illiterate. This explains why the general health status of most of these countries is abnormally low, bearing in mind that the family is the basic unit of the community. This research was therefore, intended to investigate into the utilization of family Planning services among women of reproductive age of 15-49 in Bududa District. The central question of investigation is:-“Why Family Planning services have not done much in decreasing fertility among women in Bududa District, Eastern Uganda?”

1.3 Objectives of the study

The objectives of the study were:-

General Objective

- To document information on family planning utilization in Bududa district between April 2012- May 2013.

Specific Objectives

- To ascertain the number of women of reproductive age (15-49) years using contraceptive services in Bududa district.
- To find out the distribution of components of family planning methods used among women on contraception in Bududa district.
- To examine the impact of the use of family planning services in Bududa district.
- To determine the level of acceptability of FP services in rural areas (Bududa as case study).

1.4 Research questions

This research attempts to answer the following questions:-

- Why have Family Planning services not done much to decrease fertility among women in Bududa District in Eastern Uganda?
- Is there any relationship between utilization of family Planning services among women of reproductive age (15-49) and the level of education?
- Is there any relationship between utilization of family planning services among women of reproductive age (15-49) and the level of awareness?
- Is there any relationship between husband oriented decisions and the utilization of family planning services among women of reproductive age (15-49)?
- Is there any relationship betweenthe utilization of family planning services among women of reproductive age (15-49) and cultural and religious beliefs?
- What is the impact of the utilization of family planning services among rural people Bududa?

1.5 Significance of the study

This research will significantly contribute to the understanding of actual work done by family planning implementers in Bududa district compared to other family planning national studies conducted by various research projects. By identifying the gap between the present performance and the desired, will go a long way in finding new strategies to bridge the gap.This work is also intended to enhance health care providers the ability to orient their efforts to the needs of and preferences of their clients rather than focusing only on the contraceptive methods and their characteristics ,that is their effectiveness and easy to use. The researcher believes that the family planning implementers will use his findings to make necessary adjustments that will enhance acceptability and affordability of family planning services hence the success of family planning programmes.The researcher also believes that his findings will be of great importance to future researchers who will be interested in the same field. This study is expected to act as a wayof serving as a learning experience for the

researcher; the findings of this study will be submitted to the MOE as a partial requirement for the fulfillment for the award of a Bachelors degree of Medicine and Surgery (MBchB).

Besides the research findings and recommendations could have a chance to benefit the community since one the private health facilities in Bududa had shown interest in considering to embrace recommendations reached in its reproductive health services.

The researcher also purposely selected a district of rural setting with a large catchment population in preference to Mbale and Bushenyi which would be other study districts but besides there mixed urban and rural populations they both have medical schools and study findings could probably be reproduced by other medical students who may could be researching on same topic or those who could have researched about in the previous years.

6.1 Scope and delimitation of the study

The scope of this study was from the year April 2011-May 2013 in finding out the utilization of family planning services among women of reproductive age between 15-49 years in Bududa district.

The researcher accounted multiple challenges in the cause of carrying out this research.

It took the researcher un expected time to access the health and population records as he was at first treated with some degree of suspicion but however this was resolved when he presented copies of an introductory letter from the university administration to the respective offices.

The research writing was done concurrently with the routine work load of the semester schedule, which was extremely demanding to the researcher.

The data provided for the research was not anywhere close to the literature reviewed in the text, and conflicting findings on other indicators complicated the discussion on further analysis.

Being a student, the research was straining in terms of cost, such that its success was big challenge to researcher.

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1.7 Definition of key terms

i. ***Contraceptive:*** Is a mechanism, device or substance used to prevent pregnancy.
ii. ***Women's Reproductive Age:*** This is a period during which a woman is able to conceive and generally considered to range from 15 -49 years although a few pregnancies occur before the age of 15.
iii. ***Vasectomy:*** Is the permanent surgical removal of the ducts through which semen passes from the testicles especially as a method of birth control.

iv. ***Child spacing or pregnancy spacing:*** Are both used interchangeably to mean use of family planning methods to postpone pregnancy until a couple is ready to have a child.

v. ***Prevalence:*** Is defined as the number of persons affected by a health indicator in the population at a specific period.

vi. ***Abortion:*** Is the deliberate termination or natural expulsion of a human pregnancy before it is able to survive independently.

vii. ***Morbidity***: Is the distribution or occurrence of frequency and pattern of health events in a population.

viii. ***STI*****:** A group of contagious conditions whose principal mode of transmission is by intimate sexual activity.

ix. ***Community:*** It is a group of people living in a particular place sharing a common interest, basic services, beliefs, social values and culture.

x. ***Primary Health Care (PHC):*** Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

xi. ***Research:*** Finding answers to questions in an orderly and systematic manner.

xii. ***Pills:*** Oral contraceptive.

1.8 Organization of the study

This study is divided into five chapters. Each chapter in the study contains an introductory part which in general tries to shed light on what the chapter actually consists of.

Chapter one contains, the background to the study, statement of the problem, objectives, research questions, significance of the study, the scope and delimitationand definition of key terms.

Chapter two, the researcher reviewed literature, which is related to the study. Chapter three encompasses the research design and methodology, which includes; the description of samples and sampling procedure, description of research instruments and methods of data collection and analysis. Chapter four presents the data analysis and interpretation. While chapter five gives the summary, conclusion and recommendation of the research.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

As already noted, there has so far been no research carried out on why Family Planning utilization among women of reproductive age have not done much in decreasing fertility among women in Bududa district. However, researches have been carried out elsewhere on the same or related to the subject. This chapter will try to focus on some of these prior research studies that are relevant to this study. It is hoped that this will enrich the study.

2.2 General studies of Family Planning Services

Sexuality and reproduction are naturally and inextricably bound with each of heterosexual intercourse between two fertile individuals, there is a possibility of beginning of a new life if the necessary physiological factors are normal. Now we however, live in a world in which there is increasing number of offspring's especially in third world countries with limited resources to sustain the explosive population growth. Family planning is the means by which the basic human society (family) is organized with its social, economic, and psychological resources in order to achieve maximum health for all its family members. It therefore signifies having children who are wanted and at what time in order to guarantee family's self-reliance.

This concept has been in existence worldwide throughout ages in widely differing cultures and societies. It started far back as in 1500BC in Egypt where methods including jumping up and down and breath holding during coitous by women and using condoms in form of sheep's skin or goat's bladder.

In Uganda, the method practiced by the Itesotswas where a wife after delivery would stay in her mother-in-law's house for one and half years and a husband found it too hard to have sex with such a wife and if one did so he would be considered to have committed a serious offence and would pay a heavy penalty. Similarly among the Banyankole in South West of Uganda, a young girl would be severely be punished and banished if she became pregnant in an effort to scare and discourage early unwanted pregnancies.

Among the Kikuyu of Kenya, a method called "Thingira" was used where a woman after delivery would be barred from visiting her husband for a period of 3 years. However all these methods had little impact on controlling unwanted pregnancies especially among the unmarried and population explosions warranted a need for better reliable methods of contraception.

In Uganda family planning activities were introduced by Family Planning Association of Uganda (FPAU) following the incidental visit of Edith Gates –the Executive Director of Pathfinder Fund of USA to Uganda in 1957.And two years later, the Almatta declaration was adopted at Kasangati HCIV in Mpigi district.

The economic impact caused by inadequate potential of contraceptive practices on national savings and shifting dependence burden together with direct and indirect negative consequences like infant, maternal, neonatal deaths, HIV transmission to new born babies,unnecessary abortions, teenage pregnancies, school dropouts, low standards of living and population explosions are all established consequences of low contraceptive uptake. There is also still a high degree of lack of knowledge, poor attitude, and misperception among the people of Bududa based on my interaction with clients who seek reproductive services at White Cross Medical Centre.

In 1963, comprehensive child health (MCH) and contraceptives services were started in Mpigi district and later spread to the entire nation. Today contraceptive services are an integral part of PHC in most countries and in Uganda, these services are provided by the government and non-government owned institutions and facilited by the MOH and other NGOs. The government has and is still continuing to train personnel for purposes of improvement on sustainability of Family Planning services.

The success of family planning programmes in many African countries is affected by many factors; the major one is client compliance. Women who form the majority of clients face certain circumstances that make it difficult for them to obtain the health care they need even when it is seemingly available through a specific programme.Some of the circumstances relate to their status in many parts of the world. For example in most cultures, a woman may be unable to abstainreproductive health care without the consent of her husband. In some instances, the threat of domestic violence which the women face further deters them from seeking the care.

The study revealed that the available data indicates that the frequently used Family Planning methods preferred are Oral and Injectable Contraceptives, Norplant, Female Sterilization, IUCDs, Condoms and Foam tablets. The study revealed that, Natural Family Planning is the least form of Family Planning method used due to lack of adequate information about it.

Also the particular concern to most clients is the safety of various contraceptive, therefore the need to for knowledge and advocacy for Natural Family Planning which has no cost and no side effects.

Family planning services in Uganda are almost exclusively a women affair with very minimal participation of men, yet in African setting men are the key determinants of family size and child spacing. In this illiterate and poverty stricken population, the chances of offspring survival tend to get more limited with limited utilization of Family Planning services. The knowledge, availability, accessibility, cost effectiveness; related side effects of family planning programmes influence the outcome following its implementation.

Collins(1994) states that, in the Peoples' Republic of China, couples are limited to one child. In the USA, the family norm is two children. Sexual relationship holds couples together as they jointly operate a house and rise children, but once they have a desired number of offspring's, sexuality must be separated from reproduction. In western countries in which children are not easily integrated or coped with the high costs of housing, feeding, clothing,

and educating house hold members, the need for family planning has already been long developed.

Miiro F.A (1999:14), states that the Ugandan woman is faced with a high fertility rate averaging to about 7.5%. In contrast to 1.5% in developed countries, it has prompted the Ugandan government to increase spending on family planning services. He points out that, despite the efforts put forward, the utilization of family planning methods is still low in Uganda, with the unmet need for family planning services that is, the percentage of currently married women who wish to space their next birth or stop child bearing but who are not using contraceptive was at 41% nationally by 2009 from about 35% in 2001.

Given the complexity of the physiological connection between sexuality and reproduction, the possibility of thwarting the process is underrated by sexually active couples and perhaps by health professionals as well.

Rainwater (1960) pointed out that, it is only in western cultures and perhaps a segment of middle class is where the idea that those children should be attended to and specifically planned for in order to arrive at a certain time highly valued.And even in spite of the fact that societies need to control their population growth and couples need to limit the number of their children, the desire to have children come only when they have been planned for properlyas a dominant objective thought these societies.

Wethbridge and Wang(1992) observed that the act of intentionally conceiving a child can be so daunting a responsibility that couples might prefer to have it happen “accidentally”. Even in other cultures where the desire to limit children isprevalent children may be born as they are naturally or intentionally conceived, with contraception beginning only after the desired size of the family has been reached. This discussion is in support of the notion that preventing pregnancy is a complex and demanding task. Couples attend the need for contraception with varying degrees of comfort, diligence and success.

They further stated that methods to prevent pregnancy are relatively few and vary in effectiveness. They also vary in side effects and difficulties associated with their use. Couples who do not want to conceive may be restricted to artificial methods known to be most effective, whether pills, implants, injections, intrauterine devices (IUD), sterilization. However they may be medically contraindicated or side effects may be intolerable or use may be perceived as unethical. Various contraceptive methods have side effects that can be frightening and uncomfortable. The birth control pills and IUD may both change the woman’s menstrual cycle.The diaphragm may cause cystitis, spermicidal agents and condoms may cause vaginitis.Women and men have long deferred in their willingness or ability to accept the side effects and problems of these methods. For some the prevention of pregnancy is worth the discomfort, for others effectiveness and discomfort are given equal consideration. In depth interactions with women about their actual contraceptive behavior, women occasionally reported methods considered safe but perceived less effectiveness like breast feeding, coitus interruptus, douching and cervical mucus and calculation of fertile days of the menstrual cycle.

Gallon and Kee (1981) pointed out that, in a number of cultures, a large number of children are still considered necessary for family work and to guarantee care of the aging parents, more sons are especially valued. Number of cultural norms, belief influence will always challenge which contraceptive method will be tolerable to women and men and how they will feel and be treated as they deal with the health care system.

Schapera(1978) carried out a research in Botwana and indicated that specific potions were used by women to prevent pregnancy such as certain herbs (sometimes purgatives)that were being chewed or taken in tea after sexual intercourse by Botwanans.

Conley (1990) states that,the Religious norms and restrictions may be considered as a prohibition regarding birth control. For example, the Roman Catholics are prohibited from sexual behavior that may result in conception and thus all birth control is prohibited except abstinence during fertile days, thus natural family planning may be used by devoted Catholics.Those of the Mormon faith believe the more children you have the closer one is to God, yet they would thus be reluctant to limit family size. It is clear that those living in poverty have increased numbers of unwanted pregnancies with concomitant lack of access to contraception.

In the Monitor Newspaper (Thursday 11th2002) it was indicated that among artificial methods of family planning, pills, Injectaplan and condoms are socially marketed products that provided women with reproductive choices and enabled them to successfully space their children.

Another study carried out (Oct 2000) on national contraceptive distribution (NCDS), showed that pill plan and Inject plants were the leading oral and injectable forms of contraceptives in Uganda.

In a Newsletter (1998), as a result of population Secretariat ministry of finance and economic development on world population day, it was pointed out that family planning was introduced as a basic human right promoted to play a key role in reducing proportion of high risk pregnancy among mothers and birth ensuring child survival, enhancing the status of women and rising levels of income of individuals and families, alleviating poverty and ultimately improving the quality of lives and living standards of people.

According to Chief BisiOugunleye(1994), states that in networking women and Family Planning services,“If a woman is hungry, you cannot talk to her about family planning and if her child is dying you cannot talk to her about family planning”.Contraceptive use is influenced not only by the availability of services but cultural and economic factors as well. Programmes that combine family planning and development seek to address some of the underlying causes of increased fertility such as poverty, illiteracy, women’s low social status and survival rates for children.

In recent years, Mohammed and Fischer(1991), in their book, “The African Region of International Planned Parenthood Federation (IPPF)” has intensified promotion and support

from strategies using a community based family planning approach in order to increase availability and acceptability of family planning education and services. This approach is becoming widely accepted and several family planning associations are at different stages of implementing such programmes.

Standfieldet. al.(1986),they urge that health workers are likely to handle educated mothers differently and these mothers are likely to receive more health information and are also more likely to express their disapproval of poor quality services while illiterate mothers may not openly complain but in the end could abandon the service.

John Hopkins (2001) observed that, family planning helps women to protect themselves from unwanted pregnancies. Since 1960's family planning programmes have helped women around the world to avoid 400million unwanted pregnancies. As a result many women's lives have been saved from high risk pregnancies or unsafe abortions. In several developing countries where services have been taken beyond clinics, fertility rates have declined substantially.

He further notes that the knowledge, availability, accessibility, cost effectiveness and the related side effects of family planning programmes influence the outcome following its implementation.

2.3 Conclusion

These reports are important in the researcher's study. They highlight the current factors that could limit the utilization of Family Planning services in Bududa district and the fears and concerns of potential users about health related risks of available contraceptive methods. They have also aided to elaborate and give evidence on the lack of information on natural family planning services in the district.

The challenges towards family planning methods included illiteracy, cultural beliefs, religious beliefs, lack of support from the men towards birth controls and poor methods used in the dissemination of information on family planning services in the district.

Therefore, looking at Bududa district, emphasis has been placed on women's abilities other than collective values needed to perpetuate the way of life. All these challenges and in general, economic decline jeopardize the future of the families and children. The lack of the backing by the men towards family planning services deprive the women to keep health and strong.

CHAPTER THREE

3.0 RESEARCH DESIGN AND METHODLOGY

3.1 INTRODUCTION

This chapter outlines the methods that were used in carrying out the study. The researcher describes the design that was used in the investigation to answer the research questions. It took into account the research design, target population, description of the sample and sampling procedure, research instruments, data collection and analysis procedures.

3.2 Research design

The researcher used *ex post facto* design where information was gathered systematically since it included factual information as presented in district health and population secretariat records by reviewing different components of family planning methods used and other health indicators related to family planning. The research design demonstrates the whole plan how data elicited from the intended records in Bududa district, the category of the reproductive age was between (15-45) years. Tuckman (1978) and Wiersman (1995) point out that, in *ex post facto* research, the investigator examines the variables without manipulating them. Based on this theory, the investigator set to establish the utilization of family planning services among women of reproductive ages between 15-49 years. The process has already occurred. Ogula (2002:141) supports Tuckman and Wiersman by stating that, in this ex post facto research design, the investigator attempts to determine the cause of reason for the existing differences in the status. The design is *ex post facto* because the investigator attempts to identify the major factor which has led to a difference in two groups of schools after both the effect and the alleged cause have already occurred and are studied by the investigator I retrospect.

A researcher starts with observation of a dependent variable. He/she then studies the independent variables in retrospect for their possible relations to and effects on the dependent variable. The researcher has no direct control of independent variables because their manifestations have already occurred or they are not manipulable (Kerlinger, 1973). An *ex post facto* design was selected for this study because the variables for this study, that is, determinants and utilization of family planning index have already occurred.

3.3 Description of the sample and sampling procedures

The district has one (01) general government hospital, seven (07) health Centre III, six (06) health Centre II and two (02) registered private clinics from which the district health office of records gathered data which the researcher used in this study.

The record of study was on reports/stored information on the utilization of family planning services among women of reproductive ages between 15-49 years.

3.4 Description of instruments

The researcher used one instrument for data collection namely: the study of records or stored health and population records of Bududa district from which information on the utilization of family planning services among women of reproductive ages between 15-49 years from April 2011-May 2013 was abtained.

The researcher sought important information on Utilization of FamilyPlanning services in Bududa district, distribution of components of family planning methods,determining the level of acceptability, the fears and concerns of potential users about health related risks of available contraceptive methods, information on natural family planning services in the district and the attitude of men towards family planning services.

3.5 Data collection procedure

Permission and authority to conduct the study was sought and granted from the office of DHO. The researcher personally administered the study from records information. The study involved use of district health and population secretariat records, by reviewing different components of family planning services used and other health indicators related to family planning.

3.6 Data analysis procedure

To analyze data is to search and identify meaningful patterns in the data. Kerlinger and Lee (2000:192) point out that, analysis means categorizing, ordering, manipulating and summarizing of data to obtain answers to research questions. Whereas, data interpretation is putting meaning to the quantitative or qualitative presentations of the phenomenon you are trying to predict. Data was then presented in short texts, and statistical presentations in form of tables of frequency distribution were used to show the different patterns of data categories. These frequencies were translated into percentages. Also bar charts, graphs, pie charts, were drawn and based on to analyze, discussion developed to give Bududa a true representation of family planning utilization.

The researcher coded and presented data in form of explanations with reference to the district health and population secretariat recordsof reviewed different components. The data from records was then arranged orderly and accurately.

CHAPTER FOUR

4.0 DATA PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1Introduction

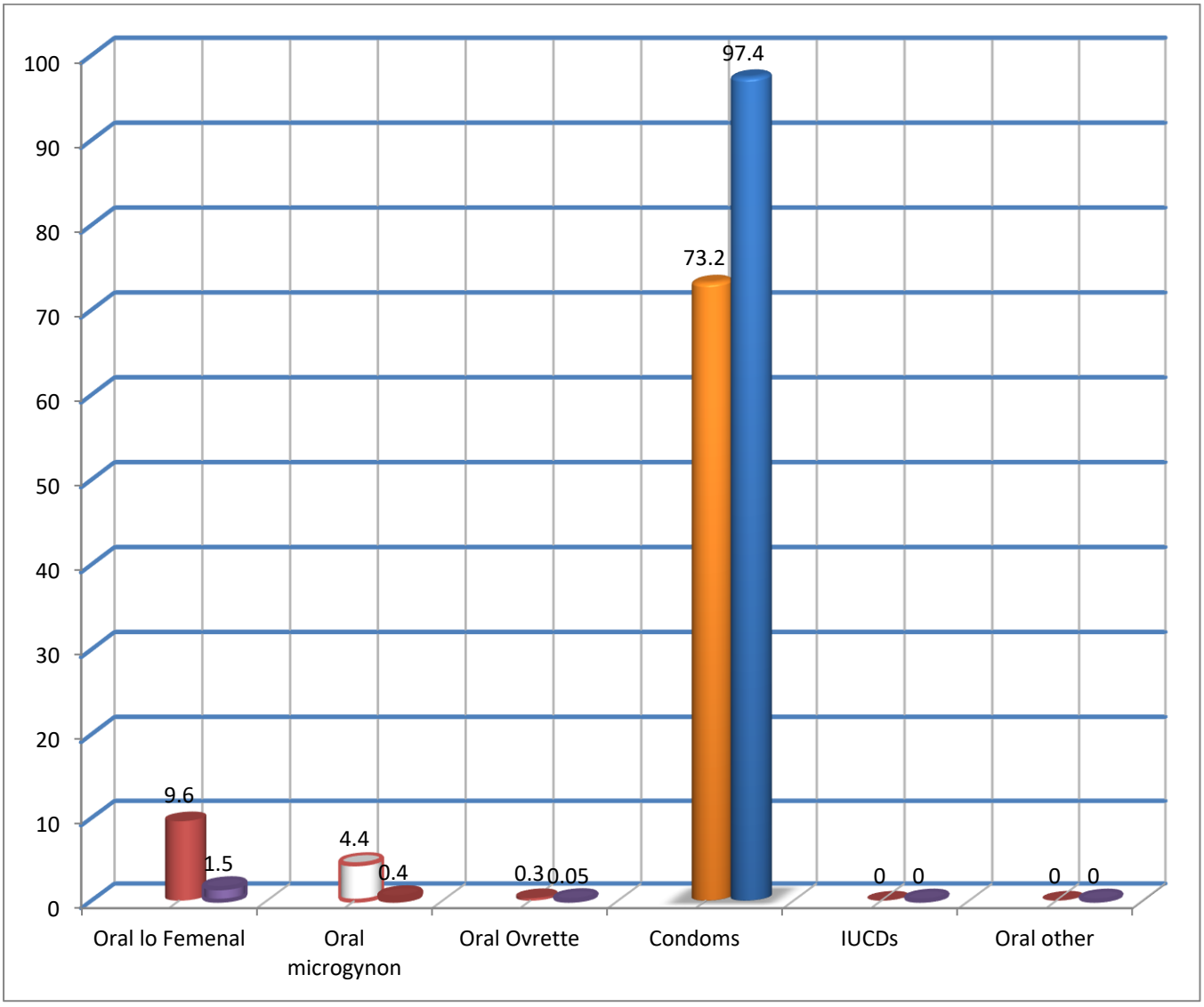
In this chapter, the findings of the study and their interpretation are presented. The findings are based on the collected data on the utilization of family planning services in women of child

Table 1: Showing distribution of components of family planning used in Bududa district

Methods	New Users	Revisits	% of New users	% of Revisits
Oral:Lo-Femenal	1178	892	5.0	8.0
Oral:Microgynon	586	537	2.5	4.8
Oral:Ovrette	35	20	0.14	0.2
Oral Others	00	00	00	00
Condoms	16659	6234	70.7	55
IUCDs(Copper T)	00	00	00	00
Injectables	5101	3632	21.6	32
Natural	00	00	00	00
Other methods	06	00	0.025	00
Total Family planning users	23565	11315	100	100

The component of family planning with the highest users was 70.7% for new users and 55% revisits, while Natural family planning, Oral Others and IUCDs (Copper T) were not used at all.

Fig 1 Showing distribution of components of family planning used in Bududa district between April 2011 –May 2013:



The component of family planning with the highest users was 70.7% for new users and 55% revisits, while Natural family planning, Oral Others and IUCDs (Copper T) were not used at all.

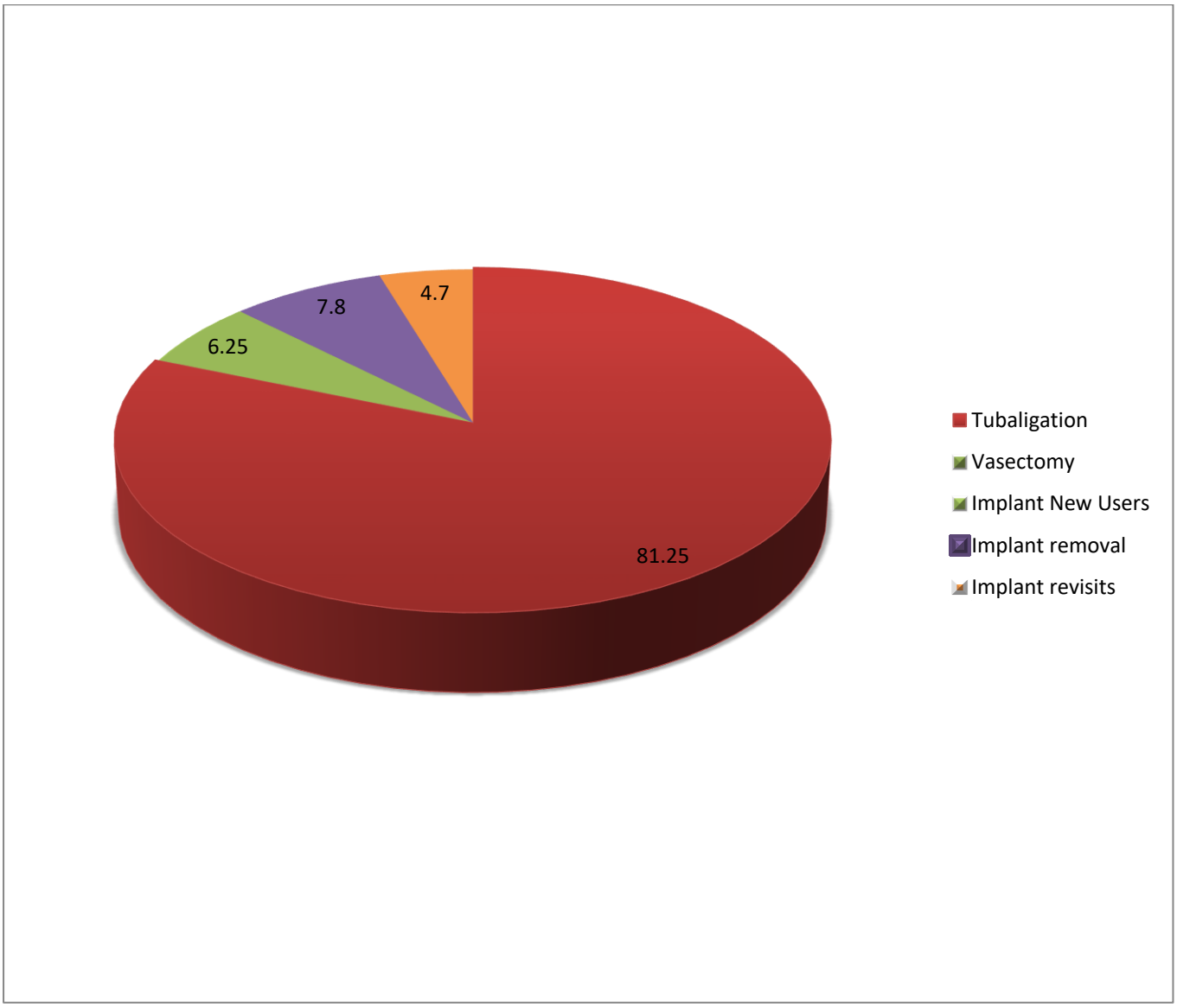
The highest component of family planning used are condoms at 16659(70.7%) of New users with a drop among revisits of 6234(55%) with no users of Natural,IUCDs and other Oral methods of family planning.

Table 2: Family Planning (F/P) Surgical Procedures Carried out in Bududa District between April 2011 – May 2013:

Category	Number	Percentage
Female Sterilization (Tubaligation)	52	81.25
Male Sterilization (Vasectomy)	00	00
Implant new users	04	6.25
Implant Removals	05	7.80
Implant Revisits	03	4.70
Total F/P procedures conducted	64	100

Majority of family planning surgical procedures conducted were female sterilization (tubaligation) at 81.25% and the least were implant new users while there were no male surgical procedures (vasectomy) conducted throughout the two years of the study period.

Fig 2:A Pie chart showing family planning (F/P) Surgical Procedures Carried out in Bududa District between April 2011– May 2013:



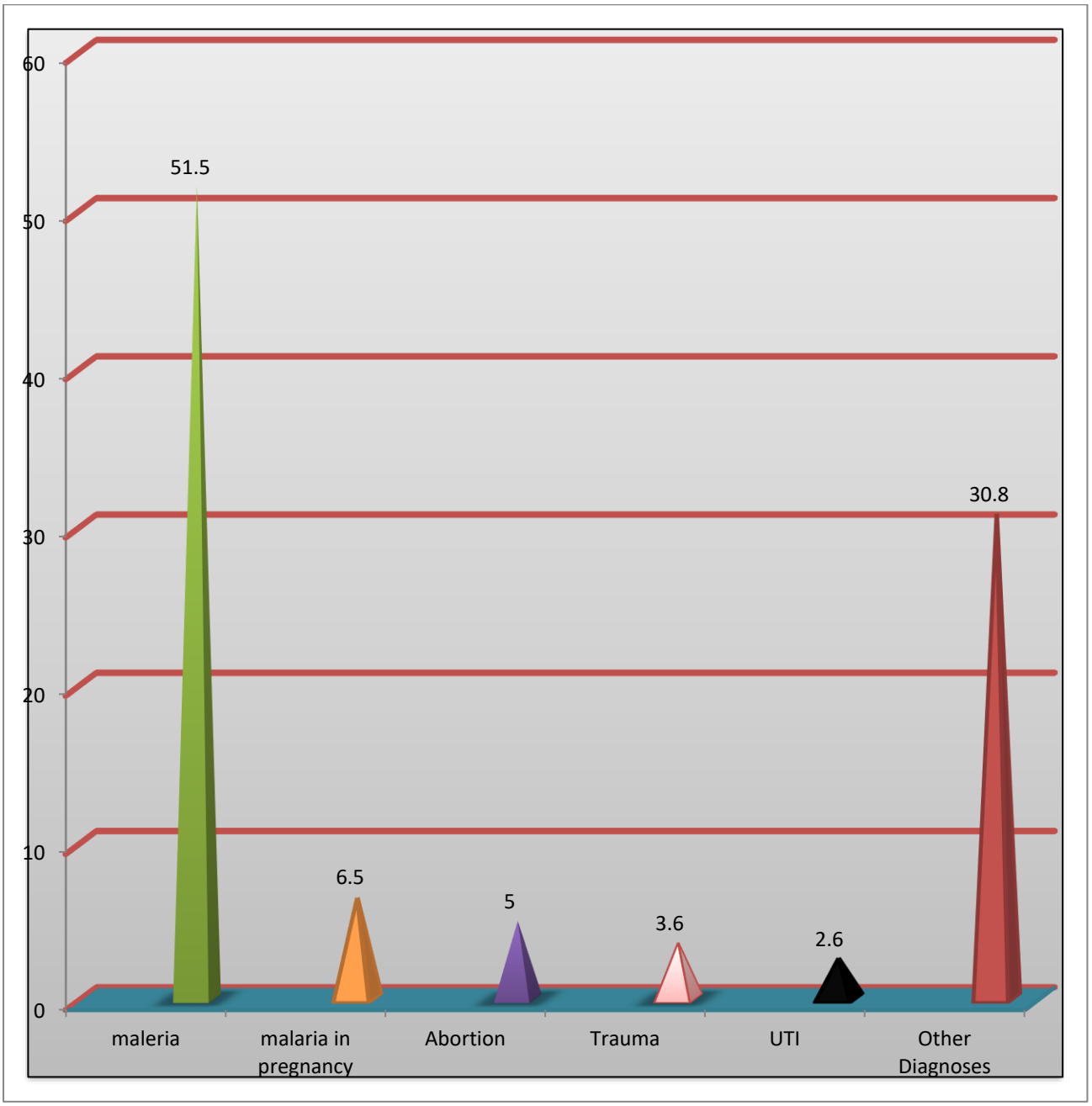
Majority of family planning surgical procedures conducted were female sterilization (tubaligation) at 81.25% and the least were implant new users while there were no male surgical procedures (vasectomy) conducted throughout the two years of the study period.

Table 3: Showing 5 Top causes of morbidity among inpatients in females aged 5 five years and above in Bududa district between April 2011 –July 2013:

Disease Condition	Number of new diagnoses	Percentage of new diagnoses
Malaria	3780	51.5
Malaria in pregnancy	482	6.5
Abortion	373	5.0
Trauma	256	3.6
UTI	188	2.6
Total rest of diagnoses	2266	30.8
Total all diagnoses	7344	100

Malaria was the highest cause of morbidity among the top five inpatients conditions among female patients with 3780 cases(51%) followed by malaria pregnancy with 482 case (6.5%) and abortion with 373 cases (5%) respectively.

Fig 3: A Graph Showing 5 Top causes of morbidity among inpatients in females aged 5 five years and above in Bududa district between April 20011–May 2013:



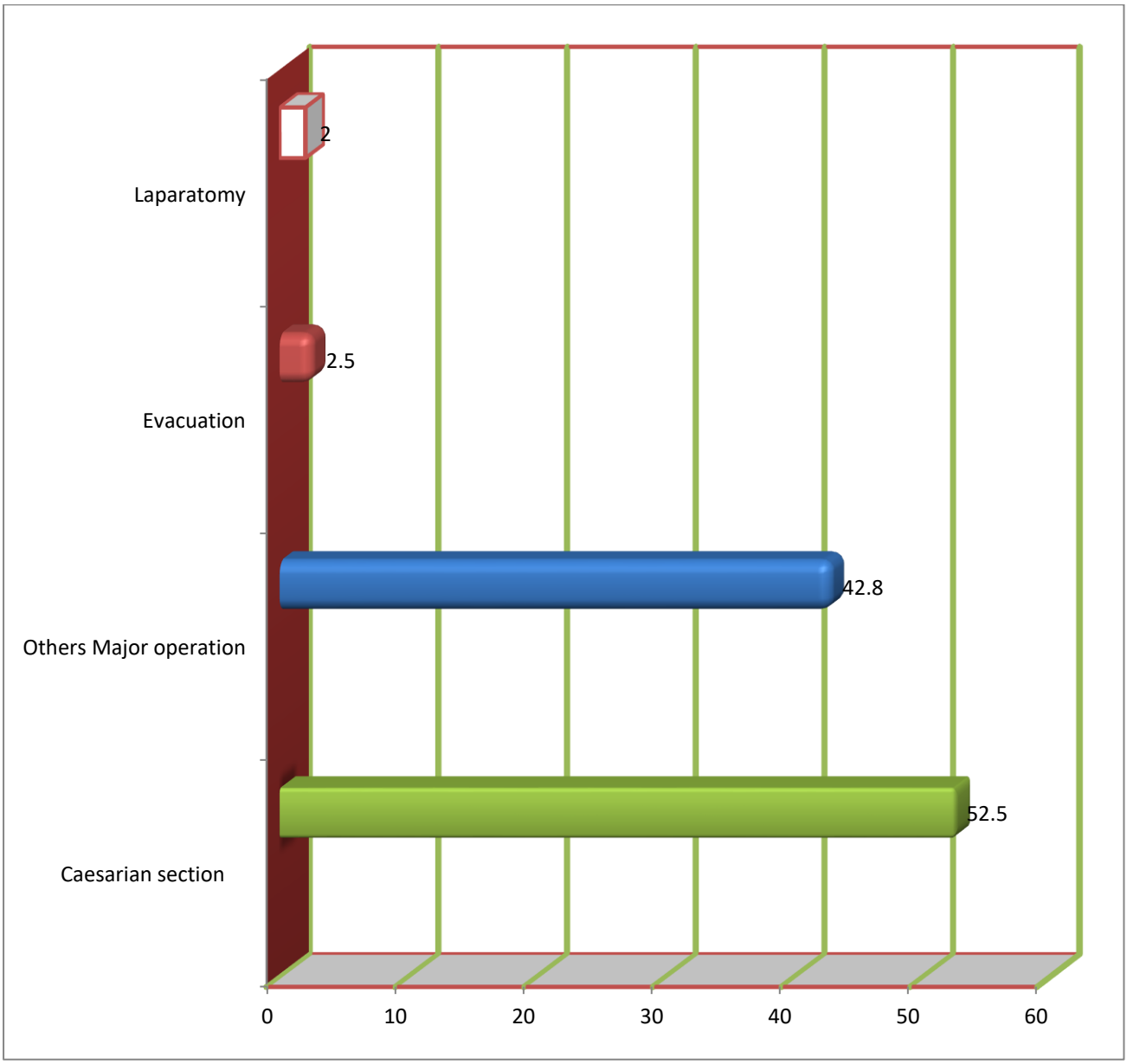
Malaria was the highest cause of morbidity among the top five inpatients conditions among female patients with 3780 cases(51%) followed by malaria pregnancy with 482 case (6.5%) and abortion with 373 cases (5%) respectively.

Table 4 : Showing Major Surgical Procedures conducted in Bududa district between April 2011–May 2013

Category	Number of procedures	Percentage of Percentages
Caesarian Sections	191	52.5
Other Major operations	156	42.8
Evacuations	09	2.5
Laparatomy	08	2.2
Total	364	100

The highest number of major surgical procedures that were conducted were caesarian sections 191 cases (52.5%) followed by 42.8 % of all other major procedures combined while the least conducted procedures were laparatomy 22.2% of the total 364 procedures carried out within the study period.

Fig 4: A Graph Showing Major Surgical Procedures conducted in Bududa district between April 2011 –May 2013



The highest number of major surgical procedures that were conducted were caesarian sections 191 cases (52.5%) followed by 42.8 % of all other major procedures combined while the least conducted procedures were laparatomy 22.2% of the total 364 procedures carried out within the study period.

CHAPTER FIVE

5.0 SUMMARY, CONCLUSION, RECOMMENDATION AND AREAS FOR FURTHER RESEARCH

5.1 Introduction

In this chapter, the researcher presents a summary of what he set out to do and the findings based on the study.

5.2 Summary

This chapter recapitulates the major themes that have emerged in the course of the discussion. The findings from secretariat records gave a clear picture about the determination of the utilization of family planning services among reproductive women of the age of 15-49 in Bududa district. The analysis of use of contraceptives at micro and macro level was identified. I have also dealt with the possible ways to advocate for the use of natural family planning to control child births among couples in Bududa.

The study also outlined some of the recommendations based on the findings of the research and I have proposed areas for further research.

Bududa is one of the districts of Uganda situated in the Eastern region of Uganda on the slopes of mountain Elgon and borders the Republic of Kenya in the East, district of Siroko in the North, Mbale in the West and Manafa in the South.The district is 97.2% rural setting and 2.8% in rural townships across the district.The district is has a total land area of 273.79km2 and this represents 1.41% of Uganda's total land area**.**

The district is administratively subdivided into Bushika, Bulucheke, Bududa, Bukibokolo, Bukigayi, Bumayoka and Bubita sub-counties which are the subdivided into parishes which are future spilt into villages to make the smallest administrative structure represented by a local council. Bududa district is a densely populated area with a dense population of 518 persons per km2 with a population growth rate of 3.8% well above the national growth rate and with a total population of about 167000 as per the 2010 census projections in relation to the 2002 Uganda National Population and Housing Census.The females are more than the males by a margin difference of 1578 as per the 2009 census projections.The Bamasaba dominate the indigenous population and constitute 98% of the population.Bududa district lies at an average of 1800m above sea level, on the slopes of Mt. Elgon with a relief characterized by volcanic cones, valleys, ridges and undulating scenery that ends in radial drainage pattern of rivers.

The diverse climate and topography of Bududa is infavour of the different economic activities carried out in the district in regard to those 2 factors. However majority of the people are farmers, growing both food and cash crops with coffee being the main income earning cash crops in the entire district.Some people rare animals (cattle) on zero grazing due

to limited land while a small population is employed in government and other people are involved in small scale business.

Demographic indicator is that the total population is 167000 of which 83000 are males and 8400 are females.The population density per. sq.km is 583 persons. The highest composition age group is 0-17years (56%).Annual population growth rate is 3.8% (higher than national); illiterate rate is 37.2%.

The health status indicators for the district are that the Bududa district has one general government hospital, 7 Health Centre 111, 6 Health Centre 11 and 2 registered private clinics and the population within > 5km from health facility is 32%.Population per health unit is at 12360.Doctor population ratio and Nurse population ratio just sickens one due to limited health workers in the such a highly populated district.

The utilization of family planning services in Bududa district are far above findings reached by several national studies as pointed out in the text.

There is a consistent increasing trend of f/p uptake in Bududa district between April 2011 – May 2013, a period of the 2yrs study.

The barrier (condom) method was the form of contraception with the highest number of users throughout the study period.

The Modern/Artificial forms of contraception (Injectables and Pills) were among the leading forms of contraception used by women in Bududa district.

Natural Family Planning (NFP) has not been promoted by f/p service providers as an integral measure in addressing contraception in Bududa district with no case registered under NFP.

Bududa has a high annual population rate of 3.8% that is well above the national growth rate.

There is still high rate of unwanted pregnancies, in Bududa as indicated by the high rate of abortions that is 3rd among top five causes of morbidity of total females admissions, high number of evacuations and caesarian sections that account for over 55.4% of the total major surgical procedures carried out during the study period.

It is evident that family planning services are almost exclusively a female issue as observed by the high numbers of female family planning surgical procedures 100% against 00% in males as well as high utilization of Modern family planning methods by women.

5.3 Conclusion

The study was concerned with the determination of the utilization of family planning services among women of reproductive age (15-49) in Bududa district. The research concluded by noting that, health workers and other family planning service providers should view family planning with a broad context, involving seeing its effectiveness beyond health centers and clinics by examining and bring services to the community, address social and individual

situations and create awareness on family planning utilization with special consideration to the rural women who are at utmost need.

They should set out to the community, empower people with knowledge so that the persistent unmet need 41% in Uganda of family planning services is recovered and Health for All (HFA) by 2020is released.

5.4 Recommendations

Having done a research on the determination of the utilization of family planning services among women of reproductive age of 15-49 in Bududa district, and having come up with some findings, the researcher made the following recommendation.

- Community based strategies should be promoted rather than vertical approach in order increase awareness, acceptability, availability, self-reliance and sustenance .
- Family planning service providers should adapt an integrated and comprehensive approach that accommodates Natural family planning rather than the sole promotion of Artificial forms of Family Planning that may medically be contraindicated, or cause high level side effects to some users or avoided on cultural, religious and moral beliefs.
- There is need to improve on family planning records so that information at hand can stand a test of proof in case data is contested by other national studies conducted in the same field that may have varying findings.
- There should be increased training of CORPs, VHC and CHWs from the current 250 to improve on service delivery.
- There is need to develop family planning approaches that target men since in African societies they are the determinants of family size.
- There is need to form women forums which can advocate for rights of women against influence of negative cultures and other social factors like inferiority and subordination to spouses.
- There is need for family planning service providers to orient their efforts to the needs and preferences of the users rather than focusing only on contraceptive methods of programme provider's choice.

5.5 Recommendations for further study

This research does not in any way claim finality. It is not exhaustive, there is much more on determinants, usage, effects and Family Planning contraceptives. What has been dealt with here is the determination of the utilization of family planning services among women of reproductive age 15-49 and the information given to the concerned. So there are other areas for further study that the researcher feels should be dealt with as out lined below:

- The study should be done on selected men of various categories on how men can be involved to appreciate family planning in Uganda.
- The simpler methods that semi illiterate and illiterate couples can easily understand and manage to use.
- Why there is still a high level of unmet utilization of family services in Uganda despite the available strategies.

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